NHS
Bedfordshire
Clinical Commissioning Group

Paper 9.0

Governing Body Meeting in Public
30th March 2017

Title: General Practice Forward View Plan	**Agenda Item: 9.0**
Presented by: Clare Steward, Director of Strategy and Transformation (Interim)	
Author: Nikki Barnes, Head of Primary (Community and Social) Care Modernisation	
Responsible Executive Director: Clare Steward, Director of Strategy and Transformation (Interim)	
Has this paper been signed off by the Responsible Executive Director? Yes	
Actions/ Recommendations required by the Governing Body: To approve the General Practice Forward View (GPFV) Plan for Bedfordshire, as submitted to NHS England on 24th February 2017.	
Purpose of Paper: To share the GPFV Plan for Bedfordshire and to seek retrospective approval from the Governing Body. The plan builds on and expands the existing work programme in Bedfordshire to support the development and sustainability of primary care. Delivering the GPFV Plan will form a core part of the Strategy and Primary Care teams' work programmes going forwards.	
Background: The national GPFV was published in April 2016, setting out a strategy for modernising and improving the sustainability of primary care. CCGs were required to submit the first of two draft plans to NHS England at the end of December (alongside Operational Plans) to demonstrate how the GPFV will be delivered locally. Guidance was received during February for requirements for second draft submissions, with a submission deadline of 24th February. The expectations between December and February significantly increased, with CCGs being required to submit plans with direct alignment to their STPs and with a wider focus on out of hospital services.	
Audit Trail: First draft submission shared with Governing Body in January 2017 Second draft submission received delegated approval from Executive Management Group in February 2017	
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? Not yet – not applicable at this stage. Equality and diversity assessments will take place for specific workstreams within the GPFV Plan as appropriate.

Executive Summary:

The BCCG General Practice Forward View (GPFV) Plan sets out the BLMK STP vision for Primary Care, alongside the local vision and delivery plans.

These delivery plans set out how we will implement specific GPFV requirements during 2017-19 and beyond, ensuring sustainability of and providing support to general practice. The plans are aligned with our wider ambition to help our residents to stay well for longer, to direct them to effective sources of support sitting outside the statutory sector and to offer a joined-up service when they receive care from us in community and home settings.

The Plan focuses on the following key elements:

- Model of care – our future vision based around the primary care home model, with services wrapped around clusters of GP practices serving populations of 30-50,000
- Access – how we intend to deliver 100% extended access by the end of 2018/19
- Workforce – how we will support the recruitment, retention and development of a motivated, resilient workforce coupled with the introduction of new roles, enhanced skill mix and new ways of working
- Workload – how we will work with and support practices to reduce GP workload, including through the development of new roles in general practice and more efficient delivery models
- Infrastructure – how we will modernise and sustain primary care estates and IM&T, including increasing the digitalisation of primary care services
- Investment – clarity around investment from the CCG towards the development of primary care, and how other sources of funding will be targeted towards specific improvements
- Leadership, governance and programme arrangements – how we will ensure robust implementation of our plans and realisation of our future vision.

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Bedfordshire CCG General Practice Forward View Plan

Second Submission – February 2017

FINAL VERSION – 24.02.17

Subject to final approval by Bedfordshire CCG Board

better care, better value, better health

Foreword

This document sets out the BLMK STP vision for Primary Care, and appends the local delivery plans, framed at the CCG level, by which we want to realise this vision. It describes how BLMK CCGs will commission services and work with providers to promote illness prevention and to deliver, safe, high quality and sustainable care in the context of the *General Practice Forward View* (GPFV)[1] .

These delivery plans set out how we will implement specific GPFV requirements during 2017-19 and beyond, ensuring sustainability of and providing support to general practice. The plans are aligned with our wider ambition to help our residents to stay well for longer, to direct them to effective sources of support sitting outside the statutory sector and to offer a joined-up service when they receive care from us in community and home settings. Key elements of the plans have also been developed with Local Medical Committee colleagues and have benefitted from insights and advice from BLMK's RCGP representative.

Our vision sets out how we will work with and support GPs to address the challenges facing primary and Out of Hospital Care. This will ensure we co-design a resilient, multi-disciplinary and high quality primary care platform to be front and centre in our local communities across BLMK GPs will be at the centre of patient care, supporting and directing the provision and co-ordination of high quality medical care and treatment for those that are ill, but also in bringing about improved health and well-being for our population as a whole.

Our local plans underpin broader BLMK STP goals. These goals see local partners commissioning and providing more care in community and home settings, along streamlined care pathways, by making better use of the resources available to us. We know that this will happen only if we do more with what we already have. As a result, we want to direct our GPFV transformation investment to:

- Free up time for our senior primary and community clinicians to provide clinical leadership for delivery of delegated care across community settings, ensuring they can focus their scarce clinical capacity on people with the most complex needs
- Maximise the contributions that the wider primary and community services workforce can make to deliver safe and effective care in community settings
- Harness technology that enables primary care to in-reach into people's homes and gives a peripatetic workforce the digital tools it needs to work effectively and efficiently
- Support those individuals (and their family carers) who have the appetite and capacity to take more control of their own care.

Our Vision for BLMK Primary Care

Responsive, proactive and accessible primary care needs to be led and orchestrated by general practice. It must be delivered though, by a wide range of professionals. In BLMK, we see this being achieved through an enhanced delivery model which, in

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[1] *NHS England: GP 5 Year Forward View, April 2016*

design and operating model, draws inspiration from the Primary Care Home (PCH) model.

The integration of community health, mental health and social care services with primary care clinicians is crucial. However, this integration will be effective and sustainable only if services are co-designed with GPs to be wrapped around a strengthened and scaled primary care delivery model.

We believe that, scaled at the 30-50,000 population level, community, mental health and appropriate secondary care services can be effectively and efficiently integrated with primary care. In addition, we can align ourselves closely with Council services, where there is direct interplay with health services, such as social care, and those, such as housing, that make such a significant contribution in determining the health and well-being of our residents.

Context

BLMK's combined population is circa 985,000 and in the next 15 years, is expected to increase by 160,000 people (17%), which is almost double the national average. Across the region, the 85+ age group is predicted to grow faster than the rest of the population. In addition, the numbers of children in Luton and Bedfordshire are also expected to increase much faster than in England as a whole.

There are also significant differences in demographics, ethnic diversity and deprivation within the footprint which our plans need to be alive to. For example, healthy life expectancy, an estimate of the average number of years lived in good health, varies from 59.3 years for men in Luton to 67.2 years for women in Bedford Borough.

There are 109 GP practices within the BLMK footprint, employing 411 GPs. At 2,349, the average list size per GP compares unfavourably with England as a whole (with Luton a particular outlier at 2,804 patients per GP). Our ageing GP workforce is a major issue, and recruitment challenges for new GPs and practice-attached nurses remain stubbornly difficult to resolve.

The legacy infrastructure with which general practice in BLMK is wrestling dictates the need for radical transformation, designed to develop capabilities, to re-purpose existing capacity and to deepen the multi-disciplinary resource base that can be drawn upon. All 16 partner organisations comprise the BLMK STP recognise this and all are committed to supporting new models of working with and alongside general practice.

Next Steps

We intend to use the PCH model as the common design template across BLMK by which our vision for primary care will be achieved. The PCH solution will, of course, manifest itself in different ways in different parts of the footprint. However, we do expect some elements of the PCH solution to be common. For example, general practices will be supported to create coherent and cohesive collaboratives,to manage the health and well-being, and deliver "out of hospital" care, to their localities numbering between 30-50,000 people.

Through the local programmed activities relating to the 10 high impact changes, collaborative working between practices, facilitated by the three CCGs, the STP and the respective LMCs, is expected to lead to better access, a more fit-for-purpose

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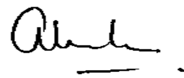
primary care workforce and more manageable workload in primary care. We have put in place an effective blend of STP-wide and locally sensitive governance mechanisms which will draw in relevant stakeholders at the right time.

The attaching local delivery plans set out, in some detail, the actions we expect to take, when we expect to take them and the results we expect to achieve. Key performance indicators are under development to provide assurance on the successful delivery of proposed changes and the impact on patient flows, on services and on health and well-being outcomes. The CEOs of the 16 partner organisations, supported by the three CCG Clinical Chairs and the LMCs, will review progress on these actions monthly at BLMK's *Accountable Care System Activation Board.*

Request

The development of primary care, more broadly, and general practice, in particular, is mission critical to the delivery of BLMK's STP goals. Based on consensus and clarity of purpose across commissioners and providers, our clearly planned programme of work and our commitment to delivery, we look forward to receiving NHS England's support to the scope, the activities and the timeline we have set out in our local delivery plans.



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1.0 Introduction to the Plan – across our STP

This introduction is in two sections:

Section 1.0 is an introduction to the vision for primary care agreed across the BLMK STP footprint, while Section 2.0 provides the context and vision specific to primary care in Bedfordshire.

1.1 BLMK STP

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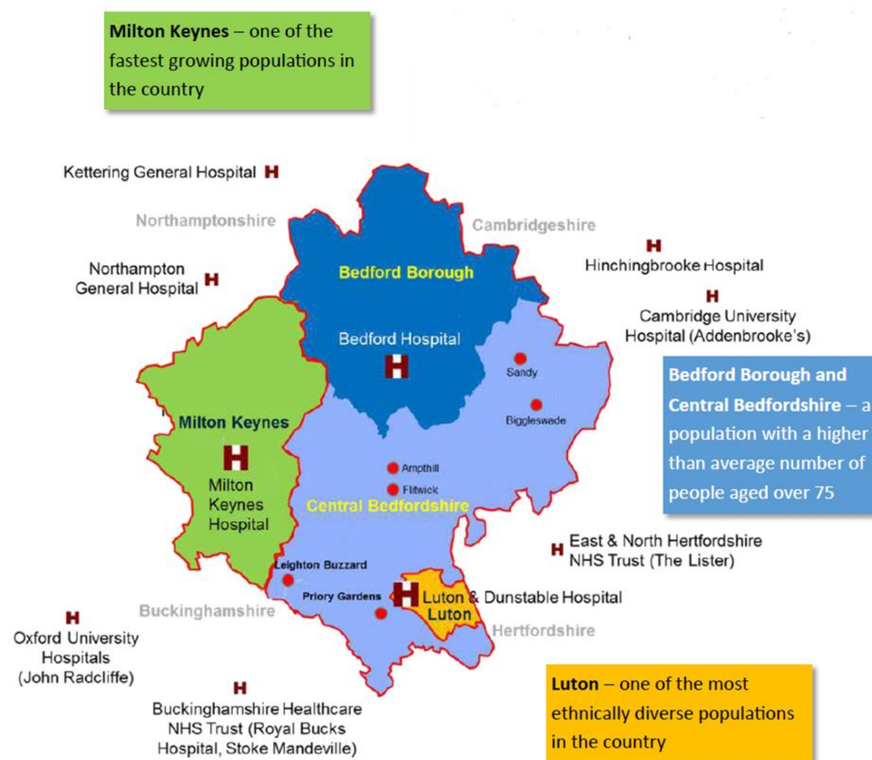

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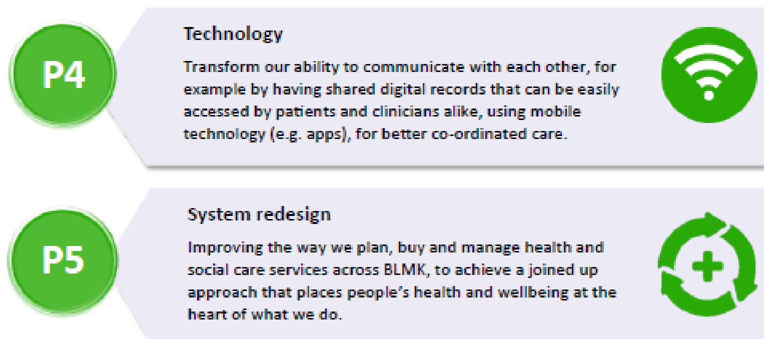
BLMK have identified a total of five STP priorities to deliver the future vision for health and social care. The five priorities all overlap, and the benefits expected will only be fully realised if all five proceed in parallel. No one priority is therefore, seen as more important than any other. The development and transformation of primary care is addressed under **Priority 2** with the aim **to deliver high quality, scaled and resilient primary care,** community and social care **services across BLMK**.



Within the STP footprint there are pockets of transformation, with more care than ever before now being delivered in the community, closer to and within people's homes. However, the resources made available to primary and community care have remained static. The GP Five Year Forward View forms an inherently important opportunity to achieve the ambitions of Priority 2 as set out within the STP, namely to:-

- Strengthen primary care services to ensure sustainability and enable transformation
- Increase the health of the population by maximising prevention and self-care
- Shift activity away from acute services to community settings, closer to home
- Ensure that people are able to access appropriate urgent care services, reducing reliance on A&E and reducing avoidable unplanned admissions
- Close integration of health and social care services
- Supports the transformation of services for people with Learning Disabilities
- Helps to integrate physical and mental health services and achieve parity of esteem

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BLMK system leaders have supported the governance structure of four placed based delivery boards and are working together to achieve the transformation goals associated with this priority. The outcomes include:

1. **Improved population health and wellbeing**
   - Improved demand management through patient activation and self care
   - Improved stratification and analysis of population health needs - more prevention, early detection and screening (addressing inequalities)

2. **Improved quality of care for patients in local communities**
   - Greater accessibility to primary care
   - Improved service availability - patients receive the right care in the right place
   - More finished episodes of care and extended continuity through proactive and integrated community therapy

3. **Improved utilisation & sustainability of local health & social care resources**
   - Improved deployment of NHS and social care resources with improved patient experience and empowerment. *(skill mix - clinicians working to the top of their license & less duplication and bureaucracy of services)*
   - Better cross-organisational working to develop care management packages for identified high risk people with complex needs to improve their wellbeing, outcomes & reduce avoidable A&E visits/admissions/lengths of stay/expensive long-term care packages

In conducting the design and development work required for the Priority 2 initiatives, the STP programme will need to rely on the full co-operation and enthusiastic participation of our GPs, of our local Councils and of our community health and our mental health service providers.

In some cases, it will make sense to create facilities that can accommodate a Primary Care Home (multi-disciplinary) -type integrated service platform for a 30-50,000 population (for example, a locality hub or care centre). Some of these solutions are already under development in BLMK, in this case led and part-funded by local Councils. For example, there is a comprehensive Hub Development Programme underway in Central Bedfordshire, as a partnership development between the Council and CCG.

In other cases, it will make sense to create “virtual hubs”, by which an integrated service platform can be created to support a more dispersed primary care terrain, and via which appropriate resources can be channeled. This new model of care is intended to deliver immediate improvements in care and quality gaps and to improve some of the wider determinants of health and well-being of our local population.

To support this work Priority 2 has been sub-divided into 6 separate, complementary work streams.

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STP P2: Work Streams

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The objectives of the streams are interlinked and teams will work together across the STP footprint to reduce duplication and ensure alignment of plans to successfully deliver improved, sustainable and high quality services to our residents within available finances.

Key projects across the footprint, for which funding is being made available include improved access, enabling on-line consultations, training of care navigators and medical assistants, and improving primary care infrastructure. The table below sets out the funding available. Detailed information on the projects and timeframes for implementation are set out in the relevant sections of this plan.

	Bedfordshire		Luton		Milton Keynes	
	17/18	**18/19**	**17/18**	**18/19**	**17/18**	**18/19**
Access	0	1,511,253	0	780,397	1,590,653	1,611,475
On-Line Consultations	122,221	163,664	59,953	80,292	74,892	100,438
Training Care Navigators & Medical Assistants	81,481	81,832	39,969	40,146	49,928	50,219
Practice Transformational Funding	695,000	695,000	350,000	350,000	430,000	430,000
Primary Care Infrastructure – Estates (ETTF)	450,000	1,607,400	80,000	1,021,700	1,627,900	
Primary Care Infrastructure – Digitalisation (ETTF)	17/18 – 1,200,000 18/19 – 300,000					

Further funding is being provided within specific schemes:

- support to 28 prioritised practices across BLMK, via NHS England under the General Practice Resilience Programme
- Practice involvement in Wave 1, and expected in Wave 2 of the Clinical Pharmacist pilot
- Expected funding towards practice-based mental health therapists.

The GPFV plan is a key delivery enabler for establishing the crucial groundwork for this scale of change. The following sections describe how we will achieve this transformation across the STP footprint and individually within BLMK CCGs**.** **Section 2** provides a description of the model of care for Primary Care Services across the STP footprint and detailed descriptions of work being undertaken in Bedfordshire to deliver improvements to Primary Care in line with this model.

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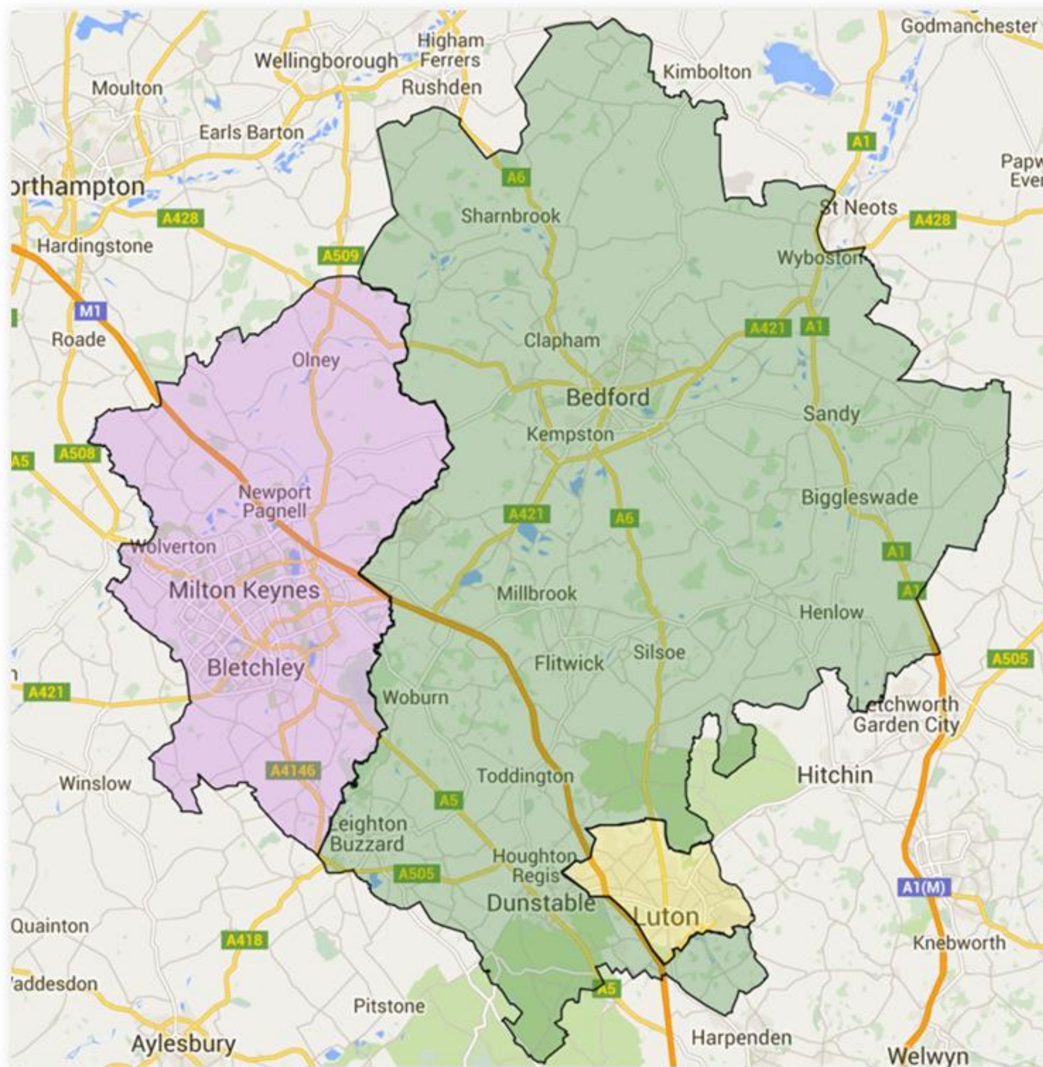
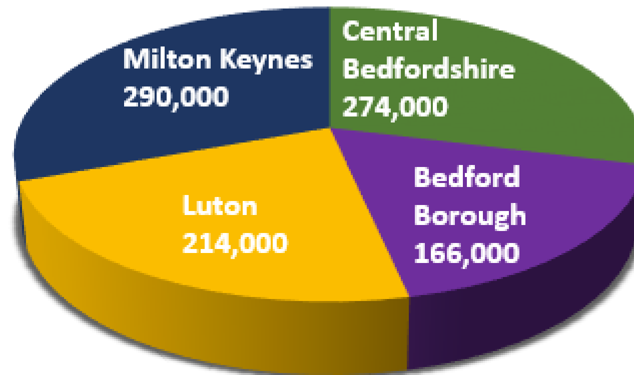
1.2.1 Our Populations

The total resident population in BLMK is circa 985,000 and, in the next 15 years, is expected to increase by 160,000 people (17%), which is almost double the national average. This means we will see some 1.1 million people living in BLMK by 2032.

The local population is served by three CCGs and four local Councils. At 467,000 Bedfordshire is the largest of the three CCGs, being a little over twice the size of Luton (230,000), and over one and half times as large as Milton Keynes (290,450) (see map below for geographical span of BLMK footprint).



There are significant differences in demographics, ethnic diversity and deprivation within the footprint. For example, the population of Luton is younger, more ethnically diverse and more deprived. Central Bedfordshire is the least diverse and least deprived, while Bedford Borough has a significantly older population. Milton Keynes population continues to grow more rapidly than other parts of BLMK but, having experienced rapid population inflows of people of working age for some decades now, is also now ageing faster.



1.2.2 BLMK Health Needs/Inequalities

Life expectancy for 2013-15, compared to the national average (79.5 years for men and 83.1 years for women) is better in Bedford Borough (79.9 years for men and 83.5 years for women), significantly better in Central Bedfordshire (81.7 years for men and 83.7 years for women), worse in Milton Keynes (79.1 years in men and 82.9 years in women) and significantly worse in Luton (78.8 years in men and 82.3 years in women).

Healthy life expectancy, which is an estimate of the average number of years lived in good health, for 2013-15, compared to the national average (63.4 years for men and 64.1 years for women) is better overall in Bedford Borough (65.6 years for men and 62.5 years for women), better overall in Central Bedfordshire (64.7 years for men and 63.1 years for women), better in Milton Keynes (64.1 years in men and 64.5 years in women) and significantly worse overall in Luton (62.1 years in men and 61.3 years in women).

There are significant health inequalities within our communities. For example, in 2009-2013 comparing the gap in life expectancy between the most and least deprived areas (MSOAs), Bedford Borough has a 4.2-year life expectancy gap for men and a 10-year gap for women, Central Bedfordshire has a 3.8-year gap for men and a 3 year gap for women, Milton Keynes has a 7.2-year gap for men and a 5-year gap for women and Luton has a 6.3-year gap for men and a 5.8 year gap for women.

Across the whole of BLMK, there is a 6.2-year age gap between the most and least deprived areas (MSOAs) for men and a 3.7-year age gap for women. However, looking at the MSOAs with the lowest versus the highest life expectancy across BLMK the gap is 14.5 years for men (71.3 years in one MSOA in Bedford Borough to 85.8 years in one MSOA in Central Bedfordshire) and 16.1 years for women (77.1 years in one MSOA in Milton Keynes to 93.2 years in another MSOA also in Milton Keynes).

In light of an aging population, and one that, as it ages, is increasingly presenting with multiple morbidities, improving healthy life expectancy, and compressing the number of years lived in poor health, it is key that as system partners we seek to contain the pressures on the health and social care system.

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Key health needs across BLMK include:

- The "big killers" driving premature mortality and health inequality in BLMK are cancers, cardiovascular disease (heart disease and stroke), and chronic obstructive pulmonary disease (COPD). Diabetes is a factor in both cancers and cardiovascular diseases.
- Smoking remains the single greatest preventable cause of ill health and premature mortality
- Alcohol-related hospital admissions are rising across BLMK
- Less than two-thirds of people with a long term condition feel adequately supported by the GP to manage their condition
- Screening (e.g. for cervical cancer and breast cancer) performance across BLMK is patchy
- Recorded prevalence of depression is rising
- Prevalence of recorded severe mental illness is rising, and ranges from 0.68% in MK to 0.95% in Luton, which is higher than the England average (0.88%)
- 19.6% to 23.1% children (across the four LAs) are overweight or very overweight by the age of five, rising to 29.4% to 40.8% by the age of 11. The proportion overweight or very overweight by age 11 is rising in three out of the four local authority areas
- Effective primary care and self-management of asthma can prevent exacerbations and unplanned hospital admissions, yet asthma admissions in the under 19s are high and rising in three out of four local authority areas.

1.2.3 Current Primary Care Infrastructure

There are 108 GP practices within the BLMK footprint, employing just over 400 GPs. At 2,349, the average list size per GP in BLMK compares unfavourably with England as a whole (see below). Luton is a particular outlier at 2,804 patients per GP.

An estimated 5 million encounters with GPs take place each year4, governed by a mix of GMS and APMS arrangements, via which £127m is spent each year.

	Bedfordshire	Luton	Milton Keynes	BLMK	Regional Average	England Average
No of GP Practices	53	28	27	108		
No of GPs	218	82	111	411		
No of Practice nurses	129	44	64	237		
Patients per GP	2077	2804	2494	2396	n/a	1650
Patients per Practice Nurse	3511	5030	4326	4073	n/a	n/a
Patients per GP practice	8234	8196	10255	8543	7690	7518
GPs per 000 patients	0.52	0.42	0.52	0.49	0.57	0.57

GP Practice nurses per 000 patients	0.28	0.25	0.28	0.27	0.29	0.27
% of GPs age >55	24%	23%	25%	24%	n/a	20%
% GP practice nurses >55	28%	25%	27%	27%	n/a	n/a
GP Clusters	Bedford 25 practices (24 from July 2017)	Medics United 5 practices	North 7 practices			
	Ivel Valley 9 Practices	Larkside 8 practices	East 7 practices			
	Chiltern Vale 10 Practices	South E Luton 7 practices	Southern 7 practices			
	West Mid Beds 6 Practices	Kingsway 8 practices	West 6 practices			
	Leighton Buzzard 4 practices					

At an STP level, the quality of outcome and patient confidence in primary care is reasonably good, although there are some unwarranted practice-level variations that need to be addressed, both in identifying disease early enough, and in managing disease once diagnosed.

Only one practice across BLMK is in "CQC special measures". This performance is being achieved despite BLMK's primary care infrastructure being fragmented and lacking resilience. The figure below underlines the fact that the ageing GP workforce is a particular issue, and recruitment challenges for new GPs (for example, in February 2016, there were 19 GP vacancies in Bedfordshire alone) and practice-attached nurses in BLMK remain stubbornly difficult to resolve, even when incentive schemes are on offer.

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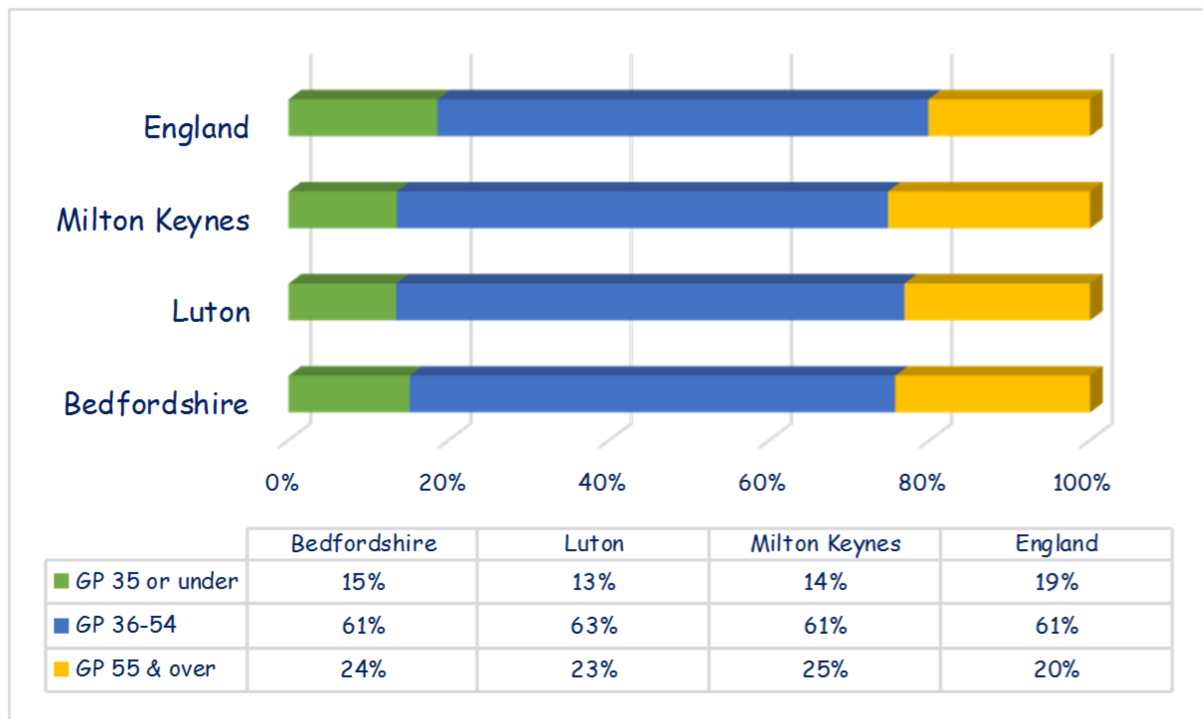

	Bedfordshire	Luton	Milton Keynes	England
GP 35 or under	15%	13%	14%	19%
GP 36-54	61%	63%	61%	61%
GP 55 & over	24%	23%	25%	20%

Age profile of GP workforce

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The capacity, scale and resilience of the prevailing operational and business model in primary care across BLMK is acknowledged as unfit to respond effectively to future challenges. Each CCG has GP cluster architecture in place. However, the supporting apparatus for cross-cluster leadership and administration remains at an early stage.

Although there are starting to be some encouraging signs, the development of GP federations across BLMK has not proceeded at the pace of other areas. BLMK is therefore lacking a developed organisational springboard in primary care, from which new models, aimed at scaling and strengthening primary care, might be launched. BLMK has not featured prominently in NHS England's New Models of Care (NMOC) programme, despite having pockets of very modern practice (for example, GP telephone triage, nurse practitioners and in-practice community pharmacy). Luton CCG is though, one of the fifteen Rapid Test Sites for the National Association of Primary Care Home Model, the agreed model of care for the STP and the Newport Pagnell Medical Centre model is a further test site for the Primary Care Home model within Milton Keynes CCG.

There is considerable interest amongst BLMK CCGs and local GPs to examine the benefits that may arise from introducing NMOCs and realising the benefits of scale. For example, Milton Keynes CCG held a number of local engagement workshops on developing a Multi-specialty Community Provider (MCP) models and has indicated its willingness to host an STP pilot site. These workshops secured broad sign-up from the CCG and acute, community, social and primary care providers in Milton Keynes, to work towards a MCP (+/-) model that would align to the overall STP ambition of an Accountable Care system.

In addition, Bedfordshire CCG has established a "Models of Care Working Group" which includes representatives from health and social care, as part of its community services work on commissioning integrated community health and social care services. Procurement of a new Community Services provider is currently underway using the competitive dialogue process.

2.0 Introduction - Primary Care in Bedfordshire

2.1 The Delivery Plan for Bedfordshire

Building upon successful working arrangements throughout 2016/17, we have developed the local element of this plan to ensure implementation of the *General Practice Forward View* (GPFV) within Bedfordshire throughout 2017-19 and beyond, aligned to our STP vision to provide more care closer to home in the community, provided by inter-operating services and pathways.

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 increasingly in partnership with our local authority partners, 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, in line with STP ambitions, over the course of the next two years, thereby ensuring a stable platform for the development of a more effective integrated out of hospital system to support local patients.

The key components of this delivery plan are as follows:

a. Targeted support for struggling practices, including delivery of the General Practice Resilience Programme and a support package from the Local Medical Committee (LMC)
b. Delivery of comprehensive Locality Development Plans with strong local ownership from practices, which include implementation of priority High Impact Actions, measures designed to reduce GP workload and improve practice sustainability, and a stepped approach towards the longer term Model of Care
c. Establishment of clusters of GP practices around populations of 30-50,000 to serve as the footprint for collaborative working between practices, delivery of extended access, and as the footprint for the local implementation of the Primary Care Home model (multi-disciplinary working)
d. Accelerated partnership working with our two local authorities and main providers through the local Transformation Boards, including implementation of a joint Out of Hospital Strategy to underpin the development of multi-disciplinary working around the GP cluster footprints and towards the establishment of integrated hubs to serve as the focal point for wider primary care teams
e. A comprehensive local RightCare programme, and establishment of a structured Advice and Guidance Service and a new Frailty Pathway, as part

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of a wider Planned Care Strategy to support the transfer of care from secondary to community/primary care

f. Integration of primary care urgent care services, through the development of a 24-hour Primary Care Access Hub on the Bedford Hospital site with streaming from A&E, new approaches to home visiting and support for care homes, and a stepped approach to closer working between the 111 service and GP practices.
g. Development of the primary care infrastructure to sustain services and to enable the delivery of the new Model of Care, including a significant workforce development programme, a primary care IM&T transformation programme across the STP, and a programme to support the co-location of services through the establishment of integrated hubs.

The various strands of investment being made available under the GPFV will all be targeted locally towards enabling delivery of this Plan, as set out in later sections.

2.2 What this will mean for our patients

These plans are designed to improve services and outcomes for local people in the short and long-term, as well as to improve the sustainability of the primary care system in Bedfordshire. We expect patients to benefit from these plans in the following ways:

- Continued access to high quality general practice services
- Improved convenience for patients needing to access primary care, through new forms of consultations, and extended opening hours
- Improved clinical outcomes for people living with long term conditions, and ensuring they and their carers feel supported. Specifically, we aim to
    - Reduce premature mortality due to cardiovascular conditions by improving detection and treatment of hypertension and other risk factors
    - Reduce poor outcomes for diabetics such as leg amputations by helping patients improve their control of blood glucose, blood pressure and cholesterol
    - Reduce hospital admissions in asthmatics
- More joined-up care for patients with complex needs who need support from a range of clinicians/professionals, particularly older people, people with multiple conditions, and children with ongoing healthcare needs
- Reduced variation in the quality of care, and avoidable referrals and admissions to hospital prevented
- Reduced health inequalities by closing the inequalities gap in Infant Mortality, absolute deaths in cardiovascular deaths and cancer deaths
- Sustainability of the wider health and care system supported through the delivery of more care closer to home and greater focus on prevention
- Older people enabled to remain independent for longer, also resulting in reduced admissions to care homes.

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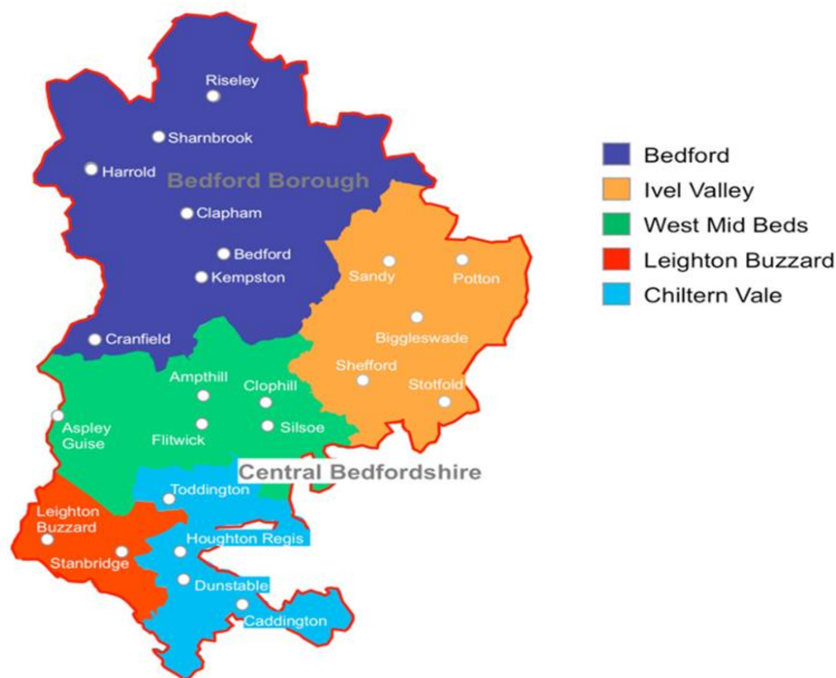
2.3 Context

This section provides background information around the current landscape of primary care provision, and an outline of local population need and the key clinical outcomes BCCG is working to improve.

BCCG comprises of five localities: Bedford, Chiltern Vale, Leighton Buzzard, Ivel Valley and West Mid Bedfordshire. Bedford locality is almost co-terminus with Bedford Borough Council and the remaining four localities form the area covered by Central Bedfordshire. There are 28 practices in Central Bedfordshire and 25 in Bedford Borough.



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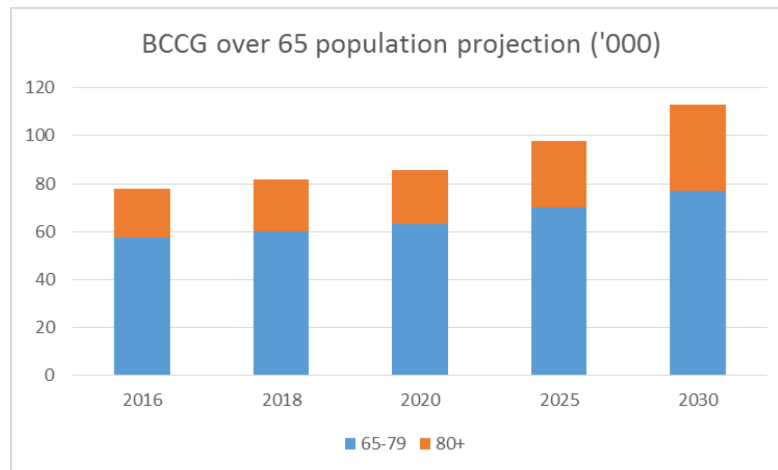
2.3.1 Population

The population of our area is growing, with the current 433,000 residents forecast to rise to over half a million in the next ten years (ONS, 2014 data). The graph below shows the projected increase in the number of older people living in the area over the coming years.



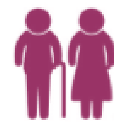
Over 20,000 new homes are planned across our area in the next five years, many of those moving into the area are expected to be young families so a rise in the number of children with health and social care needs is also expected, especially in areas of high growth such as Biggleswade, Bedford and Houghton Conquest.

2.3.2 The key challenges – Population Health

Like other areas, Bedfordshire is facing some key challenges:

- The ageing population and the increasing number of people with long term conditions (often more than one) are placing additional requirements on our local healthcare services.
- Modern lifestyles – e.g. obesity, smoking and alcohol misuse – are giving rise to additional health problems, with an increasing number of people living with long term conditions e.g. diabetes and chronic obstructive pulmonary disease (COPD).
- Enabling patients to access care at an earlier stage and at times that meet their expectations, e.g. extended access times and the use of technology solutions.

Ageing population



Highest population increases are in the over 65s

Long term conditions

More people with long term conditions that need support and care

Changing lifestyles

Modern lifestyles (e.g. obesity, smoking and alcohol) are placing extra strain on the NHS

Reduced life expectancy in deprived areas

2.3.3 Outcomes

BCCG has been working with our Public Health partners to establish priority areas for improving health outcomes within Bedfordshire, based on a range of national

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outcome measures and tools. The following areas have been identified where performance / outcomes could be improved:

- Flu vaccination for at risk individuals is low: Bedford 46.1% & Central Bedfordshire 49.4%
- Flu vaccinations for patients aged under 65 and with a long-term condition is low at 43.1%
- High prevalence of Diabetes
- Relatively low number of patients with Diabetes receiving structured self-care education (54.5%)
- Dementia Diagnosis rate not currently being met
- Variation in Diabetes management across practices
- Variation in performance across practices: QOF data
- Significantly higher premature mortality from Coronary Heart Disease than comparator CCGs
- Significantly higher premature mortality from Myocardial Infarction than comparator CCGs
- Low screening uptake – issues with workforce and system capacity to deliver standards
- Gap in number of patients who achieve the recommended treatment targets
- Insufficient uptake of eight recommended care processes (as per National Diabetes Audit definitions) (45.9%)
- High Asthma mortality rate (adults and children)

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The above, along with other local intelligence, identified that we need to focus on the following areas:

Area	Issues
Maternity and early years	• Infant mortality* High emergency admissions in under 1s
Mental health	• Access to IAPT Psychosis care Dementia need
Cancer	• Low levels of screening Poor 1 year survival
Long term conditions	• Asthma admissions and mortality Poor outcomes in diabetes • High preventable mortality especially cardiovascular mortality
Multimorbidity and frailty	• Complex patients with high utilisation Hip fractures*
Infectious diseases	• Late detection of HIV Respiratory vaccine coverage
Carers	• Poor health-related quality of life
Alcohol and liver disease	• Alcohol-related admissions Deaths from liver disease • Disproportionately high gastrointestinal spend

*Writing in purple relates to Bedford Borough only.

The majority of care within the NHS takes place within primary care and therefore our primary care services will need to play an important role in achieving clinical improvements in these areas.

2.3.4 Sustainability

Our practices are currently facing the following **key challenges**:

- **Workforce pressures** - recruitment & retention, dependency on locums, aging workforce.
- **Rising patient demand** due to:
  - Increasing population from new housing
  - Ageing population and co-morbidity
  - Rising demand for home visits, support to care homes.
- **Finance:** loss of PMS funding, increasingly large locum costs, 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. Community services working independently to practices. Lack of joined up services to prevent admissions

Four practices within Bedfordshire (three in Bedford Borough) have returned their contracts to NHS England within the last twelve months, necessitating short-term caretaker arrangements to be put in place or list dispersal, and many practices consider their businesses to be vulnerable, or their service models to be unsustainable in the long term.

In the Autumn of 2016, Horizon Health Choices, the local federated provider and caretaker of two GP practices in Bedford, served notice on these contracts and the federation ceased operating. The CCG worked closely with NHS England to ensure safe and timely contingency arrangements were established. One of these practices, with a small patient list, has since closed and patients have been allocated to nearby surgeries, and the other has acquired NH Solutions as its new caretaker. This unforeseen position of immediate pass-back from the provider, contributed to a significant increase in the re-registration of patients to alternative practices, many of whom are reaching, or have reached capacity. In addition to this, there are three formal list closures within Bedfordshire, and a number of informal list closures. Improving the sustainability of local primary care services is therefore a critical priority for BCCG.

Since the liquidation of the local federation, there are no at-scale provider organisations operating within Bedfordshire. However, discussions are significantly advanced between four Bedfordshire practices and an out of county federation/super-partnership, in addition to which, all practices are being encouraged to develop cluster arrangements to serve populations of approximately 30-50,000 in the first instance. Over the past few months, as a result of a targeted piece of work there are four emerging clusters evolving in Bedford, each of which have a clinical and managerial champion. The CCG's Bedford Borough Transformation Board is keen to oversee and assist where such barriers to consolidating these arrangements can be supported by the wider system partners.

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2.3.5 Primary Care Commissioning

BCCG formally moved into a joint commissioning arrangement with NHS England during 2016, and is working towards taking on full delegated responsibility for primary care commissioning at a suitable point. These co-commissioning arrangements have enabled the CCG to have more direct involvement in supporting the development of primary care and is enabling greater coordination of planning and commissioning of services across the spectrum of primary, secondary and community care (and social care through the Better Care Fund). This, in turn, is better enabling us to work with local clinicians to develop new models of care which increasingly break down the divisions between these services and deliver more joined up care for local people.

In our joint commissioning role, BCCG is providing significant support and local leadership to NHS England with the re-procurement of a number of APMS (Alternative Provider Medical Services) contracts which are due to expire throughout 2017. Within each re-procurement, opportunities to strategically develop more sustainable primary care services are being maximised.

2.3.6 Supporting Vulnerable Practices

Whilst the prime focus of our Primary Care Development plan is around developing future-proofed locality level solutions, there are a number of practices across Bedfordshire facing immediate challenges which are causing significant concern. NHS England have a diagnostic team and action and resource plan to support these practices, including funding from Section 96 monies. Bedfordshire CCG will continue to deliver short-term support to struggling practices in partnership with them. This support is helping practices to address their immediate challenges, whilst enabling movement towards more collaborative longer-term solutions.

Our established locality teams have an important role in supporting struggling practices, and their close relationships with practices have enabled both the CCG and NHS England to have early warning where notice has been served on contracts, which has helped to enable rapid contingency planning. Where short-term caretaker arrangements have been put in place, BCCG is working very closely with NHS England to ensure that these act as a bridge to more sustainable long-term solutions, in line with the Bedfordshire GPFV Plan.

Further information about the support we will continue to offer to vulnerable practices via the General Practice Resilience Programme is set out in Section 6.0 – Workload.

The sustainability of local practices will continue to be closely monitored through CCG Governance processes and the Joint Co-Commissioning Committee with NHS England.

2.3.7 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

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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 further 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 'fully 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.

2.3.8 Quality

The CQC has inspected all 53 of the Bedfordshire CCG practices to date (plus one practice which has since closed) under their new inspection regime which gives each practice an overall rating of either:

- Inadequate
- Requires Improvement
- Good, or
- Outstanding.

In addition to the overall rating the CQC also rates each practice in the following five domains:

- Safe
- Effective
- Caring
- Responsive
- Well-led

The CQC has published the ratings and reports for 41 of the Bedfordshire practices. All practices have been awarded an overall rating of 'GOOD' with the exception of one practice who has received a rating of 'REQUIRES IMPROVEMENT'.

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Further analysis identifies that the proportion of Bedfordshire GP Practices who have received an overall positive rating is higher than the overall position for Central Midlands DCO area, Midlands and East Region and the National position. The table below provides a summary of this comparison.

CCG Ratings Comparison

Geography	Overall Rating of Outstanding	Overall Rating of Good	Overall Rating of Requires Improvement	Overall Rating of Inadequate
Bedfordshire CCG	**0%**	**97.5%**	**2.5%**	**0%**
Central Midlands	1.44%	85.78%	10.12%	2.65%

*Six practices across Central Midlands have received an Outstanding Rating

A Primary Care Quality and Performance Primary Care Dashboard has been produced by BCCG's Locality Primary Care team to share local up to date information with NHS England relating to the performance and quality of primary medical services. This dashboard can be filtered to show an individual practice view, a locality view or a CCG overall view. This dashboard will be used in conjunction with the Quality & Performance Group meeting risk log, and information from CQC inspections to identify risks which could impact on the quality/safety of care being provided within primary medical services.

Key points from the latest version, from January 2017, are:

- **Medicines Management:** On average achieving the target for antibacterials with a small minority of practices more than 5% from target.
- **Flu:** The uptake for flu vaccine this year in our area is higher than the same period last year in all Localities. Flu vaccine rates for carers are underachieving.
- **Cancer:** The majority of practices in our area are similar to the England benchmark.
- **GP patient survey:**
  - Four practices in national highest decile and two practices in national lowest decile for Average of four elements of access to primary care.
  - Four practices in national highest decile for average of six elements of quality of Nurse Appointment.
  - One practice in national highest decile and five practices in national lowest decile for Average of six elements of quality of GP Appointment.
- **Dementia diagnosis rates:**
  - Bedford: 53%
  - Chiltern Vale: 56%
  - Ivel Valley: 52%
  - Leighton Buzzard: 53%

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- West Mid Beds: 52%
- **Diabetes:**
  - 35 practices with Type 1 Care Process Completion as expected
  - 36 practices with Type 2 Care Process Completion as expected, 10 practices as higher than expected, 3 lower than expected
  - No data for 2 practices
- **GP variation:** Mixture of practices with specialties above locality average and above locality 25th percentile

2.3.9 IM&T

All practices in our area use SystmOne as their medical records system. This will also be used by Hertfordshire Urgent Care for the integrated 111/Out of hours that will commence in April 2017. Work is underway through the implementation of the Local Digital Roadmap to ensure that SystmOne primary care records will be viewable across the system, including community service providers and acute Trusts. More detail is provided in the Infrastructure section 7 of this document below.

Practices in our area are supported by Hertfordshire Bedfordshire and Luton ICT who are currently undertaking a review and upgrade of ICT in all practices to ensure the primary care infrastructure is sustainable and able to support transformation.

Our achievement of e-referral utilisation in November 2016 was 18%. A significant amount of work has taken place since then, and continues, to improve uptake.

2.3.10 Estates

General practice services within Bedfordshire are delivered from 69 GP practice premises (54 main surgeries, 15 branch surgeries). 60% of these premises are classed as constrained or significantly constrained, many of which are not possible to extend. One-third of practices are based in converted houses.

The majority of the remainder of the out of hospital health estate within Bedfordshire consists of:

- Over 20 properties occupied by the current community services provider. These properties are owned by NHS Property Services (NHS PS) and leased to the provider, SEPT.
- Approximately 40 properties used by ELFT (East London Foundation Trust) to deliver local mental health services
- 5 sites used by current providers to deliver Out of Hours GP services.

The CCG indirectly pays for the community estate via the contracts with SEPT and ELFT, and is responsible for charges for void space within NHS PS properties within Bedfordshire. Strategic planning for general practice premises and the wider community estate has been fragmented and limited over recent years with changes in organisational responsibility for estates. Co-commissioning has also brought with it an opportunity to better coordinate estates planning and to respond to some of the associated challenges and opportunities locally.

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2.3.11 How this Plan Supports Delivery of the Nine Must-do's

1. STPs	STP core metrics set for 2017-19: • Project plans for solutions developed ('Better Care Closer' change programme; Single Point of Access and Clinical Hub) • Delivery of Primary Care Home work package (establishing GP clusters and community and social care teams) and developing transfer protocols. This plan will support the establishment of GP clusters and community and social care teams throughout Bedfordshire, as the foundation for the local Primary Care Home model.
2. Finance	Related QIPP Schemes: • Medicines Optimisation • Building capacity in anticoagulation services • Advice & Guidance/e-referral • RightCare Programmes • 111/Out of Hours Procurement • Urgent Care Advice and Guidance • Integrated Care Centre front door model • Urgent Connect – L&D • Fracture Liaison Service • Faecal Calprotectin Scheme • Minor eye conditions service • Frailty Pathway
3. Primary Care	• Provision of £3 per head Practice Transformational Funding across 2017/18 and 2018/19 to support implementation of Locality Development Plans – including establishment of GP clusters, shared delivery of functions between practices towards primary care at scale, and implementation of 10 high impact actions. • Delivery of Locality Development Plans to help reduce GP workload, and to deliver a stepped approach towards the future Model of Care • Comprehensive workforce development programme • Implementation of e-consultations from 2017/18 • Achievement of 100% extended access by March 2019 • Scoping towards development of multi-disciplinary support for care homes.
4. Urgent and Emergency Care	• Expansion of primary care streaming from A&E into new primary care hub on the Bedford Hospital site • 111: 30% of calls transferred to a clinical advisor
5. Referral to treatment times and elective care	▪ Bedfordshire RightCare Programme: Cancer, Respiratory, Diabetes, Cardiology, Gastroenterology, Genito-urinary, Mental Health, and Complex Care • Advice & Guidance Service – provision of rapid primary care access to specialist opinion in two different ways; one for urgent advice, via phone, for patients who would otherwise be sent by a GP to A&E and the other via a platform (Medefer) which will provide GPs with prompt but non-urgent Advice and Guidance when they would otherwise refer a patient into Secondary Care.

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	• Increase e-referral uptake
6. Cancer	• GP education events delivered by Acute Trusts to raise awareness of 2ww pathway • Undertake GP audit of 2ww referrals – appropriateness and quality • Work with partners (Acute Trusts, primary care, Cancer Research UK and Macmillan Charities) to develop a programme of work to understand variance in treatment pathways that could affect outcomes. • Increase uptake of screening for Bowel, Breast and Cervical cancer
7. Mental Health	• Additional psychological therapies for people with anxiety and depression. To be integrated with physical care. IAPT – improved access target 2017/18. • Development and implementation of a dementia screening tool
8. People with Learning Disabilities	• Increase number of annual reviews carried out by GPs for patients with learning disabilities
9. Improving Quality in Organisations	• Ongoing quality assurance via JCC and joint NHSE/BCCG Quality sub-group • Ongoing programme of practice visits, with detailed action plans co-produced with practices with outlier indicators, e.g. practices with poor access scores • Reduction in variation of LTC care via RightCare Programmes

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3.0 Model of Care

2.1 STP VISION

2.1.1 About this section:

Section 1 Introduction, describes the STP Footprint, population health and growth and wider plans for achieving our ambition for Primary, Community and Social Care services. It is signed by the three CCG Chairs and STP Lead.

This section provides a description of the model of care for Primary Care Services across the STP footprint and detailed descriptions of work being undertaken in Bedfordshire to deliver improvements to Primary Care in line with this model.

2.1.2 STP Model of Care

Within the STP foot print there are pockets of transformation, with more care than ever before now being delivered in the community, closer to and within people's homes, however, the resource to primary and community care has remained static. The GP Five Year Forward View forms an inherently important opportunity to achieve our ambitions to:-

- Strengthen primary care services to ensure sustainability and enable transformation
- Increase the health of the population by maximising prevention and self-care
- Shift activity away from acute services to community settings, closer to home supported by physical integrated Health and Care hubs as appropriate
- Ensure that people are able to access appropriate urgent care services, reducing reliance on A&E and reducing avoidable unplanned admissions
- Close integration of health and social care services including community and mental health services wrapped around Primary Care at scale across clusters serving 30-50,000 populations
- Supports the transformation of services for people with Learning Disabilities
- Helps to integrate physical and mental health services and achieve parity of esteem

Individual CCGs will work with their local GP members and partners to co-design the future model as relevant for each local area, based on the principles described and depending on the learning from the test sites.

BLMK understands and looks to build on the uniqueness of Primary Care and the registered practice list, this should remain at the centre of care at, or close to, home offering system-wide clinical leadership and retaining responsibility for coordinating the care that individual patients receive. The STP have utilised the Optum model identifying the top 2% of the population with complex care needs, the next 18% with high health care needs and the remaining 80% generally healthy.

Commissioners across the BLMK STP have agreed a joint approach to primary care modelling based on the following ambitions.

These ambitions are:-

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- Provision of care to a defined, registered population of between 30,000 and 60,000;
- A combined focus on personalisation of care with improvements in population health outcomes;
- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care.

These objectives are in line with the National Association of Primary Care (NAPC) model Primary Care Home (PCH) model formed to deliver the Five Year Forward View ambitions. Although PCH is not part of the Vanguard programme it is consistent with the ambitions of the Five Year Forward View and supported by the New Care Models Team. Luton CCG is one of 15 Rapid Test Sites (RTS) for the NAPC PCH model and will have access to, and be able to learn from, a RTS learning network called 'The Community of Practice'. This network will be testing the delivery of the wide-ranging components of a PCH. BLMK CCGs are developing plans to move all services to a similar baseline model. The focus of this work is to create a level of standardisation and learn from experiences in Luton, and other areas to enhance rather than replace the local development work already undertaken.

Luton CCG is one of 15 Rapid Test Sites for the NAPC Primary Care Home model and BLMK CCGs are developing plans to move all services to a similar baseline model. The Milton Keynes Newport Pagnell Medical Centre is also a test site for the Primary Care Home model to a population of 30-50,000. The focus of this work is to create a level of standardisation and learn from experiences in Luton and Milton Keynes, rather than replace the local development work already undertaken.

This innovative approach will enable us to strengthen and redesign our primary care, services, ensuring they are centered on the needs of local communities, and utilise the expertise of a wide array of health professionals within the health economy. Through it we will demonstrate that health professionals across primary care are committed to change and working in partnership. This will be another step towards greater integration between primary, community, secondary and social care services providing personal population-orientated primary care where physical, mental and social care is integrated around the needs of communities, particularly older frail people with long term conditions.

This model will be integrated as part of the planned development of community and other commissioned services across BLMK STP and will be co-designed by commissioners and providers to wrap services around patient populations of 30-50,000 with the GP at the centre of our patient's care.

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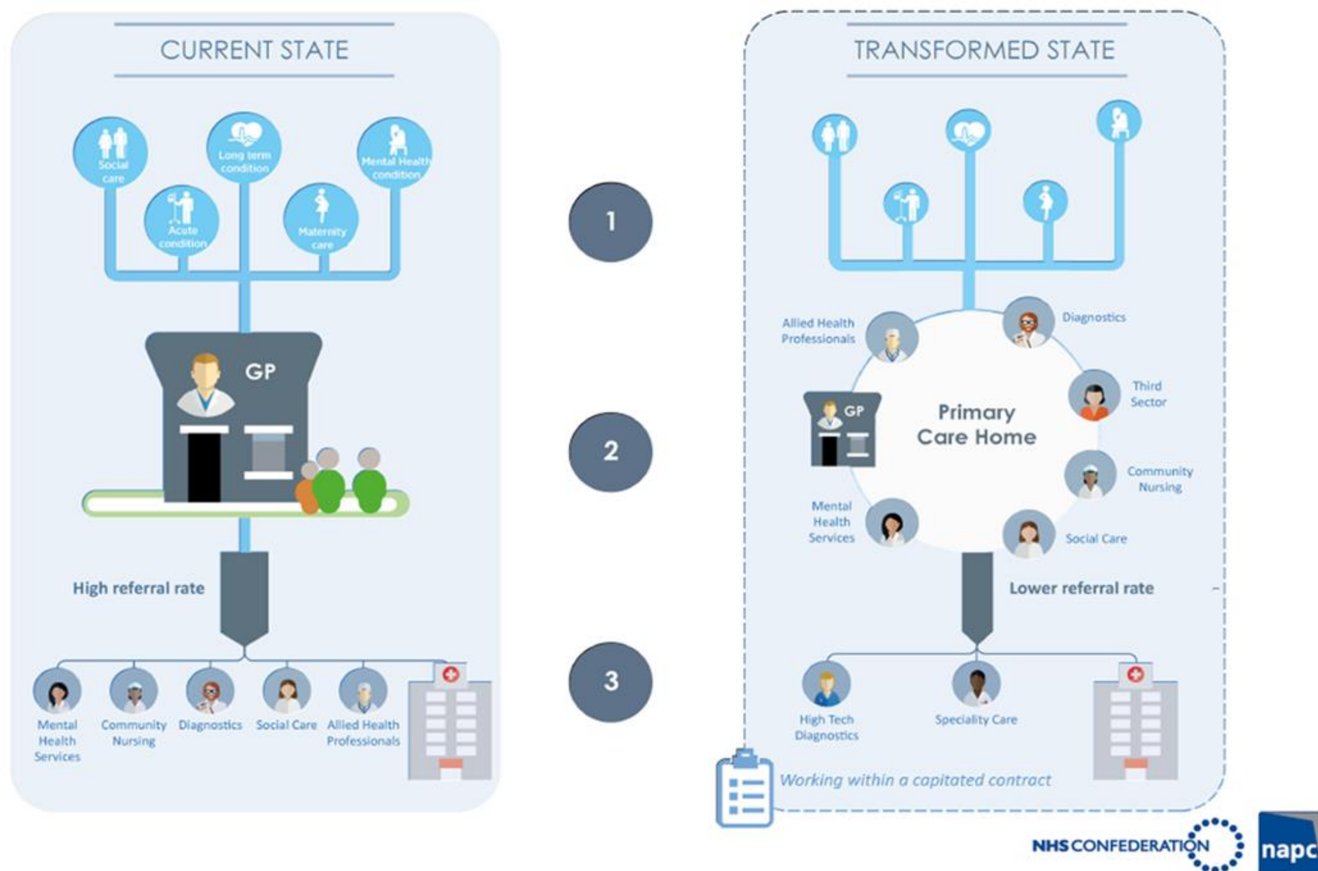
Primary Care Home - National Association of Primary Care



The new model of care ‘a complete care community’ as depicted above is built around patients and for patients, ensuring they receive the Right Care in the Right Place at the Right Time. This will ensure:

- Integrated working across the wider health, social care and voluntary community ensuring that our residents and patients receive care from the appropriate service or professional
- Patients are provided with personalised, coordinated and responsive care nearer to their home
- The GP remains central to patient care and care planning, supported by the multi-disciplinary team to coordinate care across all elements of the r health and social care system
- GP shared decision making and involvement during transitions between sites of care, e.g. when patients are being discharged from the hospital;
- Clear and timely communication and information flows between health and social care professionals, patients and their families.
- The needs of the registered population are better analysis to inform, workforce development, early detection, prevention and improved health screening.

BLMK STP has considered the four big killers: diabetes, cardiovascular disease (heart disease and stroke), cancer and chronic obstructive pulmonary disease (COPD), and has agreed that respiratory will be the first specialist area to come out in to the community. It is envisaged that specialists from the local acute trust will align

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with practice Clusters to support the PCH agenda, offering clinical advice for complex patients within a multidisciplinary environment. This process will enable the continued professional development of community and practice based clinicians across the STP footprint.

Patients will benefit by being able to access services quickly and will be helped to be more independent and manage their own health needs, understanding when and who to call for assistance if their condition exacerbates.

2.1.5 Practice Infrastructure – Technology Enabled Transformation

By working with the focus, scale and expertise available at the STP footprint level, funds already received by the Estates & Technology Transformation Fund (ETTF) will be used in the key area of technology enabled transformation.

Our responsive, proactive and multi-disciplinary approach to the delivery of primary care will be best enabled via effective use of the digital tools which are in place and are being used daily in some parts of the STP footprint. For example, effective triage and care coordination are already successfully being delivered in some areas.

Focus needs to be widened to support the change management and service redesign skills that will embed these new models of care. Increasing use of non-face to face and asynchronous consultation are fundamental to delivering the capacity required for general practice to engage with transformation.

Some successful models already exist in BLMK, which can act as demonstrator sites for others enthusiastic about transformation. These GPFV Plans will provide a mechanism for creating a more holistic programme of care pathway redesign. Technology is only a minor part of this. The main investment required is in the time and expertise to develop capabilities within individual practices and multi-disciplinary teams. Technology will enable the safe transition for GPs to increasingly lead the care of patients using the resources of the wider team in primary care. This links closely with the STP's Priority 4 work, which focuses on Digitisation, and through which we are coordinating BLMK's approach to ETTF primary care technology funding deployment.

The Local Digital Roadmap (LDR) is a key enabler for new models of care and will help to ensure patients have access to their care record. BLMK's LDR priorities are set out below. As well as focusing on improved communication for general practice, key priorities are around patient activation and self-care via access to their own records. This builds out from the already considerable progress made by some practices with regard to patient utilisation of record access options.

An example of where our LDR is focusing on innovation is in looking at the integration of new evolving pre-primary care solutions such as those delivered by patient-focusing apps. The use of these new tools within pathways to empower patients to take control of their condition is our aspiration. The role of prescribed app's to support self-care is one which the STP is seeking to embrace.

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2.1.6 Expected benefits of service offer

The new model of care is built around patients and for patients, ensuring they receive the Right Care in the Right Place at the Right Time.

By working together across the wider health, social care and voluntary community we will ensure that our residents and patients receive care from an appropriate service or professional. This will be achieved through changing the structure of our workforce and increasing the use of voluntary organisations to deliver services.

Patients will benefit by being able to access services quickly and will be helped to be more independent and manage their own health needs, understanding when and who to call for assistance if their condition exacerbates. We will do this through a variety of methods including use of "apps", web based solutions such as "The Sound Doctor" through these actions we will deliver:-

Improved patient health and wellbeing	Improved demand management through patient activation and self-care
	Improved stratification and analysis of population health needs, more prevention, early detection and screening.
	Greater accessibility to primary care reducing demand on A&E
Improved quality of care for patients in local communities	Improved service availability - patients receive the right care in the right place
	More finished episodes of care
	Extended continuity through perceptive and integrated community therapy
	Improved access and lower waiting times

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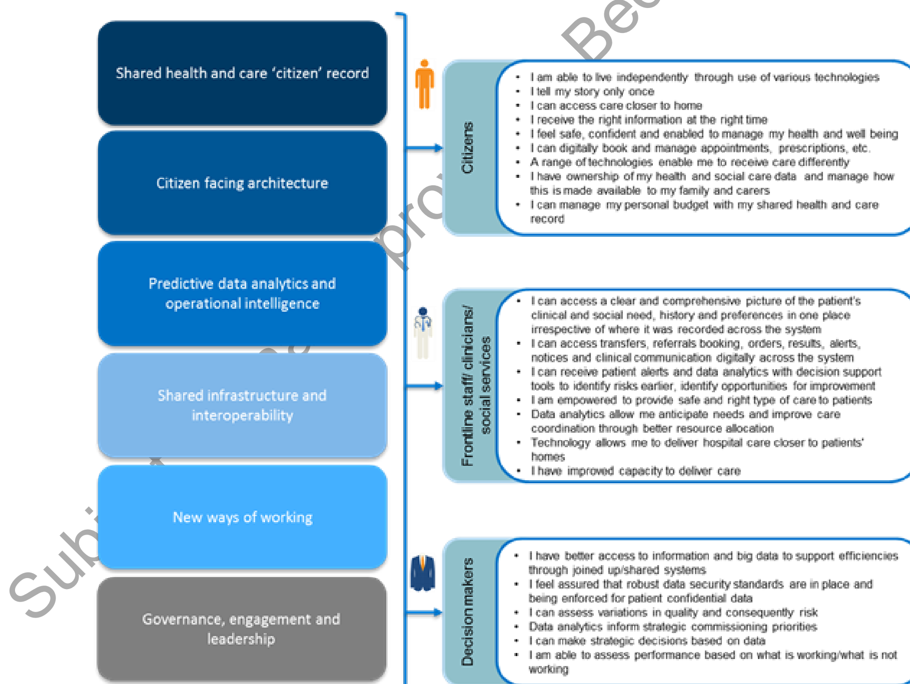
Improved utilisation and sustainability of local health and social care resources	Improved deployment of NHS and social care resources with improved patient experience and empowerment

2.1.7 Interdependencies with other transformation:

As highlighted in the introduction, our plans for the GP Forward View form an intrinsic part of the BLMK Priority 2 work stream and has interdependencies with:-

- STP Workforce workstream - details of this linkage are contained within the workforce section of this document
- STP P3 Acute Care will link with our work to reduce demand on A&E, avoiding unnecessary hospital admissions and reducing length of stay by supporting early discharge.
- STP Priority 4 Work stream which is delivering the Local Digital Roadmap. This is a key enabler for new models of care and will help to ensure patients have access to their care record. The Local Digital Roadmap priorities are set out below.



In developing our models of care, CCGs will ensure that they maximise the benefits of remote monitoring and self-care, supporting our residents and patients to manage their own health and enabling them to remain as independent as possible for as long as possible.

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2.1.8 Engagement

A full programme of engagement has been developed across the STP and within individual CCGs, each complimenting the other to avoid duplication while ensuring comprehensive engagement. We will continue to build on this through our work to define our Out of Hospital Strategy and as part of the Bedfordshire and Milton Keynes Healthcare Review. The Priority 2 Delivery Board will identify any key changes which will require public consultation and this will add further value to current engagement plans.

2.1.9 Programme Delivery

Focussed programme delivery will be required to ensure we achieve the scale of transformation to which we aspire. Our approach includes effective governance of the GP5YFV and Primary Care Home projects through a combined programme of Primary Care Transformation.

The two critical constituents of our approach are (i) Active co-design and organisational development support with Local Medical Committees and (ii) Engagement of practice management to provide personal and leadership development.

Priority 2 of the STP is focussed on providing capacity and capability to demonstrate, seed and nurture innovative solutions in General Practice. Our initial focus will be with practices that have expressed an interest in transformational change, using what is already proven within BLMK. The programme will be expanded to new practices as successful projects are delivered.

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3.2 THE VISION FOR BEDFORDSHIRE

The Bedfordshire CCG model is aligned to the planned development of integrated primary and community services across the STP footprint, in line with the NAPC model of Primary Care Home. Services will be designed to wrap around 30-50,000 cluster populations, with the GP being at the centre of our patient's care. We are working closely with our partners through the local authority-level Transformation Boards to design and implement systems based on the STP-wide Model of Care, tailored to meet local needs and circumstances. The table at Appendix 1 sets out alignment of BCCG strategy against STP priorities.

These clusters will form the footprints for collaboration and new ways of working between practices, delivery of extended access, and the development of multidisciplinary primary care teams to deliver integrated out of hospital services to our local communities. This model of care will be enabled through a stronger and more diverse workforce, through an inter-operable IM&T system - and ultimately a shared health and care record – along with the essential co-location of key services into integrated Health and Care hubs.

The programme to develop integrated hubs across Bedfordshire is a key part of this GPFV Plan, alongside a stepped programme to embed multidisciplinary working and co-location of key services.

There will be a structured transfer of services out of hospital into the community, initially across eight key pathways through the Bedfordshire RightCare programme, and better support for patients to be managed in primary care through improved access to advice from, and closer working with hospital specialists.

Equally, the integration of urgent primary care services within Bedfordshire will provide a more robust and consistent patient offer to help improve demand management across the system. This, alongside improved multi-disciplinary home visiting services and support to care homes, will help to reduce A&E services and emergency admission activity.

The transformative elements of this plan will take place alongside our ongoing work programme to continue to improve the quality of care delivered by local practices, and to support struggling practices. Key areas of focus for 2017/18 will be on improving cancer detection rates, increasing the number of annual health checks provided to people with Learning Disabilities, along with reducing variation in the quality of care delivered to people with long term conditions through our RightCare programme.

In order to support delivery, we are working with GP practices to raise awareness that they will need to operate on a larger scale (in order to increase their scope and organisational capacity) and in greater collaboration with other providers and professionals and with patients, carers and local communities. This will enable the provision of a more comprehensive range of services, which are coordinated and community-based. At the same time, general practice will need to preserve and build on its traditional strengths of providing personal continuity of care and its strong links with local communities that comes from individual practice units.

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3.2.1 Collaboration and New Ways of Working Between Practices

A key focus of our primary care development plans is supporting practices to implement locally owned primary care solutions at locality level. All five of the localities in Bedfordshire have produced Locality Development Plans, with input from all practices within the CCG, underpinned by detailed implementation plans. Patients have been engaged in the process of developing these plans via Locality-level Patient Participation Groups. The key focus of the plans is around developing more sustainable models of delivering primary care services across practices.

There are common themes across the Locality Plans, with strong alignment to the 10 High Impact Actions, and alignment with the Bedfordshire vision and to the Sustainability and Transformation Plan.

A combined locality plan is set out below which details the baseline position, how the plan will be delivered, stakeholder engagement and proposed projects for delivery (larger version included in Appendix 2).

hire CCG Board

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.

a. Collaborative management of same day demand and home visits between groups of practices

This has been identified as a key focus within our strategy. Demand for same day appointments and visits is placing practices under increasing pressure.

The CCG is working with GPs to identify appropriate solutions through collaborative working between practices. Our vision is for practices to link together to offer a single point of access for same day appointments for acute conditions and exacerbations of chronic conditions, using a similar approach to our Out of Hours Services and including the use of a multi-disciplinary team for delivery. Plans indicate that this will be a key enabler for helping practices to manage demand and capacity issues, and will help to establish footprints for delivering extended access during 2018/19.

We plan to incentivise accelerated delivery of these new models by directing a significant proportion of the Practice Transformational Funding (from the £3 per head funding) towards this priority development. Localities/clusters will be issued with a voluntary specification to receive pump priming funding for delivering same day access, home visits and frail elderly services across GP clusters in 2017/18 and potentially 2018/19.

Alongside this, we are planning to bring in additional estates support capacity (also funded via Practice Transformational Funding) to work with each locality / GP cluster to help develop locality premises plans as a stepped approach towards Hub working. This will include a specialist Healthcare Planning resource, to ensure that existing primary care assets are maximised, and also to identify the most cost effective and pragmatic solutions for enabling new ways of working for the next few years. For example, we are already supporting four practices with significantly constrained premises to establish a shared satellite clinic on a central site, for the practices to use to deliver their same day care collaboratively.

Benefits of the service include:

- Central point of contact for urgent appointments and visits
- Urgent visits throughout the day close to time of request, reducing the risk of patient's condition deteriorating and requiring admission to hospital. For example elderly patients with UTI.
- Enabling GPs to expand services for management of patients with longer term needs or chronic conditions
- Potential to increase appointment times in line with revised needs of patients
- Improved job satisfaction for GPs and others in primary care.

b. Improving support to care homes

The locality development plans set out plans for improving multi-disciplinary working and home visiting arrangements, including a number of initiatives for improve 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.

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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.

c. Improving access for patients and increasing practice efficiency through the development of new forms of consultation

We will support practices to manage demand for their services, and improve patient experience, through making more GP practice services available online via practice websites, and empowering patients to self-care and self-manage their conditions with digital support. This will include development of more online tools and smart apps to provide tailored advice and support.

In addition, using learning and experience from trials in other parts of the country we plan to work with GPs to expand the type and range of consultation experience to fit the needs of our patients including:

- structured telephone appointments
- online consultations/e-consultations
- group consultations for patients with long-term conditions/multi-morbidities.

Details around the delivery plan for e-consultations, and patient-facing technology, is provided in the Infrastructure section of this Plan.

d. Increasing skill mix and developing new roles within primary care

The future vision for primary, community and social care across Bedfordshire is aligned to this Plan, predicated on a strengthened, primary care led integrated out of hospital care service, a standardised approach to care co-ordination and an invigorated approach to self-care, self-management and the use of social capital and prescribing. Our plan is to ensure that clinicians are able to work to the top of their skill capabilities by increasing the skill mix within primary care and developing new roles to support service delivery.

The wrap of multidisciplinary teams around enhanced primary care services means that GPs and wider primary care staff will be able to work in a coordinated way to provide patients with timely access to the right professional within an out of hospital setting. This will enable:

- The development of a wider, virtual practice team, working with aligned MDT Coordinators (clinical navigator roles) and mental health workers (Primary Care Mental Health Link Workers)
- Access to timely and efficient pathways of care which ensure patients see the right professional in the right setting
- Support to work in proactive, anticipatory care approaches for patients with complex needs

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- Further reductions in clinically unnecessary GP appointments
- Coordinated working across differing sectors, organisations and professional

As a result GPs and wider practice staff will continue to build rewarding roles that support recruitment and retention of staff and offer a wider diversity of opportunities to work in a portfolio career and develop enhanced skills.

Key schemes initiated to date are set out below and further details are included in the CCG Workforce Section of this document.

- Clinical administrators – a new role focused on reducing GP workload by training administrators to undertake clinical coding. 16 administrators received training with the dedicated funding from NHS England in 2016/17, and a further 28 administrators are expected to receive training each year for the next two years.
- Clinical pharmacists – five practices involved in the Wave One pilot, further practices have applied for Wave Two
- Paramedics - employing paramedics within practices to conduct home visits.
- Practice manager development: improve resilience within the primary care system
- GP Fellowship schemes: recruiting future leaders into the locality
- CPD for nurses: to encourage role development and extension.

e. Greater collaboration between health and social care

In line with our plans for the development of multi-disciplinary hubs within our localities we will increase our joint working with social care partners through delivery of a place-based approach. This will include realignment of adult social care, CMHTs and community health services around GP clusters and will be delivered in discussion with our Transformation Boards and through our joint Out of Hospital strategy currently being produced.

Current projects in progress include:-

- Bedfordshire CCG is currently leading the procurement of an integrated community health service with partners Bedford Borough Council and Central Bedfordshire Council. These services will be required to link with primary care hubs for delivery of services and final service design will be agreed during the competitive dialogue process.

- We are developing a multi-disciplinary way of working, called Caring Together, which involves clusters of practices and a wider team of Matrons, Social Workers, Mental Health Workers, Geriatrician, CHC and the clinical navigation team meeting on a fortnightly basis to discuss patients which have been identified using both a risk stratified and a 'local knowledge' approach.

- Hub development programme, which seeks to provide focal points for multi-disciplinary teams will maximising the opportunities available to

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progress stepped solutions towards hub working in the interim. The Section 7 of this Plan provides further details.

f. Shared management of patients with long term conditions

We will support practices to develop shared management of patients with long term conditions, for example shared asthma / diabetes clinics. Whilst standards of care across primary care in Bedfordshire compare favourably with other areas of the country, there is evidence of variation in how patients with long term conditions are managed, and variation in outcomes for patients. Sharing care across groups of practices will enable specific GPs and nurses to dedicate larger amounts of their clinical time to helping patients to manage these conditions, enabling them to develop a greater degree of specialisation and enhanced skills, and greater standardisation of care.

3.2.2 Delivering More Services Closer to Home

As part of our plans we are actively promoting the appropriate transfer of care from hospital settings into primary care through the use of specialists in multi-disciplinary primary care teams and by improving primary care access to specialist opinion. We are also reducing the demand on secondary care services and evaluating the benefits of a process to support GP referrals and requirements for expert advice through the use of a new Advice and Guidance Service.

Bedfordshire CCG has established a series of clinically led Specialty Implementation Groups (SIGs) groups to review the RightCare Spend and Outcomes variation data, existing clinical pathways and local satisfaction and experience data. The aim of this approach is to ensure that commissioning plans are focused on the opportunities that have the potential to provide the biggest improvements in health outcomes, resource allocation and reducing inequalities. There are eight SIGs, which are as follows:

- Cancer
- Respiratory
- Diabetes
- Cardiology
- Gastroenterology
- Genito-urinary
- Mental Health
- Complex Care

The early opportunities relating to RightCare and the wider Planned Care Strategy for transfer of care from secondary to community/primary care includes:

- Expansion and development during 2017/18 of the **Integrated Diabetes Services** and **Integrated Respiratory Services**, focussing on increased support to Primary Care in the management of patients, access to patient and clinician education, access to advice and specialist support to complex patients. The aim is to provide the same level of services to all patients in Bedfordshire.

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- Development of **Integrated Dermatology Service** including increased engagement of GPs with Specialist Interest (GPwSI), Practice Nurses and Pharmacists. Following review of the service and contracting model, we expect services changes to take effect from August 2017 in a range of community locations across Bedfordshire.
- Implementation of the **Minor Eye Condition Service (MECS)** from April 2017, utilising the skills of optometrists to manage minor conditions in the Bedfordshire community, leading to a reduction of activity in secondary care.
- Early development of **ENT Community Services**, enhancing the access to advice and guidance and providing care closer to home for a range of routine outpatient attendances and minor procedures. Subject to development of the service model and clinical engagement, it is expected that the service will commence during Quarter 3 2017/18.
- **Faecal Calprotectin** tests now available to support primary care in the identification and management of patients with Irritable Bowel Syndrome which will lead to a reduction of elective activity for endoscopies.
- Establishing a clinically-led programme for development of primary care pathways for key clinical conditions during 2017/18 and integrated within the primary care IT offer.
- Implementation of a pilot service in March 2017 which improves access to consultant-led **Advice and Guidance** for Cardiology, Gastroenterology and Urology.

Alongside this programme, primary care access to specialist opinion will be formally available to GPs in two different ways; one for urgent advice, via phone, for patients who would otherwise be sent by a GP to A&E and the other via a platform (Medefer) which will provide GPs with prompt but non-urgent Advice and Guidance when they would otherwise refer a patient into Secondary Care. Advice and Guidance will be introduced via a phased approach commencing with Cardiology, Urology, Gastroenterology. GPs will be able to ask for advice and guidance direct from SystmOne with the response emailed back within 24 hours for the following:

- advice on a treatment plan or ongoing management of a patient within Primary Care
- clarification or advice regarding patient's test results
- advice on the appropriateness of a referral for a patient
- Identifying alternative clinically appropriate services to refer patients to

Currently GPs access consultant advice in an ad hoc manner. It is hoped that introducing the Medefer platform will enable all GPs to access advice in a quick and easy way to support their decision making.

3.2.3 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 forward provides a 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-

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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.

Alongside this, BCCG has commissioned a new combined 111/Out of Hours provider due to commence delivery of services from April 2017. We will work with the new provider to take forward a pilot with four practices initially, around integrating the 111 triage system into the triage process for these practices.

Key Milestones and Deliverables

Key Deliverables	Action/ Milestone	Milestone Delivery Date
Cluster Working		
Reaffirm/define clusters for 30-50,000 populations	Ongoing	Q2, 2017/18
Align Locality Development Plans to Local Authority priorities	Facilitated development session for each locality	Q2, 2017/18
Joint Out of Hospital Strategy developed	Multi-agency workshop; sign-off of Strategy via BCCG and Local Authority governance processes	Q1, 2017/18
Develop joint vision and implementation plan for improving support to care homes	Develop implementation plan as part of development of Out of Hospital Strategy	Q1, 2017/18
CMHT, Social Worker, and community services teams aligned to clusters	Community Health Services transformation and reprocurement; delivery through Transformation Boards	Q4, 2018/19
Estates Plans to support delivery of Locality Development Plans (see Infrastructure section below)		
Shared management of same-day access and home visiting across clusters	Specification for accessing pump priming (Practice Transformational funding to be issued to practices	Q1, 2017-18
Frailty Pathway		
Establish Frailty Pathway aligned to Bedford Hospital and Luton and Dunstable Hospital	Commission additional dedicated Geriatric capacity	Q3, 2017/18
Identification and management of patients with frailty, GMS contract 2017/18	Commission additional dedicated Geriatric capacity Develop specification for Comprehensive Geriatric Assessment and commission accordingly Improve discharge assessment process and communication and move to a single trusted assessment, and single point of coordination	Q1, 2017/18
Practice and locality MDT and risk stratification in place	Agree standard approach to identification of frailty	

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supported by geriatrician and GPSI elderly care.		
Enhanced support to Care Homes (as above)	Practice and locality MDT approach to be established across BCCG, risk stratification tool agreed.	Q1, 2017/18
Shared patient records (see infrastructure section below)		
RightCare		
Priority projects identified	Prioritisation of the emerging RightCare opportunities	Q4, 2016/17, Q1 2017/19
Project Initiation Documents	Development of service proposals and approval of PIDs via QIPP Board	Q1, 2017/19
Delivery of changes commences	Service implementation commences	Q1, 2017/19
Advice and Guidance		
Provider and system identified	Best solution identiied and agreed System rolled out to practices and implemented	Q1, 2017/18

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4.0 Access

Timely access to healthcare professionals is seen by patients as an essential component to a high quality overall service from general practice. There is a greater expectation for services to be available over 7 days with evidence that poorer outcomes are associated with reduced NHS services at weekends. Access to GP services is continually an area which receives high levels of interest and scrutiny from patients, the media, government and other stakeholder groups.

There are benefits to patients, GP practices and the wider health economy of delivering good access. Evidence also exists that suggests a correlation between GP access and A&E attendance. For example, research has been undertaken to determine a lower use of A&E services (20%) relating to ease of access to a GP by telephone.

Best practice suggests that good access to GP services should include the ability of patients to:

- Book an appointment quickly, with a reasonable timeframe, and pre-book an appointment if they wish
- See a preferred clinician if they wish to wait longer for an appointment
- Access to reliable information about the practice, so they can make their own decisions about the access they require
- Being able to book an appointment on the telephone but also by other means, such as through the internet, email, TV or by text message
- Contribute to feedback through Patient Participation Groups and other forums
- Patients being able to telephone the practice throughout the day

Currently there is wide variation across the STP for patient access in primary care; the vision is to deliver a consistent offer and access to the BLMK STP registered population, ensuring alignment with seven day services delivering increased numbers of pre-bookable appointments in the evenings and at weekends. We will commission services that align with best practice (as detailed above).

The BLMK STP will scope local need and benchmark access across its practices, sharing best practice both locally and nationally. A key priority will be commissioning services which maximise continuity of care for patients and learning from the GP Access Fund currently being delivered across Milton Keynes.

4.1 The Plan for Bedfordshire

All of the Locality Development Plans within Bedfordshire 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.

The majority of practices in Bedfordshire (38/54) take part in the Extended Access DES and are therefore already offering some services in the evenings and/or on weekends. It is expected that practices will need to work together within localities to deliver 100% extended access, and potentially with larger providers, e.g. the local out of hours provider.

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We will work closely with our practices during 2017/18 to lay the foundations for a successful extended access service to be operational by March 2019. We will work across the STP to access the learning from the MK expanding vanguard in order to act as a planning catalyst and increase the current ambition for primary care access in Bedfordshire. This will be done through a series of education events in localities and works in synergy with workforce and wider transformation plans including building access planning into the General Practice Resilience Programme and the Supporting Vulnerable Practices work.

This 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, and delivering locality-level education events in partnership with MKCCG
- enabling the development of GP clusters through the implementation of Locality Development Plans, including pump priming Practice Transformational Funding
- identifying the locations for extended access hubs within each locality, including patient engagement
- developing the Information Governance policies and technical solutions for sharing information and functionality between practice systems via the STP-wide Primary Care IM&T transformation programme
- scoping the procurement options for commissioning these services, and making key decisions around the procurement route.

Extended access services will be procured during 2018/19, to be operational by Quarter 4. 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.

These actions will build on work which will commence in 2017/18 around supporting practices to work together to deliver their same-day demand and home visiting services (supported with pump priming Practice Transformational Funding). We expect this to be an important stepping stone towards developing the cluster hubs to support extended access, and also for wrapping community, mental health and social care services around to provide more robust multi-disciplinary working, including across extended working hours.

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

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4.2 Key Milestones and Deliverables

Key Deliverables	Action/ Milestone	Milestone Delivery Date
Assessing local demand for Extended Access	Collation of Extended Access DES activity Analysis of demand for out of hours services during extended hours operating hours Patient engagement	Q2, 2017/18
Conference to show-case learning from elsewhere	Organise conference in partnership with LMC	Q2, 2017/18
Locality-level education events	Organise education events within each locality in partnership with MKCCG	Q3, 2017/18
Identify locations for extended access hubs	Patient engagement Expressions of interest from practices	Q3, 2017/18
Establish Information Governance policies for information sharing between practices	STP-wide IG policies to be developed under Primary Care IM&T Transformation Programme	Q4, 2017/18
Establish technical interoperability between practices (e.g. booking appointments into each other's systems)	Technical infrastructure already in place Development of protocols and templates Technical support and training for each locality	Q4, 2017/18
Agree scope of procurement	Scoping of options and learning from elsewhere Decision-making via BCCG Governing Body	Q4, 2017/18
Procurement	Dependent on scope of procurement (e.g. expressions of interest from practice collaborations / single-provider procurement)	Q1-3, 2018/19
100% extended access coverage operational		Q4, 2018/19

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5.0 Workforce

Ensuring the sustainability of primary care services and the delivery of future models of care is reliant on the recruitment, retention and development of a motivated, resilient workforce coupled with the introduction of new roles, enhanced skill mix and new ways of working.

The GPFV outlines the Government's commitment to expand the workforce capacity in General Practice. The aim is to double the rate of growth in medical workforce over the next five years, creating an additional 5,000 doctors working in primary care. This expansion will be supported by growth in the non-medical workforce - an extra 5,000 staff consisting of clinical pharmacists, mental health workers, nurses, physician associates and others.

The future model for primary, community and social care across BLMK is predicated on a strengthened, primary care led integrated out of hospital care service, a standardised approach to care co-ordination and an invigorated approach to self-care, self-management and the use of social capital and prescribing.

5.1.1 Current workforce – Key risks and issues

Significant workforce challenges face primary care across the Bedfordshire, Luton and Milton Keynes STP footprint. Workforce data shows a high percentage of staff reaching retirement age, and we have challenges recruiting health professionals in primary, community and social care. Compared to the East of England we have the second highest proportion of GPs due to retire in the next 5 – 10 years, 4% above the national average. There are 209 more patients per GP compared to the national average. At 2,349, the average list size per GP in BLMK compares unfavourably with England as a whole there is a growing aging population with increasingly more multi-morbidities.

In contrast, the ratio of patients per nurse is between the regional and national averages at 3780 patients per nurse compared to 3804 nationally and 3671 regionally. However, 27% of practice nurses are over 55. The percentage of advanced or specialist nurses ranks second in the region ranging from 34% in Bedfordshire to 24% in Milton Keynes.

Proportionally, Bedfordshire CCG has the fewest health care assistants, whereas across Luton Health Care Assistants make up 85% of the direct patient care staff. The vacancy rate for Mental Health Nurses is 19% with 15% over 55, Learning Disability Nursing has 17% vacancies with Social Care posts sitting at 12% vacancy rate and 27% turnover.

The workforce challenge in community health services is significant and pressing. High turnover and high vacancy rates feature prominently across BLMK. The community workforce is ageing, particularly in the large peripatetic staff groups, such as district nursing and health visiting.

Impending GP and Practice Nurse retirement, GP emigration and wide variation in the ability to recruit to vacancies and attract trainees, resulting in posts remaining unfilled or practices relying on long term locum support continues to put pressure on the existing workforce.

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Historically, a lack of comprehensive primary care workforce data has hindered the ability for effective workforce planning, impacted by a lack of focus on workforce development, career pathways and succession planning. In addition, practices' resilience issues are affecting their capacity to support increased training in primary and community care settings or provide the appropriate level of support and supervision to new roles such as Clinical Pharmacists or Physicians Associates.

5.1.2 Workforce planning

Across the STP footprint workforce planning is approached through the Local Workforce Advisory Board (LWAB), which has comprehensive and coordinated oversight of the inter-related workforce challenges and assures collective action. The LWAB includes representation from each of the three CCGs, STP partner organisations, Health Education England, education providers, Community Education Provider Network (CEPN) leads and the Local Medical Committee. The LWAB is responsible for the workforce strategy and transformation plan and reports directly into the STP steering group.

The modelling provided in Appendix 4 of the GP Forward View Guidance indicates a demand-supply gap (high end threshold) of 1 extra doctor working in primary care and 8 'other primary care clinicians'. Further analysis of the figures relating to 'other primary care clinicians' is required particularly in relation to overseas recruitment and the number of mental health therapists working in primary care as they do not resonate with our local intelligence.

5.1.3 Community Education Provider Networks

Bedfordshire's Community Education Provider Network was established in April 2016 and draws together key system partners including GP educationalists, practice nurse and practice manager representatives. The network collectively plan local primary care recruitment and retention initiatives, strategies for increasing pre and post registration training placements and mentors and the development of wider multi-professional education and training.

Luton CCG was successful in their application for wave 3 CEPN status in January 2017. The three CCGs will work increasingly more closely to share learning, best practice and maximise opportunities to work collaboratively and at scale, on workforce initiatives across the STP footprint with the aim of;

- increasing resilience through new ways of working
- providing education and development to create an energised and sustainable workforce
- motivating, valuing and engaging existing teams
- creating vibrant organisations, interesting roles, career structures and supported development opportunities
- attracting more people to want a career in BLMK through targeted marketing campaigns
- developing a flexible workforce made up of skill mixed teams and extended teams that reflect the needs of the population
- supporting the implementation of new approaches to the delivery and organisation of care such as integration, extended roles in risk stratification, care planning and case management.

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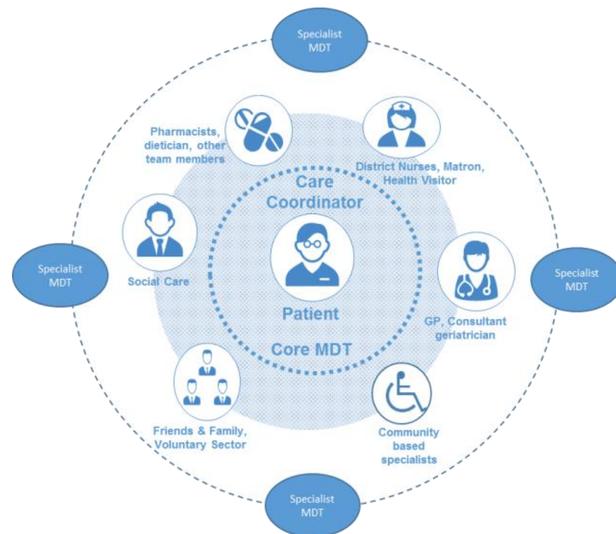
5.1.4 New Models of Care: Workforce Implications

Underpinning the Primary, Community and Social care model within BLMK are the primary care home principles of a single integrated and multidisciplinary team, working to provide comprehensive and personalised care to individuals.

Figure 1. Primary Care Home



This will be delivered through new ways of working within general practice and primary care, providing strengthened, enhanced GP services and also supported through a wider health and social care workforce, wrapped around GP services, to offer coordinated, joined up,

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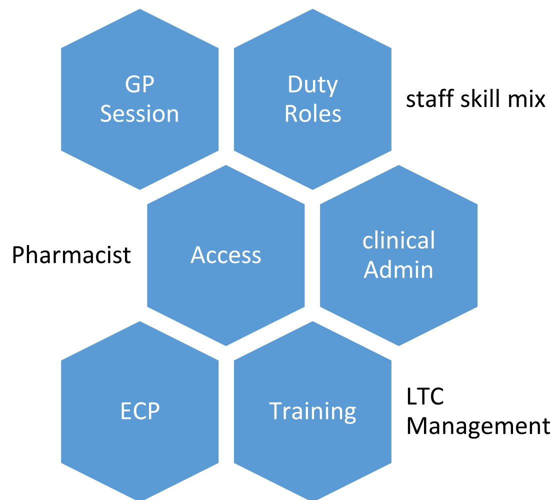
The workforce implications of this future model of care will be;

- New ways of working to enable ready access to stronger multi-disciplinary clinical skills
- Staff trained to enable ready access to high quality decision support systems & technology
- Professionals able to operate at the “top of license”,
- Development of specialist skills with focus of scarce skills on patients with complex or chronic needs
- Capacity created to undertake anticipatory care and to in-reach into care hot-spots, such as care homes
- Closer co-ordination between GPs and hospital clinicians across care pathways
- Closer connectivity between GPs and hospitals facilitating a smooth transition for patients between care settings, either into or out of hospital
- Hospital clinicians supporting the development of specialist clinical expertise in the community
- New ways to engage with and incentivise GPs and other Primary Care clinicians to support vulnerable practices or to solve “hard to recruit into” areas/practices
- The opportunity to enhance skill mix, freeing up GPs and other primary care clinicians to focus on care management and delivery and reduce administrative burden
- The opportunity to develop rotational placements, embed career pathways and create generic roles

5.1.5 New Ways of Working in Primary Care

Luton CCG's Primary Care Home initiative provides a test bed for new ways of working in General Practice that will be rolled out across BLMK to develop strengthened, enhanced GP services.



Since May 2016 Lea Vale Medical Group in Luton have revolutionised the general practice team, introducing new ways of working and new roles with significant results:

- GP capacity increase by 44%
- DNA rate reduced from 8% to 2%
- Patients seen by most appropriate clinician = 16% of GP work moved down to nursing team, ECP and practice pharmacist
- Team based working = reduced stress of whole team

Following a six month planning period, including engagement with the patient participation group and a comprehensive staff training programme, new ways of working have improved patient access and staff workload:

5.1.6 The GP Session

Traditional Practice	New Way of Working	Impact	Outcomes
1 GP Session - 18 pre-booked patient requested Appointments - Booked up to 6 weeks in advance - High numbers of clinically un-necessary appointments with GPs	GP Telephone Triage - For all pre-booked appointments - For all call slot appointments	1 GP Session - 5 pre-booked 10 min appointments - 16 telephone triage 5 min appointments - 5 same day call in 10 min appointments	- 8 additional patient contacts per GP session - 1 WTE GP = 3,240 extra patient contacts per year - Patient contact clinically appropriate - Patient choice on appointment time - All time slot used

5.1.7 The Duty Role

Traditional Practice	New Way of Working	Impact	Outcomes
Duty GP for patients unable to see own GP that day	Duty GP supported by: - Duty Nurse; telephone triage or face to face appointments - Duty HCA; same day ECG, dressings etc. - Duty Admin; all non-clinical queries and liaises with other services	- Improved coordination and information sharing with other services e.g. District Nurse, Ambulance, Care Home - Telephone or face to face access for patients - Option for same day or later appointment	Duty Team approach consisting of GP, Nurse, HCA and Administrator offers more effective and efficient service

5.1.8 Staff Skill Mix

Traditional Practice	New Way of Working	Impact	Outcomes
GP, Practice Nurse, HCA, Practice Manager Admin & Reception Staff	Introducing new skill mix and roles: - Emergency Care Practitioner - Clinical Pharmacists - Advanced Nursing Roles - Physicians Associates - Clinical Administrator - Long term locums - Physiotherapist	- Variety of prescribing professionals (either independent or protocol) - Nurse Led LTC Clinics - Greater support to paediatric care (ECP) - Protocol driven review of clinical info (Admin) - Home Visit support - Medicines optimisation	- Release GP time for clinically appropriate appointments - 70% reduction in GP paperwork - Multi-professional learning and support -

5.1.9 Enhanced Primary Care Services at the heart of Community Integrated Health and Social Care Teams

Wrapped around enhanced, strengthened Primary Care and jointly providing coordinated, joined -up care, community integrated health (including mental health) and social care multidisciplinary teams will provide intensive case management and rapid response services.

5.1.10 Joint Community and Primary Care Initiatives

Across Luton CCG Joint workforce transformation initiatives are being developed that can be shared across the BLMK footprint. These include:

- Baseline workforce assessment profiles that include community services to identify opportunities for joint solutions
- Development of collaborative approach for post registration nurse pathways in community health and practice nurse roles
- Cross sector planning for developing roles (e.g. support worker roles) and implementing new roles (e.g. Physicians Associates) at scale

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- Developing rotational opportunities for staff e.g. ECPs in Primary Care which the local place-based system also support to ensure services are not depleted of staff e.g. Emergency Nurse Practitioners rotate into ambulance service also.
- Roll out of Primary Care Mental Health Link Worker
- Development of multi-professional, collaborative 'team' leadership training opportunities

5.1.11 What does this mean for Primary Care?

The wrap of multidisciplinary teams around enhanced primary care services means that GPs and wider primary care staff will be able to work in a coordinated way to provide patients with timely access to the right professional within an out of hospital setting. This will enable:

- The development of a wider, virtual practice team, working with aligned MDT Coordinators (clinical navigator roles) and mental health workers (Primary Care Mental Health Link Workers)
- Access to timely and efficient pathways of care which ensure patients see the right professional in the right setting
- Support to work in proactive, anticipatory care approaches for patients with complex needs
- Further reductions in clinically unnecessary GP appointments
- Coordinated working across differing sectors, organisations and professional

As a result GPs and wider practice staff will continue to build rewarding roles that support recruitment and retention of staff and offer a wider diversity of opportunities to work in a portfolio career and develop enhanced skills.

5.2 The Plan for Bedfordshire

5.2.1 Workforce Profile – Key risks and issues

We have recently undertaken an annual refresh of the general practice workforce data baseline assessment across Bedfordshire, achieving a 68% return rate. In comparison to the 2016 workforce profile the number of WTE GP and Practice Nurse vacancies have reduced across the patch, with the most significant reduction in Bedford locality from 18.6 WTE GP vacancies in January 2016 to 7.5 (based on 76% return rate from the Bedford Locality). However, locally the % of GPs and practice nurses over the age of 55 is 24% and 28% respectively and 14 GPs and Practices Nurses and have indicated they will retire within the next 12 months. Two Practice Managers have indicated they will retire over the next 12 months, however 24 are over the age of 50 years.

Analysis of the current profile indicates that across Bedfordshire, practices employ 9 specialist nurses, 25 HCAs, 5 Clinical Pharmacists and 1 paramedic. 16 practices are accredited training practices, with a number taking medical students and offering nurse student placements. Across the CCG over the past year we have increased our mentorship capacity by training and updating 27 mentors and 5 sign off mentors and will continue to update mentors as part of a rolling programme. Through the

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2017 workforce data assessment we have also captured where practices have indicated they are interested in hosting new roles or sharing resource across practices.

Key risks and issues:

- Ongoing GP and Practice Nurse vacancy rates
- Difficulties in recruiting and reliance on long-term locums
- Number of GPs, Practice Nurses and Practice Managers nearing retirement
- Practice resilience issues (workforce and premises) are affecting their ability to take students
- Practice resilience issues (workforce and premises) are affecting their ability to host and provide the appropriate level of support or supervision to new roles such as Clinical Pharmacists or Physicians Associates

5.2.2. Recruitment and Retention

The Community Education Provider Network (CEPN) will continue to work collaboratively to implement our workforce development plan and focus efforts on;

- Addressing the shortfall in Primary Care workforce provision
- Enhancing the development and availability of innovative primary care roles
- Improving educational quality through better integration and communication across educational partnerships
- Expanding multi-professional capacity, skills and educational opportunities
- Continuing to provide evidence-based and practical support for practices around workforce development and new models of service delivery

Local initiatives include;

a. GP Future Leaders programme

The CCG funded recruitment initiative has successfully attracted two out of area post-CCT GPs to a three year programme designed to develop our clinical leaders of the future. A portfolio career option, the posts comprise of clinical sessions, a commissioning placement with comprehensive induction and training programme and a funded MBA.

b. GP Fellowship scheme in partnership with Health Education England

Through the GP Fellowship scheme we have successful retained two post-CCT GPs within Bedfordshire and attracted a further two GPs from outside of the area. The four GPs will all undertake a commissioning placement with the aim of developing their commissioning and leadership capabilities.

Both programmes have generated nation-wide interest and we have built a database of ‘interested GPs’ and connected our GP Future Leaders and GP Fellows into a national post-CCT GP network.

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Over the coming year we will continue to work in partnership with Health Education England, the Local Medical Committee and our practices to offer further placements on the GP Fellowship scheme and explore further recruitment solutions.

c. GP Induction and Refresher and GP Retainer Scheme

We currently have two GPs on the Retained Doctor scheme and continue to promote both schemes to our practices through our GP Tutor and Locality Teams. We are planning a more targeted marketing approach towards GPs not currently practicing, as part of a wider campaign focused on retention solutions such as portfolio careers and the development of innovative posts spanning clusters of practices or hubs.

d. Overseas recruitment

Working in partnership with NHS England and our local Medical Director we will explore the potential of overseas recruitment, learning from the experience of Lincolnshire.

5.2.3 Practice Nurse Development and Support

We will continue to maximise the Practice Nurse Tutor post to provide mentorship and support to both experienced and new practice nurses, to encourage retention and promote development and training. We are currently undergoing a training needs analysis of our Practice Nurses and Health Care Assistants to inform CPD requirements for 2017-18 and will work in partnership with Luton CCG to maximise the funded opportunities available to our workforce.

We are working closely with our local University to expand the number of student nurse placements available in practice and have expanded our mentorship capacity from none up to 27 local mentors. As part of the workforce baseline data assessment we have captured the level of specialism within our practice nurse teams to help inform the strategic picture of how existing and future skill mix might support the delivery of new models of care and primary care at scale.

5.2.4 Promoting skill mix and development

To support the release of GP time and promote and develop the use of other health care professionals in practice we have commissioned training packages to up-skill our practice nurses in a rolling programme of core competency skills as well as advanced skills such as Nurse Prescribing.

Three Health Care Assistants are currently undertaking the Flexible Nursing programme and in April we will train our first cohort of Health Care Assistants to ‘Assist with Medical Procedures’ and are planning further phlebotomy training.

Five newly recruited Practice Nurses are undertaking the University of Hertfordshire Practice Nurse Development Programme which incorporates a six month programme core competency, leadership and mentorship training. Three Health Care Assistants are currently undertaking the Flexible Nursing programme and in April we will train our first cohort of Health Care Assistants to ‘Assist with Medical Procedures’ with plans for further phlebotomy training.

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a. Clinical Pharmacists

Through the Wave 1 Clinical Pharmacist pilot we successfully recruited 5 Clinical Pharmacists who work across 8 practices and have applied for a further 5 posts to work across 7 practices. If successful this will equate to ten Clinical Pharmacists working across fifteen practices with Bedfordshire.

This new role is already delivering demonstrable impact in practice, providing extra support to deliver more self-care, self-management, and extra help with long term condition management and medicines management advice. An audit undertaken in Q3 2016-17 by a Wave 1 participating practice has indicated that 8 weekly sessions of clinical pharmacist time has equated to 0.6 of a whole time equivalent GP.

In the second phase of the programme there is greater emphasis on the requirement for GP clinical supervision in participating practices, with the expectation that supervisors are appropriately trained as clinical supervisors and practices approved learning environments. The Bedfordshire CEPN has successfully bid for further funding to provide this training and further multi-professional development opportunities across Bedfordshire and Hertfordshire and Mid Essex.

b. Clinical Administrators

Utilising the 2016-17 GPFV allocation we have successfully trained sixteen Clinical Administrators and eleven GP champions across eleven practices using the Brighton and Hove accredited training programme. Mentored in general practice by their GP champion the clerical team are upskilled to read code and action incoming clinical correspondence. Evaluations have been extremely positive and we will roll out further cohorts of training over the coming year ensuring that every practice or cluster of practices has the opportunity to train members of their team. We have encouraged the development of a peer support network across practices to share learning, best practice and protocols.

c. Physicians Associates

We are exploring the role of Physicians Associates in practice and have facilitated an experienced Physicians Associate and Course Lecturer to speak to a group of practices on the benefits of the role and how it works in general practice. The University of Hertfordshire has submitted a bid to host a Physicians Associate programme and we will work in partnership with Health Education England to encourage our practices to provide student placements.

d. Emergency Care Practitioners

One Emergency Care Practitioner has recently been appointed to a practice in the Ivel Valley Locality to help with the management of minor illnesses and to conduct acute home visits. We will work in partnership with Milton Keynes and Luton CCGs to learn from their experience of the role in practice and consider the implementation of rotational career option with the ambulance trust.

e. Practice Manager Development

A Practice Manager led group has been established to inform and design bespoke, local support for their peers. Based on their recommendations we are developing;

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- A ‘burn-out’ prevention programme including sessions to support Practice Manager resilience, including coaching and mentoring

- Learning sets of 5-6 Practice Managers provide peer support and cover technical subjects in relation to practice management for example, QOF, CQRS, financial claims.

Additionally, we are developing a Practice Manager Leadership and Innovation Group to co-design and drive change while also encouraging our Practice Managers to express an interest in the NHS England Practice Manager Leadership Programme.

5.2.5 Primary Care at Scale

Through their Locality Development Plans practices have identified areas where they will work more closely together and consider the sharing of back office functions. Within our Chiltern Vale Locality, the ten practices have worked collaboratively to produce locality-wide generic practice protocols and policies and during 2017 will broaden this approach. The six practices in West Mid Beds have worked together to develop a common, linked website to increase self-management/care and locality-wide use of “ask the GP” with plans to expand this to a shared e-consultation within 2 years. Practices in the localities of Leighton Buzzard, Bedford and Ivel Valley have committed to working together to share both clinical and administrative best practice and to link IT systems.

We have proposed that £100k of the Practice Transformation Funding be set aside to develop dedicated Administrative and Clinical Leadership to support at-scale provision and multi-disciplinary team development. A further £50k will be made available to commission specialist workforce diagnostic and change management support to work with groups of practices to review opportunities to improve skill-mix and redesign how care is delivered.

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5.2.6 Key Milestones and Deliverables

Key Deliverables	Action/ Milestone	Milestone Delivery Date
Clinical Administration Training	Roll out of second cohort of training – 28 administrators	Q1 2017-18
GP Fellowship Scheme	Subject to available funding, partnership working with HEE, LMC and practices to offer educational package as element of recruitment strategy	Q1 2017-18
GP Retainer, GP Induction & GP Refresher Schemes	Wide spread promotion of schemes via GP tutor and Locality networks Targeted campaign to raise awareness amongst GPs not currently working	Q2 2017-18
Overseas Recruitment	Partnership working with NHS England Medical Director to explore recruitment option	Q1 2017-18
Clinical Pharmacists	Recruitment to Wave 2 pilot posts	Q2 2017-18
Promotion of other Health Care Professionals in practice	Ongoing programme via protected learning events and joint working - LMC conference	Q2 2017-18

Workforce baseline assessment	Annual refresh	Q4 2017-18
Practice Nurse and Health Care Assistant Development	Ongoing programme of education and developmental support via protected learning events	Ongoing
Physicians Associates	Joint working with Hertfordshire CCGs to encourage and support student placements	Q3 2017-18
CEPN development	Joint working with Luton CCG to explore economies of scale and opportunities to share learning and work collaboratively, at scale	Q2 2017-18

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6.0 Workload

Across the STP footprint we recognise our practices' workload has increased significantly due to unprecedented levels of demand, increased bureaucracy and workforce pressures. While some of this workload pressure can be addressed by increasing the workforce, ensuring appropriate skill mix and more integration with the wider health and care system, practices need support to help moderate demand, divert unnecessary work and to be able to reform to support and organise services.

In consultation with NHS England, over half of the practices across the three CCGs were identified for support under the GP Resilience Programme, 26% were shortlisted to receive support during 2017-18. Across Bedfordshire and Luton CCGs this support will be provided by the Local Medical Committee and will take the form of a diagnostic assessment followed by support to create an appropriate business development plan. The development plans will enable practices to understand the steps needed to increase their resilience and to be in a stronger and more sustainable position to be able to progress opportunities of working together in different ways. Within Luton CCG four practices have also been identified to receive intensive team coaching and within Milton Keynes CCG two practices have been identified to receive rapid intervention.

Across Milton Keynes and Bedfordshire CCGs both individual and clusters of practices have submitted expressions of interest for the Time for Care Programme. The practices, supported by their locality teams, are working in partnership with the Sustainable Improvement Team to organise facilitated workshops planning for the implementation of the 10 High Impact Actions. We will work across the STP to share local learning, best practice and encourage further expressions of interest.

We will share national case studies and work in partnership to ensure there is widespread awareness of the further opportunities available to practices through the General Practice Development Programme, including the support available to;

- Build Capacity for Improvement
- Create a Productive General Practice
- Training for Reception and Clerical Staff
- Practice Manager Development
- Online Consultations

6.1 General Practice Resilience Programme

During Q3 of 2016, 27 Bedfordshire practices applied for the GP resilience funding with support from their locality teams. NHS England shortlisted 14 practices for support under the programme, in consultation with the CCG and Local Medical Committee. These practices serve a population of 148,061 patients. The submissions comprised of individual practice submissions and groups of practices

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working collaboratively. The successful bids specifically outlined their intention for stronger joint working.

The majority of practices have been encouraged by NHS England to access a support package designed by the Local Medical Committee. The package incorporates an in-depth practice diagnostic tool followed by support to increase resilience in a range of areas from planning to work at scale, new ways of working, financial stability and the development of different pathways, for example shared access. The LMC will work with the practice/s to create an appropriate business development plan. Part of the development plan will look at what further future support the practice may need, and will position the practice more favourably to make an application for further GPRP support if appropriate.

Should the outcome of the LMC support package be the desire for practices to work in collaboration or merge with other practices an LMC legal support package can be added to the overall package. The LMC have written to all practices, requesting the completion of an initial questionnaire and will begin the process of undertaking the diagnostic assessments and visits over the coming months.

It appears that a significant number of the unsuccessful practices will be re-applying particularly those in areas of increasing vulnerability or where the vulnerability of specific practices could impact on practices in the surrounding area. The locality teams will encourage joint bids from unsuccessful areas and support practices to develop bids in recognition of the fact that those most in need do not necessarily have the capacity to develop a successful approach to bidding.

6.2 General Practice Development Programme

A group of eight practices within the Bedford Locality have expressed an interest in the Time for Programme, with the potential for a further five practices to join the group. The NHS England Sustainable Improvement Team will be facilitating a series of workshops with the practices to embed the concepts of improvement science, change management and to help develop improvement capability. The first session will take place in March where the practices will come together to agree the High Impact Action(s) they would like to work on and to create a plan for delivery. The NHS England team will support with the utilisation and application of improvement tools.

One practice within the Time for Care cluster sits in a particularly deprived area and was successfully awarded Lottery funding three years ago to fund a Health Champion. This role has had a tremendous impact on the patient population in terms of social prescribing, navigation of services and promoting self-care. The Health Champion actively sees patients on an appointment basis and has brought patient cohorts together to organise ‘Park Runs’, supported the elderly and socially isolated with group lunches and contacted and mapped a variety of community support groups. The practice have now funded the post themselves and will be sharing their learning and experience across the Time for Care cluster.

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Working with our Locality Chairs, Locality Boards and Practice Manager Forums we will ensure that all practices across the CCG are aware of the opportunities available through the General Practice Development Programme and specifically the national collation of 10 High Impact Action case studies. The portal remains open for expressions of interest until 2019 and we will actively work with our localities to ensure that any further groups of practices wishing to express an interest do so within this deadline. Similarly, we will actively promote the 'quick start' Productive General Practice Programme and the Practice Manager Development Programme.

6.3 Delivering the 10 High Impact Actions through 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. 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 /multimorbidities, 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 trialing 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.

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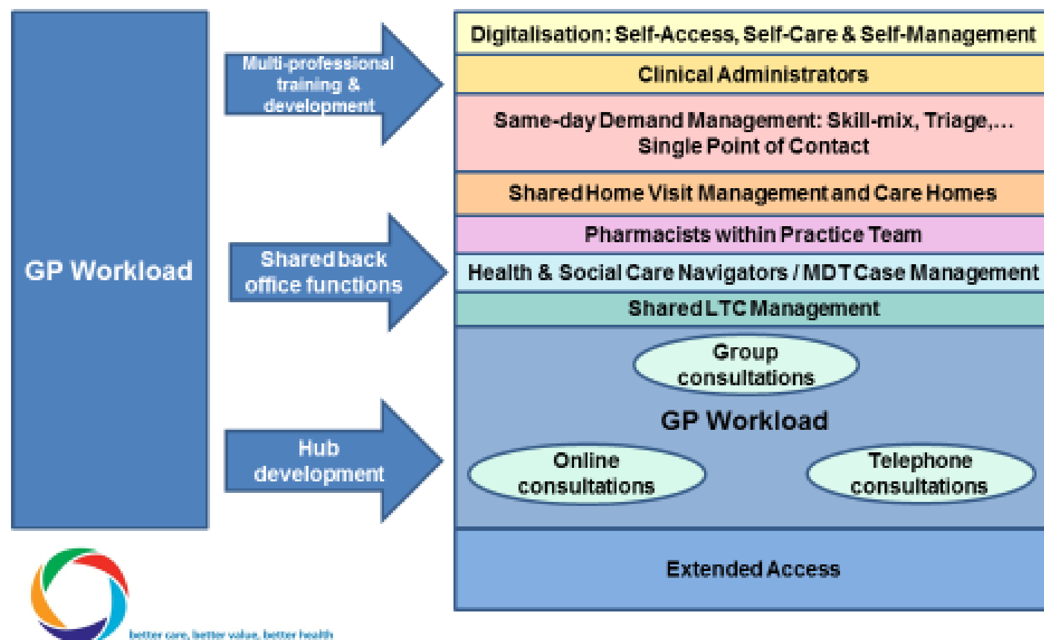
The diagram below illustrates the intended impact of these initiatives on reducing GP workload.



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

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Key Milestones and Deliverables

Key Deliverables	Action/ Milestone	Milestone Delivery Date
GPRP – second wave applications	Locality teams to work with unsuccessful practices to submit second application to GPRP	Q1 – Q2 2017-18
GPRP – second wave applications	Locality teams to identify further practices / groups of practices for support and type of support needed	Q2 2017-18
Promotion and support for implementation of 10 High Impact Actions	Promotion via GP newsletter, website, Locality networks, shared learning events Support via dedicated workforce resource and locality teams to implement 10 HIAs described within Locality Development Plans	Ongoing
Promotion and support for implementation of General Practice Development Programme	Promotion via GP newsletter, website, Locality networks, shared learning events Support via dedicated workforce resource and locality teams to implementation of Locality Development Plans	Ongoing

7.0 Infrastructure

Delivering more sustainable primary care services, and delivering our future model of care, requires significant development of our out of hospital infrastructure.

7.1 Estates

All four Local Authorities within the BLMK STP are areas of significant housing growth. This is set against the current position where many of the facilities used to deliver primary care services are already too small for their existing patient lists, and many are not ideal for the delivery of modern and integrated primary care services.

The future vision for primary, community and social care in BLMK is centred around integrated multi-disciplinary teams delivering an expanded range of out of hospital services, so ensuring an adequate community-based estate to deliver and enable these models of working is essential. The estates strategies for each of the CCGs, and the STP Estates work programme, all focus on maximising the use of existing assets, delivering projects to increase the capacity of general practice services for this growing population, and increasingly working towards developing facilities which can be used flexibility by a range of providers to support a more integrated model of care.

The CCGs' local estates plans are directly aligned with the BLMK STP estates work plan where the identified priority areas include:

- The need for joint working across primary, community and social care to optimise the use of existing estate across the footprint
- Rationalisation of estate and development of flexible facilities to deliver long-term value
- Opportunities to release capital proceeds where sites are declared surplus to requirement
- Consideration of back office services and functions provided within secondary care estates to drive consolidation in community settings
- Opportunity to consolidate estate management services and Facilities Management provision

All three CCGs are working increasingly closely with Local Authority partners to maximise opportunities around partnership working to deliver priority estates projects. This includes maximising section 106/CIL contributions to developments, and Council-led delivery of primary care capital projects. There is a well-established One Public Estate programme in Bedfordshire, which has provided funding to support the local hub development programme, and a One Public Estate programme has recently been established in Luton. These provide key forums for bringing partners together to develop joint estates solutions.

In Bedfordshire, the development of the estate utilised to deliver out of hospital services is considered a key enabler for supporting new models of working. This is particularly relevant where estates can be developed to provide a focal point for

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delivery of integrated services. For example bringing practices together, providing a base for more robust multi-disciplinary working. A comprehensive BCCG Estates Development Implementation Plan has been produced, and is being delivered via the BCCG Estates and Premises Sub-Group.

The hub development programme is Central to the Local Estates Plan. It is BCCG's strategic ambition to develop 7/8 integrated hubs throughout Bedfordshire, with local partner organisations, enabling services to co-locate to provide more joined-up care to local people, in significantly improved facilities.

Bedfordshire CCG is working in partnership with Bedfordshire Borough Council and Central Bedfordshire Borough Council localities to align health and social care services into hubs (within each locality) which will deliver integrated health and social care services and an expanded range of out of hospital services. These hubs will be based around the 30—50,000 populations and the approach, recognised as best practice, is accredited by the National Association of Primary Care (NAPC).

The development of these hubs will take into consideration the long term population growth, including established plans for housing development in our boroughs over the next 20 years and how this might affect demand and delivery of services. This will ensure that services agreed today will have a built in ability to expand and adapt to cover the needs of our population as it grows. Our plans align with those of our STP partners, and take into consideration.

- the requirements of patients who may be registered with Bedfordshire GPs but reside in our bordering localities
- potential partnership working between practices across our locations, where close geography demonstrates a potential benefit to the system, our residents and patients.
- Hubs will draw together practices either physically (into a single location) or virtually across a geography, to work together to deliver healthcare services to their identified 30-50,000 populations. Our Hub development programme will provide focal points for multi-disciplinary teams, and will maximise opportunities to progress stepped solutions towards hub working in the interim.

BCCG intends to use the £2.3million secured via the Estates & Technology Transformation Fund (ETTF) to develop Full Business Cases for the first three hubs in Bedfordshire: in Dunstable, Biggleswade and Bedford (North). Further ETTF funding has been requested to support the production of a business case for the development of a 24-hour primary care access hub on the Bedford Hospital site (the Bedford South Hub).

The hub development programme is a multi-agency programme which will be delivered through the recently established Transformation Boards with each Local Authority and provider organisations. Capital funding for the hubs is expected to come from a range of sources, including from Central Bedfordshire Council, NHS Property Services and STP funding potentially. The business cases are expected to identify how the additional revenue costs for the hubs will be offset by savings through reduced hospital activity.

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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). It is hoped that ETTF funding will also enable the establishment of an interim hub in Bedford (North) – enabling five practices to share the management of their same-day demand from a new facility – providing essential additional premises capacity for these very constrained practices.

In partnership with both local authorities in Bedfordshire, BCCG has also recently been awarded further funding from the One Public Estate programme, to support scoping work for the potential development of further hubs across Bedfordshire: in Ampthill/Flitwick, Leighton Buzzard, and Houghton Regis.

We will support practices with taking forward a stepped approach to hub working during the next few years, helping them to implement practical interim estates solutions which better enable collaborative working between practices, "hub" delivery of extended access solutions, and closer working with community and social care colleagues. £70k of the Practice Transformational Funding for Bedfordshire in 2017/18, and potentially 2018/19 will be directed towards additional Estates development support, with a prime focus on supporting the development and implementation of short-term locality/cluster premises plans. There may also be the opportunity to utilise s106 funding to support implementation of these plans where they will clearly improve capacity, and therefore access, for constrained practices and/or where funding will enable multi-disciplinary team working prior to the longer-term Hubs becoming available.

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. New premises are in the process of being secured for Shortstown Surgery, and an options appraisal is underway to consider the best future configuration of services for the Cranfield, Marston Moretaine and Wootton communities.

7.2 IM&T

The three CCGs in the STP footprint submitted a joint application to the ETTF (Estates & Technology Transformation Fund), and were successful in being awarded funding 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.

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By the end of the first year of delivery of the programme (2016/17) the programme will have:

- Achieved technical interoperability between GP practices and 111 / Out of Hours service in time for go-live of new urgent care services across Bedfordshire and Luton by April 2017
- Begun to enable technical interoperability across multiple providers to support STP ambitions in relation to development of multi-disciplinary working.

The programme will build on this and other existing work in 2017/18 by developing and implementing the following schemes of work:

- Develop the use of the existing core Primary Care clinical system (SystmOne/ Emis Web/ Vision) as a basis for information sharing and clinical collaboration, including:
  - Technical access & configuration arrangements to enable record sharing
  - Templates
  - Information Governance, RBAC and consent model
  - Develop information sharing and enhanced technology pilot with the BLMK STP work stream, Innovation and Technology in Care homes
  - Develop Child Protection – Information Sharing (CP-IS) in unplanned primary care settings to ensure compliance, and work towards improving child protection information across all settings.

- Develop information sharing for provider services to access key primary care clinical information via the most appropriate solution, including:
  - GPs able to access clinical records across the locality / hub
  - Authorised members of the MDT in the locality hub able to access agreed data sets within the record
  - Access to GP record from provider settings (Acute, Community, MH, OOH)
  - Improved information flows for End of Life (EOL) patients.

- Identify and implement remote triage and care services through phased pilots, including:
  - E- consultations – suite of technical solutions to be offered to practices/clusters during Q2 of 2017/18 following options appraisal
  - Remote monitoring
  - Palliative / EOL care
  - Online tools & smart apps to provide tailored advice and support

- Scope and develop interoperability between GP practices' appointment booking systems and community/111 and out of hours providers

- Undertake a strategic options appraisal to identify the best approach to patient access and personalised health records to support self-care, shared care planning with professionals and patient ability to add and view data.

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The programme will work towards the following outcomes:

- Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions
- Information accessed for every patient presenting in an A&E, Out of Hours or 111 setting where this information may inform clinical decisions (including for out-of-area patients)
- Information accessed in community pharmacy and acute pharmacy where it could inform clinical decisions
- Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC) subject to patient consent, encompassing reason for medication, significant medical history, anticipatory care information and immunisation
- Development of digital operating models to enable Primary Care at scale/ primary care hubs, enabling shared access
- Interoperable appointment-booking systems enabling integrated working and GP extended access
- Patient and Citizen access to their own care record, combined with high quality information about effective care planning
- Enabling earlier more effective self-care preventing disease development and exacerbation.

A programme to take this work plan forward has been established, interlinked to the STP Digitalisation workstream.

The wider Digitalisation workstream will lead a number of key strategic IM&T developments across the STP. 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.

In addition to the STP-wide transformation programme, BCCG has established a Primary Care IM&T Sub-Group (reporting to the Joint Co-Commissioning Committee via the Primary Care Working Group) 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 also has specific responsibility for over-seeing the local project for increasing e-referral utilisation into secondary care.

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7.2.1 Supporting Technologies - Active & Planned Technology Projects

a. WiFi

The NHS WiFi programme is rolling out WiFi access for staff and patients across NHS providers. GP practices outside of the Early Adopter areas will start to receive their new WiFi services from April 2017 onwards, with hospitals and secondary care following in 2018. This initiative aligns with the commitment set out in the General Practice Forward View commitment (NHS England, 2016).

WiFi will allow patients, visitors, and staff to connect to the internet using their digital devices, including computers, tablets, and smart phones.

BCCG has received capital funding for the provision of staff side N3 WiFi. The funding was confirmed towards the end of the 2016/17 financial year and rollout will commence imminently.

Funding to Clinical Commissioning Groups from the NHS WiFi programme will be provided, we will use this funding to provide patient facing WiFi in all practices. The funding is based on a calculation of GP surgery size, and will be allocated to CCGs as an 'in year revenue transfer' which covers:

- the implementation costs in 2016/17 and 2017/18 only
- funding for quarterly services charges in 2016/17, 2017/18 and 2018/19 financial years (for a maximum of eight quarters from the implementation date)

b. HSCN / N3

The Health and Social Care Network (HSCN) will replace the current N3 provision and provide a reliable, efficient and flexible way for health and care organisations to access and exchange electronic information.

HSCN offers a standards-based network that will enable multiple suppliers to provide interoperable network services to health and social care organisations.
The HSCN offers a number of benefits over the existing N3 private network, such as:

- a competitive marketplace that encourages innovation, driving down cost and increasing quality
- offering a choice of suppliers and procurement options to suit your needs
- enabling easier connectivity through a simpler 'Connection Agreement'

Within the BLMK STP area, an N3 replacement project is starting up under the Priority 4 ‘Shared Infrastructure’ work steam. All five main IT service providers are engaged with the project and will meet regularly to plan and agree the approach.

a. GPIT Operating Framework Driven Developments

In line with the requirements of the GPIT Operating Model 2016-18, a specific focus will be given to training and system optimisation activities. BCCG is aiming to deliver

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a training service that supports the safe and effective use of core clinical systems and their optimisation. A key work stream will the design and delivery of Clinical Systems Health Checks.

The CCG is also considering ways to provide Data quality training, advice and guidance, including support for

- National data audits / extracts / reporting e.g. National Diabetes Audit
- General reporting
- Template development / QA
- Spreading best practice
- Clinical / medical terminology

d. Universal Capabilities Driven Developments

The promotion, deployment and support of national digital systems, including SCR, EPS2, e-RS, Patient Online and GP2GP is key to delivering the CCGs overall LDR goals and ambitions.

The e-Referral Service will be undergoing a number of system enhancements to make it easier, quicker and more convenient to use. The Advice and Guidance functionality will enable providers to set up and operate Advice and Guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients into secondary care. Deliverables in the NHS e-Referral Service roadmap will help providers meet the targets set out in the Advice and Guidance CQUIN. BCCG will be working with GP practices and providers to implement and fully utilise the potential of this service.

To boost the usage of the Electronic Prescription Service (EPS), refresher training is available to practices. The in house training team provides refresher training on an ongoing basis. Practices will be encouraged to take this up.

Practices have experienced problems with patients not attending booked appointments (DNAs). The CCG has started to utilise SMS messages to remind patients of upcoming appointments. The SMS service means messages can also be sent to patients to remind them to come in for vaccinations, health checks, medicine reviews and screenings.

7.3 Key Milestones and Deliverables

Key Deliverables	Action/ Milestone	Milestone Delivery Date
Establishment of interim hub for Bedford (North)	Business Case Refurbishment of Gilbert Hitchcock House Interim hub operational	Q3-4, 2017/18
Full Business Case for Bedford (North) Hub	To be commissioned by NHSE from Community Health Partnerships (CHP)	2017
Full Business Case for Dunstable Hub	To be commissioned by NHSE from CHP	2017
OBC and Full Business Case for Biggleswade Hub	To be commissioned by NHSE from CHP	2017

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Scoping for Ampthill/Flitwick Hub	Commission specialist agency to develop strategic case for hub	Q1-2, 2017/18
Scoping for Leighton Buzzard Hub	Commission specialist agency to develop strategic case for hub	Q1-2, 2017/18
Scoping for future needs of Houghton Regis	Commission specialist agency to carry out options appraisal to establish long-term plan	Q1-2, 2017/18
Business case for Bedford (South) Hub	Subject to additional ETTF funding	Tbc
New premises for Shortstown Surgery	NHS PS to secure head lease	Q3, 2017/18
Options appraisal for Cranfield, Marston Moretaine and Wootton	Completion of options appraisal Recommendations to be progressed as appropriate through joint commissioning governance processes	Q1, 2017/18

Key Deliverables	Action/ Milestone	Milestone Delivery Date
Resource to deliver project (i.e. business analysts, change managers, functionality experts)	Plan and recruit resource	Q4 16/17-Q1 17/18
IG Sharing matrix	Produce IG sharing matrix for BLMK	Q4 16/17-Q1 17/18
Baseline of current capabilities and gap analysis	Determine current interoperability across whole system	Q1 17/18
Information sharing agreement	Develop information sharing (IG) across system	Q1 17/18-Ongoing
E-consultation 'suite of options' for practices	Options appraisal for e-consultations produced and procurement undertaken	Q4 16/17, Q1 & Q2 17/18
Specification	Establish information sharing requirements across each care setting	Q1—2, 17/18
Primary care/out of hours booking interoperability	Utilisation of appointment booking between practices and out of hours/111 services	Q1—2, 17/18
Options appraisal for technology solution/s	Develop options appraisal for approach to sharing GP-held patient record across all relevant care settings	Q3 17/18
BLMK health and social care shared record (with patient and citizen access) options appraisal	To be commissioned and developed	Q2-Q4 17/18

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Deployment plan	Planning for implementation of primary care record-sharing solution implementation	Q3-4 17/18
Primary care record sharing	Implementation and roll-out of sharing solution	Q4 17/18, Q1-2 18/19

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8.0 Investment

The various forms of investment towards delivery of the GPFV will provide an essential lever for enabling the transformation required across primary care within BLMK, and for improving its ongoing sustainability. Transformation and practice resilience funding will be deployed to maximise progress towards place-based solutions, whilst addressing some of the shorter term sustainability issues within each area.

We will work across the STP to share the learning from the MK expanding vanguard for extended access, to support the planning for taking forward appropriate models within Bedfordshire and Luton from 2018/19, and maximising the benefit from the available funding.

£1.7m ETTF funding has been secured across the three CCGs for an STP-wide primary care IM&T transformation programme – to 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. This funding will also include the project resource for conducting an options appraisal for the best technology solutions to support e-consultations. The solutions will be commissioned within each CCG using the dedicated online consultations funding in line with the outcome of this options appraisal.

8.1 Funding to Support Delivery of the GPFV Plan in Bedfordshire

The table below provides a summary of the relevant funding streams to be deployed within Bedfordshire to support delivery of this plan.

Funding Source	Amount	Description
% increase in core primary care allocation	NHSE to advise	Increase to NHSE primary care budget for Bedfordshire, to fund contract changes. (Bedfordshire – Joint Commissioning status only)
Practice Transformational Funding	2017/18: £695,000 2018/19: £695,000 (£3 per head)	• c. £400k directly towards implementing Locality Development Plans/primary care at scale provision • £75k Workforce Project Support • £50k Specialist Workforce Diagnostic and Change Management Support • £70k Estates Development Support • £100k Dedicated Admin & Clinical Leadership for MDT Working
Online GP Consultation Software	2017/18: £122,221 2018/19: £163,664	Procurement of e-consultation software following options appraisal (to be carried out under STP-wide primary care IM&T programme)

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Training for care navigators and medical assistants	2017/18: £81,481 2018/19: £81,832	To fund clinical administrator training for 28 individuals each of the two years
General Practice Resilience Programme funding	NHSE to advise	Bespoke GPRP Support package that NHSE have agreed to support & fund. This support & facilitation will then enable practices to determine if further support will be sought from NHSE. LMC package of diagnostic support endorsed by NHSE as one of the tools available to practices.
Extended access funding	2018/19: £1,511, 253 (£3.34 per head)	To commission 100% coverage of extended access services by Q4, 2018/19
Estates & Technology Transformation Fund (Estates Projects)	£2.33m	Funding to support development of planning and business case development for three first integrated hubs within Bedfordshire
Estates & Technology Transformation Fund (IM&T)	2017/18: £1.2m 2018/19: £300,000	Funding to deliver STP-wide IM&T programme to support implementation of the primary care facing elements of the Local Digital Roadmap
One Public Estate funding	2017/18: approx. £90,000	To support scoping work for an additional three integrated hubs within Bedfordshire

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8.2 Practice Transformational Funding

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.

The following principles have been developed to support the prioritisation and allocation of Practice Transformational Funding for supporting delivery of the Locality Development Plans:

- Funding to be directed towards priority projects identified within Locality Development Plans to improve the sustainability of primary care, as set out in the GPFV.
- 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.

These proposals have been discussed with all five of the Locality Boards, with no objections received. The Locality Plans form a central plank of the local primary care development (GPFV) plan, and it is expected that this transformational funding will help to pump prime and enable delivery of key projects.

The following process has been approved by the Joint Co-Commissioning Committee for allocating funding to localities. Localities will be provided with the choice of completing one of two templates:

1) An application form for localities, based on a PID (Project Initiation Document) format, for practices to explain how they will utilise the funding to support collaborative working between practices, and what outcomes they expect to deliver. This will form the basis for agreeing key milestones and Key Performance Indicators with the CCG.

2) A pre-prepared offer (similar to a specification) for those localities who wish to use the funding to pump prime collaborative management of same-day access / home visiting and/or care for the frail elderly. A number of key milestones and Key Performance Indicators will be embedded within the criteria for this offer.

Localities/clusters of practices will be asked to submit completed templates to BCCG, to be reviewed by a non-conflicted panel. Payment will be made available prospectively to localities quarterly. Progress against agreed milestones and Key Performance Indicators will be reviewed mid-year. Localities will be advised that funding may cease where insufficient progress has been made at key checkpoints.

The BCCG/NHS England Joint Co-commissiong Committee are supportive of the approach that any application for spend must be congruent with the objectives set out in this plan, recognising the emphasis required on delivering Primary Care sustainability at scale.

8.3 Online GP Consultation Software

Under the STP-wide primary care IM&T programme (funded via the ETTF), an options appraisal will be conducted regarding the various technology solutions available to support the delivery of e-consultations. The ring-fenced online consultation funding will be utilised to purchase software following the completion of the options appraisal. A local e-consultations group for Bedfordshire is being established to ensure local ownership and enthusiasm for this development.

8.4 Care Navigators and Medical Assistants

For 2016-17 we have prioritised the training of Medical Assistants (Clinical Administrators) to support our practices and maximise 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 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. BCCG

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expects to arrange training for 28 clinical administrators for each of the next two years, to be commissioned from the accredited provider, HERE.

8.5 Access to General Practice

We will deploy 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 4 of 2018/19, to build upon the elements of extended access already provided by 38 of our practices under the NHS England-commissioned DES. Further information around our approach to implementing extended access is provided in the Access section of this plan.

8.6 Infrastructure Funding

Further information regarding the ETTF and One Public Estate funding is provided in the Infrastructure section of this plan.

8.7 Other Investment

The Workforce section of this plan describes how we are working with Health Education England to maximise opportunities around further funding to support workforce development and new roles in primary care.

We will continue to work with NHS England to develop services provided under the public health Section 7A Agreement. In 2017-18 this is likely to include increased school aged immunisation provision as not all providers were able to meet the national service specification, an increase in the delivery of flu & pertussis vaccinations in pregnancy via maternity providers and continued roll-out of Bowel Scope Screening (BSS).

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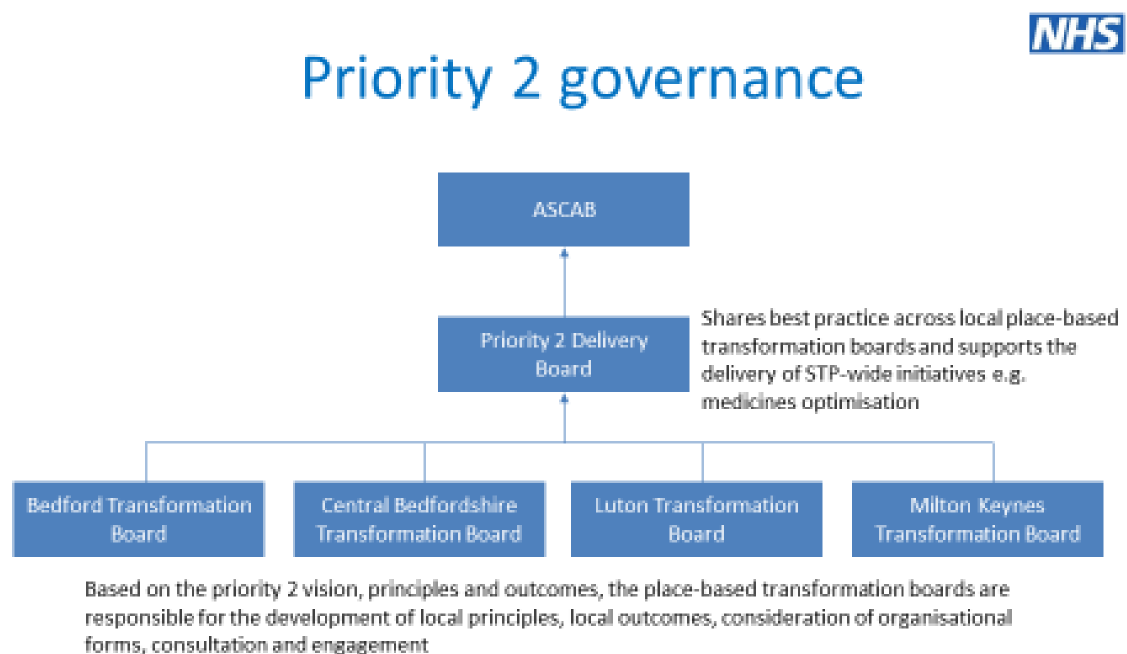
9.0 Leadership, Governance and Programme Arrangements

9.1 STP Wide Leadership Governance and Programme Arrangements

The BLMK STP programme has been overseen and driven by an STP Steering Group. This includes 16 key STP partners, all of whom act as equal partners in the STP programme.

The four local Councils that operate across the BLMK footprint all play a full and active role in the STP Programme. The CEO of Central Bedfordshire Council is acting deputy to the nominated STP lead, Pauline Phillips. Representation on the STP Steering Group is at the CEOs and/or Director level and attendance and involvement in the creation and evolution of the STP Programme has been exemplary.

CCG Board



9.1.1 STP Wide Clinical Leadership

Clinical Leadership and Engagement is a high priority for this work stream and the wider STP.

Dr Nina Pearson, Chair of Luton CCG is the clinical lead for P2 and works with the wider STP Programme Management Office on all forms of engagement. Engagement includes:-

- Bi-Monthly Clinical Congress held in the evenings to maximise opportunities for attendance. The last evening in January 2017 was attended by over 100 Clinical staff from primary, secondary and community care settings.
- Engagement of a consultancy to visit GP forums across the STP footprint to raise the level of awareness and involvement.

The STP CEO Lead for this Programme is Matthew Tait, Accountable Officer for BCCG.

Individual CCG engagement is detailed separately below.

9.1.2 Programme Delivery

The overarching design principle drawn upon to formulate the STP work programme has been that, as far as practical, the STP working groups draw on resources provided and/or insourced from STP partners. This helps to ensure that:

- Ownership is achieved
- Barriers in accessing data, intelligence, people and advice are reduced
- Local expertise is harnessed
- Third party costs are minimised

Each of the work streams (see Section 1.1 above) has both a Work stream (subject matter expert) lead and a STP Steering Group sponsor.

9.1.3 Communications & engagement

The STP has established a communications collaborative, comprising communications leads (or delegated representatives) from all STP partners. This group, chaired by the designated communications lead for the STP, seeks to ensure all work streams and the overarching STP has appropriate tactical and strategic communication and engagement plans in place.

9.2 Bedfordshire Leadership Governance and Programme Arrangements

The Transformation Boards (Bedford and Central Bedfordshire) form one of the key planning/oversight forums between local and STP wide programmes. Board membership is representative of our commitment to partnership working and includes CEO leaders from local authority, provider partners across acute and community care alongside our CCG Governing Body Locality Chair GPs. The seniority of membership provides high level agreement of strategies and ensures that any blockages to delivery can be quickly resolved.

The diagram below sets out the work streams which link into the Transformation Boards to ensure both upward and downward communication and delivery.

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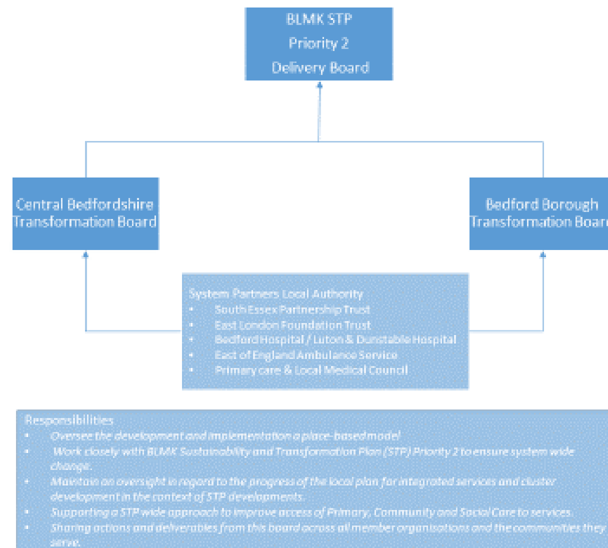

9.3 Delivering the Plan for Bedfordshire

This GPFV Plan has been developed by the BCCG Primary Care Working Group, with representatives from the five localities within Bedfordshire, NHS England and the LMC. From June 2016, BCCG has had a formal joint commissioning role with NHS England for the commissioning of general practice services, and these commissioning responsibilities are overseen by a Joint Co-Commissioning Committee (JCC), a sub-committee of the BCCG Governing Body. The Joint Co-Commissioning Committee will be accountable for overseeing the delivery of the Bedfordshire elements of this plan, with implementation via the Primary Care Working Group. The CCG has recently created a Head of Primary (Community and Social) Care Modernisation post, to support implementation of this plan alongside the Primary Care Delivery team.

Risks to delivery of this plan are included on the JCC Risk Register, and are monitored and managed by the Primary Care Working Group and JCC. An extract from the Risk Register is included in Appendix 3.

There has been significant engagement with local practices as part of the development of Locality Development Plans, which provide a core element of this delivery plan.

This GPFV Plan is only one element of a wider *Out of Hospital Strategy* being developed by BCCG in partnership with both local authorities, to support delivery of the place-based solutions specific to Bedford Borough and Central Bedfordshire. This strategy will include the work underway to transform community health services, to develop stronger partnerships and pathways between health and social care via the Better Care Funds, and the redesign of the urgent care system. There are therefore significant interdependencies with these other workstreams.

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Appendix 1: How this Plan Supports Delivery of the STP

There are strong synergies between this General Practice Forward View (GPFV) Plan for Bedfordshire and 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 trialing 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.

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	Improved management of home visits across clusters of practices
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.

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Appendix 2: 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.