NHS
Aylesbury Vale
Clinical Commissioning Group

NHS
Chiltern
Clinical Commissioning Group

PRIMARY CARE

GP FORWARD VIEW PLAN

2017/18 – 2018/19

Primary Care: GP Forward View Plan

Contents

Please note this Plan relates to implementation of NHS England guidance[1] relating to the *GP Forward View* and should be read in conjunction with the CCGs' Operational Plan 2017 – 2019. The Operational Plan is a comprehensive document that sets out the CCGs' intentions, delivery plans on the transformation required to meet system priorities, and the ways in which the CCG will improve and deliver the constitutional pledges and national targets.

[1] NHS England, *NHS Operational and Contracting Guidance,* 2016.

Primary Care
GP Forward View Plan

1. Introduction

The challenges faced in Primary Care today in Buckinghamshire are no different to those in other parts of England. Difficulties recruiting clinical and non-clinical staff, lack of investment, increased workload and premises that are becoming cramped mean that CCGs must support primary care providers to ensure that a sustainable model of primary care can be preserved for the future.

NHS England has acknowledged that action is needed to accelerate the support offered to general practice[2] and a set of funded actions have been announced to help make a tangible difference to both practices and their patients. This, together with the CCGs Operational Plan for 2017/18 and the wider, longer term Sustainability and Transformation Plan (STP)[3] across Buckinghamshire, Oxfordshire and Berkshire West (BOB) will provide the CCGs with a clear vision for how primary care services will be transformed so that they are affordable, of high quality and equitable for all. The BOB STP has three strong place-based systems and delivery of the GP Forward View (GPFV) will be in local settings, as part of an overall strategy for integrating health and care. However, BOB has the benefit of access to innovation and research that many other STP footprints do not enjoy. BOB-wide work will therefore be focused on innovation in primary care clinical practice via collaboration with the Academic Health Sciences Network and NIHR work locally.

This document sets out how the CCG will respond to the *General Practice Forward View* and will act as the first stage in developing a rolling programme of support to primary care over the next 5 years that will deliver the **Buckinghamshire Primary Care Strategy** *Primary Care in Buckinghamshire: our strategy for proactive, co-ordinated, out of hospital care.* The Plan includes timelines for delivery and will address the national "must dos" as well as the 10 point action plan, drawn up by NHS England, Health Education England, the Royal College of General Practitioners and the British Medical Association's GP Committee to address the need for a skilled, trained and motivated workforce.

It should be noted that Primary Care encompasses all health care taking place outside hospital and is the cornerstone of the NHS. Primary care is generally the first point of contact that the vast majority of patients will have with health care services. Primary care is multi-disciplinary and includes doctors and nurses working in general practice, community nursing services, dentists, opticians and community pharmacists. This plan focuses on supporting general practice to provide sustainable primary care services.

[2] NHS England, *General Practice Forward View,* 2016.
[3] NHS England, *Delivering the Forward View Planning Guidance 2016/17 – 2020/21,* 2015.

2. The Buckinghamshire Primary Care Strategy

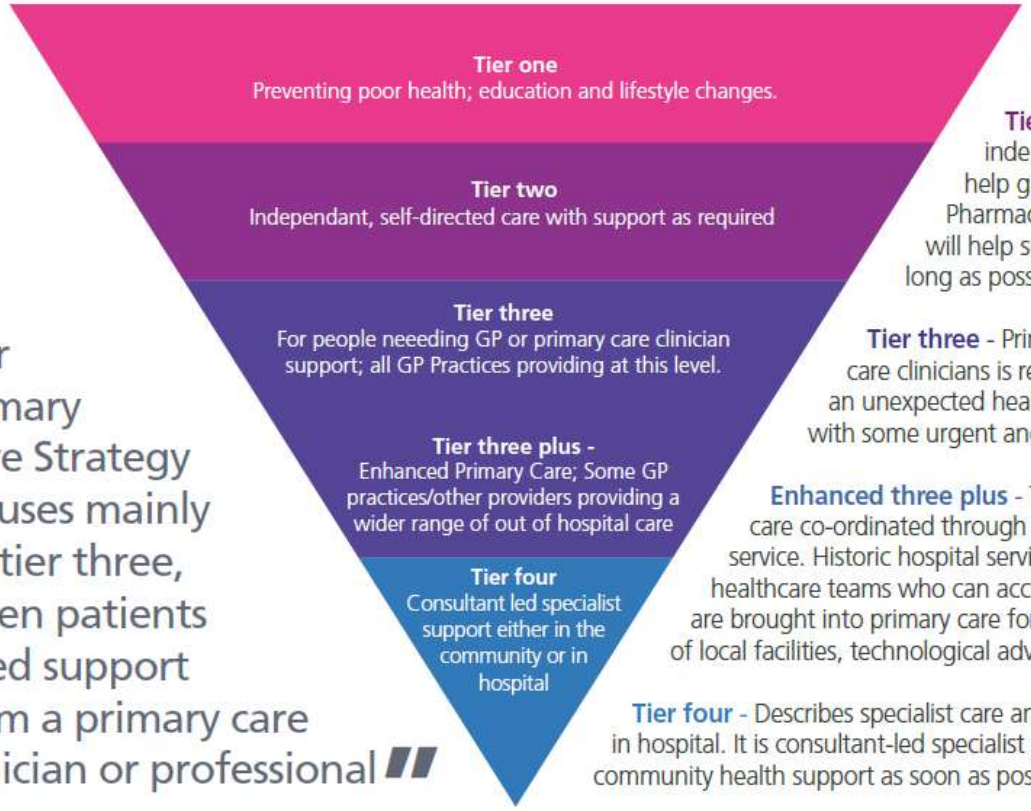
The CCGs see primary care transformation as an absolute priority if we are to keep pace with rapidly changing demographics. Recent locality health profiles and population projections provided by the Buckinghamshire County Council Public Health Team (November 2016) reveal that, across Bucks, the population is set to age rapidly over the next two decades with the proportion of >60s increasing by 44% and the proportion of >90s increasing by 140%. The CCGs will not only need to cater for highly complex patients being managed in primary care but the resultant increase in the number of older people living in care homes.

The amount of housing built between 2015 and 2033 will have a significant impact upon the growth of the population. Using Office for National Statistics (ONS) 2015 mid-year estimate data, the population is set to increase by an extra 73,746 people and 37,950 new homes will be required to sustain this increase. The four district councils in Bucks have either consulted on their Local Plans for housing growth or are planning this for 2017/18. The CCGs have been actively involved in discussing plans and inputting to Infrastructure Delivery Plans (IDPs) with the relevant planning departments. They have also stressed the need for developer contributions either through S106 or Community Infrastructure Levy (CIL) where larger developments of new houses are being planned.

In 2014/15, a group from across various local commissioner and provider organisations was created, working under the guidance of a team from NHS Improving Quality on a large-scale transformational change programme. The outcome of this piece of work provided a local snapshot of primary care in Buckinghamshire, along with emergent thinking on models of future primary care services which informed the public consultation that followed. This pre-planning phase informed the development of the CCG's Primary Care Strategy. The vision for primary care which underpins the strategy, and was shaped by the public and the CCG's member practices, is:

'Everyone working together to provide high quality, personalised care to help keep Buckinghamshire people happy and healthy, optimising value from our collective efforts'

Tiers of care



"Our Primary Care Strategy focuses mainly on tier three, when patients need support from a primary care clinician or professional"

Tier one - Education and self support to maintain a healthy lifestyle.

Tier two - People manage most health needs independently with support such as websites, self help groups and other community professionals (e.g. Pharmacists). Planned GP appointments (see tier three) will help support people to remain independent for as long as possible.

Tier three - Primary Care support, where input from GPs or Primary care clinicians is required either to support long term condition(s) or an unexpected health concern. This is mostly planned appointments with some urgent and unexpected interventions from time to time.

Enhanced three plus - This is the real transformation, with patient centred care co-ordinated through GPs at the heart of a seamless integrated health service. Historic hospital services will be provided in local communities led by local healthcare teams who can access specialist advice as required. Exactly what services are brought into primary care for local delivery is subject to factors such as availability of local facilities, technological advances and value for money.

Tier four - Describes specialist care and advice, either in community-based setting or in hospital. It is consultant-led specialist care that aims to return the patient back to their community health support as soon as possible.

The strategy identified six goals to achieve the vision with 4 tiers of care broadly identified (see page 5) to cover the whole population. Tier 3 Plus is the transformational element of the model of care, with some GP practices (or other providers) able to offer a wider range of community and primary care services and with GPs at the heart of seamless integrated health care.
The six strategic goals are to:

- Enable people to take personal responsibility for their own health and wellbeing
- Promote health, social care and voluntary sector providers to work together to offer community-based, person-centred and co-ordinated care in the community and primary care setting
- Improve appropriate access for all to high quality, responsible primary care
- Develop clearly understood care pathways that offer consistent and co-ordinated care
- Improve health outcomes for the whole population; and
- Commit to invest in and support our primary care providers.

Primary Care transformation is the cornerstone for our success in delivering these goals as well as our STP, strategic and operational plans and the GPFV Plan - these will be the means by which we are able to deliver the primary care vision for 2020.

The GPFV Plan covers 4 key enablers:

- Workforce
- Workload
- Infrastructure
- New Ways of Working.

3. Workforce

The CCGs will work with partners to ensure that we explore every opportunity to support workforce recruitment, retention, training and development. In so doing, the CCGs will take on board the British Medical Association's 10 point plan[4].

There are four key strands to this work:

- Improving recruitment into general practice
- Retaining doctors within general practice
- Supporting those who wish to return to general practice
- Training and Education.

To this end, the CCGs have been successful in applying for a grant to establish a Buckinghamshire-wide Community Education Provider Network (CEPN) and have appointed a Project Manager to commence this work. Commonly known as Training Hubs, CEPNs are a new way of developing the primary care workforce and offer an opportunity for general practice and other primary care providers to get involved in developing and delivering education and training as part of a supported network. The Bucks CEPN has been set up in partnership with FedBucks (the local GP Federation) who will be responsible for co-ordinating all primary care workforce training requirements and programmes based on local needs. The CEPN will act as the key player in delivering the four key workstreams.

The CCGs are also working closely with the newly-appointed NHS England GPFV Transformation Leads, who are linked into workforce issues across the STP. A Local Workforce Action Board has been established and a BOB-wide workforce strategy is being developed in 2017. The CEPN will link with the STP workforce workstream and will be a key player in delivering local workforce strategies.

Now that the CEPN has been established, in 2017/18 the NHS England workforce data baselines for GPs, nurses and patient-facing staff will be used together with results from a local workforce audit (soon to be underway) to validate our existing workforce and their current and future training needs. The 2015 Training Needs Analysis of Out of Hospital Workforce across Thames Valley[5], authored by Buckinghamshire New University, and our own Primary Care Workforce Options[6] paper will then be used to determine the primary care element of the workforce strategy that will link to our service redesign plans. The primary care paper on local options articulates the local challenges within primary care

[4] BMA/RCGP/NHS England, *Building the Workforce, the New Deal for General Practice*, 2015.
[5] Schaub, J. et al. *Future Care: a training needs analysis of the Out of Hospital Workforce across Thames Valley,* 2015, Bucks New University.
[6] Gadhia, S. *Primary Care Workforce Options,* 2016, NHS Chiltern Clinical Commissioning Group.

(demography as well as recruitment) and explores new workforce roles that are already being taken forward within primary care (clinical pharmacists, specialist paramedics).

The CCGs have taken a collaborative approach with practice managers throughout Bucks to identify the best use of funding to support the training of non-clinical staff working in general practice. Practice managers have agreed that workflow optimisation should be addressed as a priority and two providers of training have been identified. The CCGs anticipate that training in this aspect of non-clinical workload will be rolled out in 2017/18. The CCGs are also progressing the development of a Care Navigation training programme, to be piloted in a small number of practices before being rolled out to all practices during 2017/18.

Key Deliverables	Actions	Action Owner	Timescales
Improving Recruitment into General Practice			
Address the current shortfall in GPs and practice nurses and utilise other clinical skills in innovative ways	Investigate new ways of working and new roles in primary care (paramedic practitioners, physician associates, pharmacists in primary care).	CCG	Throughout 2017/18 and 2018/19
Increase the number of practices becoming training practices (GP and Nurse Placements)	Work with HEE to provide greater opportunities for GPs to train locally. Evidence suggests that trainees are more likely to take permanent jobs locally when they finish training.	CCG	Throughout 2017/18 and 2018/19
Develop supportive environment for newly qualified staff	The CCGs will promote the First 5 Forum that exists across Thames Valley for newly qualified GPs within the first 5 years of general practice.	RCGP	Throughout 2017/18 and 2018/19
Promote Nurse Forum	Through the Primary Care Lead nurses, the CCGs will continue to promote the Nurse Forum for nurses at all levels and stages of their career.	CCG	Throughout 2017/18 and 2018/19
Retaining Doctors within General Practice			
Explore training opportunities (e.g. Leadership courses), working across primary/secondary care interface (delivery of community and primary care services). Talent management and succession planning schemes to safeguard leaders for the future	New guidance issued on Retained Doctor Scheme outlines increases in funding for practices employing a retained GP and an increase in the annual payment to the GP towards professional expenses. CEPN, working within the wider workforce project across STP to consider rotations across primary, community and acute sectors.	Practice/NHS England/STP	2017/18 2017/18

Supporting those who wish to return to General Practice			
Encourage doctors to consider joining General Practice in Bucks	Support the drive to recruit returning GPs and support via First Five Forum.	NHS England/ Health Education England Thames Valley	2017/18
Encourage more retirees to consider providing sessions in the local area	Encourage practices to be more flexible in their approach to recruiting GPs so that part time hours and flexible working arrangements can be accommodated.	CEPN/CCG	2017/18
Training			
Inform future workforce requirements and draft Workforce Strategy that links with service redesign plans which include new ways of working in integrated teams and delivery of 24/7 access to primary care	Build on local audit findings and training needs analysis completed by Bucks New University in 2015.	CEPN	2017/18
Develop primary care workforce strategy	Draft strategy to be developed in line with wider STP work on workforce and signed off by CEPN Board.	CEPN	2017/18
Look to develop training opportunities for non-clinical staff to play a greater role in patient navigation and processing clinical paperwork	Planned roll out of training to all practices in Bucks using GPFV funding for non-clinical training.	CCG	2017/18 – 2018/19
Continue to support Protected Learning Time (PLT)	There are 10 PLT sessions per year, the CCGs host 4 sessions with the remaining sessions being practice-led.	CCG	2017/18

4. Workload

Workload was identified by the 2015 BMA survey as the single biggest issue of concern to GPs and their staff[7], and the GP Forward View dedicates a whole chapter to workload in primary care. Since 2015, the CCG has been supporting workstreams around:

- GP Workload
- Locality Integrated Teams
- Practices working Together

These workstreams remain key to delivering sustainable primary care, but to ensure the CCGs' focus remains aligned to NHS England's, the CCG has added a section on Primary Care Resilience.

We recognise that our practices are facing increasing demand from a growing population with an increasing prevalence of long term conditions. Through our locality structure, we shall promote the 3-year Releasing Time for Care programme announced by NHS England in the summer of 2016 and would expect that during 2017/18, the CCGs, via its Locality structure, will have submitted Expressions of Interest to NHS England for support with this programme. They should also have a local delivery plan in place to drive efficiencies in general practice through the adoption of some of the 10 high impact actions.

NHS Aylesbury CCG has already redesigned the Quality and Outcomes Framework (QOF) in an effort to reduce the administration burden on primary care and maximise practice potential to manage patients with long term conditions. This way of working is also being offered to Chiltern practices in 2017/18. The majority of Bucks practices use EMIS and, through the use of standardised templates, the CCG will be able to streamline data extraction, validation and payment of services, outside core GMS using EMIS Enterprise; this way of working will save valuable practice staff time.

Our Digital Road Map also contains a number of plans to reduce unnecessary workload in primary care, for example:

- **Online Consultations:** specific funding has been earmarked for implementing online consultation systems in 2017/18 and plans are being developed to identify the most suitable system for our practices to adopt.
- **E-referrals:** reducing the number of queries to practices regarding referrals.

[7] British Medical Association, *Quality First – managing the workload in General Practice*, 2015.

- **Care home remote support** – working with Airedale NHS FT Vanguard to deploy nurse-led clinical triage and support to staff across approximately 40 care homes. Data shows that this has reduced the demand on GP practices with reduced calls and reduced visits to Care Homes.
- The introduction of **technology** which will simplify processes or save time within Primary Care.

While technical deployment of Patient Online (GP Online) has been completed, work continues to increase utilisation of its functionality. This is achieved through a communications workstream, with utilisation rates being monitored using available national reporting statistics. These national usage figures are supplemented by clinical system reporting to give a more up to date report and inform the action required. Results are then fed back to the GP practices via the SCWCSU newsletter "The Wire".

When visiting GP practices and locality meetings, Digital Transformation Project Managers within the CSU and Locality Business Support Managers in the federated CCGs use the opportunity to discuss and promote Patient Online. They aim to find out any barriers to increasing usage and also to ensure utilisation rates increase.

Key Deliverables	Actions	Action Owner	Timescales
General Practice Workload			
Increase public awareness of where to go to get help for both routine and urgent health care needs	Use training funds to upskill GP receptionists to become care navigators. More emphasis on local publicity campaigns to ensure patients make use of the most appropriate service to meet their needs.	CCG	Starting Winter 2016/17
Develop training packages for non-clinical staff on workflow optimisation	Use training funds to commission workflow optimisation training for non-clinical staff.	CCG	Starting Winter 2016/17
Work with patients, GPs and secondary care to cut inappropriate demands on primary care	Support FedBucks to establish regular liaison meetings between primary and secondary care clinicians.	FedBucks	Starting 2017/18
Reduce unnecessary workload requests	Use the existing contract monitoring process to challenge inappropriate workload requests from secondary care.	CCG	Starting 2017/18
Support patients to self-care	Continue to promote and develop "Live Well, Stay Well" to support patients with long term conditions.	CCG	Ongoing – started 2016/17

Locality Integrated Teams			
Roll out integrated teams in all localities to support patients in the community who have complex needs	Evaluate current pilots operating in two localities to inform the development of the service model for integrated teams wrapped around groups of GP practices.	CCG/local stakeholders	2017/18 and 2018/19
Single Point of Access (SPA) to a range of services	Following the GP Access Centre proof of concept in Aylesbury, look at how a SPA could be used to provide access to a number of community and primary care services, including general practice.	CCG	2017/18
Explore how LITs can work with Care Homes to reduce GP workload	Preparatory work to support strategy of improving health in care homes.	CCG	2017/18
Explore the value and benefits of LITs becoming more multi-disciplinary	Learn from paramedic practitioner pilot how this role could become an integrated part of the LIT.	CCG	2017/18
Practices working Together			
Encourage practices to work together to produce “at scale” working across a larger geographical area.	Commission external provider to facilitate discussions and provide expertise to practices looking to work at scale.	CCG	2017/18
Encourage practices to work together to share clinical expertise in specialist areas	Localities or “like minded” practices to consider areas where they might share clinical expertise across a wider area.	CCG	2017/18
Encourage practices to work together within networks/clusters to develop resilience	Localities to consider areas where they might work at scale i.e. back office functions, 24/7 primary care access.	CCG	2017/18
Primary Care Resilience			
Support individual practices who are identified as being vulnerable	Develop and agree action plan and funding to support practices at risk of becoming vulnerable.	CCG/NHS England	Ongoing from 2016/17
Develop a programme of support for all practices	Use the GPRP to foster collaboration between GP practices and to develop concept of locality community hubs to build resilience.	CCG	Ongoing from 2016/17
Explore the establishment of a Locum Chambers	GPs have indicated that one of the biggest drains on resources is finding and affording GP locums. FedBucks to explore how a Locum Chambers might help address this.	FedBucks	Ongoing from 2016/17

5. Infrastructure

Estates and Technology Transformation Fund (ETTF)

Both CCGs identified priorities for premises development as part of the ETTF application process with schemes being appraised locally and at regional level against a number of set criteria. The use of capital ETTF is distinctly different to that of minor improvement grant funding in that it is to be used to support the development of infrastructure that helps transform how care is provided. One new-build scheme in Buckinghamshire (Simpson Centre/Millbarn Medical Centre, Beaconsfield) was successful in being approved for ETTF funding and the practices involved are currently working on their outline business case. The CCGs are also exploring a number of other new-build proposals involved in the pre-project planning phase. These are:

- **Berryfields Medical Centre**, Aylesbury — New build to replace existing temporary buildings.
- **Trinity Health**, Thame — Review of Thame, Brill and Long Crendon surgeries.
- **Hawthornden/Pound House**, Bourne End — New build consolidating two surgeries and two branches onto one site.
- **Cressex Health Centre**, High Wycombe — Remodel existing building.
- **Rectory Meadow**, Amersham — Extension to existing building to provide dedicated health and wellbeing space.

A number of other projects are also being supported using minor improvement grant funding, whereby schemes are funded by NHS England for 66% of overall cost.

Key Deliverables	Actions	Action Owner	Timescales
Strategic Estates Planning			
Development of Community Hubs	Working in tandem with emerging GP clusters, undertaking assessments at locality level of all primary care infrastructure to understand estates opportunities and needs with regard to delivery of new service models.	CCG	Ongoing from 2016/17
Member of the Bucks Estates Group	Forum to identify what public sector assets exist and whether their utilisation can be maximised to the benefit of the health and social care system i.e. One Public Estate.	CCG as member of this group	Ongoing from 2016/17

Secure support and funding from key stakeholders to deliver infrastructure needed to accommodate growth in Buckinghamshire population via Local Plans and Infrastructure Delivery Plans	Work with district and county councils to establish a methodology for CIL/S106 contributions from developers concentrating on the Wycombe Plan, Vale of Aylesbury Plan and also the Chiltern and South Bucks Plan.	CCG	Ongoing from 2016/17
Work across BOB STP Footprint	Ensure that proposed developments are in line with STP strategic priorities and are affordable.	CCG	Ongoing from 2016/17
Operational Estates Management			
Estates and Technology Transformation Fund	Support practices that have been successful in their application for funding from ETTF.	CCG	Ongoing
Support General Practice plan for future service delivery	Six facet survey of all general practice premises to be undertaken.	CCG	2016/17
Support Quality in Primary Care	Work to support general practice so that by 2018 no GP practice has an overall inadequate rating from CQC due to poor premises.	CCG	Ongoing
Improve fabric of premises within primary care	Work to secure funding and improvements for individual practices through the minor improvement grant process.		Ongoing

In terms of the Technology elements of the ETTF scheme the CCGs have been successful in securing both capital and revenue funding to support New Ways of Working in Primary Care. The funding is being used to support a number of new initiatives and further extension and development of existing work. The initiatives underpin wider transformation programmes as identified in the STP and CCG plans.

The key areas this is being used to develop are:

1. Record and Appointment book sharing to support federated working and delivery of services by federations/groupings of GP practices and integrated teams
2. Mobile working for GP practices and for Integrated teams
3. Remote support to Care Homes
4. Digital support to underpin access and supported self-care.

Some examples of our work are as follows:

Federated working across GP practices - practices working together to facilliatate triage and care for patients across practices, the delivery of extended opening hours, more flexible working arrangements to increase resilience, and greater access to specialist primary care based services. EMIS Clinical services and other software which supports cross organisational working, mobile technology and WiFi access are being implemented to support these new ways of working.

Support for Integrated working - A project is underway to implement EMIS Clinical Services to support the delivery of integrated care for specific teams and cross organisational working for GP practices. Initial work has commenced with Diabetes teams and teams delivering integrated care to over 75s, and one grouping of GP practices. The full benefits case of integrated working project is dependent on Phase 2 of MCR to provide the technology integration between clinical systems. Use of the EMIS Clinical Services module will allow services, such as Shared Locality Integrated Teams to accept referrals and then view the GP record for that patient. Experiences from this work will inform the wider interoperability project and will support enhanced coordination of care across GPs, patients, hospital consultants and specialist services. Engagement activities with staff and system configuration have commenced. It is expected that the first teams will go live in early 2017 with an initial review of benefits by summer 2017.

Key Deliverables	Actions	Action Owner	Timescales
Strategic Technology Planning			
Implementing the local Digital Road Map in order to deliver a fully interoperable health and care system by 2020.	Bucks LDR development complete with further work to combine with Berks West and Oxon to form BOB LDR to support delivery of STP. Workstream leads identified to deliver universal capabilities across BOB footprint.	CCG	Ongoing
By 2016/17 minimum of 10% of patients actively accessing primary care services and/or consultations online or through apps (i.e. Health Help Now). Trajectory and plan for achieving a significant increase by 2020.	Continuation of Access and Supported self-care pilots to increase the use of digital access to services and care. Evaluation of pilots and development of plans for wide scale rollout if successful.	CCG	2016/17 2017/18 onwards
Every patient has access to digital health	To be delivered through Patient Online	CCG	Ongoing

records that they can share with their families, carers and clinical teams.	Programme and GP Access pilots		
By 2020, 95% of GP patients to be offered e-consultation and other digital services and 95% of tests to be digitally transferred between organisations	Continuation of GP Access pilot to include integrated capability to offer e-consultation. Investment in technology to allow wider offering of e-consultation across both CCGs in all practices STP wide workstream identified to deliver 95% of tests to be digitally transferred between organisations.	CCG CCG STP	2016/17 onwards 2016/17 onwards Ongoing
CCGs will promote EMIS as GP system of choice.	100% coverage to support inter-operability to be achieved by 2020.	CCG	Ongoing
GPs will hold and be able to share electronic patient records (with the patient's consent) with GP practices and other providers.	Information Sharing Agreements already in place to support sharing of GP held patient records with OOH, Acute and Adult Social Care through the My Care Record programme. Phase 1 (MIG) to be completed in 2016/17 with additional capability to be implemented to allow access for Mental Health teams in support of STP aims. Sharing of EOL patient information in place using Summary Care Record with Additional Information. EMIS Clinical Services and wider interoperability to be implemented as Phase 2 of My Care Record to support the development of integrated teams and new ways of working in Primary Care	CCG CCG	2016/17 2016/17 onwards
Operational Matters			
CCGs will increase online offer to patients beyond repeat prescriptions and GP appointment booking. Increase in % of patients accessing and using their electronic health record.	Patient Online Programme in place with resources from within the Digital transformation team and CCG Localities team to increase services available and usage levels.	CCG	2016/17 onwards
80% of referrals made using e-referral	Work programme in place to increase usage	CCG	Ongoing

service.	by 20% by end Mar 2017 with further increases throughout 2017/18.		
Provide clinical decision support to GPs.	Work programme underway building on current use by GP practices across Chiltern CCG.	CCG	Ongoing

6. New Ways of Working

Transforming Primary and Community Services through Integration

As GP-led commissioning organisations, we recognise that the majority of our patients' care takes place outside of hospital and that their first contact and gateway to services is through the GP practice. However, supporting services such as specialist advice, community nursing, mental health, local diagnostics and comprehensive information access for long term conditions remain poorly co-ordinated across weekdays, evenings, overnight and weekends, and consequently take a lot of time to set up around our patients. Added to this, General Practice is experiencing unprecedented workload and workforce challenges as outlined in previous sections; this means that whole system transformation of both community and primary care services is required in order to turn our primary care strategy and longer term sustainability plans into reality.

Groups of GP practices, working together through common geographies and population demographics will be supported by rapid access to diagnostics and a wrap-around wider team of practice and community nurses, mental health workers, pharmacists, social and voluntary supporting services. These will be co-ordinated through a local 'community hub' that ensures timely access to the right care response.

Traditional 'out of hours' services will be transformed through the commissioning of extended GP practice hours within each locality. Overnight and further weekend support will be provided by secondary care, working collaboratively with all other community, social and voluntary services, and supported by our ambulance service and NHS 111.

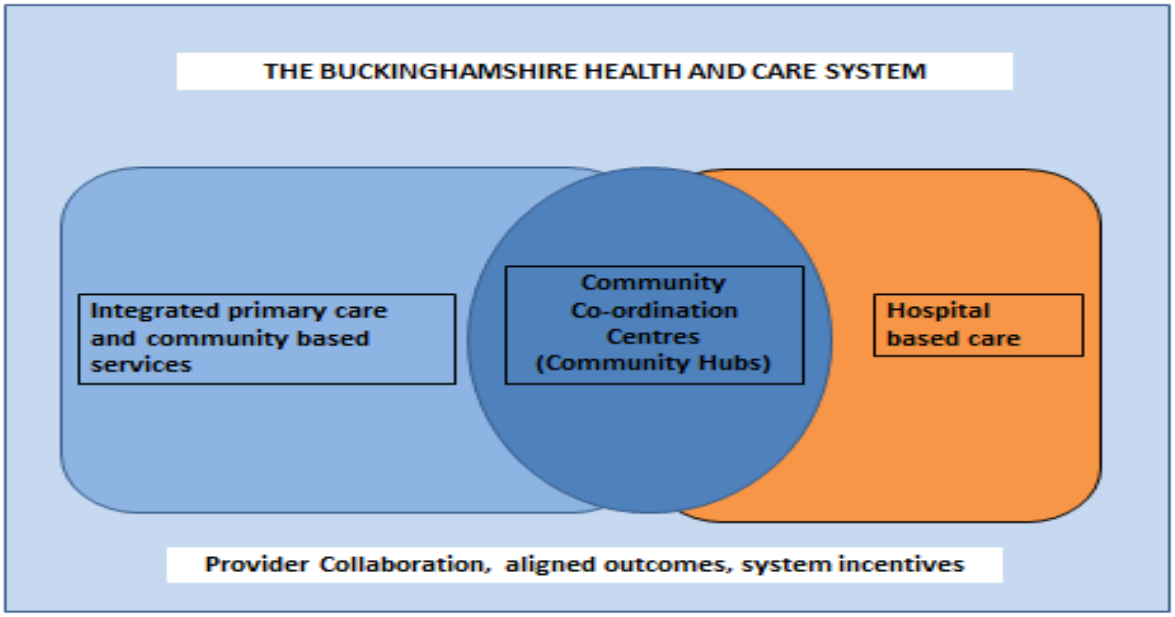
The NAPC work on Primary Care Home[8] and the Multi-Specialty Community Provider (MCP) model[9] from the *Five Year Forward View* supports the concept of groups of GPs working at scale. National and local evidence suggests these at-scale groups are most effective around a population base of 30 to 50 thousand registered list patients[10]; this means a maximum multi-disciplinary team of around 150 personnel which is suggested to be optimal for communication and integrated working practices.

We recognise the importance of timely access to other high quality supporting services, such as diagnostics (ECG, X-ray, bloods) and to specialist professionals (such as tissue viability nurses, cardiologist advice). Our community hubs will be the centres where these services can

[8] http://www.napc.co.uk/primary-care-home
[9] http://www.aylesburyvaleccg.nhs.uk/wp-content/uploads/2013/03/Buckinghamshire-Commissioners-5-Year-Plan-V4-04042014.pdf
[10] National Association of Primary Care, *The Primary Care Home*, 2015.

be co-ordinated and locally provided. This may mean a physical building where tests can be carried out and where video conferencing can bring specialist consultant opinion and support to the patient; equally it may be a virtual centre of co-ordination.

Our vision for how our services will integrate to provide seamless care is illustrated below:



Localities

When CCGs were first created a key aim was to enable services to be tailored and adapted to local needs. Our primary mechanism for this is through locality assessing the needs of its local population and developing plans to meet them. Many themes are shared across localities but implementation may vary in each and there are several projects specific to the needs of individual areas. The localities are also the route to understanding local people's views about current services.

We know that some of our GP practices are already working at scale; for example, the North Aylesbury locality has just formed an MCP known as Medicas, and the pan-Buckinghamshire organisation FedBucks currently covers over 85% of our practices. There are many more examples of GP collaboration, such as the Wooburn Green and South Aylesbury locality practices piloting a home visiting service using specialist paramedics. We know from experience that such initiatives are most successful when local clinicians themselves have developed their ideas, working to a set of outcomes, rather than working to a commissioner-led specification.

Our Community Services Programme Board ensures this work is given the highest priority and has the support of the right clinical leadership and management expertise to facilitate the changes required.

We have some long established projects where services have been integrated to develop solutions for our frail and/or elderly patients; these have provided significant reductions in emergency admissions and lengths of stay. Some projects in other localities are building on this experience and are tailoring their integrated working to fit their specific patient group needs, aiming for similar outcomes.

At locality level, there is a greater understanding of the current health needs of the population, the views of the community on healthcare and the assets available to them in that community. As such, the locality clinical leads can act as the driving force behind localisation and implementation of services appropriate to their population needs, making this model a very effective way to deliver change.

Over the next two years we will be taking advantage of the current enthusiasm for integrated services and will begin to support a wider roll out of these working practices. 2017/18 will be our year of transition, where commissioner efforts will be focussed on developing willing groups of GP practices to work collaboratively with their wider multi-disciplinary community teams, aligning their work efforts to reduce admissions and lengths of stay for their population. The reductions in non-elective care episodes will help us to fund our community services development.

Whilst some practices are already stating intentions to work together, other groups of practices will require more support to achieve this. We anticipate a slightly varied response and will ensure that our leading light groups of practices will be strongly encouraged to develop at pace, while we actively support our follower practices to achieve a similar working model. To this end, the CCGs have utilised funding identified in the *GP Forward View* to commission experts in change management to support practices during 2017/18.

From April 2018/19 we aim to be commissioning a single outcomes based contract with our GPs, secondary care and mental health providers. We will have a Buckinghamshire system of health and care, made up of seven localities with groups of GP-led multi-specialty providers (including social care) working collaboratively, regardless of their employing organisation and supported by community hubs.

Improving Access to Primary Care

The CCGs continue to receive feedback on access to primary care services through Healthwatch Bucks, locality community events and regular review of the national GP Patient Survey. The survey results by CCG for July 2016 compared to the national average are as follows:

GP Patient Survey Question	Aylesbury Vale CCG Average		Chiltern CCG Average		National Average	
Ease of getting through to someone at the GP surgery on the phone	70% easy	27% not easy	71% easy	26% not easy	70% easy	26% not easy
Convenience of the appointment offered	92% convenient	8% not convenient	92% convenient	8% not convenient	92% convenient	8% not convenient
Satisfaction with the hours that the GP surgery is open	72% satisfied	11% not satisfied	73% satisfied	11% not satisfied	76% satisfied	9% not satisfied
Overall experience of GP surgery	85% Good	6% Poor	86% Good	5% Poor	85% Good	5% Poor

Good access to primary care remains a priority for the CCGs and we are proposing a series of patient engagement events, starting in June 2017, at where the CCGs will discuss plans for integrated team working as well as our vision for improved access to 24 hour primary care. We are also keen to learn from patients and the public how we can tailor our services to ensure people from all areas across Buckinghamshire are are aware of them and can access them.

The CCGs have opened discussions with member practices regarding the vision for 24/7 access to primary care, and how this will be fully delivered. We anticipate that new funding will be available to CCGs that demonstrate they can achieve 100% population coverage with more seamless care, in and out of existing core primary care hours, by March 2019.

The vision to-date for improved access is that:

- GPs working in clusters or localities, supported by multi-disciplinary community hubs, will provide routine bookable and same day access to general practice services between 8am and 8pm weekdays. GPs will be seen as the clinical leaders within this model, maintaining continuity of care and utilising their relationships and local knowledge to maintain an element of individual care that is highly valued by patients. This model may be extended to 10pm weekdays in some localities, thus creating more seamless care for both scheduled and unscheduled needs.

- To provide 7 day access to routine bookable and same day access primary care, it is likely that practices will collaborate over a wider geography to provide services that meet local population needs. The CCG is working with its GP membership to establish the best physical locations and scale for this element of the service.
- Beyond 10pm weekdays and outside weekend opening hours for primary care, it is likely that a countywide out of hours service will be provided through a collaboration of current providers of extended access systems (e.g. primary care, community care services, ambulance and acute care providers) so that access to services continues to be seamless, consistent and integrated.
- Staff working across the local health economy will be skilled in signposting patients to the most relevant part of the service that gives the best fit with the patient's needs.

The CCGs will use existing available data on take up of the Extended Hours DES, activity at Wycombe MIIU, surrounding A&E units/Walk-In-Centres and GP Out of Hours services to provide evidence that the proposed 7 day model will cover the expected population needs. The CCGs will also use the GP workload tool currently being tested and rolled out nationwide to ensure that sufficient capacity is modelled into the service to meet anticipated demand. The proposed model will also be triangulated against the best practice framework for 7 day access, which is being developed across the BOB STP to standardise care across primary, community and secondary care setting.

Key Deliverables	Actions	Action Owner	Timescales
Improving Access			
100% of the population has access to weekend/evening routine GP appointments by March 2019.	Procure improved primary care access to ensure that all patients have access to routine and urgent appointments in the evenings and on Saturdays and Sundays (according to need). Different localities will require different approaches.	CCG	Developing the model in 2017/18 with phased implementation expected in 2018/19
Resolve issues of inequality in patients' experience of accessing general practice	Evaluate Vanguard sites and other pilots and engage with patients to ensure that suggested improved access scheme meets patient requirements.	CCG/local stakeholders	2017/18

New Ways of Working			
Roll out integrated teams in all localities to support patients in the community who have complex needs.	Evaluate current pilots to inform the development of the service model for integrated teams wrapped around groups of GP practices.	CCG/local stakeholders	2017/18
New Models of Care			
New care model programme covering at least 50% of population	Introduce new models of care i.e. MCP or PAC. Support localities using the GPRP fund to consider which (if any) new model of care they wish to adopt and to develop business case. The CCGs have submitted an expression of interest to transition to an Accountable Care System from April 2018.	CCG	Ongoing and during 2017/18

7. Funding Streams

The financial summary on pages 25 and 26 sets out funding available to primary care for 3 years starting 2016/17.

In 2016/17, the CCGs used Vulnerable Practice Scheme funding to support the following:

CCG	Use of Vulnerable Practice Scheme funding
Aylesbury Vale	• Support practices involved in a managed list dispersal • Support one practice with reconfiguration in order to increase capacity.
Chiltern	• Support for two practices with CQC Special Measures rating • Support for a practice with business planning and internal working processes with a CQC Requires Improvement rating • Support for one practice to offer customer care training to reception staff and diagnostics to identify potential efficiencies.

Vulnerable Practice Scheme funding is non-recurrent and not available in 2017/18.

The CCGs have utilised 2016/17 General Practice Resilience funding to encourage collaboration and, in some cases, merger between practices within localities. This work requires the skills of external facilitators and advisers who have already made the move to work collaboratively so that the concept of 'working together' can be fully explored. It also addresses the more practical details of how clusters of practices might work together, what types of services could they deliver differently and what types of infrastructure they would require.

The sum of £3 per head of registered population non-recurrent transformation funding, as advised in the planning guidance, will also be invested in primary care across the 2 financial years 2017/18 and 2018/19. CCGs will be measured against how this funding is spent and this will be monitored both through scrutiny of CCG Accounts and also through engagement with LMCs. CCGs are expected to spend the money on either:

- Supporting practices to begin to deliver extended access where they are not already doing so.
- Supporting development of 'at scale' primary care organisations, including GP federations

- Other support to practices where the above is already in place, so they can begin to transform delivery of enhanced primary care provision.

The CCGs will invest the £3 per head split across 2 years: £2 per head in 2017/18 and £1 per head in 2018/19. The CCGs intend to support implementation of enablers (such as IT, working in different ways and improving workflows, new skill mix, etc.) which will pave the way to deliver 7 day access , and plans for use of the funding will be discussed with the LMC. The funding will also be used to support implementation of this Plan, which has been drawn up as part of our broader primary and community care transformation programme and aims to address current pressures by creating a sustainable primary care service.

The CCGs have taken a collaborative approach with practice managers throughout Bucks to identify the best use of funding to support the training of non-clinical staff working in general practice. Practice managers have agreed that workflow optimisation should be addressed as a priority and two providers of training have been identified. The CCG anticipates that training in this aspect of non-clinical workload will be rolled out in 2017/18. The CCGs are also progressing the development of a Care Navigator training programme that will be piloted in a small number of practices, before roll out to all practices during 2017/18.

Funding has been earmarked for implementing online consultation systems in 2017/18 and we plan to identify the most suitable system for our practices to adopt.

Investment	**Recurrent/ non Recurrent**	**NHS Aylesbury Vale CCG**	**NHS Chiltern CCG**		**Total**
2016-2017		**£000s**	**£000s**		**£000s**
Business As Usual ie Contract, Premises, QOF, DES, Dispensing, PC Other, S96	R	25,893	39,277	*	**65,170**
Share of Vulnerable Practices Scheme Funding	NR	35	35		**70**
Share of General Practice Resilience Programme Funding	NR	44	70		**114**
Training care navigators and medical assistants	NR	18	29		**47**
Community Enhanced Services	R	1,364	1,458		**2,822**
Total 2016-2017		**27,354**	**40,869**		**68,223**

2017-2018		£000s	£000s		£000s
Business As Usual i.e. Contract, Premises, QOF, DES, Dispensing, PC Other, S96	R	26,455	40,333	*	**66,788**
Delivering Improved Access to General Practice Services (national investment)	R	801	1,703		**2,504**
Transformational Support (£2 per head)	NR	424	683		**1,107**
Share of Vulnerable Practices Scheme Funding	NR	0	0		**0**
Share of General Practice Resilience Programme Funding	NR	22	35		**57**
Training care navigators and medical assistants	NR	36	59		**95**
Online general practice consultation software systems	NR	55	88		**143**
Community Enhanced Services	R	989	1,337		**2,326**
Total 2017-2018		**28,782**	**44,238**		**73,020**

2018-2019		£000s	£000s		£000s
Business As Usual ie Contract, Premises, QOF, DES, Dispensing, PC Other, S96	R	27,048	41,514	*	**68,562**
Delivering Improved Access to General Practice Services (national investment)	R	-	-		**-**
Transformational Support (£1 per head)	NR	212	342		**554**
Share of Vulnerable Practices Scheme Funding	NR	0	0		**0**
Share of General Practice Resilience Programme funding	NR	22	35		**57**
Training care navigators and medical assistants	NR	37	59		**95**
Online general practice consultation software systems	NR	73	117		**190**
Community Enhanced Services	R	1,033	1,368		**2,401**
Total 2018-2019		**28,425**	**43,435**		**71,860**

8. Governance

Primary Care Commissioning Committees

NHS Aylesbury Vale and NHS Chiltern CCGs are categorised as Level 3 in respect of delegated commissioning arrangements and they assumed responsibility for commissioning primary care in April 2016 and April 2017 respectively.

A Primary Care Commissioning Committee is established as a sub group of the Governing Body, which has GP representation and is chaired by a lay member of the Governing Body. From 2017/18, the two CCGs hold Primary Care Commissioning Committees 'in common'. This means that each CCG has its own committee but they meet together at the same time and in the same place. Having the committee meetings in common promotes cross CCG working and helps manage conflicts of interest through greater transparency.

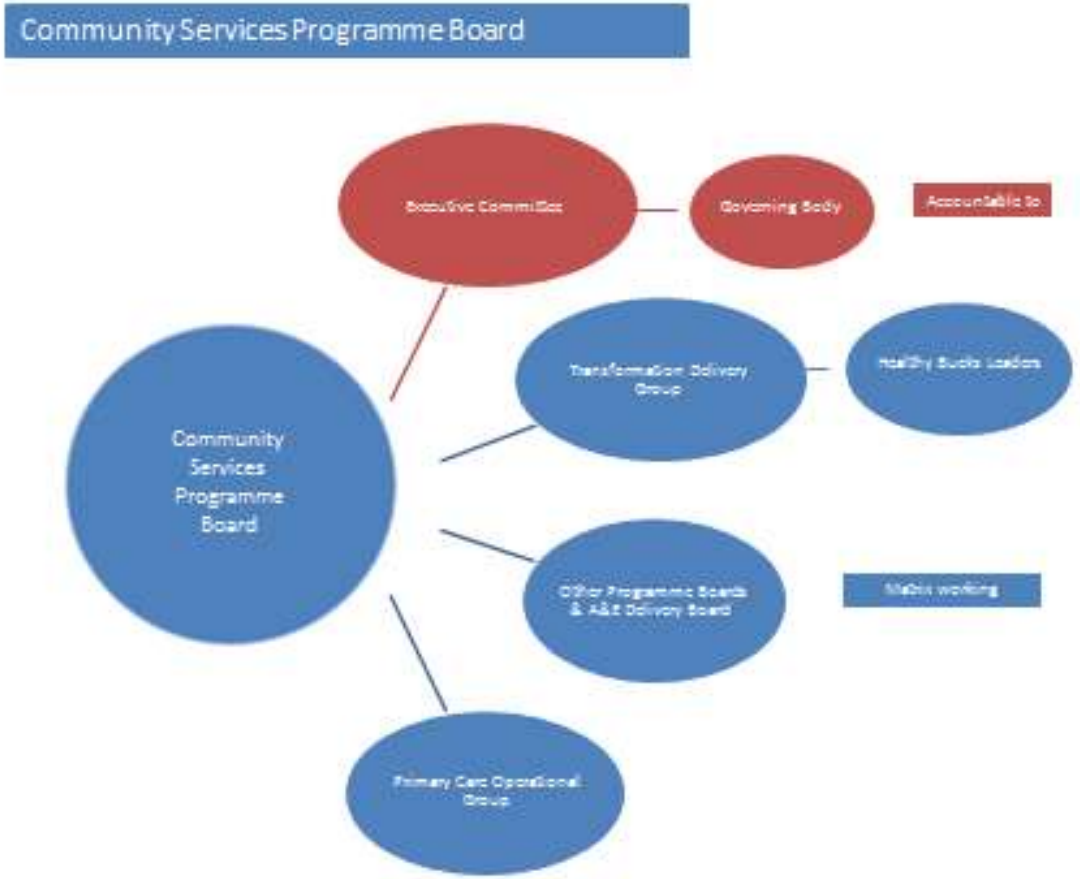
The Primary Care Commissioning Committees will be responsible for monitoring the CCGs' progress against the GP Forward View Plan which includes all actions and targets associated with delivering sustainable primary care over the next two years. We also aim to work collaboratively with other CCGs in the BOB STP footprint and the NHS England transformation teams to deliver common objectives.

Community Services Programme Board

The aim of the Community Services Programme Board is to build 24/7 sustainable resilience and capacity within Primary and Community Services and commission alignment of the services within the oval of services in the diagram on page 29. The programme board is responsible for delivery of 3 key priorities:

- **Primary Care transformation** enabled by GP clusters, 24/7 access to GP led care, consistent triage models for urgent primary care requests, new models of care, innovative direct awards and established ERS with real time information.
- **Integrated multidisciplinary teams** offering comprehensive cover across the 24/7 period as appropriate to GP clusters with a single point of access for rapid response, to avoid admissions and support prompt discharge from A&E.
- **Care Homes** becoming integrated with community services and actively supported in the care of residents with complex needs and those at the end of life, by consistent and high quality community services and primary care.

The Programme Board is chaired by a GP and is formally accountable to the CCG Executive Committee as one of its sub-committees. The following diagram illustrates the matrix working arrangement between other groups and accountability to the Governing Body.


Community Services Programme Board
Executive Committee
Governing Body
Accountable to
Community Services Programme Board
Transformation Delivery Group
Healthy Books Leads
CSP or Programme Boards & A&E Delivery Board
Matrix working
Primary Care Operational Group

9. Summary

The challenges faced by Primary Care today in Buckinghamshire are no different to other parts of England: difficulties recruiting clinical and non-clinical staff, lack of investment, increased workload and premises that are becoming cramped mean that CCGs must support primary care providers to ensure that a sustainable model of primary care can be preserved for the future.

NHS England has acknowledged that action is needed to accelerate the support offered to general practice[11] and has set out a number of funded actions to help make a tangible difference to both practices and their patients. This Plan sets out how the CCGs will implement the *GP Forward View,* providing a clear vision for how primary care will be transformed so that services are affordable, of high quality and equitable for all.

Through this Plan the CCGs will deliver:

- A resilient primary care workforce, skilled in providing a wider range of services in the community
- General practice working together to provide 24/7 services to patients within their locality
- GPs leading a wider network of professionals, all working to the same improved patient outcomes
- Improved access to primary care throughout the week and in extended hours
- Key enablers such as estates and technology to support the delivery of community hubs in line with our integration model
- More support for people to self-care or be managed nearer to home by the right professional at the right time.

Delivering the GP Forward View will ultimately provide:

- Better patient care, including equity of access to services
- More benefits for primary care staff working in Bucks
- Greater efficiencies made possible through new ways of working; and
- Robust resilience within primary care.

Drafted December 2016, finalised May 2017

[11] NHS England, *General Practice Forward View,* April 2016.