



Primary Care in Buckinghamshire

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

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Our Vision



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



Strategy development

- Bucks wide
- Public engagement events
- Practice Visits
- Provider engagement
- Locality discussion
- National scoping
- Aligns with BCF priorities

Tiers of Care based on Patient Need

Tier One - education and support to maintain a healthy lifestyle.

TIER ONE

Preventing poor health; education and lifestyle changes

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 3) will help support people to remain independent for as long as possible.

TIER TWO

Independent, self directed care with support as required

Tier Three - for people who require input from GPs or Primary Care clinicians either to support their long term condition(s) or to check an unexpected health concern. This is mostly planned appointments with some urgent and unexpected interventions from time to time.

TIER THREE

For people needing GP or primary care clinician support; all GP Practices providing at this level

Development of this tier is the real transformation of Primary Care, 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.

Enhanced Primary Care:
Some GP practices/other providers providing a wider range of out of hospital care

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

TIER FOUR

Consultant led specialist support either in the community or in hospital

Our Six Goals



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.

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.

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

Our Six Goals



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

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

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

Supporting the Change



Enablers	Critical Success Factors
Information management & technology	Engagement – Patient & community empowerment
Practice premises & community assets	Engagement – Integrated & partnership working
New contracts & incentives	Dynamic and responsive localities
Workforce	Better Care Fund
Programme Management	



Next steps

- More engagement!!
- Shared for comment
- Draft product
- Expect the strategy to evolve
- Essentially aimed at next 3 years
- Co-commissioning runs in parallel