Paper 11.0 (b)

Governing Body Meeting in Public

Thursday, 26 January 2017

Title: General Practice Forward View Plan	**Agenda Item: 11.0 (b)**
Presented by: Clare Steward, Director of Strategy & Transformation (Interim)	
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Responsible Executive Director: Clare Steward, Director of Strategy & Transformation (Interim)	
Has this paper been signed off by the Responsible Executive Director? Yes	
Actions/ Recommendations required by the Governing Body: The Governing Body is asked to ratify the BCCG plan submitted to NHS England on 23rd December for implementing the General Practice Forward View within Bedfordshire.	
Purpose of Paper: To provide a robust plan for implementing the General Practice Forward View within Bedfordshire. The local plan is based on the requirements set out in the national guidance published in September and December 2016, and reflects the work which has been taking place to develop locally owned locality-based primary care development plans. A further version of the plan is required to be submitted to NHS England in February 2017, to be co-produced with NHS England, providing further detail in a number of key areas.	
Background: The national primary care strategy, the General Practice Forward View, was published in April 2016. National planning guidance was issued in September 2016, setting out expectations for CCGs in relation to implementing the General Practice Forward View at a local level. A summary of the requirements within the planning guidance was presented to the CCG Board in November 2016, which highlighted the synergy between the national expectations and the local primary care development plans already being implemented within Bedfordshire. Further national guidance was issued to CCGs in December explaining that an initial plan should be submitted to NHS England alongside the Operational Plan on 23rd December, and that a further, more detailed plan would need to be submitted in February 2017 based on a national template to be issued. In line with the Operational Plan submission, the BCCG Executive Management Group was given delegated authority to approve the BCCG General Practice Forward View Plan prior to the December submission to NHS England.	
Audit Trail: N/A	
Strategy Implications: Directly aligned to the BCCG Primary Care Development priority and the wider CCG financial sustainability agenda	
Financial Implications:	

The CCG is required to make available a total of £3 per head of population funding across 2017-18 and 2018-19 as Practice Transformational Funding, to support implementation of the General Practice Forward View at a local level.

Risks:
All Primary Medical Care Co-commissioning and primary care development related risks are captured on the Primary Medical Care Co-commissioning Risk Register.

Legal:
N/A

Has appropriate engagement and consultation taken place?
A summary of the BCCG General Practice Forward View Plan was presented to all Locality Boards during December 2016. A summary was also shared with both Overview and Scrutiny Committees during November and December.

The plan is significantly based on the locality-based primary care development plans which have been produced over the last few months, which have been discussed with Locality Patient Participation Groups.

Has an appropriate equality and diversity assessment taken place?
N/A

Executive Summary:

The BCCG General Practice Forward View plan sets out the local plans for implementing the national strategy for primary care within Bedfordshire throughout 2017-19 and beyond. The plan sits alongside our STP vision to provide more care closer to home in the community, provided by inter-operating services and pathways.

The principal BCCG focus during the course of the plan is to work closely with member practices and our relevant partners to deliver at-scale sustainable primary care solutions through locality based primary care development plans, whilst maximising the focus on developing the key enablers, infrastructure and partnerships that will enable us to deliver new models of working fit for the future.

Through the development of locality plans, member practices have identified key priorities for continuing to improve the care they offer to their patients, and for improving the sustainability of their services. The plan sets out how BCCG will support the delivery of these new service, workforce and business models, including through targeted transformation funding.

In synergy with the locality-based initiatives, the plan explains the local approach to the following:

- Improving and extending access to primary care services
- Integrating the primary urgent care system
- Improving Support for Care Homes
- Developing the key enablers:
  - Workforce development, including establishing new types of roles within general practice
  - Estates/hub development
  - Modernising the Primary Care IM&T Infrastructure
- Ensuring short-term support for vulnerable practices, and
- Developing the capabilities for delegated commissioning.

NHS
Bedfordshire
Clinical Commissioning Group

Bedfordshire CCG General Practice Forward View Plan

December 2016

better care, better value, better health

1.0 Introduction

Building upon successful working arrangements throughout 2016/17, we have developed this plan to ensure implementation of the *General Practice Forward View* (GPFV) within Bedfordshire throughout 2017-19 and beyond. This plan sits alongside our STP vision to provide more care closer to home in the community, provided by inter-operating services and pathways. Our local primary care development plan is very much in line with this broader design, and supports its delivery. For primary care this means:

- Strengthening primary care services;
- Maximising prevention and self-care;
- Shifting activity away from acute services to the community;
- Clearly defining urgent care services according to need, reducing reliance on A&E and avoidable unplanned admissions;
- Integrating health and social care pathways by developing care networks;
- Helping to integrate physical and mental health services.

There are significant primary care sustainability issues within Bedfordshire (as there are across many areas of the country), and targeted support is being provided to vulnerable practices. Alongside this, practices are being supported to develop longer-term primary care solutions at locality level, and significant work is underway to develop the key enablers to underpin the delivery of more sustainable models of primary care: helping to create a workforce, primary care estate and IM&T infrastructure which is fit for the future.

We believe that this plan provides a pragmatic and realistic roadmap for significantly improving the sustainability of primary care services within Bedfordshire over the course of the next two years, ensuring a stable platform for the development of a more effective integrated out of hospital system to support local patients.

2.0 Delivering the 10 High Impact Actions through Locality Development Plans

The principal BCCG focus during the course of this plan is to work closely with member practices and our relevant partners to deliver at-scale sustainable primary care solutions through locality based primary care development plans, whilst maximising the focus on developing the key enablers, infrastructure and partnerships that will enable us to deliver new models of working fit for the future.

2.1 Locality Development Plans

All five of the localities in Bedfordshire have now produced a locality development plan, designed to enable delivery of longer-term primary care solutions (including the 10 High Impact Actions) which reflect the local needs of providers and their patients. These are framed within the context of the local Primary Care Strategy and the General Practice Forward View.

There are common themes across the locality plans, including:

- Collaborative management of same-day demand between groups of practices, for example through shared telephone triage, and movement towards establishing a single point of contact. The plans indicate that this could be a key enabler for helping practices to offer appointments across evenings and weekends, i.e. 'extended access'.
- Improving access for patients and increasing practice efficiency through the development of new forms of consultations, e.g. offering more structured telephone appointments, online consultations, and group consultations for patients with long-term conditions/multi-morbidities, which have all found to be very successful in trials in other parts of the country.
- Increasing skill-mix and developing new roles within primary care, for example developing clinical administrators to help reduce GP workload pressures, rolling-out the clinical pharmacist pilot across further practices, utilising paramedics and other healthcare professionals to be involved in conducting home visits and care home visits.
- Greater collaboration between health and social care, through the development of more robust multi-disciplinary team working and trialling of care coordinator/navigation roles, and improving the way proactive support is provided to care homes.
- Empowering patients to deliver more self-care and self-management, through a greater focus on patient education and the use of digital technology, e.g. health apps accessible through patient's mobile phones.
- Helping to manage demand on practices by enabling patients to access more general practices services online (e.g. accessing diagnostic test results, requesting sick notes, etc).
- Shared management of patients with long-term conditions, for example enabling clinicians to develop more specialist skills and to manage patients across groups of practices, e.g. through locality clinics. This approach could help to improve personalised care and support planning for patients, and effective sharing of care plans between relevant teams.

The locality plans have been developed into robust implementation plans, and delivery will be assured by the Bedfordshire Primary Care Working Group, as a sub-group of the Joint Co-Commissioning Committee with NHS England.

2.2 Extended Access

All of the locality development plans include intentions around developing the capacity and capability to deliver extended access across groups of practices. BCCG is in the process of establishing a dedicated project to ensure delivery of 100% coverage of extended access during the latter half of 2018/19.

Key elements of this plan will include scoping local need during Quarters 1 and 2 of 2017/18, organising a pan-Bedfordshire conference to showcase models which are already operating successfully in other areas of the country, scoping the procurement options for commissioning these services, and encouraging practices to develop locality-based models for delivering extended access collaboratively and with other partners where necessary. A key priority will be commissioning these services in a manner which maximises continuity of care for patients through the involvement of local GP practices in the delivery of these services as far as possible, within the framework of a single operating model which enables an equitable access offer to all Bedfordshire patients.

This project will also link closely to work described in section 3.3 around supporting practices to offer new forms of consultations to patients, particularly including structured telephone and online consultations.

2.3 Integrating the Primary Urgent Care System

A key development towards establishing new models of managing urgent / same-day demand in Bedfordshire is the recent re-commissioning and re-location of a GP practice onto the Bedford Hospital site. The new surgery has provided an immediate solution to prevent the closure of the practice, and going forwards provides a potential platform to develop an in-hours streaming model from the A&E department, and to establish the facility as a 24-hour primary care access centre in partnership with the out-of-hours provider, offering a consistent and sustainable alternative to A&E. The site also has the potential to develop into a hub for delivering extended access within this area.

2.4 Improving Support for Care Homes

The locality development plans set out plans for improving multi-disciplinary working and home visiting arrangements, including a number of initiatives for improving the care provided to people living within care homes. In addition to this, BCCG has recently conducted an evaluation of the national models of care supporting care homes, and has assessed current support to care homes in Bedfordshire against the Enhanced Care in Care Homes Framework produced from the learning of the care home vanguards.

This work is suggesting that care home residents should have their planned care needs provided by a multidisciplinary team which includes enhanced primary care support. Early considerations have commenced around how the primary care element of this can best be delivered, e.g. whether this is provided through alignment of GPs to care homes, through commissioning an alternative provider of medical services (APMS) or through another means.

3.0 Enabling Delivery of Locality Development Plans

The Primary Care Delivery team within BCCG is structured around the five localities, providing dedicated project management to support the delivery of the locality development plans. In addition to this, there is dedicated capacity focusing on delivering the key strategic modernisation enablers, particularly workforce, estates and IM&T.

3.1 Workforce

A significant amount of work has taken place during 2016/17 to establish a comprehensive primary care workforce development plan for Bedfordshire, led by a recently established Community Education Provider Network (CEPN). The CEPN has achieved successes already with taking forward a coordinated approach to increasing recruitment and retention within primary care; promoting and supporting new roles in practice; expanding training and mentorship capacity; and helping to develop an integrated multi-professional workforce.

We continue to work in partnership with Health Education England to develop the Bands 1-4 and apprenticeship workforce and maximize the opportunities for our workforce to access training and development opportunities to enhance roles and develop and embed attractive career pathways. We have set in place informal networks with our STP CCG partners and neighbouring CCGs to share our workforce development plans, including recruitment and retention initiatives, the development of new roles and portfolio careers across the spectrum of the workforce.

Our workforce development plan will be built upon and expanded into 2017/18 to continue to provide evidence-based and practical support for practices around workforce development and new models of service delivery. Key elements of the plan for 2017/18 and 2018/19 will include:

- Establishing a local *Time for Care* programme, including supporting groups of practices to apply to access national resources available through this programme;
- Continuing to support the recruitment and retention of GPs locally through GP fellowship and GP Future leader programmes, and supporting practices to create more flexible career structures for GPs;
- Commissioning specialist workforce diagnostic and change facilitation support across groups of practices;
- Maximising the recently recruited Practice Nurse Tutor post to provide mentorship and support to both experienced and new practice nurses, to encourage retention and promote development and training;
- Continuing to support multi-professional development, mentorship and career opportunities.

- Encouraging practices to apply for further waves of the NHS England-led Clinical Pharmacist pilot (applications for Wave 2 due in January 2017) and continuing to support practices with embedding these new roles;
- Supporting the development of clinical administrators working within practices to safely and effectively reduce the administrative burden for GPs
- Developing a local modular Practice Manager development programme offering fundamental practice management components as well as strategic leadership development.
- Additionally, developing a Practice Manager Leadership and Innovation Group, to co-design and drive change.
- Undertake a quarterly refresh of the workforce baseline assessment (including practice level vacancies) to inform workforce development, succession planning and training capacity

3.2 Estates/hub development

The development of the estate utilised to deliver out of hospital services is a key enabler for supporting new models of working, particularly where it can be developed to provide a focal point to bring together services working more closely together, i.e. bringing practices together, and providing a base for more robust multi-disciplinary working. A comprehensive Estates Development Implementation Plan has been produced and is being delivered via the BCCG Estates and Premises Sub-Group.

BCCG recently received the very positive news that a number of bids made to the national Estates & Technology Transformation Fund have been successful in principle. Providing BCCG successfully passes the appropriate due diligence requirements, this funding, which could be in the order of £2.3million, will enable Full Business Cases to be developed for the first three hubs in Bedfordshire: in Dunstable, Biggleswade and Bedford. To varying degrees, these hubs will enable services to co-locate to provide more joined-up care to local people, in significantly improved facilities. The Dunstable and Biggleswade hubs are being taken forward as joint initiatives with Central Bedfordshire Council, to maximise the opportunities to co-locate key services together. It is expected that Full Business Cases will be completed during 2017, with the intention of commencing construction of these new facilities in 2018 (subject to business case approval).

In partnership with both local authorities in Bedfordshire, BCCG has also recently submitted an application for further funding to the national One Public Estate programme, requesting funding to support scoping work for the potential development of four further hubs across Bedfordshire. The application seeks further investment of £340,000.

In addition to these activities, close links are also being developed with the planning teams within the local authorities, to ensure that opportunities within Section 106 agreements with housing developers are maximised going forwards. A number of schemes are already underway to scope the potential for improving priority practice premises.

3.3 Modernising the Primary Care IM&T Infrastructure

Delivering the local primary care aspirations set out in the locality implementation plans will require a robust IM&T infrastructure, and the development of new technical solutions to underpin new models of working, particularly where practices intend to work together and in partnership with other providers.

A Primary Care IM&T Sub-Group (reporting to the Joint Co-Commissioning Committee via the Primary Care Working Group) has been established with responsibility for ensuring improvements in the primary care IT infrastructure, including through implementation of the two-year GP IT Turnaround Plan already underway across Bedfordshire. The Sub-Group will continue to focus on improving efficiency and effectiveness by optimising existing systems and infrastructure, and developing innovative and effective approaches that will better support changes in the delivery of primary care services. The Sub-Group will also have specific responsibility for over-seeing the local project for increasing e-referral utilisation into secondary care.

In addition, BCCG alongside the other two CCGs in the STP footprint, has also been successful in being awarded funding from the Estates and Technology Transformation Fund to support implementation of priority elements of the Local Digital Roadmap. The £1.7million funding awarded across Bedfordshire, Luton and Milton Keynes, will enable development of the technologies required to support primary care at scale, the sharing of patient information across GP practices, with the out-of-hours/111 provider, and with members of the multi-disciplinary care team. With help from additional funding from NHS England for implementing e-consultations, this programme will also help to improve the technical infrastructure needed to support new forms of patient consultations, e.g. online consultations, Skype, etc, and technologies to better empower patients to self-care and self-manage their conditions.

The ambition is for an integrated Health and Care Record which has the appropriate information sharing governance built in to it. Work will need to be undertaken in relation to supporting relevant staff in the use and maintenance of this record to ensure that it is relevant and enables effective multi-organisational patient care.

A programme to take this work plan forward is currently being established, inter-linked to the STP Digitalisation workstream, and is expected to also include consideration of how best to improve technical links with care homes. Work has already commenced on ensuring inter-operability with the new 111/out-of-hours provider for Bedfordshire and Luton when their contract goes live in April 2017.

4.0 Short-term Support for Vulnerable Practices

Whilst the prime focus of the BCCG Primary Care Development Plan is around developing future-proof locality-level solutions, there are a number of practices across Bedfordshire facing immediate challenges which are causing significant risks to their business models and ability to continue to deliver their GMS contracts.

Improving the sustainability of local primary care services is a critical priority for BCCG. In addition to the longer-term primary care development work to support the establishment of more sustainable business and delivery models, we will continue to deliver short-term support to struggling practices in partnership with NHS England. This support will help practices to address their immediate challenges, whilst enabling movement towards more collaborative longer-term solutions where possible.

The sustainability of local practices will continue to be closely monitored by the CCG Executive Management Group, the CCG Primary Care Working Group and the Joint Co-Commissioning Committee with NHS England.

4.1 Supporting Vulnerable Practices and General Practice Resilience Programmes

Twelve practices in Bedfordshire have been successfully prioritised to receive support from the national 'Supporting Vulnerable Practices' programme. Whilst the diagnostic phase of the programme is expected to take place by the end of 2016/17, delivery of the six-month implementation plans developed with support from NHS England will continue into 2017/18, and BCCG's Primary Care Team Delivery Team will support individual practices with maintaining delivery of these plans. The additional General Practice Resilience Programme has also short-listed sixteen practices within Bedfordshire to receive rapid support with specific resilience issues, and again the BCCG team expects to support practices with delivering their action plans developed through this programme.

4.2 LMC Support Package to Practices

The Local Medical Committee (LMC) has developed a support package to offer to practices across Bedfordshire and Hertfordshire, for which funding has been approved in principle by NHS England. The package will include a practice health-check diagnostic tool to support practices gauge where they are on the spectrum from "struggling" to "succeeding", and coaching and facilitation to support practices with developing forward plan solutions aimed at achieving maximum stability for practices and localities. BCCG will continue to work closely with the LMC and NHS England to support implementation of this support package.

5.0 Delegated Commissioning

Working with member practices, the CCG has commenced the preparation required to assume Delegated commissioning functions, to ensure a safe managed transfer from NHS England, at the appropriate stage.

Scoping work is underway to assess the competencies and capacity needed to ensure robust commissioning of primary medical services in a delegated role, and design a clear plan to establish these at a local level, including consideration of joint working arrangements with STP partners.

We will continue to work closely with NHS England to undertake a full and proper risk assessment and the necessary due diligence to ensure the organisation is in a state of readiness, while exploring options for working in shadow arrangements.

Delegated commissioning arrangements provide the opportunity to develop 'place-based' commissioning and joined up care pathways at scale and pace in line with our strategic plans, while managing potential risks such as conflicts of interest and resource pressures. It is the driver for developing the new models of care described in the Five Year Forward view and will enable the alignment of primary care development initiatives, contracting and investment for out of hospital care.

Moving from Joint to Delegated commissioning arrangements will enable the CCG to maximise its contribution to the sustainability of general practice and wider Primary Care through:

- enabling equitable investment
- improving our ability to influence developmental support
- improving our ability to make redesign decisions across a portfolio of providers and pathways tailored to local needs
- engaging with our patients and public about the totality of the expectations for general practice, the out of hospital care offer and wider system integration.

6.0 How this Plan Supports Delivery of the STP

There are strong synergies between this General Practice Forward View (GPFV) Plan for Bedfordshire with the BLMK STP, in particular the Priority 2 Workstream relating to Primary, Community & Social Care. The table below demonstrates the linkages between the plans. Delivery of this GPFV Plan will help to strengthen and improve the sustainability of local primary care services, providing a stable platform for the wider development of the out of hospital system, particularly the establishment of care management teams centred around GPs.

STP Primary, Community & Social Care Workstream Goals	Bedfordshire GPFV Plan Priorities
Strengthen primary care services to ensure sustainability and enable transformation	Delivery of at-scale sustainable primary care solutions through locality based primary care development plans. Supporting vulnerable practices with immediate challenges.
Increase the health of the population by maximising prevention and self-care	Empowering patients to deliver more self-care and self-management, through a greater focus on patient education and the use of digital technology, e.g. health apps accessible through patient's mobile phones and other technologies to better empower patients to self-care and self-manage their conditions.
Shift activity away from acute services to out of hospital care, closer to the patient	Improved access to general practice services (extended access) Greater collaboration between health and social care, through the development of more robust multi-disciplinary team working and trialling of care coordinator/navigation roles, and improving the way proactive support is provided to care homes.
Ensure that people are able to access appropriate urgent care services, reducing reliance on A&E and reducing avoidable unplanned admissions	Collaborative management of same-day demand between groups of practices, for example through shared telephone triage, and movement towards establishing a single point of contact. Improved access to general practice services (extended access). Development of 24 hour Primary Care Access Hub on the Bedford Hospital site,

	providing streaming from A&E Department. Consistent and sustainable alternative to A&E.
Improve services for people with learning disabilities; and combine physical and mental health care	Greater collaboration between health and social care, through the development of more robust multi-disciplinary team working.
Improve interoperability and capabilities for alignment in relation to the particular needs of patients between health and social care services	Greater collaboration between health and social care, through the development of more robust multi-disciplinary team working and trialling of care coordinator/navigation roles, and improving the way proactive support is provided to care homes. Development of the technologies required to support primary care at scale, the sharing of patient information across GP practices, with the out-of-hours/111 provider, and with members of the multi-disciplinary care team.

7.0 Transformational/ Additional Funding

BCCG's Primary Care Development Plan includes clear identification of the various funding streams available to support the transformation initiatives planned, and an agreed approach for maximising the opportunities for utilising this funding.

7.1 Practice Transformational Funding

Subject to engagement with our member practices, we will make available £1.50 per head of population in 2017/18 and a further £1.50 per head in 18/19 (£3 per head in total) as Practice Transformational Funding;

- to support practices to implement the ten high impact changes as per the priorities identified in our locality primary care development plans, including pump-priming new workforce models
- to deliver targeted workforce diagnostic assessment and facilitated change management across groups of practices
- to fund dedicated administration and clinical leadership capacity to support new models of integrated mutli-disciplinary working with community services and social care
- to ensure additional project capacity to support the *Time for Care* programme and to support primary care estates development.

Principles are being developed to support the prioritisation and allocation of Practice Transformational Funding for supporting delivery of the Locality Development Plans. It is suggested that these principles should be based around the following considerations:

- Funding to be directed towards priority projects identified within Locality Development Plans to improve the sustainability of primary care .

- Funding to be made available to support schemes across groups of practices covering a minimum of 30,000 population. It is not anticipated that funding will be made available to individual practices.
- Funding to be made available to localities on a fair share basis as far as possible, providing the criteria above are met.

7.2 Care Navigators, Medical Assistants and online consultations

For 2016-17 we have prioritised the training of Medical Assistants (Clinical Administrators) to support our practices and maximize the impact in terms of relieving the administrative burden for GPs. The funding received has been utilised to provide a training programme for sixteen clinical administrators across the first 11 practices within Bedfordshire from January 2017. GP Champions have been identified in each of the practices and will provide in-house support and mentorship for the developing clerical staff. The additional funding in 2017/18 and subsequent years will enable the phased roll-out of this training across all Bedfordshire practices by 2020/21.

The introduction of care navigators into practices is largely dependent on enabling access to comprehensive, standardised directory of community services and web and app based portals providing self-help and self-management resources. We will work with our practices to develop these and facilitate access prior to the roll out of care navigator training.

Additional funding to implement e-consultations will be utilised to support the implementation of the work programme described in section 3.3, to modernise the GP IT platform and to develop technical solutions to enable new modes of delivering primary care services.

7.3 Access to General Practice

We will employ funding from NHS England (£3.34 per head of population in 2018/19) to make progress towards commissioning 100% coverage of extended access by Quarter 3 of 2018/19, to build upon the elements of extended access already provided by 38 of our practices under the NHS England-commissioned DES.

8.0 Deliverables Summary and Trajectories

Deliverable	Trajectory
Primary care extended access	100% by end of Q3 2018-19
Clinical Administrators working in practices	Working within 11 practices by April 2016, within all practices by 2020/21
E-consultations	E-consultations offered to 40% of patients by end of Q1, 2018/19 E-consultations offered to 100% of patients by 95% of patients by end of Q4, 2019/20
Increased e-referral utilisation	80% utilisation by September 2017 100% utilisation by April 2018

Appendix 1: Combined Localities' Development Plan – Plan on a Page

Primary Care Development Summary of Locality Plans November 2016

Baseline Position

Key Challenges:

- **Workforce pressures** - recruitment & retention. Dependency on locums. Challenge of increasing skill mix.
- **Rising patient demand** due to:
  - Increasing population from new housing
  - Ageing population and co-morbidity
  - Rising demand for home visits, care homes.
- **Finance:** loss of PMS funding, increasingly large locum costs and lack of clarity surrounding funding for primary care. Delays in receiving rent & rates reimbursement.
- **Premises:** lack of space and quality of buildings
- **External factors:** Instability of political situation. New ways of working – shift of work from secondary to primary care. Difficulty in making practice based services work due to complicated reporting arrangements. Community services working independently to practices. Lack of joined up services to prevent admissions

Quality:

- Overall quality indicators compare favourably to national averages.
- Good QoF attainment generally
- Primary care web tool shows handful of practices triggering an NHS England quality visit.

Patient Access:

	BCCG
Ease of getting through to someone at GP surgery on the phone	74%
Overall experience of making an appointment	75%
Overall experience of GP surgery	86%
Recommend GP surgery to someone who has just moved to the local area	78%

Patient Satisfaction:
Average of four elements of access to primary care: 78%

How it will happen

Engagement:

- Via Locality Boards & Practice Manager meetings
- LPPG and engagement groups
- PLZ/HEAT sessions

Leadership:
Locality Chairs / designated leads

Sustained leadership / practice engagement:

- Locality Board members to ensure individual practice engagement and ownership
- Leads to be identified for specific projects

Expert support:

- LMC
- Learning from Vanguards and best practice elsewhere. Evidence base to support interventions.
- Technical support for establishing locality website, sharing of clinical records and e-consultation.
- GPRP and GPDP

Locality team support:
Analyst, project management, admin support.
Applications for transformational funding streams.

Support

Support needed from BCCG:
Practice Transformational Funding
Workforce expertise
Support to integrate ICT systems
Medicines Management support

Support needed from LMC:
To help enable shared records/ e-consultation development
Challenge for change

Impact on BCCG Commissioning Intentions:
Impact on outpatient activity

Resource implications:
To be identified
Pump priming for new home visiting models
Funding for training
Funding for hubs and premises improvements (ETTF and S106)

Suggested priorities for PMS money 17/18:
None specifically identified from plans

Links to General Practice Resilience Programme:
Applications from practices / localities

What we propose to deliver

- ***Collaborative management of same-day demand between groups of practices***, for example through shared telephone triage, shared website, and movement towards establishing a single point of contact. Also, shared management of home visits, utilising greater skill-mix. Key enabler for helping practices to offer appointments across evenings and weekends, i.e. 'extended access'.
- ***Improving access for patients and increasing practice efficiency through the development of new forms of consultations***, e.g. offering more structured telephone appointments, online consultations, and group consultations for patients with long-term conditions/multi-morbidities.
- ***Increasing skill-mix and developing new roles within primary care***, for example developing clinical administrators to help reduce GP workload pressures, rolling-out the clinical pharmacist pilot across further practices, employing paramedics within practices to conduct home visits.
- ***Greater collaboration between health and social care***, through the development of more robust multi-disciplinary team working and trialling of care coordinator/navigation roles, and improving the way support is provided to care homes.
- ***Empowering patients to deliver more self-care and self-management***, through a greater focus on patient education and the use of digital technology, e.g. health apps accessible through patient's mobile phones.
- ***Shared management of patients with long-term conditions***, for example enabling clinicians to develop more specialist skills and to manage patients across groups of practices, e.g. through locality clinics.
- ***Improving the resilience of the workforce***, through practice management development, GP fellowship schemes, CPD for nurses, more flexible career structure for GPs, more training practices to 'grow our own'.
- ***Collaborative business models***, including development of a super-partnership across 5 practices in Bedford, and sharing of back-office functions in some localities.
- ***Hub development programme***, to enable co-location of practices to enable more efficient delivery models, and to provide a focal point to support MDT working.