Primary Care in Buckinghamshire

Our strategy for proactive, co-ordinated, out-of-hospital care.

NHS Aylesbury Vale Clinical Commissioning Group and NHS Chiltern Clinical Commissioning Group

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> In short, there has never been a more exciting time to create a vision for a transformed primary care.

Foreword

NHS Aylesbury Vale Clinical Commissioning Group

We are proud to introduce our Primary Care Strategy for Aylesbury Vale and Chiltern CCGs, for the period 2015 – 2020.

Shaped by the public, our member practices and other stakeholder contributions, we hope that by reading about our plans for transformation of primary care services, you will share our excitement for the real opportunities this provides us to deliver a better service for our patients and service users.

The construction of this Primary Care Strategy began in summer 2014; AVCCG hosted a half day event for practices, with the LMC, Local Authority and Bucks Healthcare Trust in attendance. We specifically started with 'a blank sheet' to encourage participants to freely think about future options of service delivery.

In the autumn a Clinical Executive Board member visited each of our member practices to discuss ideas with GPs, nurses and other team members. Public engagement events were held in all 3 of our localities to gain views and opinion from potential users of future health services and we linked all relevant public comments from our previous consultations such as the out-of-hours services work.

Primary care in England faces unprecedented challenges. Challenges so great, that failure to meet them head on is not an option. Putting it simply, people are living longer and many more people are living with complex, long-term medical conditions, like diabetes, heart disease and dementia.

It is not unreasonable to say the future success of our National Health Service, as a whole, depends upon getting primary care right. Although the challenges are daunting, we believe there is now a unique opportunity for transformational change. The recently published NHS Five Year Forward View, which places primary care at the heart of the NHS, illuminates the possibilities ahead of us.

Technology will facilitate the empowerment of patients. The recent advent of co-commissioning will, for the first time ever, mean that clinicians are playing a part in the design and commissioning of all parts of the wider healthcare system.

This strategy reflects the collective view of both CCGs across Buckinghamshire, Chiltern CCG having engaged with partners in the south of the county.

In short, there has never been a more exciting time to create a vision for a transformed primary care.

Dr Graham Jackson
Clinical Chair AVCCG

Dr Malcolm Jones
Primary Care Lead AVCCG

"The Bucks Primary Care Strategy - a model for proactive, co-ordinated, out of hospital care."

Foreword

NHS Chiltern Clinical Commissioning Group

As local GPs in Buckinghamshire for many years we have seen that the needs of our local population have changed. Thanks to the success of the NHS and better living standards, people are living longer. With longevity, however, comes differing needs - long term illnesses, often several of them together. Dealing with these conditions requires a different type of general practice to that which developed when the NHS was new, when communities were close knit, infections were the main illnesses, life expectancy was shorter and hospital based care was needed for many treatments.

For 21st century primary care to flourish and respond to current demands a new model of working is needed. For people living with more complex illnesses and frailty a much more integrated, joined up approach between health and social care professionals in Buckinghamshire is needed. This can offer better outcomes, enable co-ordinated high quality care to be delivered in the community avoiding hospital admissions or visits where these are not necessary and a more comprehensive patient experience. This is the vision for this Primary Care Strategy.

In order to develop this strategy for new potential integrated models Chiltern CCG has worked extensively with health and social care professionals across Buckinghamshire, bringing them together in a programme of large scale change workshops under the facilitation of NHS Improving Quality (NHSIQ). GP members of both Buckinghamshire CCGs have been integrally involved and given valuable contributions throughout the development of this strategy.

We have engaged members online and at learning events, locality meetings and practice visits. We have consulted the public and patients in local meetings, via our new consultation portal www.letstalkhealthbucks.nhs.uk and our Engagement Steering Group.

We are pleased to present the culmination of this work "The Bucks Primary Care Strategy - a model for proactive, co-ordinated, out of hospital care". This has been produced in collaboration with Aylesbury Vale CCG.

We hope that you will share this vision for an integrated future. This is just the start. We will continue to work with patients, GPs and other health, social care and voluntary sector providers on a locality basis through the next steps for development of community based services.

Dr Annet Gamell
Chief Clinical Officer
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Primary Care Lead
Chiltern CCG

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Introduction

This is the Primary Care Strategy that underpins our vision across Buckinghamshire for proactive, co-ordinated, out-of-hospital care.

In order to ensure our proposed primary care strategy is fit for purpose, a group of some thirty individuals from across local commissioner and provider organisations was created and worked under the guidance of NHS Improving Quality on a large-scale transformational change programme from June to September 2014. The outputs of this change programme have significantly contributed to this work.

Although it is strongly focused on the role of general practice in primary care, the implementation of the strategy will require the support of independent contractors, nurses, therapists, hospital doctors and all other clinicians and managers involved in the delivery of primary and community care.

Together, NHS Aylesbury Vale and NHS Chiltern Clinical Commissioning Groups (CCGs) aim to ensure that primary and community care is offered as part of a whole system network to provide person-centred care as accessible and close to home as possible.

What is primary care?

Broadly speaking, primary care could include any part of the healthcare system that has first contact with a patient embarking on an episode of care. Traditionally, primary care services have been thought of as general practice, community pharmacy, dental services and optometry. The scope of primary care however is much wider and could also include appropriate self-care interventions, mental health support, community healthcare teams that incorporate nursing and other multidisciplinary care. Given that general practice has been such a large element of what has traditionally been viewed as primary care, it will be a core component of this document.

This strategy will also consider the role of other providers and professionals like community pharmacy in delivering a more personalised and proactive model of care that builds our out-of-hospital services. We aim to keep people healthy and independent, ensuring those who require treatment or care are treated in the most appropriate place by the right person.

The two Buckinghamshire CCGs consider this strategy to be a transformational journey for building patient centred, out-of-hospital care which will be realised over a number of years. A key area of focus will be on improving outcomes for patients and thinking beyond traditional boundaries as system leaders.

One System, 7 Localities, 53 Practices

Buckinghamshire has 53 GP practices forming two member organisations, Aylesbury Vale and Chiltern CCGs. Within the CCGs, clusters of GP practices have formed into seven geographical locality groups.

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.

At CCG level, the wider population current and future health needs are taken into account, including monitoring hospital activity and trends of healthcare challenges. Commissioning is at greater scale at this level and enables greater value for money.

Across Buckinghamshire, the two CCGs actively work together, addressing the countywide health needs and sharing commissioning responsibilities on behalf of their populations to maximise efficiencies. The two CCGs share the same community, main acute, mental health and social care providers and act as a single unit of planning.

At this level, the county wide system of health and social care works closely together, formally linked thorough the Health and Wellbeing Board, where our overarching strategy for Health and Wellbeing is developed.

River barge – Aylesbury

Further reading

Edwards, Smith and Rosen's work (2014) on primary care offers a framework for developing primary care services and plans that has influenced our strategy.

Design Principles

Aylesbury Vale and Chiltern CCGs aim to commission out-of-hospital care services that have the eight characteristics described below. These principles will be widely adopted and systematically applied in any future commissioned service.

In Buckinghamshire we are committed to a primary care which will be:

Safe and high quality - care will be evidence-based whenever possible and clinical decisions will be informed by peer support and review.

Comprehensive - with access to a wide range of professionals in order to meet the majority of the patient's physical and mental healthcare needs; to include wellbeing and prevention, acute and chronic care (e.g. multi-specialty community providers).

Person-centred and holistic - recognising the impact of broader life influences such as housing, education and family circumstances on a patient's health and care. Patients and their carers will be at the centre of decision making about their care and treatment and will be offered continuity of care.

Population orientated - focused on the needs of those resident in a specific geographical location, and/or individuals in certain population groups such as those with specific long term conditions, the frail elderly or the homeless.

Maximising care in the community setting - acknowledging patients and clinicians agree that more care could move further away from traditional hospital based care into community settings.

Co-ordinated across a whole system - accountable for transitions between providers; building and sustaining open, clear coordination and communication between the patient and their care teams.

Accessible - responsive to the patient's needs with appropriate waiting times for initial consultation and advice, diagnosis and care.

Sustainable - viable for the future in terms of finance and workforce. Maintain public trust and fit with the wider health system.

The case for change

Our local population and health inequalities

As our population ages and more people are living longer with disease and multiple illnesses, the demand for healthcare services in every sector of health and social care is increasing. These factors, and the enabling features of new medicines and technology, change the focus of healthcare requirements and mean that current models of care delivery need review. This is very much the case in primary care where around 90 per cent of patient interaction with the NHS occurs.

What is "Primary Care"?

When a patient has their first encounter with healthcare, it is usually in what is known as Primary Care.

Over the years, primary care services have been thought of as general practice (doctors' surgeries), community pharmacies, dental services and optometry. However, the real picture of primary care is much wider and can also include a patient's self-care, mental health support and community healthcare teams made up of nursing and other care specialists.

Modern healthcare – a need for integration

More people are living longer with disease and multiple illnesses meaning the demand is increasing for healthcare services in every sector of health and social care.

Primary care, where around 90 per cent of patient interaction with the NHS occurs, will need to operate at greater scale and in greater collaboration with other providers and professionals so that we can transform patient experience.

Modern healthcare

A need for **integration** of health and social care if the NHS is to remain viable for those that need it, we need to provide **solutions** and **support** for those whose attendances could be avoided.

64% are overweight or obese. Almost a quarter of people are inactive.

If we carry on like this, by **2023** there will be:

54% **increase in diabetes**

28% **increase in high blood pressure**

18% **increase in heart attack**

5% **increase in stroke**

Numbers in training to become GPs has dropped, and almost **20%** of GPs in Bucks are over **55**

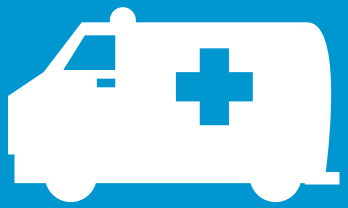
The number of older people with care needs will **increase by** **60%** in the next **twenty years.**

What patients want

A **co-ordinated approach** across all providers, increased **access to GP services**, greater **use of technical solutions** and **help to self-care.**

In 2013-14 there were attendances at **A&E** **108,604**

This is expected to rise by **10%** in 2015-16

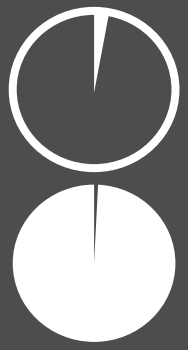


the typical cost of attending **A&E** is **£100**

General practice

8.39% is the amount general practice has of the NHS budget

95% is the amount of urgent care needs handled in general practice.



The average emergency admission charge is around **£2,200**

90% of **patient interaction** with the NHS occurs in **primary care**

There are **536,442** **people registered with a GP**

Aylesbury CCG received **£965** **per person**

Chiltern CCG received **£856** **per person**

...the England average is **£1,115**

Aylesbury Vale General practices are allocated around **£113** **per patient** per annum

Chiltern General practices are allocated around **£110** **per patient** per annum

more than **16%** of **residents are aged over** **65** and this will rise to more than **20%** by **2025**

Further reading

The Joint Strategic Needs Assessment and the CCGs' Locality Profiles.

In order to respond to these growing health challenges, general practice will need to operate at greater scale and in greater collaboration with other providers and professionals as we all move towards a whole system transformation.

This will not necessarily require changes in organisation form and mergers, it will be achieved through practices working in partnership and networking.

More evidence on the case for this change and the benefits of networks/federations is outlined in the Kings Fund and Nuffield Trust Report on Securing the Future of General Practice (2013).

Primary Care – Voice of the People

Both CCGs have undertaken stakeholder engagement, the outputs of which have been used to inform this strategy. During October and November 2014 engagement with the public, patients, primary care clinicians and secondary care was undertaken with a series of meetings and online surveys.

From August to November 2014, Buckinghamshire County Council's Health and Social Care Select Committee undertook a robust and comprehensive inquiry into access to GP services and have shared with us their final report.

In early autumn, Healthwatch consulted the public on urgent care services and the headline findings relevant to this strategy have been taken into account.

Public and patient involvement in developing this strategy identified four common themes:

- more support for people to manage their own care
- greater use of technical solutions including shared health records
- increased access to GP services
- a co-ordinated approach across all providers

Our stakeholder feedback included:

The Bucks Health and Social Care Select Committee (HASC) GP Inquiry Report. This covers the area of access to general practice in some detail. The key findings in respect of access were:

- Demand for urgent appointments is being met
- A lack of capacity for non-urgent appointments has led to variation in waiting times
- There is a need to reduce avoidable appointments with GPs
- There is a need to promote and support more people to self-care

Our work with NHS Improving Quality and other stakeholder feedback included:

- There are opportunities in working differently and in closer collaboration
- Improving communication between providers using information technology
- Reducing duplication by improving care co-ordination and system integration
- Patients would prefer care in the community
- Acknowledgement of a greater role for community pharmacy

Our member practices told us:

There were a number of common themes which emerged across localities, with GPs acknowledging challenges, but also welcoming the opportunity to establish the "direction of travel" within a Primary Care Strategy:

- Patient's needs are becoming more complex, requiring more time and resource
- Need to improve information sharing between providers
- Joined up care from community nurses and social services needs to significantly improve
- The increase in workload means less time to think innovatively or to manage the changes required
- The reducing GP workforce needs to be addressed.

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

Our vision

Our collective Buckinghamshire vision, developed with all our local stakeholders and agreed across the system's health and social care providers and commissioners is:

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

In order to achieve this, we must develop a much more integrated approach to our delivery of commissioned services. Such a seamless way of working requires a new model of delivery across the whole health and social care system, including primary care.

Our population's health needs can be broadly categorised into four tiers of care (see diagram on page 13). These tiers of care are recognised by the Health and Wellbeing Board and enable us to develop a framework for all our health, social and voluntary services, which clarifies for patients exactly what levels of support will be delivered at each level of service.

Tier Three – Transforming Primary Care

Our Primary Care Strategy focuses mainly on Tier Three, when patients need support from a primary care clinician or professional.

With more people managing their own health (in tier two), at times they will require input from GPs or other primary care clinicians. This might be because they require some additional support in managing their long term condition(s) or to check an unexpected health concern. This tier of care, mainly planned appointments with some urgent interventions from time to time, forms the core elements of care provided by all GP practices.

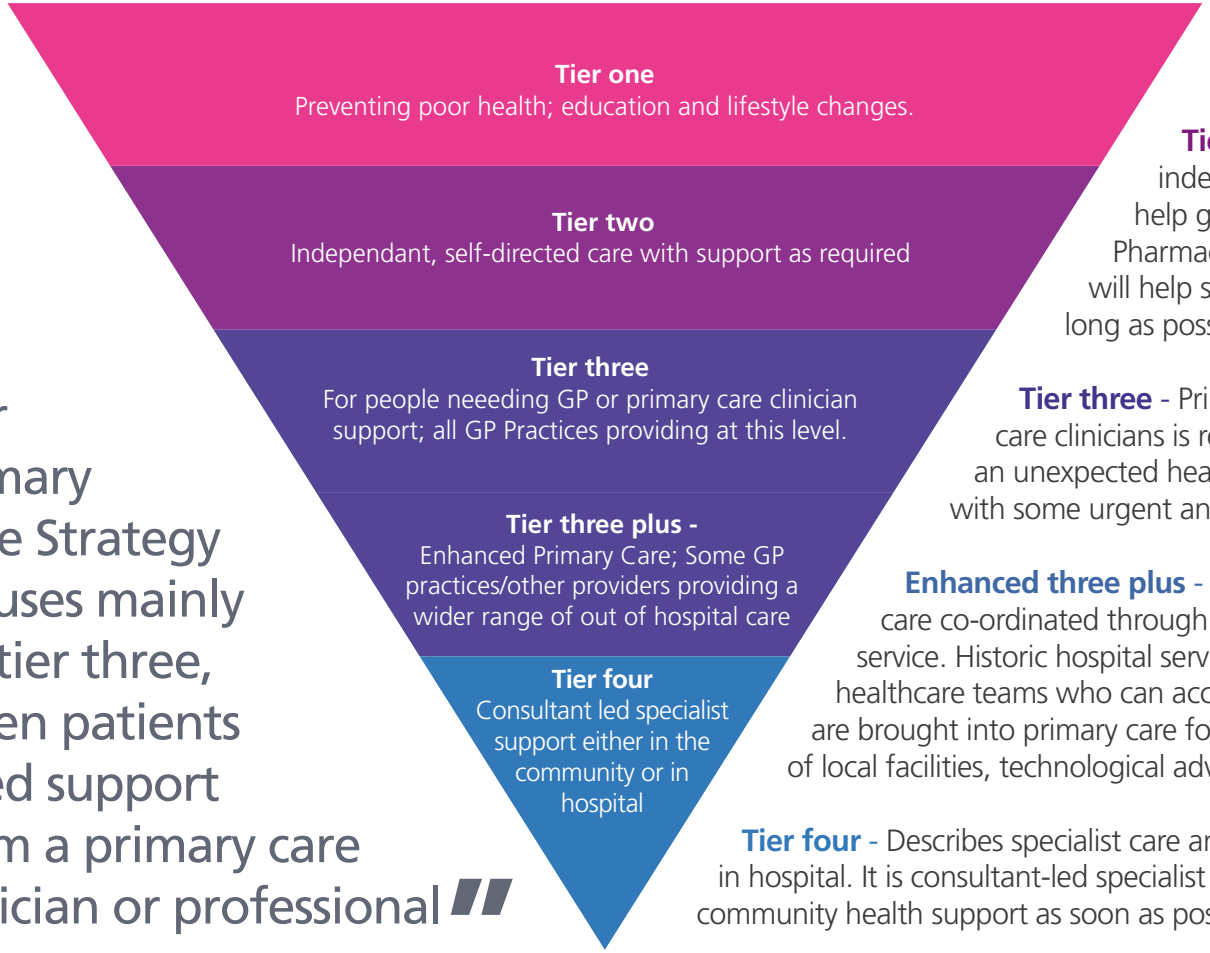
In moving care out-of-hospital and closer to home, an additional "Tier Three Plus" is created, with services that were historically provided in hospital now being available in the community, led by local healthcare teams with access to specialist advice as required.

Development of this tier is the real transformation of primary care, with proactive patient-centred care being co-ordinated through GPs at the heart of a seamless integrated health service.

This transformation will develop across Buckinghamshire, significantly changing the way we work as a health and social care system. Transformation will also take place at CCG locality level, as different communities have different health needs and different local facilities available.

Exactly which services are moved out of hospital and into primary care for local delivery is subject to a number of other factors.

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.

Our goals:
achieving the transformation

We have identified six goals which we believe will achieve our vision.

Defining these goals and identifying what we mean is only the beginning. They are a starting point to help us work with you over the next five years to develop and implement innovative solutions which meet our shared vision and aspirations.

So we can stimulate ideas about the way we deliver these goals, we have given examples describing how our goals could be delivered. We hope this encourages everyone to think about the best way of getting the outcomes we need.

Our Goal: Enable people to take personal responsibility for their own health and wellbeing, and for those that they care for, with access to validated, localised and readily available educational resources.

What this means: People will be encouraged to manage their own mental and physical health and wellbeing (and those they care for) so they stay healthy, make informed choices about care and treatment to manage their conditions, and avoid complications.

This could include group-based educational and self-management courses, as well as encouraging "expert by experience" peer support.

How it could happen – the patient's perspective:
Jo Smith is boasting about the new man in her life – her husband of 20 years. Pete has been transformed by a health coach.

He was overweight, drank too much, smoked, and never exercised. Only in his 40s, he had developed heart disease and diabetes. When he lost his job he sank into depression and took little interest in anything other than the telly.

Jo went online to get support and found out about steps Pete could take to help himself, but he wasn't interested. Then a community forum member told Jo about health coaches, who help individuals find the best solutions for their health and wellbeing challenges.

The best part about it was that Jo could ask the health coach to come and see Pete, it didn't rely on him making the first move.

It took a few weeks for Pete to accept that he needed to change, but once he did he hasn't looked back and working with a group of other people with similar problems has meant they are all helping each other, as well as themselves.

How it could happen – the clinician's perspective:
Fiona, a GP in her mid-40s had become increasingly frustrated in recent years.

She felt under severe pressure from a huge growth in demand for her practice's services. She felt particularly frustrated that many patients were coming to see her for self-limiting minor illnesses while many of her complex patients with serious long term conditions grumbled that they could never get to see her.

She was sceptical when her practice manager bought a web-based self-help programme for patients to access through the practice website. However, over the course of a couple of years, she noted a definite drop in the number of people consulting for minor illnesses. On the other hand, through her training in "year of care" care planning, she felt more enabled to assist her more complex patients to better manage their health and wellbeing.

She was able to engage Pete in the care planning process. Pete for the first time was taking his heart disease and diabetes seriously and Fiona felt optimistic about his future care.

Our Goal: Health, social care and voluntary sector providers working together to offer community based, person-centred, co-ordinated care which proactively manages long term conditions, older people and end of life care out of the hospital setting.

What this means: Combining resources and expertise so that people receive joined-up care.

Moving away from the traditional barriers between different care-giving and wellbeing organisations, so people's needs are understood and shared between the different organisations with which they come into contact.

People understand their needs are being met through proactive teamwork and they do not have to distinguish between different caregivers.

How it could happen – the patient's perspective:
Ethel Walker has always been house-proud. When her husband Albert died she thought it would mean giving up and moving into a home.

What was worrying her particularly was giving up Albert's beloved dog Jack. Ethel suffers from arthritis and breathing difficulties, so Albert had done most of the housework, walked Jack and had made sure Ethel took her pills and ate well.

Grieving over Albert and worrying about the future were taking their toll on Ethel. But then Emma came into her life. Emma, a nurse, was part of an integrated locality team and called in a few days after Albert died. She explained she was Ethel's first point of contact for any problems she had. Emma made sure Ethel's care needs were assessed, got her some benefits advice and ensured she got proper home help.

Emma worked with the locality team to assess Ethel's medical treatment and made sure they understood what Ethel wanted out of life and how they could all work together to make it happen. She even took the trouble to find a local charity which offered volunteer dog walking services, so every day Ethel has a visitor who takes Jack and Ethel out for a walk, a trip to the shops or just for a cup of tea and a chat.

How it could happen – the clinician's perspective:
Fiona had been Ethel and Albert's GP for many years. Ethel had lots of health issues but with her husband's support, had generally only come to the surgery when required.

When Albert died, Fiona was worried that Ethel would rapidly deteriorate both mentally and physically and become housebound. Fiona was worried how she, as Ethel's GP might best meet her changing needs. Her experience in similar situations in years gone by suggested there would be inexorable decline towards a health or social crisis point, which would result in hospitalisation and placement in a care home.

However, Fiona referred Ethel to the integrated locality team – comprising district nurses, social workers, physiotherapists, occupational therapists, with input from all the local general practices and the community gerontology and older people's mental health services.

The locality team had a more proactive and holistic approach to assessing and managing a patient's risk of decline and Fiona felt the team was providing a level of service to Ethel that could never have been emulated by Fiona's efforts alone.

Clock Tower – Aylesbury

Our goal: Improved and appropriate access for all to high quality, responsive primary care that makes out-of-hospital care the default.

What this means: Making sure people can access good quality advice and care in the most suitable and convenient way possible, as early as possible to prevent problems becoming more serious.

Understanding that not everyone needs to "see someone" and that care can be provided by phone, email or online and, when needed, face-to-face anytime, day or night.

How it could happen – the patient's perspective:
Paul Jones doesn't even know what his GP looks like. A fit and busy 54-year-old, he can't remember the last time he had to go to the doctor.

But just lately he's seen all the adverts about bowel cancer on his commute into London and he's worried because there is some blood in his poo.

He goes online while he's travelling to work and the advice tells him to go and see the doctor if the symptoms persist for more than three days. Days later he can still see blood in his poo so he phones his GP surgery on the way home from work. They aren't open late that evening, but make an appointment for him the same evening at another surgery in the locality.

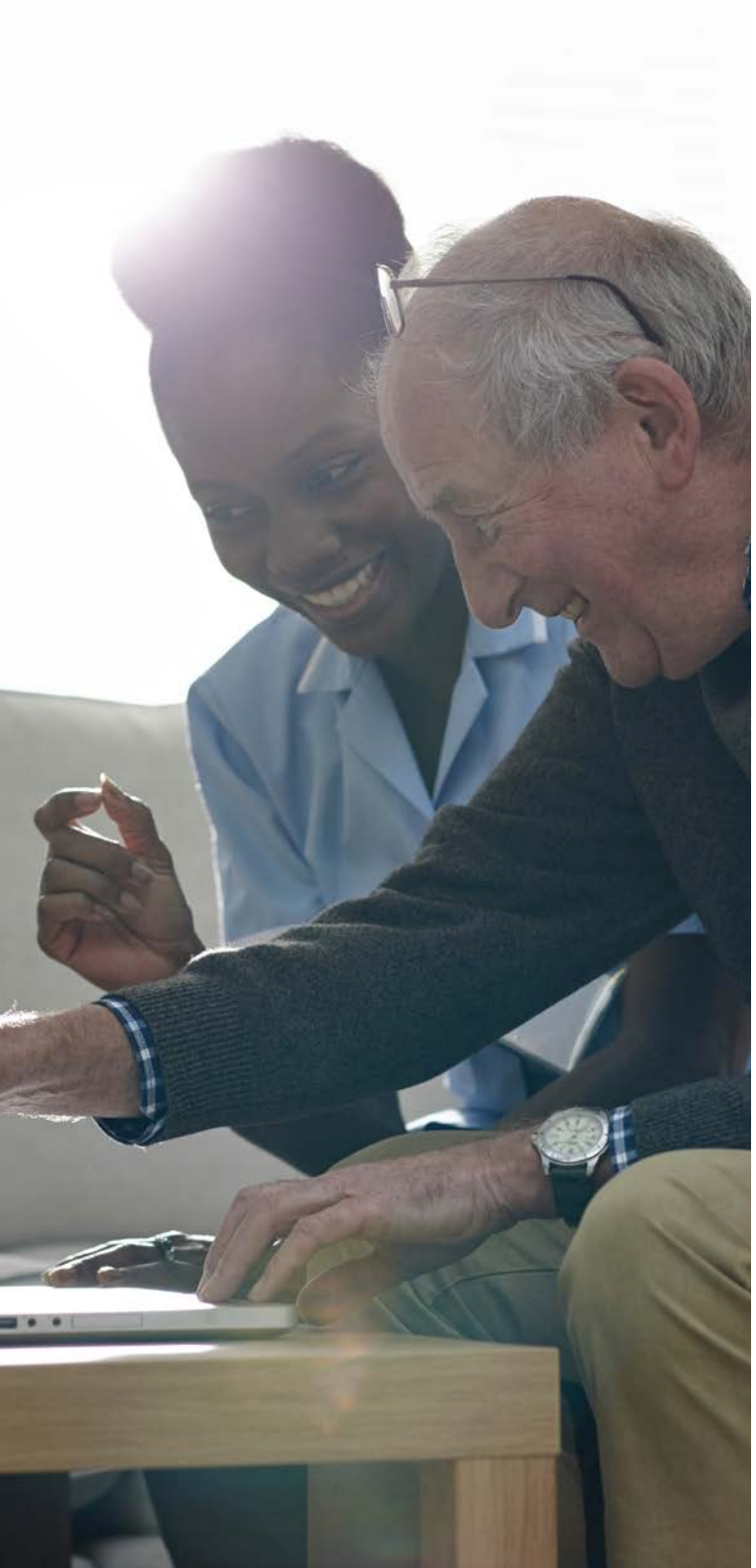
He actually has haemorrhoids and is given advice and access to online resources about how to manage his condition. They also book him in for an NHS health check with the practice nurse at his usual surgery.

How it could happen – the clinician's perspective:
Fiona, Paul's GP, perpetually felt it was a struggle to keep her work-life balance right – especially given the ever changing needs of her young family.

When discussions were mooted about her practice extending its hours, she felt both anxious and angry – how could she possibly make this work? However, by pooling the resources of the other locality practices, it became clear that commitment to working some extended hours was nowhere near as onerous as she feared.

In fact, working one late evening a fortnight quite suited her as it meant she had a later morning start at the practice once a fortnight – which made for a much less stressful school run and gave her valuable daytime hours to get other household jobs done.

She enjoyed her late evening clinics – they tended to have a different "feel" to them than her daytime surgeries and the patients often expressed great satisfaction with the service.



Our goal: Develop clearly understood care pathways that offer consistent and co-ordinated care, using bed-based services only when necessary.

What this means: Giving people access to specialist support in their community, working with a named responsible clinician.

Working together, patients and their care co-ordinator would identify a clear plan about the type and level of care the patient needs. This would be provided by a team of clinicians, who may be from different providers, but they all have access to a shared care record which will also be available to the patient.

Care would be regularly reviewed so potential issues are identified and dealt with early and locally.

How it could happen – the patient's perspective:
When Harry Evans' dad got diabetes in the 1980s he was in and out of hospital all the time, went blind and had to have a leg amputated. So when Harry developed diabetes himself he expected the worst.

But he worked with a diabetes nurse, Jenny, who talked him through what was going to happen and how he would be working with a team of people to help him manage his condition.

She arranged for him to meet a nutritionist and they sorted out his diet and he had regular meetings with Jenny on Skype, so he didn't even have to leave work to have a check-up.

Jenny also arranged for an ophthalmologist to assess his eyesight so they could understand how his vision might be affected by the diabetes.

How it could happen – the clinician's perspective:
Fiona found the "year of care" approach to care planning had led to a transformation within her practice.

All the clinicians in her practice had been trained in this approach and most of the care planning was done by the practice nurses.

As a consequence the practice was achieving better glucose and blood pressure control with its diabetic population

Fiona was only directly involved in the care planning of the more complex patients. It was of great benefit to her to be able to share electronically her patients' care plans with the local community diabetes consultants. This enabled Fiona to get the best advice for her complex patients more conveniently, and expediently.


Penn Pond - Chiltern

Our goal: Improve health outcomes for our whole population through adopting best practice, stimulating innovation and aspiring to improve.

What this means: Working together on prevention, not just as professionals but with communities and individuals.

Reducing variation and inequalities in health outcomes by increasing health screening and early interventions, in particular targeting groups of people whose health outcomes are not as good as they should be.

How it could happen – the patient's perspective:
Becky now has the courage to be the mum she always wanted to be and give her son, Sam, the best possible start in life.

When Sam was born Becky was on her own and she didn't think she had what it took to be a good mum.

But her health visitor set her up with a mentor, Heather, who helped Becky discover for herself what she needed to do for the best and introduced her to other mothers nearby.

Becky is even looking after herself better now, using online resources, knowing how important it is to stay healthy so she can care for Sam and set him a good example.

How it could happen – the clinician's perspective:
Jean was Becky's community midwife. She had seen many young, socially disadvantaged single mums over the years and often worried how they would fare during those early years of parenthood.

However, the local health visiting team, in conjunction with the family nurse partnership, had become more aware of those at risk during the early years and were employing a much more proactive strategy for engaging with their clients.

Our goal: A commitment to invest in and support our primary care providers in helping build our out-of-hospital services.

What this means: Making sure people being cared for at home, or in their care home, is the default and that services are focused on this.

Co-commissioning with NHS England will enable us to shift investment to primary and community care. Using this investment we aim to improve infrastructure, provide more comprehensive services which support GPs to enable more care in the community, to enhance training for community nurses and other primary care staff including extended use of community pharmacists.

How it could happen – the patient's perspective:
Keeping Sally at home isn't easy for her daughter, but the team supporting her makes it as smooth as possible.

As Sally has dementia it is always difficult if she has to go into hospital, but just lately she has been able to stay at home, even when she got a chest infection, because the team monitors Sally and has a plan to manage any risks to her health.

Using a pre-agreed care plan, Sally's daughter called the integrated locality team as soon as her mum appeared to be unusually breathless. A qualified healthcare professional came out to assess her.

They decided with the right medication, regular checks by the care co-ordinator and a package of support from the locality team, there was no need to send her to hospital.

How it could happen – the clinician's perspective:
Fiona was half way through a busy morning surgery when a message from the locality integrated team appeared on her screen.

The message was to let Fiona know that they had received a call from Sally's daughter at 8am, saying that Sally was very breathless. Fiona had been Sally's GP for more than 10 years, over which time the combination of dementia and COPD was proving a real challenge; Sally had been hospitalised on a number of occasions.

Fiona was relieved to have the assistance of the integrated locality team – under other circumstances, she would not have been able to visit Sally until mid-afternoon, by which time she might have become more unwell.

The locality team was treating Sally at home with intravenous antibiotics and oral steroids and were going to continue to manage this acute episode until Sally was fit for discharge back to GP care.

Fiona was able to keep abreast of events, as the locality team were able to access Sally's medical record from the same IT platform that Fiona used in her practice.

Supporting the change: enablers and critical success factors

In order to achieve the vision and goals set out in the strategy a number of key enablers and critical success factors will be vital.

The Better Care Fund

The Better Care Fund (BCF) is a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the CCGs and the local authority.

This creates an opportunity to bring resources together to address immediate pressures on services and lay foundations for a much more integrated system of health and care.

However, the funding is not new or additional money; part of it comes from CCG allocations, in addition to NHS money already transferred to social care. This means that the integration of services needs to happen swiftly, in order to achieve value for money and shift activity and resource from hospitals to the community.

Information Management and Technology (IM&T)

In order to deliver our strategy we need to exploit the opportunities offered by the information revolution and we should significantly enhance our use of information and technology.

Buckinghamshire's comprehensive IM&T strategy is designed to deliver this, setting out clear goals to leverage maximum benefits from existing systems and deploying new systems to fill identified gaps.

Those goals can be summarised into four key themes:

- commissioner enablement
- shared records interoperability
- use of patient centred technology (including Telehealth)
- developing an enabling infrastructure across our whole system and beyond.

Practice premises and community assets

In order to achieve the ambition of care delivered in alternative settings with a shift into the community, it will be necessary to understand the premises assets and challenges across the whole health and social care system.

Joint working across all local commissioners and providers will be required to do this. This includes NHS England which has committed to supporting the preliminary stages of this work with an audit of estate encompassing fitness for purpose and usage. This will enable the CCGs to understand what the opportunities and challenges are across the system so that informed decisions can be made on the best use of existing resources and the investments required.

Working with partners across the system will also enable the CCGs to not only be aware of planned housing growth and the associated increase in demand for healthcare services, but also to work with the local authorities as part of the planning decision making process. NHS England offers a national commitment to support and invest in the development of primary care infrastructure and both CCGs are keen to maximise this opportunity.

New contracts and incentives

The methods by which we commission services will be influential in shaping how providers can respond effectively. There are a number of different approaches being piloted nationally and the CCGs will want to test some of these. New models of commissioning and new payment arrangements such as lead / prime provider and joint ventures which encourage organisations to work collaboratively to improve patient outcomes could be of great benefit.

The CCGs will work with providers to develop contractual mechanisms, approaches to measurement and rules of behaviour that facilitate the development of new models of care while managing any associated risks.

These new models of care could include multispecialty community providers, primary and acute care systems, or enhanced health in care homes as described in the Five Year Forward View or the development of other innovative and transformational models

Co-commissioning will be a significant opportunity for CCGs to increase their involvement in the commissioning of primary care. It is expected to be a key enabler in developing seamless, integrated out-of-hospital services as CCGs will be able to commission care across the whole patient pathway through different sectors including primary care. This is an opportunity that the CCGs will take up with their members support

Workforce

The current primary care workforce will be very challenged to deliver this transformation of service delivery. In line with the national picture, Buckinghamshire has an increase in the proportion of part-time workers and declining numbers of GPs and practice nurses which creates pressure in the system.

This transformation of service delivery into out-of-hospital services creates significant workforce requirements that are a challenge to the whole health and social care system.

Additional capacity is unlikely to be met by investing in additional people alone - simply providing more of the same is not the answer for the future. Providers will look to create new roles with different skills that adapt to the patient's changing health needs in order to improve productivity and create a seamless care service for our patients.

As new models of care develop and existing roles change, there will be a need to understand the changing educational needs of our workforce and how we meet these future requirements.

The CCGs will continue to work with partners including Health Education Thames Valley (HETV), Oxford Academic Health Sciences Network (AHSN), and The Institute of Integrated Care at Bucks New University (IIC) to undertake local workforce mapping, describe potential new roles and identify subsequent educational and recruitment needs.

In the meantime, the CCGs will actively work with partners to review recruitment and retention locally and consider initiatives such as making posts more attractive and encouraging people back to work after maternity leave, career breaks and retirement.

This could be supported in part by offering education to healthcare professionals that ensures they are competent not only to deliver the essential requirements of primary care (ongoing education and "back to work" courses), but also courses offering a higher degree of competence for the new enhanced levels of out-of-hospital care where some specialist skills and knowledge will be required.

Programme management

In order to do this effectively, a programme management structure will be put in place designed to ensure that the most appropriate people are working together, that changes made continue to be relevant, that responsibilities for delivery are clear and that risk is managed.

Engagement - patient and community empowerment

A key element to success will be the ongoing and meaningful engagement of patients, carers, communities and stakeholders.

The CCGs recognise the need to work differently with our communities to maximise their input into designing services and decision making. For each individual project area the most appropriate way to engage with the target population will be considered.

The aim will be to involve the relevant community in the most effective way, thereby attempting to engage with those that have historically been described as "hard to reach".

The outcome of this will be to empower patients to have a say in the services that affect them and their community. This will be supported by a multichannel communication plan which will define a number of communication methods available including group sessions, expert patients and web based discussion forums.

Engagement - integrated and partnership working

Achieving transformation of out-of-hospital care will require effective partnership working to:

- understand local nuances and variation in service delivery, healthcare roles, patient needs, behaviours and cultures
- align expectations
- ensure clarity and continuity of message
- ensure effective delivery.

Where necessary this will be through informal relationships and networks, also more structured approaches as required.

Dynamic and responsive localities

The importance of locality working in achieving our ambition has been highlighted earlier in this document.

Our vision for increased out-of-hospital care is clear. It is strongly believed that different localities may wish to adopt different approaches to delivering our overarching Primary Care Strategy to their particular population and the diversity of innovation required would be supported.


View from Great Missenden Church - Chiltern

Next steps

The next step on our journey for primary care and increased out-of-hospital provision is to get the strategy out to our stakeholders so that they know and understand the positive intention for primary care. This will take a concerted communications effort and some of this work has started as a work stream under the diabetes redesign. This requires responsive and capable providers so work will be ongoing to assist providers to respond effectively to this strategy.

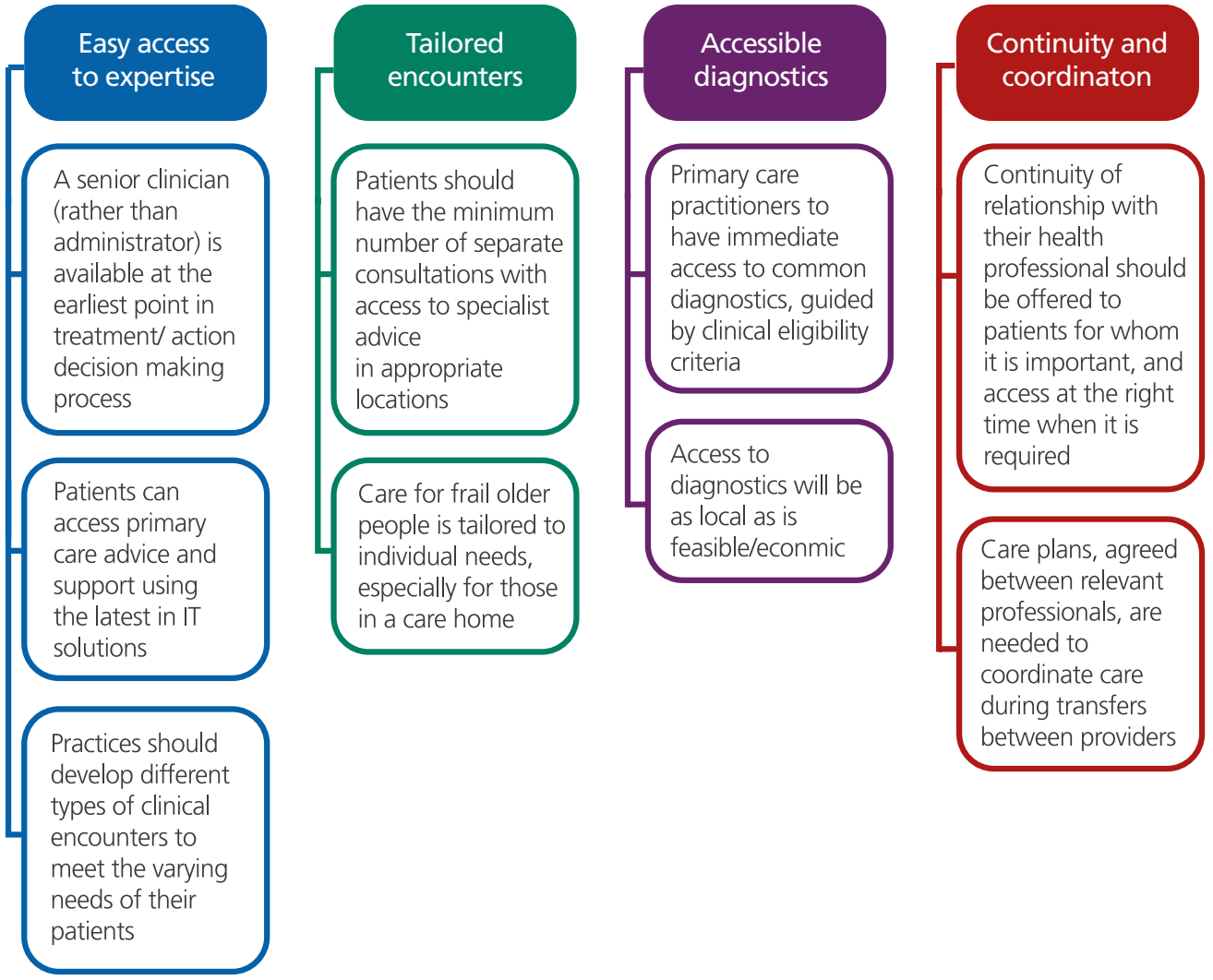
This is a five year strategy which will be delivered through a number of operational plans owned by the relevant CCG locality and project teams. These plans will be more focused with clear deliverables expected over a one to two year period depending on the scope and complexity of work. The plans will be reviewed each year to ensure alignment with the strategy, local ambition and subject to agreed programme management structures.

During year one it is our ambition to deliver the following:

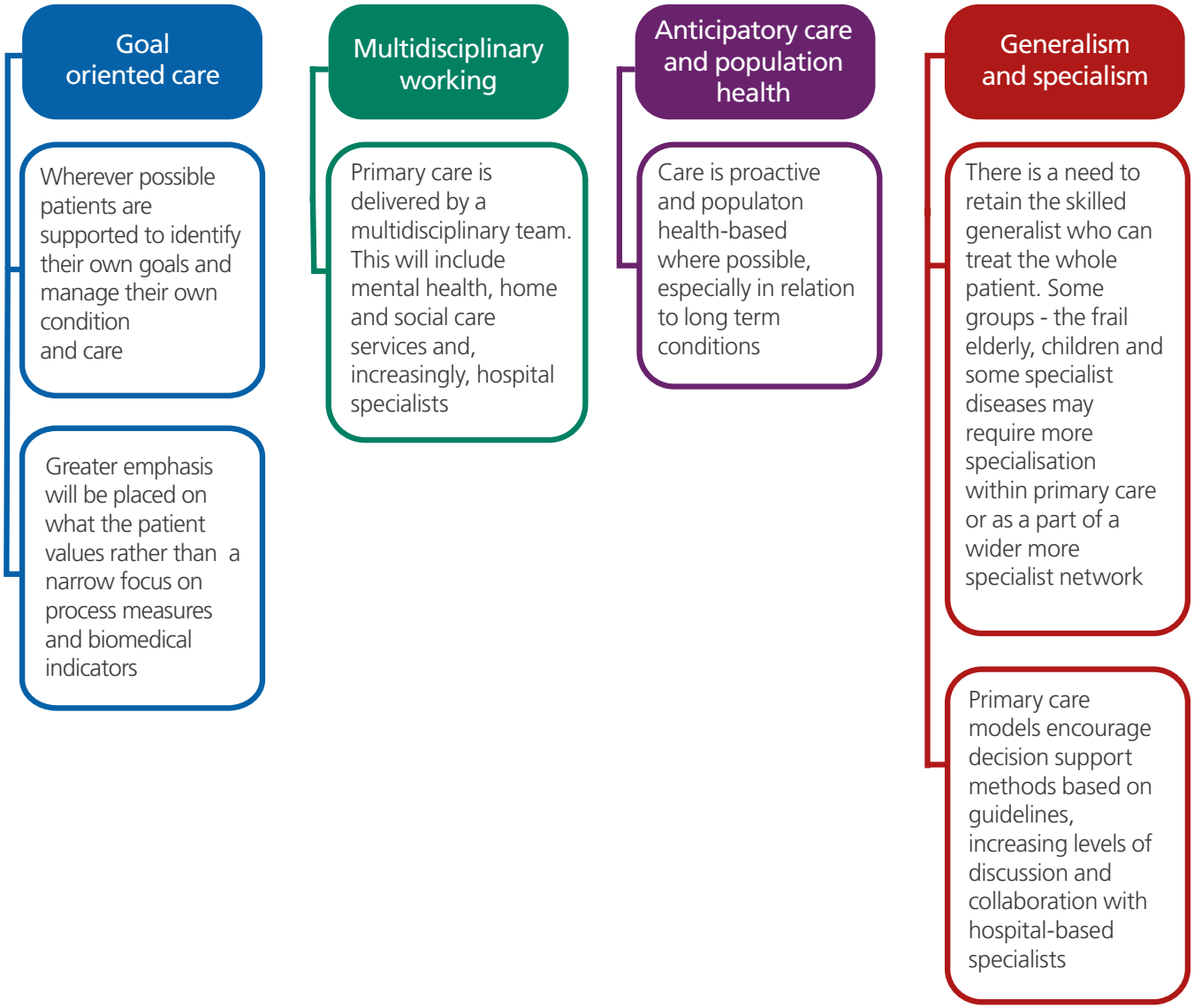
- Primary care workforce audit and plan in collaboration with partners including NHS England, HETV, Oxford AHSN, and The IIC.
- A whole system programme to increase self-management building on the Stay Well-Live Well model (see appendix 2). This model brings Public Health programmes and Psychological Wellbeing services together for the first time in primary care to support patients and primary care practitioners. It will proactively encourage patients to understand the impact of lifestyle choices on both their mental and physical health - to either reduce the risk of developing long term health conditions (i.e. to 'Stay Well') and/or to limit the impact of an existing long term health condition/s (i.e. to 'Live Well' with the condition). This work will contribute to the general practice demand management action plan as recommended from the HASC inquiry and linked to NHS England under co-commissioning.
- An integrated 24/7 patient record building on the work started with the Bucks Co-ordinated Care Record and implementation of the Medical Interoperability Gateway (MIG).
- Implementation of system-wide care planning approach to care supported by the House of Care Model developed by the Year of Care Partnership. Our aspiration is to embed a new system of working to deliver a care planning "Quality Standard" across services using diabetes as the preliminary focus and then systematically rolling it out.

Appendix 1 - Design Principles

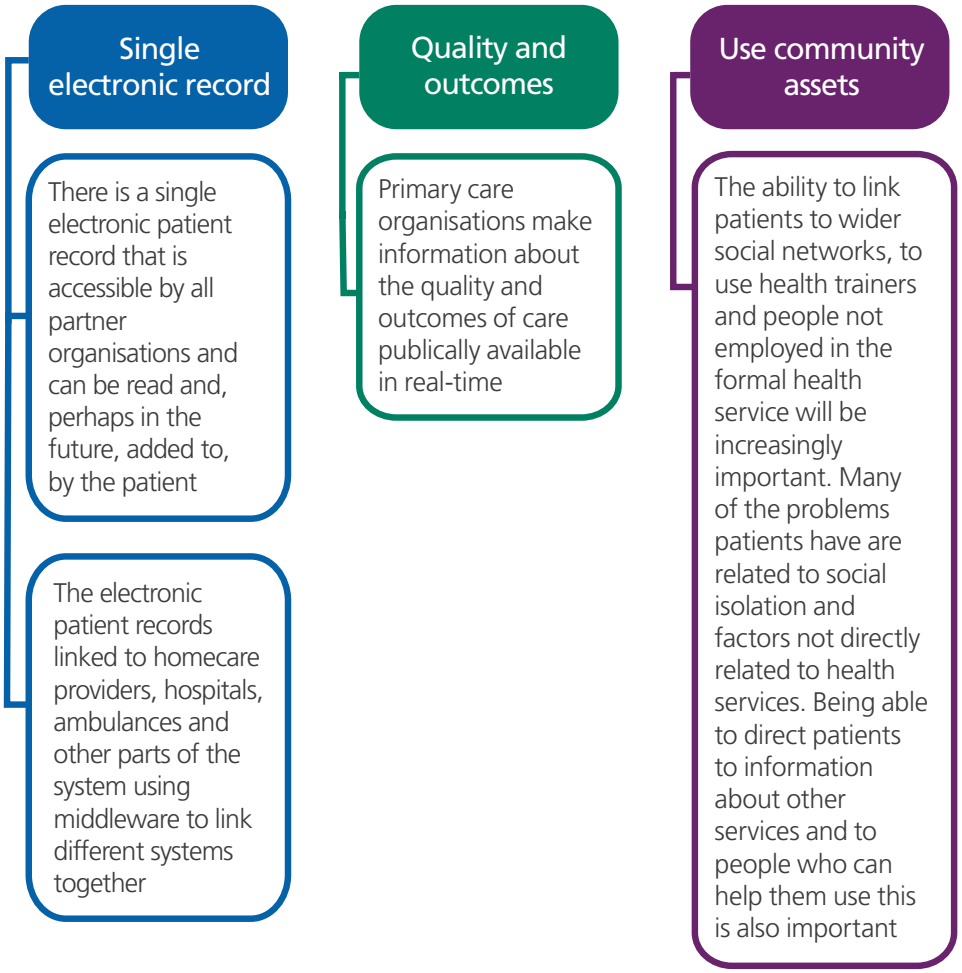
Access and Continuity



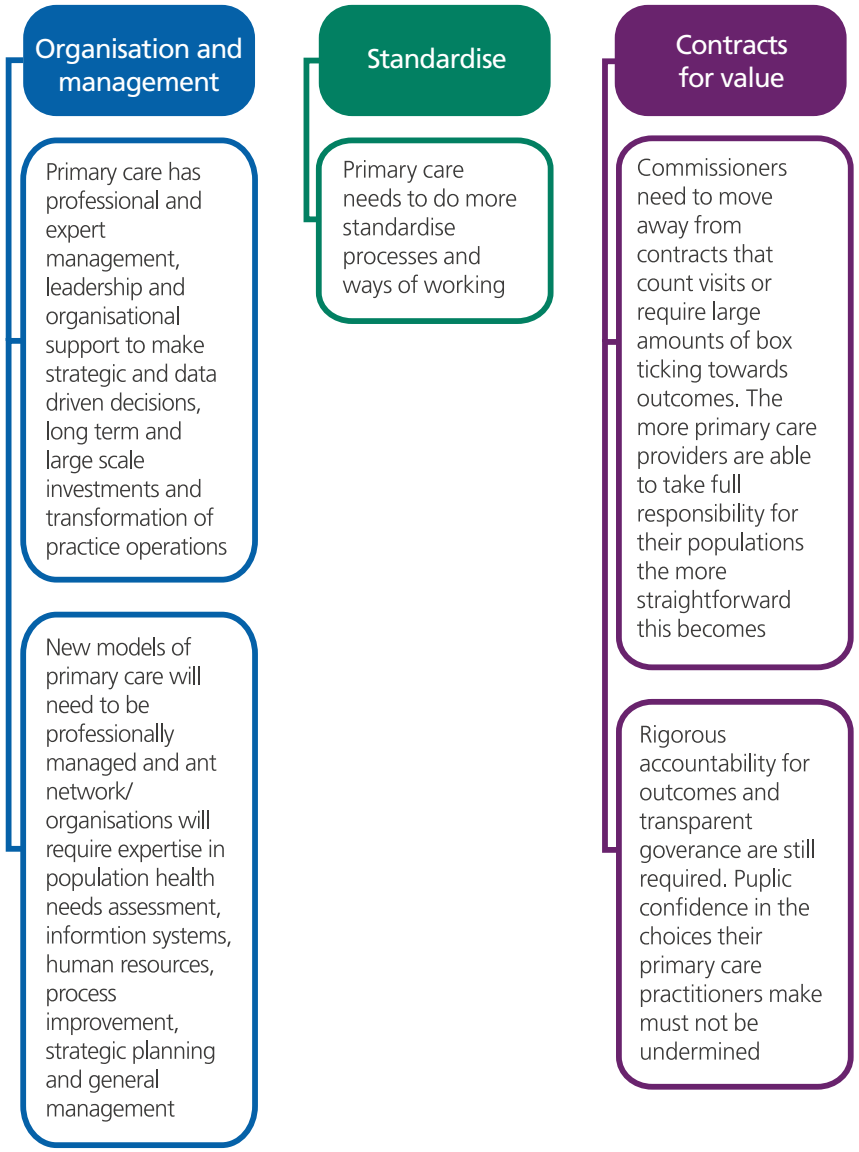
Patients and populations



Information, outcomes and engagement



Management and accountability



Appendix 2

Stay well - live well

Identification and Brief Interventions (MECC principles)

Step one
Patient: Low-risk factors, motivated, access to and understanding of internet and /or local services – self support

Step two
Patient: medium risk factors Low in motivation and/ or needs some support to identify /navigate local services or web based information

Step three
Patient : Complex condition/s, multiple risk factors and/or very low motivation

Population focus (Health Checks, QoF, QIS)

- Healthy eating/weight
- physical activity
- Alcohol
- emotional wellbeing
- Stop smoking

Referral / Signposting

Light touch, signposting. Web based information and support tools; Library services; Practice leaflets. Patient sets own goals.

Lifestyle Gateway (PAM to determine level of motivation; planned care and follow up & data analysis feedback loop)

Primary care Principles

- Parity of Esteem – equal attention to mental and physical health needs
- Staying healthy – a personal responsibility
- Self-care – supporting patients as required
- Strengthening community assets , including volunteers
- Co-design – expert by experience

Mixed solutions but primarily groups or telephone based support. Lifestyle services, CBT based interventions, expert patient groups, digital follow up. Patient works with peers or others. (eg family/health coach) to set goals.

More intensive support. Face to face, MDT and/or multi agency groups. Digital support Care planning in place with practitioner.

Direct referral to services

Underpinned with revised workforce competencies and demand management tools.
Robust technology platform, real time data feedback, community needs and asset maps

Designed by NHS South Central and West CSU