Berkshire West Primary Care Strategy

2015 – 2019

DRAFT

1. Introduction

The Berkshire West CCGs 5 Year Strategic Plan describes how, by 2019, enhanced primary, community and social care services in Berkshire West will work to prevent ill-health within our local populations and support patients with complex needs to receive the care they need in the community, only being admitted to hospital where this is absolutely necessary.

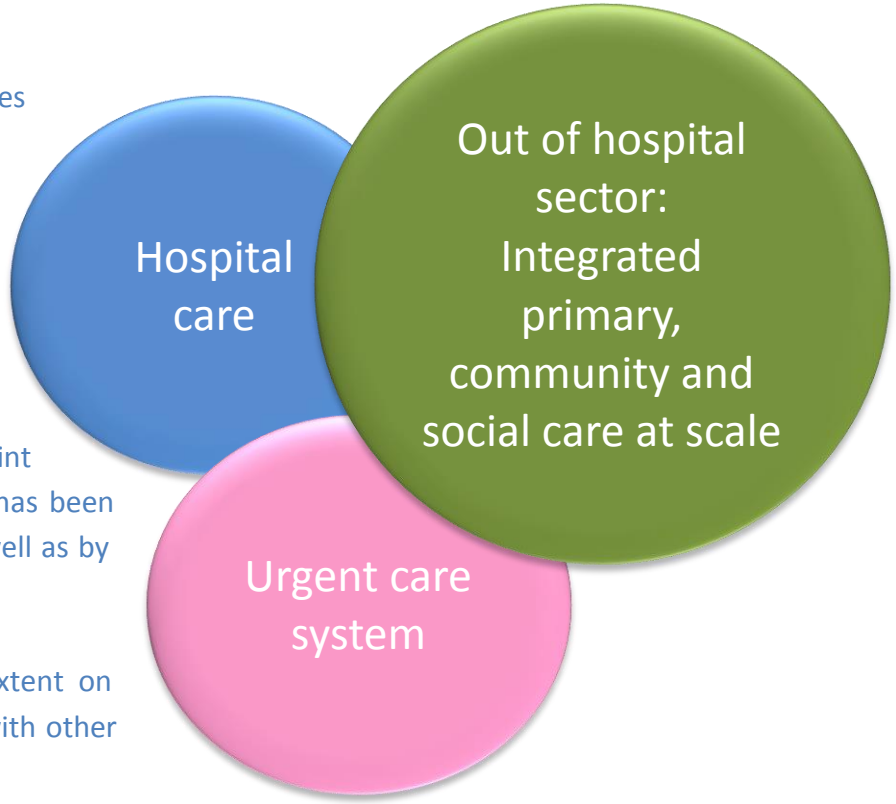
The overriding aims of our overarching Berkshire West CCGs plan which underpin this strategy are:

- Placing a greater emphasis on prevention and putting patients in control of their own care planning.
- Moving away from disease specific services to the commissioning of person centred care.
- Implementation of new models of care which support better integration, and which expand and strengthen primary and out of hospital care.
- Development of new payments mechanisms which incentivise the delivery of outcome focused care and which support the future sustainability of the local system.
- Development of urgent and emergency care networks which ensure patients get the right care at the right time in the right place.
- Better use of technology and innovation to achieve better outcomes for patients and improved demand management.
- Achieving parity of esteem for people with mental health problems and learning disabilities.

Over the coming year we will be exploring options for the development of locally appropriate models of care which offer innovative solutions to support delivery of these objectives in the context of the Five Year Forward View (NHS England October 2014), addressing both the financial challenges facing our system, and the increasing demand for services.

This Strategic Plan builds upon the overarching CCGs Strategic Plan by describing a more detailed vision for Primary care service in Berkshire West; anticipating that Primary care will play a pivotal role in delivering new models of care and in ensuring the sustainability of the broader health and social care system in the light of increasing demand and financial pressures.

This Strategy also describes what we intend to do to address the current challenges facing the sector including financial issues, growing workload pressures and increasing challenges in recruiting and retaining GPs and other key healthcare professionals.



The Strategy has been jointly developed by the four Berkshire West CCGs working together with NHS England as the statutory commissioners of primary care services, and with patients and partners (see Appendix 1). Its development has been overseen by our joint Primary Care Programme Board (shortly to become the Joint Primary Care Co-Commissioning Committee, membership listed at Appendix 2) and has been guided by a Task and Finish Group including GPs, Practice Managers and Nurses, as well as by discussions in each of the four GP Councils.

At this stage the Strategy focuses on primary medical services, and to a lesser extent on community pharmacy, but the opportunities and importance of integrated working with other community services is also a key theme.

Implementation of the Strategy will be overseen by the Joint Primary Care Co-Commissioning Committee, linking with the CCGs' other Programme Boards as appropriate. The Terms of Reference for the Joint Primary Care Co-Commissioning Committee are available at INSERT HYPERLINK.

2. Our Vision for Primary Care

By 2019, primary care in Berkshire West will be:

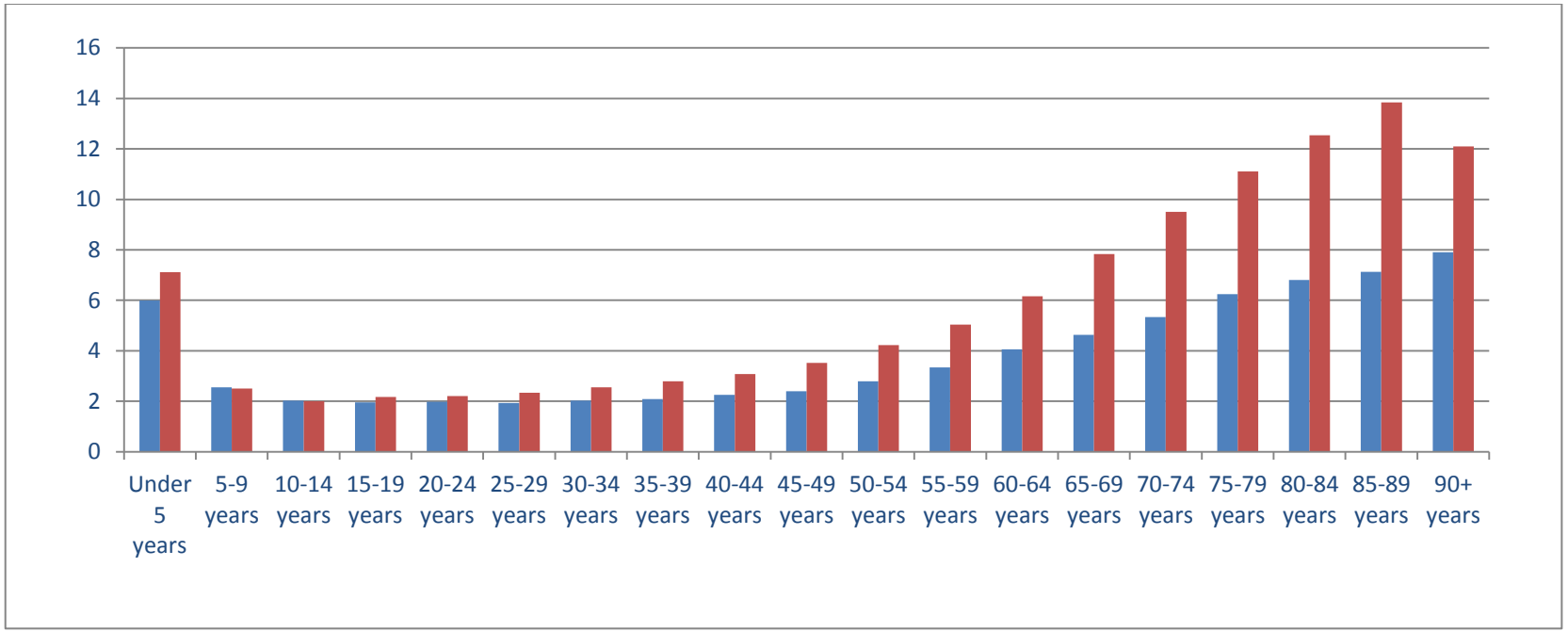
3. The Case for Change

There are 55 GP practices in Berkshire West, providing care to 550,000 patients from 77 surgeries. For 2014-15, the total budget for general practice services in Berkshire West was £64.9m, made up of £59.1m NHS England funding for contractual payments including QOF and enhanced services, and £5.8m invested by the CCGs in community enhanced services including Admissions Avoidance (care planning for Over 75s), support to care homes, early identification of diabetes and extended hours.

All practices in Wokingham CCG and all but one in Newbury and District CCG hold GMS contracts. In North and West Reading and South Reading CCGs, the majority of practices hold PMS contracts. There are currently four APMS contracts in place in Berkshire West, one of which includes a Walk-in Centre component and two of which are one-year interim contracts held by Berkshire Healthcare NHS Foundation Trust (BHFT). All four contracts are therefore due for re-procurement within the next two years. Out-of-Hours services are provided by Westcall (part of BHFT).

The quality of primary care provision in Berkshire West is generally high. The CQC's Intelligent Monitoring System (GP Intelligent Monitoring : Care Quality Commission) brings together data from the Quality and Outcomes Framework, EPACT prescribing data, GP patient survey results and Hospital Episodes Statistics (HES) to rate GP practices from 1-6 according to levels of variance from national norms. Currently the vast majority of Berkshire West practices are rated as either Band 5 or 6 (where Band 6 signifies the lowest level of risk). It is however recognised that there is some variation in performance against the indicators measured and a small number of practices were prioritised for an earlier CQC inspection based on this data.

It is becoming increasingly evident that pressures affecting the wider UK primary care system are starting to impact upon Berkshire West practices. The national increase in consultation rates, reflecting an ageing population increasingly suffering from one or more long-term conditions (see Figure 1, below), is being replicated in Berkshire West where over the 2014-15 Winter period, practices reported a 25% increase in consultation rates when compared with the previous year.



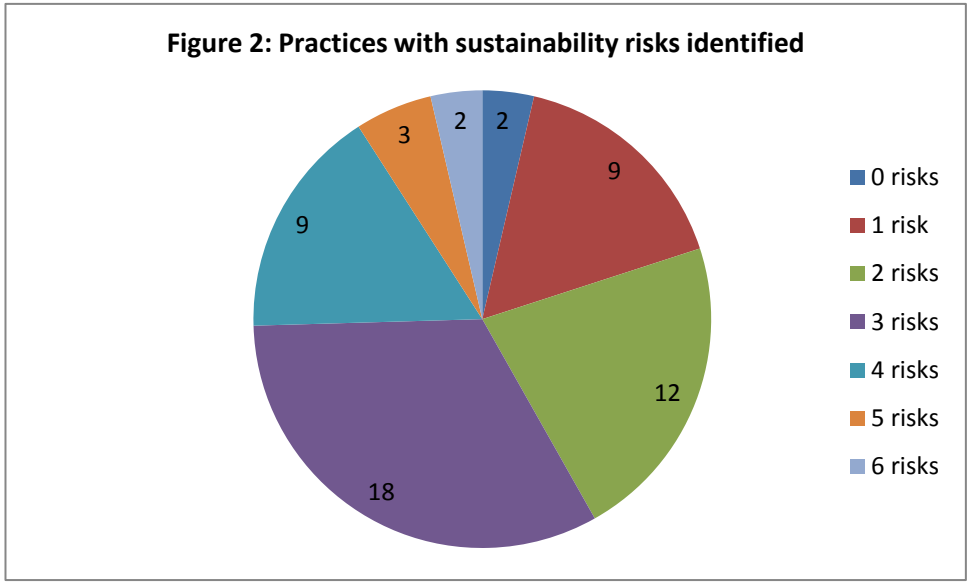
Changes in consultation rates 1995-2008 (HSCIC)

A further pressure relates to GP recruitment and retention. The Royal College of General Practitioners (RCGP) reports that the number of unfilled GP posts has quadrupled in the last three years and that applications to undertake GP training have dropped by 15%.[1] The Nuffield Trust reports that a third of GPs aged under 50 are considering leaving the profession in the next five years due to workload pressures.[2] There is an increasing trend towards part-time posts with 12% of general practice trainees now working in this way and towards salaried employment with just 66% of GPs now working as partners compared to 79% in 2006.[i] 27 of the 55 Berkshire West practices have indicated that they are currently experiencing issues with recruiting GPs and other

[1] http://www.rcgp.org.uk/news/2014/october/over-500-surgeries-at-risk-of-closure-as-gp-workforce-crisis-deepens.aspx
[2] *Is Primary Care in Crisis?*, The Nuffield Trust, November 2014

clinical staff and with a high proportion of Berkshire West GPs and Practice Nurses aged over 50 these issues are expected to become more acute over time.

Patients have told us that they are generally happy with the standard of care provided but would like services to be better co-ordinated so that they only have to 'tell their story once'. Some feel that access to GP services could be improved, particularly by surgeries being open in the evenings and at weekends, but patients also recognise that they need to play a role by accessing services appropriately and considering self-care for minor conditions. Patients would welcome being supported to take a greater role in their care and also believe that primary care could work more effectively with other organisations including in the voluntary sector to promote health and wellbeing. Further information about the priorities identified through patient engagement, together with details of how these are reflected in the Strategy are included in Appendix 1.



The CCGs have recently undertaken a 'risk mapping' exercise aiming to assess the stability of the CCGs' GP practices in order to work with them proactively to address risks and avoid potential contract failures. In addition to recruitment and retention and workload pressures associated with serving a deprived or growing population, this took into account CQC risk ratings, practice size, condition of premises and the potential financial impact of NHS England's review of PMS contracts and phasing out of the Minimum Practice Income Guarantee currently paid to some GMS contractors. Eight measures were considered in total and Figure 2 summarises the level of 'sustainability risks' identified. This data will now be triangulated with quantitative data from other sources such as the national Primary Care Web tool, other CCG reporting tool and demographic information with a view to establishing an ongoing mechanism for identifying and responding to risks associated with primary care contracts.

Both NHS England's *Five Year Forward View* and our own Strategic Plan highlight the importance of a strong primary care sector working at the heart of integrated care provision for patients within the community. But to play this role it is recognised that primary care will need to change, working at scale to overcome current challenges and interfacing with other organisations in new ways.

The remainder of this document describes the strategic objectives and key workstreams which will enable us to realise our vision for primary care.

4. Strategic objectives

In order to deliver our vision, we have set the following five strategic objectives for primary care:

- Addressing current pressures and creating a sustainable primary care sector.
- Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting.
- Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.
- Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Using new approaches to ensure access to primary care in line with patient need.
- Making effective referrals to other services when patients will most benefit.

The following sections describe in more detail the models of care that we intend to develop in relation to each of these strategic objectives or 'asks' of primary care. In delivering these models, we will also address other aspects of our vision, such as ensuring that primary care in Berkshire West is sustainable, cost-effective and an attractive place to work, and that patients value the services provided and are supported to access them appropriately.

Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector.

Innovative solutions will be employed to address the challenges currently facing the primary care sector. We will work to address the current workforce crisis at all levels; improving pre-registration training provision, improving job satisfaction through more rewarding continuing professional development opportunities and working to improve retention of mid-career GPs and others by working with practices to offer more varied and flexible employment opportunities. We will also look to maximise the potential of new roles in primary care including Physicians' Associates, practice-based pharmacists and enhanced administrative and care co-ordination roles. Alongside this we will work to enable practices to respond to demand in new ways (see Strategic Objective 3) and to ensure that the expansion of the role of primary care is accompanied by an increase in primary care investments (see Strategic Objective 2).

Digital systems are the foundation upon which we will build a modern, efficient and responsive primary care sector. Enabling information to flow between care providers within and beyond organisational boundaries, and between care providers and patients, is a key means by which we will achieve a sustainable primary care sector. GP IT systems sit at the heart of primary care technology facilitating and recording thousands of interactions with patients every week. GP practices have led the way in the move from paper to digital record-keeping and recently begun offering online transactions, such as appointment bookings, repeat prescriptions, and online access for patient to their GP- held records.

In a challenging financial environment, IT services must not only improve the quality of care through enhancing the patients' experience of services, but also enable the practice to realise efficiency benefits such as a reduced administrative burden. Building on the solid foundations which are already in place in primary care, our vision is to support practices to develop IT functionality which responds to the evolving needs of patients and underpins integration across care pathways.

It is our view that addressing workforce challenges, capitalising on IT developments and providing the models of care set out under the following strategic objectives will require primary care providers to operate at scale. Single-handed and small practices are unlikely to be able to provide the range and

breadth of services described, or manage the communication and relationships required to operate as part of a truly integrated system. Similarly investment in IT and premises infrastructure is only likely to be cost effective where it serves a large patient population. Going forward, our intention is therefore to make commissioning and investment decisions that support the development of providers with at least 6,000 registered patients, and ideally 10,000 or more. There is evidence that encouraging the emergence of larger providers is likely to result in sustainable provision and improved outcomes for patients going forward.[3]

Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting

Existing community-based care pathways, such as that developed for diabetes, will form the starting point for expanding similar models to other specialties. Virtual outpatient clinics and community-based consultants will become the norm and technology will be used to maximum effect to support self-care and timely liaison between clinicians working in primary and secondary care. Where additional services are commissioned from primary care, the associated investment must follow.

The implications of providing a greater range of services in primary care must be fully factored in to all levels of workforce and premises planning. Larger primary care providers will be better placed to take on expanded roles, and in any case collaboration will be required so that specialists can interface across practices.

[3] *Securing the future of general practice: new models of primary care,* Nuffield Trust and the King's Fund (2013)
Primary Care: Today and tomorrow – Improving general practice by working differently, Deloitte Centre for Health Solutions (2012)
Breaking Boundaries – a manifesto for primary care, NHS Alliance (2013)
Primary Care for the 21st Century, Nuffield Trust (2012)
Does GP practice size matter?, Institute of Fiscal Studies (2014)

Strategic Objective 3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.

Primary care should work as part of the broader health and social care system to avoid patients going into crisis and requiring emergency admission and to support effective discharge from hospital. Proactive care planning for patients with complex needs who may be at risk of admission, including those in care homes, will be further developed to become a core element of primary care provision. A multidisciplinary approach will be taken, with technological solutions supporting the sharing of care plans so that patients only have to 'tell their story' once and different organisations can work together in a co-ordinated way to meet their needs.

Primary care will take a more active role in working to improve the health of the population it serves. Practices will provide more primary and secondary prevention services, linking extensively with public health, the voluntary sector and other community organisations to prevent ill-health and promote wellbeing.

Supporting the broader health and social care system will be our programme for information sharing and connecting the health and social care system - "Connected Care". This has already commenced with the introduction of static interoperability, between practices and Out of Hours primary Care, but over the next 18 months practices will join a wider dynamic programme connecting, practice systems, with acute, community and social care system.

Strategic Objective 4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Using new approaches to ensure access to primary care in line with patient need.

New technology will enable practices to respond to demand in different ways such as through greater use of the telephone, online consultations and email advice systems (with safeguards in place to ensure these systems are used appropriately), as well as technology enhanced mobile working. Patients will be supported to self-care where appropriate and to access the right services at the right time. Community pharmacy may also play a greater role in providing advice and guidance to patients.

The CCGs will encourage practices, especially smaller ones, to work together to respond to same day requests for appointments in a different way, thereby freeing up time for staff to focus on planning care for at-risk patients and on managing long-term conditions. The potential for NHS 111 to take an enhanced role in managing same day demand will be explored through the forthcoming re-procurement process.

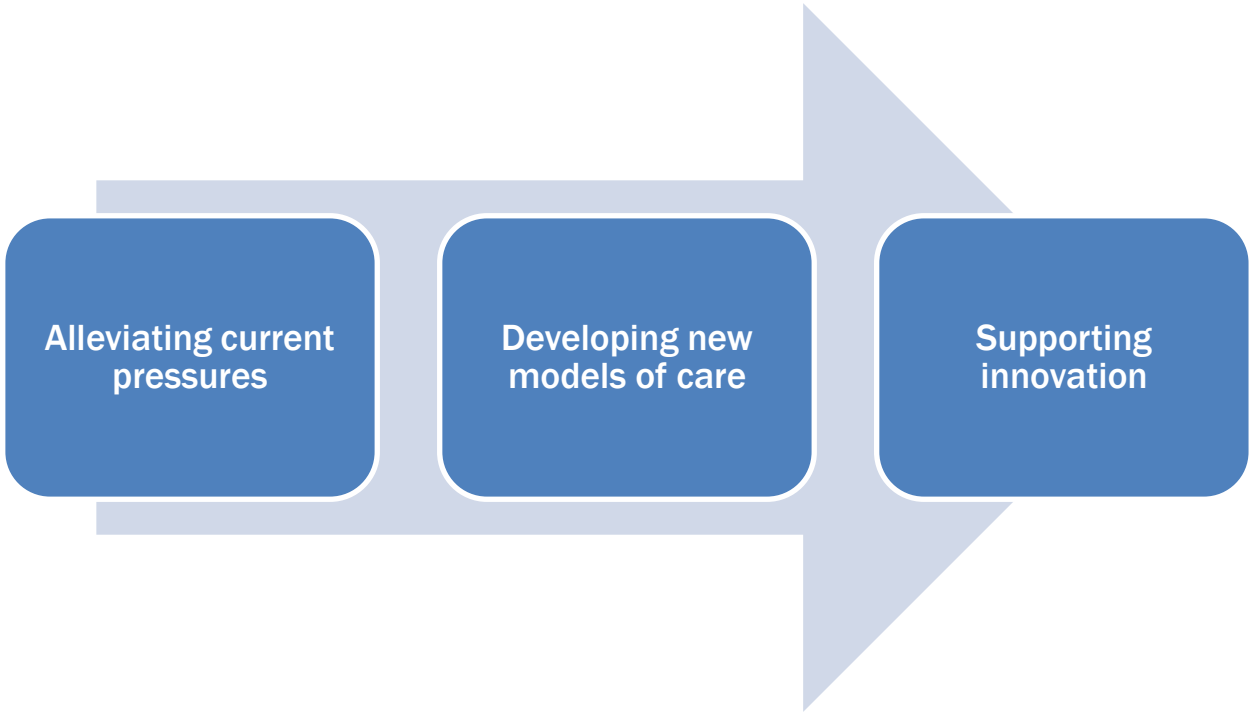
Primary care will function as a key component of the urgent care system and primary care providers and practices will therefore be commissioned to provide more appointments in the evenings and on Saturday mornings and potentially at peak times in-hours. By also providing bookable appointments within these sessions we will improve patient experience and avoid patients attending other services inappropriately outside of core hours. It is likely that practices will increasingly work together to meet demand for same day appointments, possibly through 'hub and spoke' arrangements. In developing such hub arrangements, the CCGs will have regard to the principles set out in the Keogh Review of ensuring patients have access to the right advice or treatment, in the right place and at the right time and the likely emergence of the 'Urgent Care Centre' model.

Strategic Objective 4: Making effective referrals to other services when patients will most benefit

The CCGs will work with practices through peer review and closer liaison with secondary care colleagues to reduce unexplained variation in levels of referral between practices and individual clinicians, thereby ensuring that patients are referred to the services that will most benefit them and at the most appropriate stage of their treatment. Support to referrals will be strengthened through the development of the DXS system which will work as an integral part of practice clinical IT systems, providing a directory of services and detailed information on agreed care pathways and local referral criteria.

5. Our Strategic Approach

The previous sections have highlighted that there is a real opportunity to build upon the high standards of provision in Berkshire West to create an expanded primary care sector as described in our Strategic Plan, but also a risk that this may be stifled by the pressures currently facing general practice. This strategy therefore takes a maturation approach whereby we will first look to support primary care providers to address the very real challenges they are facing, moving on to develop the new models of care described above, with a view to the primary care sector as a whole then being in a position to take a lead role in delivering the innovation required to create the integrated health and social care system we envisage operating in Berkshire West by 2019. The workstreams and investment plan set out below span these three areas and will inform the development of a more detailed Implementation Plan.



a) Workstreams to deliver our Strategic Objectives

Strategic objective for primary care	Anticipated workstreams
1: Addressing current pressures and creating a sustainable primary care sector.	• Supporting new roles in primary care, e.g. Physicians' Associates, prescribing pharmacists, AHPs. • Development of generic primary care nurse role allowing greater flexibility around where care can be delivered. • Expansion of training provision and development of network of multi-professional training practices. • Offering student nurse placements in primary care • Shared training programmes for existing staff including clearer career structures for e.g. practice nurses and administrative staff. Greater sharing of training with other providers / across disciplines. • Development of new roles around care planning and signposting e.g. care navigators, voluntary sector co-ordinators and enhanced case co-ordinator roles • Supporting collaborative approaches to recruitment and development of shared posts and portfolio careers. • Shared locum arrangements. • More effective linking with HETV and other appropriate organisations around workforce planning and training provision. • More co-ordinated appraisal system and CPD arrangements including a structured programme to support nursing revalidation and care certification for HCAs. • Further development of specialist nursing and medical roles working across networks of practices. • Supporting text messaging to communicate messages to patients • Install new servers, single domain and Wi-Fi in every practice. This is the biggest upgrade to GP Practice IT in 20 years and will mean Berkshire West has one of the most advanced infrastructures in the country. • Development of premises strategy, focussing on Reading and Wokingham initially.
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a	• Roll out of existing community-based pathways to other specialties e.g. respiratory medicine. • Development of virtual outpatient clinic model and more community-based clinics • Expansion of community-based consultant roles, building on community geriatrician and community diabetologist models • Improving interface between primary and secondary care clinicians, e.g. greater provision of advice via Choose and Book, E-referral

community setting	and other means, using technology to share information between clinicians electronically, psychiatrists to visit practices to jointly review patients with complex mental health needs. • Further developing GP specialist roles working across clusters of practices, including in mental health in order to support effective management of mental health conditions within primary care. • Supporting the roll out of Eclipse from Diabetes to provide risk stratification system for use across GP Practices in West Berkshire to identify Long Term Condition Patients at risk of emergency admissions.
3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Systematic development and implementation of risk profiling and multi-disciplinary care planning for Over 75s and patients with complex health needs, including improved sharing of information and using technology to further develop the role of patient in managing their care. Anticipatory Care CES to be commissioned in 2015-16 supporting face-to-face care planning, medications review and sharing of information through Adastra. Improving care planning and systematic annual reviews for patients with chronic mental health needs and improved processes to review the health needs of patients with a learning disability. GP job plans to include care planning as a core component of their regular workload. • Improving interface between primary care, community services, social care and the voluntary sector through the development of neighbourhood clusters based around groups of GP practices. • Building on existing preventative work e.g. targeted screening for diabetes and exercise schemes to focus more strongly on promoting health and wellbeing amongst the practice population and ensure such work is appropriately reflected in contractual arrangements. • Supporting practices to better meet the needs of carers, including through provision of Directory of Services enabling improved signposting to voluntary sector support. • Supporting information sharing between practice and wider health and social care system through the Berkshire West Connected Care Programme
4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Using new approaches to ensure	• Practices to be commissioned to offer more appointments in the evenings/early mornings and on Saturday mornings, and potentially at peak times in-hours. Smaller practices to be encouraged to work collaboratively to increase appointment availability, sharing patient records as appropriate. Extended hours sessions to include routine and urgent appointment capacity. • Empowering patients to self-care where possible and to access services appropriately.

access to primary care in line with patient need.	• Enabling practices to utilise technology to maximum effect to offer patients different options for accessing services e.g. via telephone or online consultations or through email advice portals. • Supporting practices to work together to respond to same-day demand in new ways thereby meeting urgent needs more efficiently and freeing up capacity for other aspects of primary care. To include considering shared call handling / urgent clinic models and potential role of NHS 111 in triaging in-hours calls. • Further exploration of potential role of community pharmacy as part of urgent care response. • Establishing clearer standards and expectations of practices with regard to capacity based on review of current local practice and patient feedback. • Supporting practices to deliver care through mobile working of existing practice system • Ensuring availability of a same day primary care response to patients in mental health crisis as part of the implementation of the local action plan linked to the Mental Health Crisis Care Concordat.
5: Making effective referrals to other services when patients will most benefit	• Roll-out of the DXS system and the associated service directory to be available to all practices and to include information on voluntary sector provision and carer support. • QIPP scheme to reduce variation in referrals and non-elective admissions where there is no clinical rationale behind this. To be delivered through peer review, CCG support and education sessions.

b) Co-commissioning

Delivery of our strategy will be underpinned by recently agreed co-commissioning arrangements with NHS England. The CCGs have been approved to jointly commission primary medical services with NHS England with effect from 1st May 2015. Responsibilities will be discharged through the Joint Primary Care Co-Commissioning Committee and will reflect the nationally determined scope of joint commissioning arrangements as well as guidance around governance and arrangements for managing conflicts of interest. Over time consideration will be given to moving to a fully delegated model.

Co-commissioning will play a crucial role in the delivery of the workstreams outlined above. It will enable CCGs to influence the content and management of core and enhanced primary care contracts (within national parameters) and to align the commissioning of primary care with the organisations' broader commissioning intentions, thereby enabling care to be commissioned across the full extent of the patient pathway.

The following opportunities and priorities have been identified:

- Through co-commissioning we will work to further develop our local definition of what high quality primary care looks like, what level of service patients can expect and anticipated outcomes, linking back to the strategic objectives set out in this document. We will take every opportunity to reflect this in contractual arrangements and in decision-making with regard to future practice changes. This will include encouraging 'upscaling' and collaboration between practices as we have recognised that this will best support delivery of the models of care described in this Strategy. We will work to develop an APMS contract offer as well as a similar consolidated 'contract plus' offer for GMS and PMS practices (following conclusion of the forthcoming NHSE review of PMS contracts) which reflect our strategic objectives and will reduce the bureaucracy associated with managing multiple contracts. This will move us towards our vision of ensuring that all patients have access to a defined level of service irrespective of the model of delivery.

- Linked to this, the CCGs will work with NHS England to develop a framework for further improving quality and addressing unwarranted variation in primary care. This will incorporate CCG-led peer support and sharing of best practice alongside arrangements to address any ongoing performance issues including those highlighted by CQC inspections. We will explore the potential to develop a local quality incentive scheme (potentially superseding some or all of QOF), aligned to the strategic objectives set out in this document. By risk mapping practices on an ongoing basis we will also be able to ensure that we offer targeted support to practices experiencing particular issues and work with those most under pressure to develop plans for the future.

- Through co-commissioning we will work to ensure that any PMS premium funding released as a result of the review of PMS contracts is re-invested in such a way as to further our strategic objectives for primary care. Over time the CCGs will look towards aligning funding levels for all practices irrespective of the type of contract they hold.

- We will work to develop a strategic plan for primary care premises, ensuring that investment is targeted towards premises developments which will underpin delivery of the new models of primary care described in this strategy and that the system is able to respond proactively when national funding streams are made available

c) CCG-level planning

The four GP Councils have been engaged in the development of this strategy through a series of workshops and the strategic objectives set out in this document reflect the collective output of these sessions. However whilst the associated workstreams (see above) will span the four CCGs, it is envisaged that implementation arrangements will vary between them, reflecting their differing population needs and the nature of their existing models of primary care provision. The focus of developments to date within the CCGs has also varied somewhat and further Council discussion will be required as set out in Section 7, in particular to consider any aspects of the strategic objectives for primary care for which a local approach has not yet been agreed.

The following table summarises the extent to which the emerging local vision of each CCG aligns with the broader strategic objectives for primary care identified in this document by identifying key elements of discussion in each area. More detailed information about CCG discussions to date is included in Appendix 2.

	Newbury & District	North and West Reading	South Reading	Wokingham
1: Addressing current pressures and creating a sustainable primary care sector.	• Self-care and automating QOF • New 'GP Personal Assistant' admin role • Freeing up GP time to focus on most complex patients • Multidisciplinary training environment	• Discussions have focussed on how can work together to make roles more attractive. • Consider role of other professionals e.g. pharmacists • Shared approach to multi-disciplinary training, appraisal and CPD	• Discussions have focussed on potential for practices to work more closely together through hub and spoke model thereby creating efficiencies.	• Discussions have focussed on cluster model. This would enable practices to work together to create back office and other efficiencies. • Consider role of Cluster Primary Care Urgent Care Centres
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a	• Direct access diagnostics and new ways of working with consultants	• Building on diabetes model to develop further care pathways and work differently with consultants, including with psychiatrists	• Hubs would have critical mass to offer new services and interface with consultants and others in new ways.	• Clusters would have critical mass to offer new services and interface with consultant and others in new ways.

community setting				
3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Continuity when it matters – team of staff focussing on most needy patients; linking with other services as appropriate	• Looking to establish care planning for all long-term conditions • Preventative work e.g. Beat the Street • Age UK care workers • Practices to work as part of integrated Neighbourhood Health and Social Care Teams	• Hubs would act as point of interface with other organisations, thereby supporting cluster working as set out in BCF plan. • Practices could collaborate to meet on the day demand thereby freeing up time for care planning for patients with the highest needs.	• Cluster Care planning working with Care Navigators • Social workers, housing officers etc would be aligned to clusters enabling services to work together more effectively to meet people's needs in the community. • Voluntary Sector Co-ordinator role to be piloted.
4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Using new approaches to ensure access to primary care in line with patient need.	• Exploring shared call handling and collaborative approach to 'extras'	• Additional extended hours capacity to be commissioned in accordance with patient need – evenings and Saturday mornings	• Hub and spoke model would offer flexible approaches to extended hours provision and potentially in-hours requests for same day appointments.	• West cluster to pilot collaborative approach to meeting demands for urgent care and providing extended hours.
5: Making effective referrals to other services when patients will most benefit	• Directory of Services likely to be delivered as part of DXS system. To facilitate direct access to other professionals and improved service navigation.			• DXS information will improve co-ordination of care and links with voluntary sector. • Considering how to reduce variation in referral rates for some time and now working with other CCGs on BW scheme.

6. Investment plan

Core primary care services are funded through NHS England's GP commissioning budgets. A high-level summary of 2014-15 budgets is provided below. Further enhanced services are commissioned by unitary authority Public Health departments.

CCG	GP Contract Payment £000	QOF and Aspiration £000	PCO Admin £000	GP Drugs Payments £000	GP Premises £000	Misc. Items £000	Enhanced Services £000s	Total Area Team £000
Newbury and District	8,464	1,197	331	515	1,197	125	812	12,641
North and West Reading	8,892	1,139	312	427	1,127	117	762	12,776
South Reading	12,245	1,056	380	490	1,777	143	917	17,007
Wokingham	10,980	1,625	449	608	1,786	169	1,102	16,720
Total	**40,580**	**5,017**	**1,472**	**2,040**	**5,887**	**554**	**3,592**	**59,143**

CCG budgets relating to primary care in 2015-16 are set out below. In addition to GPIT funding of £1.3m and established enhanced services funding of £0.5m, we intend to use the £5 per head funding to support the care of the Over 75s (as per the 2014-15 planning guidance) to invest in an Anticipatory Care CES designed to significantly advance our third Strategic Objective (Managing the health of a population in partnership with others). In addition, the Better Care Fund plans we have agreed with the local unitary authorities include £2.5m of this pooled budget being invested in extending GP access into extended hours and at peak times in-hours, following a £1m pilot scheme in 2014-15. These two schemes equate an 8.4% increase in investment in primary care. Details of current IT investment plans are included in Appendix 3, below.

	CCG Budgets				
CCG	£5 per head "anticipatory care" £000	BCF Enhanced Access £000	Enhanced Services Recurrent £000	GPIT £000	Total CCG £000
Newbury and District	576	576	101	299	1,552
North and West Reading	560	560	116	279	1,515
South Reading	643	643	94	352	1,732
Wokingham	722	722	187	406	2,037
Total	**2,500**	**2,500**	**498**	**1,336**	**6,836**

Further investment in primary care may follow where it is identified that this will result in overall cost savings in other parts of the CCGs' commissioning budgets. It is also intended however that the strategy will be delivered through the re-alignment of existing commissioning budgets to better reflect the strategic objectives described. As set out in the above co-commissioning section, key priorities will include:

- Development of an APMS offer that reflects our strategic objectives with KPIs aligned to local patient need.
- Redesign of QOF to reflect local priorities.
- Ensuring infrastructure investment furthers our strategic aims.
- Re-investment of released PMS premium funding in service models which reflect this strategy, and with the intention of aligning GMS and PMS funding levels in the future. The mechanisms for doing this require further discussion.

7. Delivering the Strategy

The following table summarises the outcomes that would result from successful delivery of our strategic objectives. Baselines and mechanisms for reviewing progress against these outcomes will be agreed by the Joint Primary Care Co-Commissioning Committee which will assess progress and review the strategy periodically in the light of developments in co-commissioning and in the broader health and social care economy's approach to integration and sustainability.

Strategic objectives	Outcome measures
1: Addressing current pressures and creating a sustainable primary care sector.	• Decreased number of vacancies within practices, application rates improved as primary care is seen as a more attractive place to work. • Staff satisfaction improved • Smaller practices working in federation or other collaborative forms from fewer/better premises serving populations of at least 6,000 but ideally 10,000 patients • No new contracts awarded to single-handed practitioners or practices that would have a list size of less than 6,000 • All primary care premises are fit-for-purpose • Primary care workforce diversified to include pharmacy, nursing, therapists and physicians associates. • Multidisciplinary and joined up arrangements in place for pre-registration training and continuing professional development • Practices receive a consistent level of funding for a defined level of service so that patients in Berkshire West have access to a consistent level of provision. • Services provided outside of core contracts are resourced appropriately. • Contractual arrangements simplified and bureaucracy reduced. • Quality standards are maintained or improved and unexplained variation between practices is addressed. • Strategy underpinned by a robust financial plan which incentivises new ways of working.

2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• New care pathways in place between primary and secondary care resulting in fewer visits to hospital. • Improved control of long-term conditions e.g. reduced HbA1C level etc • Positive feedback from patients with long-term conditions
3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Directory of Services in place supporting improved links with the voluntary sector and increased signposting to voluntary services. • Risk stratification actively used to identify and develop care plans for at-risk individuals. • Preventative work in place with lower risk groups. • Improved patient feedback regarding co-ordination of care • Interoperability achieved and services therefore able to share information with patient consent
4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Using new approaches to ensure access to primary care in line with patient need.	• Primary care available from 8am-8pm in the week and on Saturday mornings. • Improved patient survey results / Friends and Family test responses
5: Making effective referrals to other services when patients will most benefit	• Unwarranted variation in referral and non-elective admission rates reduced for specialties where this has been identified.

8. Next steps

Section 5 of this document describes the progress of the individual CCGs in formulating a local vision for primary care which will support delivery of the four overarching strategic objectives for primary care. As part of signing off this strategy, the four GP Councils will be asked to further review the extent to which the vision they have articulated to date, together with the associated local workstreams, will deliver the strategic objectives for primary care set out here, and to consider developing a 'Plan on a Page' around the key aspects of this Strategy. The resulting plans will be discussed at a joint meeting of the four GP Councils. As well as providing an opportunity for Councils to share ideas, this will aim to ensure that co-ordination between local projects and the overarching workstreams and enable identification of any areas of overlaps or potential for gaps in delivery.

Further engagement with patients around the workstreams set out in this Strategy will be undertaken as part of the CCGs' broader Communications and Engagement Strategy. An associated primary care communications plan will be developed.

Delivery of the strategy will be overseen by the Joint Primary Care Co-Commissioning Committee. The Committee will develop an implementation plan which will form the basis of a strategic programme for primary care for which it will take lead responsibility, identifying and working to mitigate risks as appropriate. It will also link extensively with the CCGs' other Programme Boards around specific workstreams.

Appendices

Appendix 1: Summary of key messages from patient engagement to date

The following table has been collated based on feedback from Call to Action events in 2014, the Reading GP question time event held in November 2014, a patient engagement event focussing on primary care held in Newbury in March 2015 and Wokingham CCG engagement around cluster working, as well as discussion with individual Patient Voice Groups.

As set out above, a more detailed Communications and Engagement Plan will be developed around the key workstreams identified in this strategy.

Key themes identified through patient engagement to date	How these are reflected in Strategy
People want better co-ordination of care between organisations so that they only have to tell their story once. There is a view that this should be achieved through shared IT system, and should include working to avoid admissions from care homes. Patients with the most complex needs should be prioritised and plans should be in place to ensure they do not have to explain their illness at every consultation. IT systems should ensure confidentiality of data. Technological solutions should not be a substitute for good face-to-face care.	• Integration with social care and other services through neighbourhood clusters will improve communication between organisations • Patients identified as being most at risk of admission will have care plans in place which can be accessed by other organisations through Adastra. This will incorporate specific care planning processes for care home residents. • Berkshire West Connected Care Programme currently allows the out-of-hours GP service to access patients' records with their consent. Over time this will be expanded to cover A&E and other organisations. Data confidentiality and information governance are key considerations in all initiatives being progressed under this programme. The programme aims to ensure that technology is used to maximum effect to support patient consultations and enhance patients' overall experience of care.

Whilst satisfaction with opening hours is generally high, a significant proportion of patients would like their GP practice to be open more in the evenings and at weekends, although others felt that good access in-hours with an ability to see their own GP was as important as extended opening. Appointments could also be different lengths according to patient need.	• We will commission practices to provide extended hours opening across weekday evenings and on Saturday mornings, in some cases working together to maximise access for patients. Maintaining and expanding capacity in-hours, particularly at peak times, will also be a focus. • Under the 2015-15 GP contract, practices are required to offer patients a named GP responsible for co-ordinating their care.
People recognise that there is a need to promote self-care and to ensure that patients access services appropriately.	• We will use new technology to support self-care as a component of care for patients with long-term conditions. • Our Communications plan will provide more information about self care for minor ailments and appropriate usage of A&E and other services.
People believe that the voluntary sector could play a greater role in meeting peoples' needs, although there it is important to assure the quality of the services offered and to fund these organisations appropriately. GPs need to be more aware of voluntary sector provision.	• Wokingham CCG are piloting a Voluntary Sector Co-ordinator role as part of their cluster working project. • We are working to improve signposting to voluntary sector provision for example through the Directory of Services linked to the new DXS system and through pilot role such as the Voluntary Sector Co-ordinator in Wokingham. The provision of information about support to carers through this system is also being explored.
People identified the need for primary care to work with other agencies to support wellbeing and help prevent mental health issues. A particular focus should be ensuring that young families have access to the support they need. Young people were also identified as a priority group.	• Our vision for primary care involves practices working at the heart of the communities they serve and with other agencies to prevent both physical and mental ill health and to work as proactively as possible to minimise the impact of illness. • Wokingham's pilot Voluntary Sector Co-ordinator role will have a particular focus on the needs of young families moving to the area. • Information on support services and organisations will be better available to

	practices through the DXS system (see above).
There is also a view that GP practices should routinely offer more information on the benefits of exercise and how to prevent diabetes and that young families need more support. It was recognised that practices should work in partnership with other organisations to enable early intervention and prevention of more complex health issues.	• NWR and Wokingham GPs are promoting physical exercise through the 'Beat the Street' initiative. We have also commissioned practices to provide support to patients identified as being at risk of diabetes or in the early stages of diabetes. Through this Strategy we will work with Public Health to further build the role of primary care in preventing ill health (see above).
It is recognised that practices will increasingly involve teams of different healthcare professionals, thereby widening the workforce.	• The workforce sections of this Strategy describe how different professionals such as Physicians' Associates, pharmacists and emergency care practitioners. may increasingly become involved in delivery primary care, with a wider practice team working to support the specific needs of different groups of patients.
People want more planned care for long-term conditions, including continuity of care where possible.	• The CCGs recognise that continuity of care is important to patients with complex needs and where this improves outcomes practices should endeavour to provide this. Where different professionals are involved in a patient's care, care planning and better sharing of information will improve communication between them (see above). GPs are also now required under their contracts to identify a named GP for all patients.

Appendix 2: Summary of CCG discussions to date

Newbury and District CCG	
Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector	• Services will work to support patients to self-manage their condition where appropriate thereby freeing up GP and other healthcare professionals' time to focus on work that can only be done by them personally. Technological solutions will be employed where possible to enable patients to enter their own data into the GP record where possible, to remind patients to attend for monitoring appointments and to automatically update associated parts of patient records following completion of other elements. • Focussing on patients with the most complex needs (see below) and using skill-mix more effectively will require GPs to work 'at the top of their licence', thereby removing tasks that do not require their input. Whilst the implications of GPs having a more complex casemix will need to be considered, managed appropriately this is likely to make roles in general practice more challenging and rewarding. Extending the role of training and trainee workforce will help foster a learning environment for everyone in the team to benefit from shared expertise and keeping up to date in professional practice. Collaborative approaches to recruiting to posts working in different parts of the primary care system will also be considered.
Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Direct access diagnostics and improved communications between GPs and consultants will reduce the need for referrals to secondary care and, where these are required, outpatient consultations will increasingly be provided in a community setting by community-based consultants with all appropriate tests having been done in advance. Within Newbury there is also an aspiration to develop a Diagnostic and Treatment Centre which would undertake tests and provide treatment where possible thereby avoiding the need for many patients to be admitted to an acute hospital.

Strategic Objective 3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Discussions in Newbury have focussed on the concept of continuity when it matters. This would involve developing GP-lead teams of healthcare professionals able to prioritise a smaller list of patients for whom continuity is important and may affect clinical outcomes (e.g. those with complex multimorbidity, severe enduring mental illness, a severe single condition, or requiring end-of-life care). These teams would consist of GPs, Primary Care Nurses (a new role combining elements of current community and practice nurses), Community Matrons and Physicians Associates, supported by an enhanced 'GP Personal Assistant' administrative role created by freeing up the staff time associated with dealing with on-the-day demand (see below). These staff would mainly be involved with this prioritised list and so would get to know the patients over time.
Strategic Objective 4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Ensuring appropriate access to primary care services in line with patient need.	• The Newbury practices are exploring the potential of shared call handling provided either through one or more central hubs, or by using a locally-agreed uniform protocol to handle in-hours requests for GP appointments. This will create efficiencies within practices allowing administrative staff to take on enhanced roles (see below). Using a standard threshold for appointments could then enable practices to work collaboratively to meet excess on-the-day demand through a hub involving GPs, minor illness nurses and Nurse Practitioners. This will free up the time of GPs and others to focus on the patients who most need their care and will give GPs more control over their working day, thereby potentially improving retention. Hub working will also support more effective links with social care and other services. • Electronic consultations will enable GPs to review a succinct patient history prior to seeing or speaking to the patient. It is likely that telephone and/or Skype consultations will also become more common.
Strategic Objective 5: Using the DXS system to make effective referrals to other services when patients will most benefit	• Newbury GPs have discussed the concept of a Directory of Services which is likely to be delivered as part of the DxS system (see above). This will be used by practices, NHS 111 and out-of-hours to facilitate direct access to other appropriate professionals e.g. IAPT, Social Services, Physiotherapy etc. A service navigation function will support patients and practices to access the services they need.

North and West Reading CCG	
Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector	• Practices in the CCG recognise the need to make General Practice in North and West Reading an attractive place to work and will work together on this in order to respond to the current workforce crisis. As well as considering how posts can be made more attractive, the role of other professionals such as pharmacists will be further developed. Improving retention of staff will be a particular focus and it is felt that a more co-ordinated and multi-disciplinary approach to training, appraisal and continuing professional development focussed on the particular needs of the local population will support this.
Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Practices in the CCG are keen to build upon the success of the diabetes model to develop further community-based pathways with a strong self-care component for patients with other long-term conditions. Improved access to consultant advice should work to reduce referrals and support the management of patients within primary care. One of the strong features of the diabetes model is that GPs regularly meet with the Consultant Diabetologist and have direct access to him for urgent advice. The CCGs hopes to expand this to have better access to all other Consultants. GPs also want to ensure that there is a process for direct "doctor to doctor" conversations about any concerns about the quality of care delivered to patients in the hospital and community. The CCG wishes to see patient centred care /care planning adopted for all long-term conditions. This is at the centre of the Diabetes re-design and the respiratory work that is happening in 2015/16. • The interface with mental health services is a particular area of focus and GPs wish to improve the availability of advice from consultant psychiatrists and other mental health professionals.
Strategic Objective 3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary,	• The CCG will work with practices to take a more preventative approach to care. A key focus will be on promoting walking and cycling through an extended 'Beat the Street' campaign. Work is also underway to support the national cancer screening programmes and to identify and address gaps in the support provided to carers in primary care. The CCG will maximise opportunities to better support our population with self-care. • Providing better co-ordinated and proactive care for frail elderly patients is a key priority for all practices in the CCG.

community and social care to support patients at home	The CCG will work with and further develop the community geriatrician model to support practices avoid unnecessary admissions. As well as embedding and further developing care planning for those with the most complex needs, the CCG plans to commission two Age UK care workers to proactively seek out and support older people, particularly those socially isolated, not currently under medical or nursing care. Over time practices will look to work as part of Integrated Neighbourhood Health and Social Care Teams providing more joined up care for patients.
Strategic Objective 4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Ensuring appropriate access to primary care services in line with patient need.	• The CCG will look to commission further extended hours working in a way that addresses patient need and maintains GP work/life balance without de-stabilising core in-hours and out-of-hours provision. In common with the broader principles set out elsewhere in this Strategy, at present this is likely to involve practices offering additional capacity in the evenings and on Saturday mornings, working collaboratively to do this where appropriate.
Strategic Objective 5: Using the DXS system to make effective referrals to other services when patients will most benefit	• To be considered further by the NWR GP Council.

South Reading CCG

In South Reading primary care discussions to date have focussed on how GP practices might work together to address the challenges of growing demand and difficulties in recruitment and to expand the primary care sector. South Reading practices are well-placed to offer services collaboratively as there are a large number of smaller practices working in close geographical proximity. A sub-group of the Council is currently meeting to explore how the CCG can move towards a network of geographically-determined 'hubs and spokes'.

Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector	• The hub and spoke model would offer significant potential efficiencies for practices in terms of sharing back office functions, providing enhanced services collaboratively and offering opportunities to work together to address growing demand.
Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Hubs would potentially serve a population of around 25,000 and would therefore have the critical mass required to offer services beyond those historically provided in general practice and to interface with consultants and others to provide more community-based care. Practices would also be able to collaborate to provide enhanced services.
Strategic Objective 3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Hubs would act as a point of interface with other organisations, thereby supporting the development of cluster working as described in Reading's Better Care Fund Plan. • Practices would also be able to work collaboratively through hubs to offer enhanced services and potentially also to meet on-the-day demand for services, freeing up time within 'spoke' practices to proactively plan care for patients with the highest level of need.

Strategic Objective 4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Ensuring appropriate access to primary care services in line with patient need.	• Practices would collaborate through the hub model to meet the needs of patients requiring same day appointments and to offer extended hours provision.
Strategic Objective 5: Using the DXS system to make effective referrals to other services when patients will most benefit	• To be considered further by the South Reading GP Council.

Wokingham CCG

Wokingham CCG is working with Wokingham Borough Council and other partners on the development of cluster working. Clusters will be a grouping of services working together to meet the needs of a defined population. There will be three clusters within Wokingham (East, West and North), each serving a population of 40 – 60,000 people. Wokingham is experiencing significant population growth as a result of new housing development and key focus is planning to meet the primary care needs of an estimated additional 32,000 residents by 2022. Each cluster will pilot a key collaborative project in the first year which will be evaluated and rolled out as appropriate. Cluster working will enable practices to work together to address key challenges such as recruitment and retention and growing demand, thereby delivering a more sustainable workload for primary care teams.

Strategic Objective 1: Addressing current pressures and creating a sustainable primary care sector	• Cluster working offers significant opportunities for practices to work more efficiently by sharing back-office functions, working together to meet rising demand and potentially providing services collaboratively.
Strategic Objective 2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• Clusters will have the critical mass required to offer services beyond those historically provided in general practice and to interface with consultants and others to provide more community-based care. There will be opportunities to further develop GP specialists supporting a number of practices and to work in new ways with secondary care clinicians.
Strategic Objective 3: Managing the health of a population in partnership with others. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home	• Over time, by managing urgent demand collaboratively, clustering should free up GP time to focus their efforts on providing proactive, community-based care for patients with higher levels of need. • It is envisaged that social workers, housing officers and other key professionals in other services will be aligned to clusters thereby enabling services to work together jointly to plan for meeting patients' needs in the community. • The Clusters will bring in the role of care navigators. This will support practices to signpost people to the extensive range of voluntary sector services available to them. It will also work to reduce social isolation amongst older people and will work proactively to help people to access support at an early stage. A further focus will be meeting the needs of young families moving into the Wokingham area who may not have local family networks to support them.

Strategic Objective 4: Offering extended provision to improve access and better meet the needs of patients requiring urgent care. Ensuring appropriate access to primary care services in line with patient need.	• The Clusters will pilot a joint approach to meeting demands for urgent care through a cluster based primary care urgent care centres with a particular focus on working together to deliver both in hours and extended hours services. Opportunities to work jointly to respond to requests for same day appointments will also be explored.
Strategic Objective 5: Using the DXS system to make effective referrals to other services when patients will most benefit	• Co-ordination of care between services and links with the voluntary sector will be underpinned by information provided through DXS which will be readily available to all practices. • Wokingham CCG has been considering how to reduce variation in referral rates between practices for some time and will work with the other CCGs on the implementation of a Berkshire West scheme to progress this.

Appendix 3: IM&T investment plans