NHS Wokingham Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

NHS North and West Reading Clinical Commissioning Group

NHS Newbury and District Clinical Commissioning Group

Berkshire West Primary Care Strategy

2015 – 2019

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 together 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:

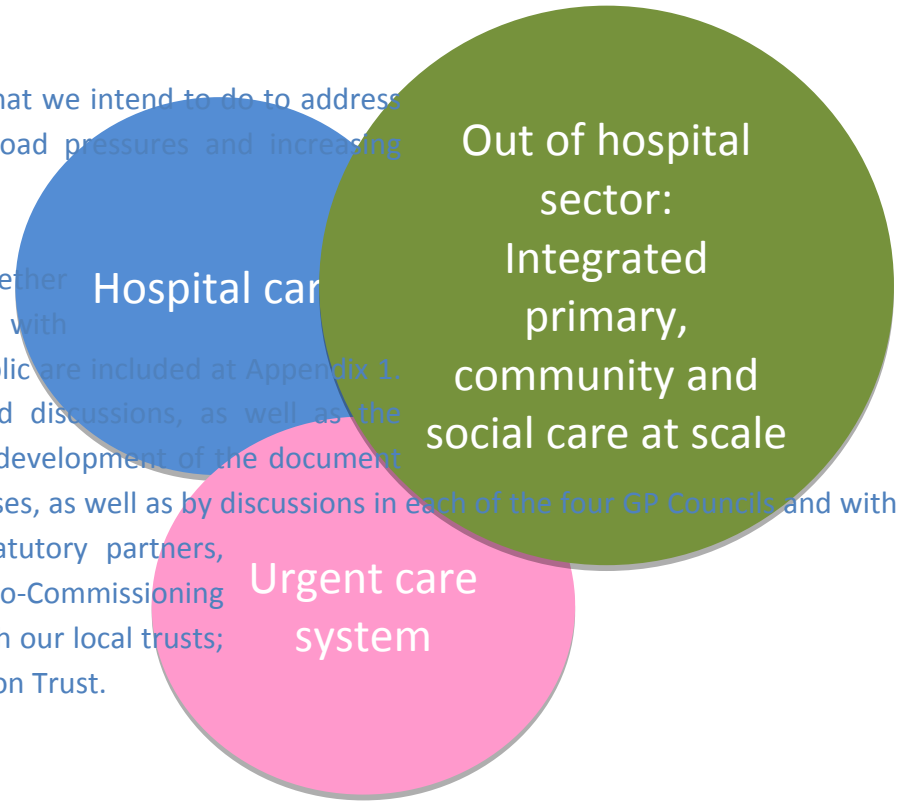
- Placing a greater emphasis on prevention and putting patients in control of their own care planning.
- Moving away from disease specific services to the commissioning of person centred care.
- Implementation of new models of care which support better integration, and which expand and strengthen primary 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.
- Commissioning highly responsive services urgent care services which ensure patients get the right care at the 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.

The Berkshire West local health economy is innovative and high performing, benchmarking well on key measures such as non-elective admission rates and prescribing. However it is recognised that the system faces significant operational, clinical and financial challenges to sustainability going forward. The CCGs are therefore working with partners to define a new model of care reflecting the triple aims of the *NHS Five Year Forward View* which are to increase the emphasis on primary prevention, health and wellbeing, to improve the quality of care by improving outcomes and experience for patients and achieving constitutional standards, and to deliver best value for the taxpayer by operating a financially sustainable system. There is an emerging consensus locally that a clinically and financially sustainable health economy can best be delivered through the creation of an Accountable Care System (ACS), bringing together commissioners and providers to assess population need, determine priorities,

redesign services, agree and measure outcomes and allocate resources along care pathways and in such a way as to incentivise all organisations to work towards the same goals. Such a system would ultimately function on the basis of a place-based capitated budget incorporating all aspects of healthcare including primary medical services with providers and commissioners jointly incentivised to deliver specified outcomes in a cost-effective way.

This Strategy builds upon the CCGs' overarching Strategic Plan to describe a detailed vision for primary care services 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.

To ensure primary care is able to function in this way, 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.



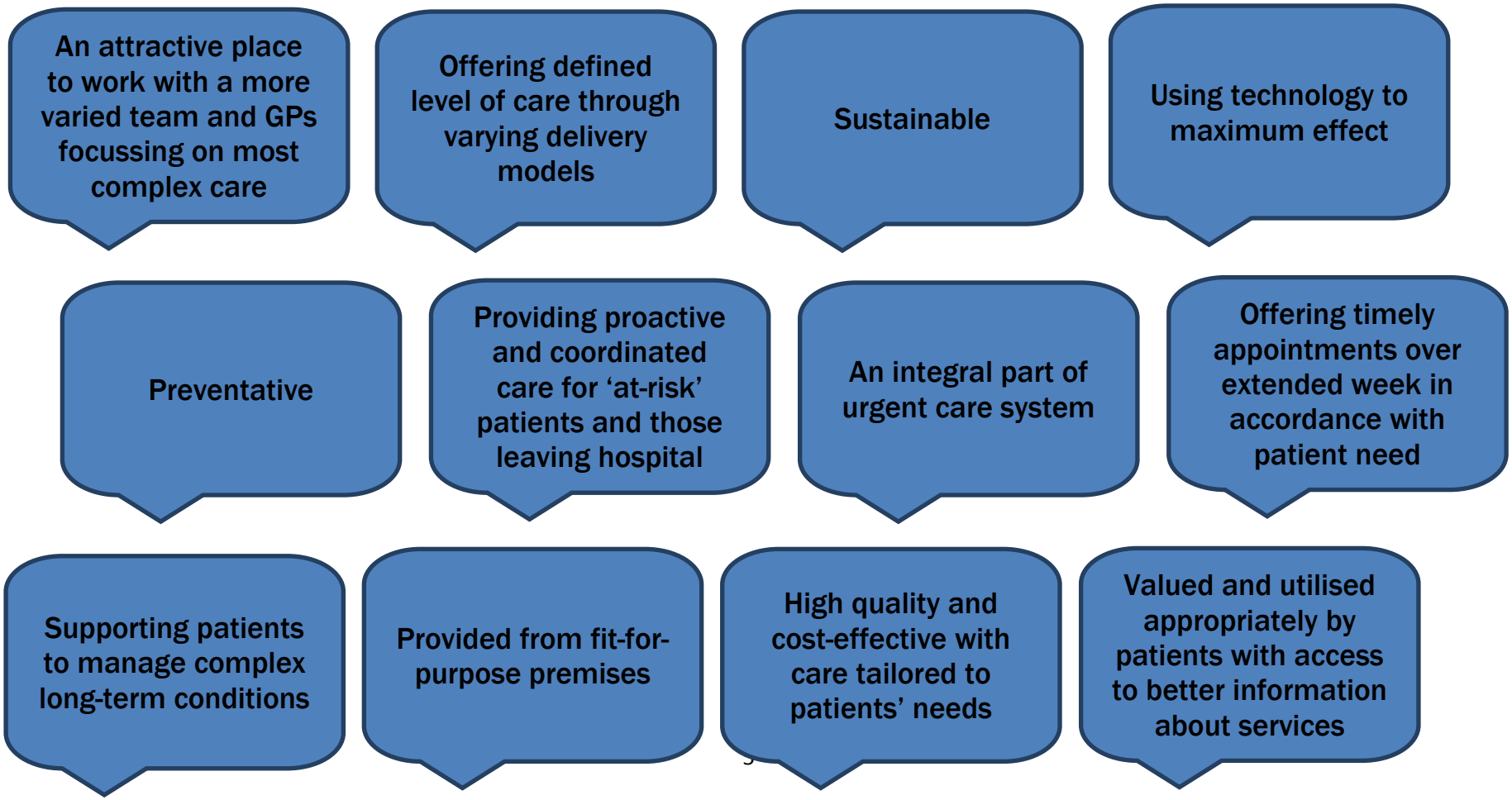
The Strategy has been jointly developed by the four Berkshire West CCGs, working together with NHS England as the statutory commissioners of primary care services, and with patients and members of the public. Further details of our engagement with the public are included at Appendix 1. This has included a combination of online surveys, public meetings and targeted discussions, as well as the publication of a summary version of this strategy aimed at a patient audience. The development of the document was also 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 and with the four Governing Bodies. We have also discussed the Strategy with our statutory partners, Healthwatch and the Local Medical Committee through our Joint Primary Care Co-Commissioning Committee (JPCCC) and Health and Wellbeing Board meetings, and have shared it with our local trusts; the Royal Berkshire NHS Foundation Trust and the Berkshire Healthcare NHS Foundation Trust.

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 (JPCCC), linking with the CCGs' other Programme Boards as appropriate. The Terms of Reference for the Joint Primary Care Co-Commissioning Committee are available at http://www.wokinghamccg.nhs.uk/joint-primary-care-co-commissioning-committee.

2. Our Vision for Primary Care

By 2019, primary care in Berkshire West will be:



3. The Case for Change

There are currently 53 GP practices in Berkshire West, providing care to approximately 520,000 patients from 75 surgeries. For 2015-16, the total budget for general practice services in Berkshire West was £66.9m, made up of £61.2m NHS England funding for contractual payments including QOF and enhanced services, and £5.7mm 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.

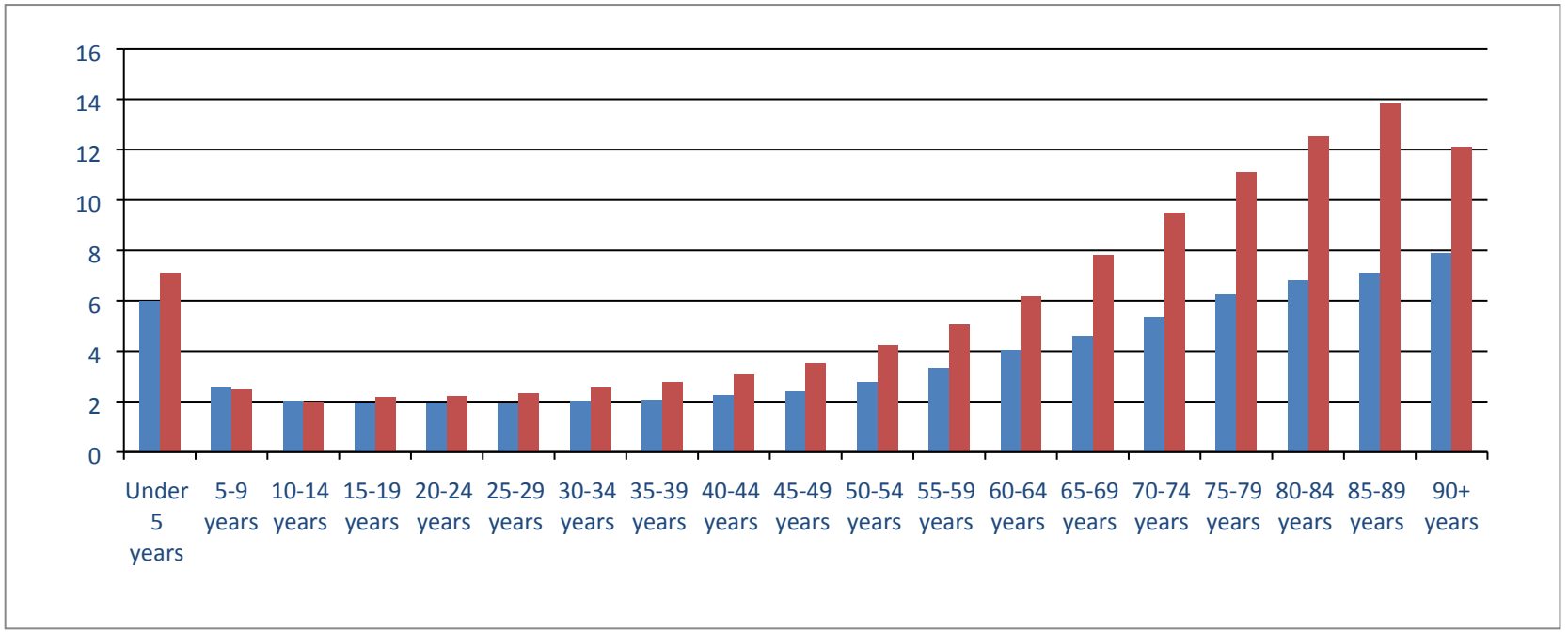
All practices in Wokingham CCG and all but one in Newbury and District CCG hold GMS contracts. In North and West Reading and South Reading CCGs, the majority of practices hold PMS contracts. There are currently four APMS contracts in place in Berkshire West, one of which includes a Walk-in Centre component and two of which are one-year interim contracts held by Berkshire Healthcare NHS Foundation Trust (BHFT). The Walk-in Centre contract will be re-procured during 2016-17 whilst the other three APMS contracts are currently being re-procured with the intention of new contracts commencing from July 2016.

The quality of primary care provision in Berkshire West is generally high. Average QOF achievement exceeded the England average for three of the four CCGs and was also above average in 11 practices in the remaining CCG. The Primary Care Web Tool collates key primary care quality data such as QOF achievement and prevalence, prescribing, screening and immunisation uptake rates, A&E attendances, non-elective admissions for patients with long-term conditions and National Patient Survey results. Practices that are outliers on more than six indicators are identified as requiring further investigation to understand the reasons behind this. No Berkshire West practices are in this group although some are outliers on a smaller number of indicators. There is also some local variation between practices serving similar populations which needs to be understood and addressed as appropriate. 25 practices have so far been visited by the Care Quality Commission (CQC) of which 61% have been rated as good or outstanding. Where practices have been rated as 'Requires Improvement' many of the issues identified have been procedural matters which have been relatively easy to address. A small number of local practices have been placed in special measures in recent months and the CCGs and NHS England have worked closely with the practices on Quality

Improvement Plans which are proving successful in addressing the issues identified. Going forward the CCGs are now working to support all practices to better understand the CQC requirements and inspection process.

Out-of-Hours services are provided by Westcall (part of the Berkshire Healthcare NHS Foundation Trust). Westcall is recognised as being a high quality provider of out-of-hours care and is staffed to a large extent by local GPs. This knowledge of local services and care pathways, together with access to patient records through the Medical Interoperability Gateway and to care plans via Adastra, ensures that the service is able to work effectively to meet urgent care needs and avoid unnecessary admissions to hospital during the out-of-hours period.

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. We are undertaking further work locally to understand levels of capacity and demand in primary care which will inform our future commissioning decisions.



Changes in consultation rates 1995-2008 (HSCIC)

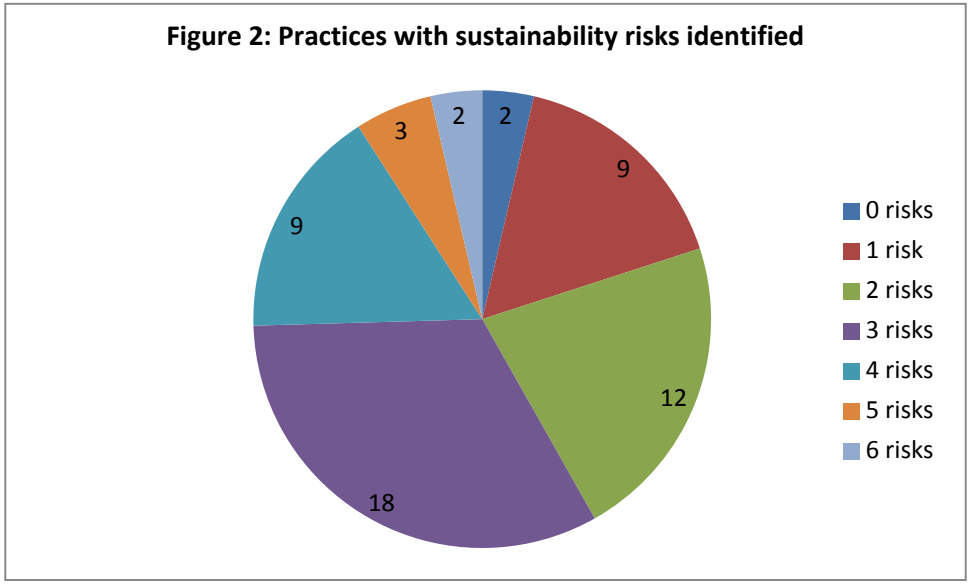
A further pressure relates to GP recruitment and retention. The Royal College of General Practitioners (RCGP) reports that the number of unfilled GP posts has quadrupled in the last three years and that applications to undertake GP training have dropped by 15%.[1] The Nuffield Trust reports that a third 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'. Around 60% of patients say that current surgery opening times meet their needs. Where weekend access is provided the preference is for Saturdays mornings. Waiting times for appointments and continuity of care are frequent concerns but people are increasingly willing to consider alternative access models such as speaking to GPs over the telephone or seeing different members of the practice team such as pharmacists or physicians' associates. There is also consistent across all age groups feedback that people want to interact with their surgery online although some indicate that they would need help to register for online services. 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 recently undertook 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 contractual changes. Eight measures were considered in total and Figure 2 summarises the level of 'sustainability risks' identified. This data is now being triangulated with quantitative data from other sources such as the national Primary Care Web tool, other CCG reporting tools and demographic information to establish a dashboard of quality and risk relating to primary care contracts.



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 by working in partnership with others to prevent ill-health. 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.
- Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and appointments are available in the evenings and at weekends.
- 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, building job satisfaction through more rewarding continuing professional development processes 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 investment (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 and reduce 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 to 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. 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] 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 and to support collaborative working between practices through federations, networks and joint provider organisations.

- **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 by working in partnership with others to prevent ill-health. 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 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.

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.

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, and through a proof of concept testing process connecting GP practices with secondary care. Over the next 18 months all practices will join a wider dynamic programme connecting, practice systems with acute, community and social care systems.

- **Strategic Objective 4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and appointments are available in the evenings and at weekends.**

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, guidance and treatment 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 Thames Valley procurement of an Integrated Urgent Care Service. . This service will work with GP practices, out-of-hours, the Walk-in Centre, A&E and other services to meet the needs of people with urgent care needs in accordance with the *Safer, Faster, Better* guidance.[4]

We will continue to commission extended hours primary care provision, reflecting NHS England planning guidance. Currently we are focussing on improving patient experience through bookable appointments to be provided across an extended weekday and at weekends by single providers or through collaborative models. Additional capacity will also continue to be commissioned at peak times in-hours over the Winter period thereby working to reduce demand on other services, particularly A&E.

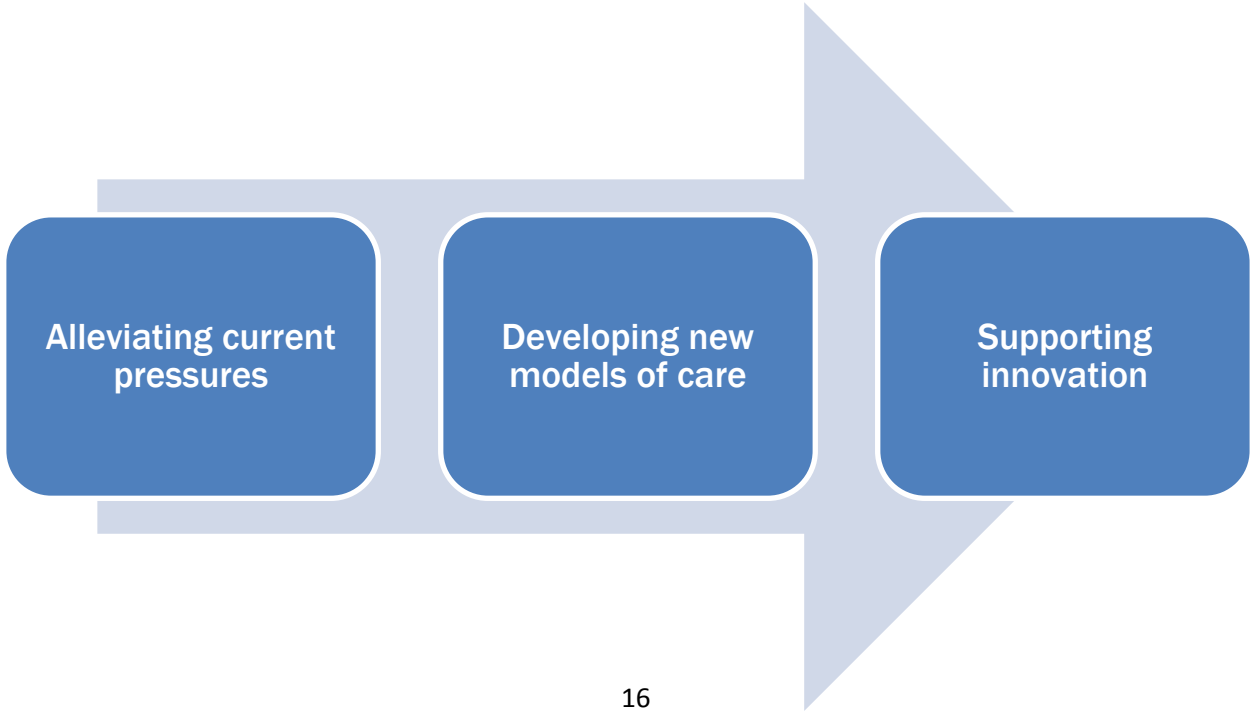
- **Strategic Objective 5: Making effective referrals to other services when patients will most benefit**

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 further development of the DXS system which works 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.

[4] *Safer, Faster, Better: good practice in delivering urgent and emergency care,* NHS England, 2015, www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf

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 the new integrated model of care we envisage operating in Berkshire West by 2019. The outline workstreams and investment plan set out below span these three areas and will inform the development of a more detailed Implementation Plan. The following section also describes how co-commissioning arrangements agreed with NHS England will underpin the delivery of this Strategy.



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.	Four sets of inter-related workstreams will aim to achieve sustainability for the local primary care sector: Workforce: • 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 or training hubs. • 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. IT (see also other objectives, below): • Maximising potential of self-care/triage apps • Installation of 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.

	Premises: • Systematic planning for population growth • Maximising investment from housing developments • Maximising investment from national funding streams such as Primary Care Infrastructure Fund • Planned investment in premises which will enable delivery of the models of care described in this document, including underpinning the 'upscaling' of provision as described above. Organisational form: • Developing commissioning approaches that support upscaling and collaborative working between practices e.g. through federations, networks and joint provider organisations as a means of sustaining primary care by achieving economies of scale and efficiencies. This work will also put providers in a better position to take up opportunities to develop an extended role for primary care as part of the broader new model of care we are looking to develop in Berkshire West.
2: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting	• 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 and telephone , 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. • Risk stratification of patients with long-term conditions • Supporting self-care for patients with long-term conditions including through technological means, remote monitoring and wearable devices.

3: Managing the health of a population by working in partnership with others to prevent ill-health. 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 support 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 practices and the wider health and social care system through the Berkshire West Connected Care Programme.
4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends.	• Practices to be commissioned to offer more bookable appointments in the evenings/early mornings and at weekends , reflecting NHS England planning guidance. Additional capacity to be commissioned at peak times in-hours to support system resilience. Smaller practices to be encouraged to work collaboratively to increase appointment availability, sharing patient records as appropriate. Empowering patients to self-care where possible and to access services appropriately. • 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 • 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

Co-commissioning will be a key enabler for the delivery of this Strategy. The CCGs were approved to jointly commission primary medical services with NHS England with effect from 1st May 2015. Responsibilities are discharged through the Joint Primary Care Co-Commissioning Committee (JPCCC) which follows national guidance with regard to the scope of joint commissioning, governance requirements and arrangements for managing conflicts of interest. We are now considering taking on fully delegated responsibility for commissioning primary medical services from 1st April 2016.

Co-commissioning 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, and supporting the move towards place-based budgeting as set out above.

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 our anticipated outcomes, linking back to the strategic objectives set out in this document. We will then work to reflect this in contractual arrangements including our APMS service specifications and an associated 'contract plus' offer for GMS and PMS practices. This will ensure that providers are paid the same rate where they provide the same level of service irrespective of the type of contract that they hold and that

patients have access to a defined level of service even though delivery models may vary. This 'contract plus' offer will be funded initially through re-invested PMS premium funding but we are committed to working towards aligning funding levels for all practices by also commissioning it from practices that do not have access to this source of investment.

- We will take every opportunity to ensure that the commissioning decisions we make support delivery of strategic objectives for primary care, for example 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.

- Linked to this, the CCGs will look to develop a framework for further improving quality and addressing unwarranted variation in primary care. This will be based upon CCG-led peer support and sharing of best practice but will also incorporate arrangements to identify and address any ongoing performance issues. 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. We will also support practices to prepare for CQC inspections and to make improvements to services where these are identified as a result of visits.

- Over time we will explore the potential to re-design QOF and directed enhanced services to better reflect local needs. We will look to consolidate enhanced services commissioning to reduce the bureaucracy associated with managing multiple contracts.

- 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 engaged with 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 following table shows how the emerging local vision of each CCG aligns with the broader strategic objectives for primary care identified in this document by identifying key priorities identified for each CCG area. .

	Newbury & District	North and West Reading	South Reading	Wokingham
1: Addressing current pressures and creating a sustainable primary care sector.	• Supported self-care and automating QOF. Using technology to support self-care for long-term conditions; enabling patients to enter their own data and reminding them to attend for appointments. • New 'GP Personal Assistant' admin role • Freeing up GP time to focus on most complex patients and work that can only be done by them personally, thereby ensuring they are working 'at the top of their licence'. • Multidisciplinary training environment; learning environment enabling everyone in the team to	• Increase use of pharmacists • Shared approach to multi-disciplinary training, appraisal and CPD, utilising where possible existing programmes run by local trusts • Maintain and develop Nurse and HCA training programme • Explore the potential of the voluntary sector in supporting the needs of patients • Continue to explore the potential of collaborative working arrangements across practices and proactively plan for future provision of services for patients in North	• Discussions have focussed on potential for practices to work more closely together through hub and spoke model thereby creating efficiencies. These 'clusters' would share back office functions and provide services jointly where appropriate, thereby creating efficiencies and improving choice for patients. • Part of PMS premium funding to be used to establish Transformation Fund to support service developments aimed at achieving sustainability. Plan for use of this funding being developed across	• Discussions have focussed on how practices can work together to deliver efficiencies. Federated and networked models have been considered but progress to date has been focussed on the neighbourhood cluster model. This would enable practices to work together to create back office and other efficiencies, to jointly address workforce issues and to improve the interface with other services. There will be three clusters, each serving a population of 40-60,000 people. • Key priority is planning for population growth – it is estimated Wokingham will

	benefit from shared expertise, to keep up to date and to develop their skills. • Development of pharmacist roles. • Consideration to be given to collaborative recruitment approaches. • Fostering collaboration between practices as providers to achieve economies of scale and support sustainability.	Caversham. • Work with BHFT to pilot new ways of working across Community Nursing and Practice Nurse services • Support GP manpower by encouraging retiring GPs to join 'bank' arrangements	three key areas of IM&T infrastructure, workforce and premises. • Premises strategy being developed in line with clustering approach.	have an additional 32,000 residents by 2022.
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 new ways of working with consultants to reduce the need for referrals. • Geriatrician to support GPs in looking after care homes • Care closer to home using West Berkshire Community Hospital as a hub. Outpatient appointments provided in community by community-based consultants. Aspiration to develop West Berkshire Community Hospital as a Diagnostic and Treatment Centre, avoiding the need for travel to acute hospitals.	• As lead commissioner of urgent care across Berkshire West we will review patient pathways to identify potential improvements in a community setting.	• Hubs (likely to service around 25,000 patients) 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. There will be opportunities to further develop GP specialist roles working across practices and linking in new ways with secondary care clinicians.

	• Supporting collaboration between practices as providers to expand the range of services offered by primary care.			
3: Managing the health of a population by working in partnership with others to prevent ill-health. 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 – implemented by an extended team(see above) led by an accountable clinician such as a GP or community matron, focussing on patients from whom continuity is important and could affect clinical outcomes (e.g. those with complex multi-morbidity, enduring mental illness or requiring end-of-life care). • Further development of anticipatory care planning • Personal recovery guide jointly with social care and the voluntary sector.	• Explore potential of care planning for other long-term conditions • Work with Public Health to increase preventive work, including increasing physical activity rates through Beat the Street . • Ensure that all practices utilise the Living Well pilot and evaluate its benefits • Consider the benefits of introducing a specialist GP role for care home patients and the frail/elderly • Instigate/participate in coproduction opportunities as they arise	• Hubs would act as point of interface with other organisations, thereby supporting cluster working as set out in BCF plan. •	• 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 being piloted. This role supports practices to signpost patients to the range of voluntary sector services available to them, with a particular focus on reducing social isolation amongst older people and supporting new families moving into Wokingham.
4: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring	• Different length appointments according to patient need • Extended Hours capacity commissioned in accordance with patient need and linked	• Ensure that 80% of practices provide extended access • Discuss and agree how an integrated urgent care system could best support practices to manage patient	• Hub and spoke model would offer flexible approaches to extended hours provision and potentially in-hours requests for same day appointments.	• Considering collaborative approach to call handling and meeting on the day demand through cluster-based urgent care centres. Over time this should ensure GPs have the

urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends.	to the Out of Hours provision • Exploring triage to prioritise appointments using a combination of the most experienced clinician and enhanced reception roles • Develop collaborative working to deliver improved access across the 11 practices, including exploring potential of shared call handling through hubs (involving GPs, minor illness nurses and Nurse Practitioners) and/or a locally-agreed protocol and thresholds for on-the-day appointments. This would give GPs in practices more control over their day and enable them to focus on most complex or those needing continuity (see above). • Exploring utilising technology to obtain succinct patient history prior to appointments and more use of Skype and telephone consultations.	demand for urgent care	• Practices could collaborate to meet on the day demand thereby freeing up time for care planning for patients with the highest needs.	capacity to focus on providing proactive, community-based care for patients with higher levels of need.

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 (e.g. IAPT, Social Services, Physiotherapy) and to incorporate a service navigation function which will support patients and practices to access the services they need.	• Ensure practices are aware of voluntary sector services available to support their patients and that these are included on DXS • Continue to provide practices with referral benchmarking information at practice visits and as routine every quarter • Through regular reporting of referral benchmarking information reduce levels of variation between practices.		• 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 QIPP scheme.

6. Investment plan

Core primary care services are funded through NHS England's GP commissioning budgets. A high-level summary of 2015-16 budgets is provided below. Further enhanced services are commissioned by unitary authority Public Health departments.

CCG	GP Contract Payment £0	QOF and Aspiration £0	PCO Admin £0	GP Drugs Payments £0	GP Premises £0	Misc. Items £0	Enhanced Services £000s	Total Area Team £0
Newbury and District	8,624	1,141	448	914	1,143	339	850	13,459
North and West Reading	8,997	1,170	427	386	1,109	315	669	13,073
South Reading	12,750	1,101	418	74	1,781	300	849	17,273
Wokingham	11,191	1,549	596	442	1,954	438	1,108	17,278
Total	**41,562**	**4,961**	**1,889**	**1,816**	**5,987**	**1,392**	**3,476**	**61,083**

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 have used 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, we have invested £2.5m to extend GP access into the evenings and weekends as well as at peak times in-hours over the Winter period, following a £1m pilot scheme in 2014-15. These two schemes combined equate to an 8.4% increase in investment in primary care. Further information about current IT investment plans are included in Appendix 3, below.

	CCG Budgets				
CCG	£5 per head "anticipatory care" £000	Enhanced Access £000	Other Enhanced Services £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**

In addition, the CCG is responsible for commissioning the Westcall Out-of-Hours service provided by the Berkshire Healthcare NHS Foundation Trust. For 2015-16, £5.02m was spent on commissioning this service.

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 types of outcomes that would result from successful delivery of our strategic objectives for primary. More specific outcomes will be developed as we move towards implementation and progress against these will be monitored by the Joint Primary Care Co-Commissioning Committee. The Committee will also take oversight of the delivery of the Strategy as a whole and will assess progress and review this document periodically in the light of developments in co-commissioning and the broader health and social care economy's approach to integration and sustainability.

Strategic objectives	High-level 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. PMS premium funded reinvested to support delivery of models of care set out in this Strategy. • 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.

	• Patients supported to access practices online. • Patients are supported to use self-care apps • Opportunities to interface with patients in different ways e.g. through telephone and Skype consultations, patient history-taking apps etc. are utilised to full effect thereby enabling practices to manage growing demand.
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 by working in partnership with others to prevent ill-health. 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 thereby reducing avoidable hospital admissions • 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: Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends.	• Bookable GP appointments available from 8am-8pm in the week and at weekends, reflecting NHS England planning guidance • Improved patient survey results / Friends and Family test responses • Practices utilising shared call handling and/or on-the-day provision where appropriate to create efficiencies which free up time for GPs to focus on more complex patients.

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. • DXS utilised to maximum effect to support delivery of agreed care pathways and signposting to other services as appropriate.

8. Next steps

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.

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. A communications plan will be developed for each workstream which will aim to build upon the useful information already obtained with regard to many of the themes covered in this Strategy document.

Appendices

Appendix 1: Patient Engagement

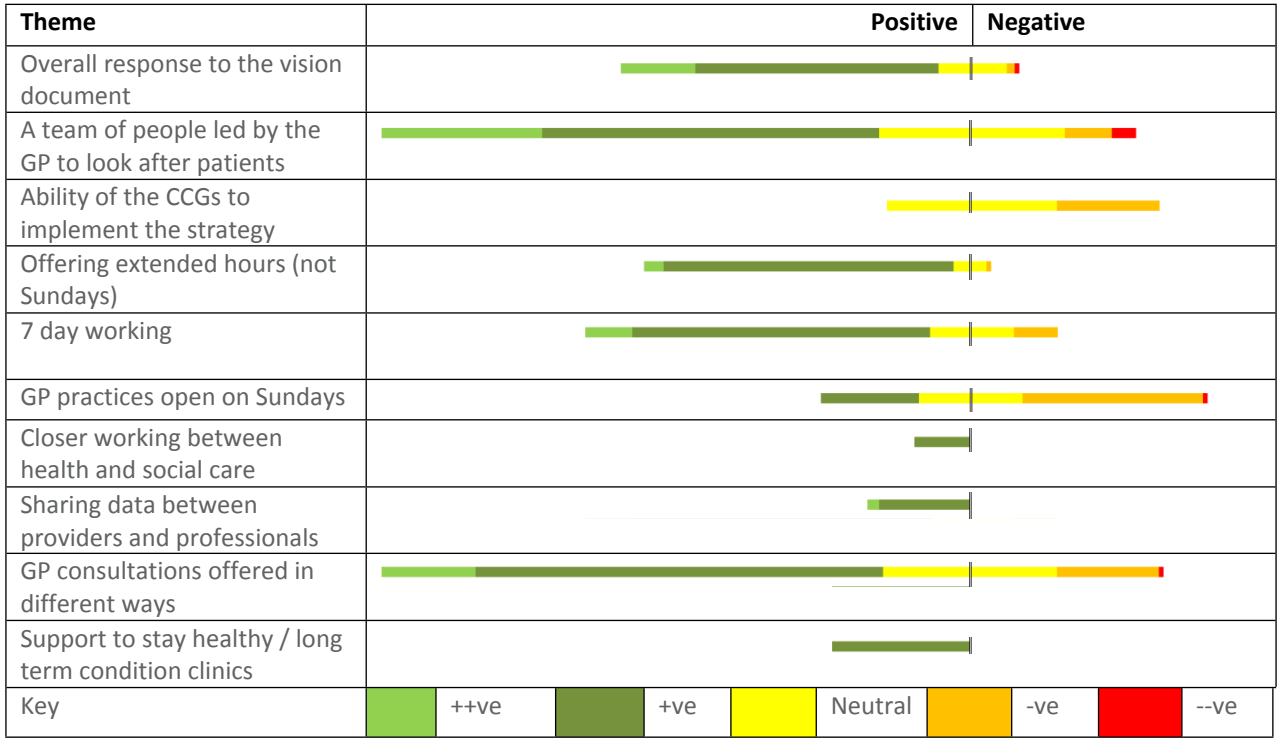
The CCGs' engagement with the public regarding primary care began with the Call to Action events held in 2014. Since this time we have developed an ongoing dialogue with individual Patient Voice Groups and have raised primary care through broader engagement work undertaken as part of the CCGs' overall Communications and Engagement Strategy.

Following production of the draft of this Strategy, a patient-facing version was produced which has formed the basis of an intensive programme of engagement over the last few months, as well as an online survey. Specific engagement has also been undertaken in relation to the three APMS contracts we are procuring in 2015-16 which has elicited useful feedback in terms of our overall direction of travel for primary care commissioning. The following table summarises key recent engagement events and activities which have had a primary care focus:

Date	Event
November 2014	Reading 'GP Question Time' event
March 2015	Wokingham 'Have your say'
March 2015	Newbury Primary Care Event
July 2015	North and West Reading CCG annual meeting and engagement event
August to December 2015	Primary Care Strategy survey live on Berkshire Health Network.
September 2015	South Reading CCG annual meeting and engagement event
July – August 2015	NHS111 engagement
September 2015	APMS engagement: Circuit Lane
September 2015	APMS engagement: Priory Avenue
October 2015	APMS engagement: Shinfield Medical Practice
October 2015	Woosehill Surgery PPG survey
October 2015	Wokingham PCS engagement event
November 2015	South Reading Patient Voice PCS engagement
November 2015	Trinity School, Newbury – sixth form
November 2015	Mailout to more than 70 residential care homes across Berkshire West to promote feedback on the strategy

The heat map below demonstrates the key areas of interest for patients reading the vision document and responding to the online survey. The length of line indicates the volume of responses and the bar colour the sentiment of respondents. The heat map below represents 988 statements (83% of total). The map tells us that respondents were overwhelmingly positive towards the ideas set out in the vision document, welcome a wider range of professionals offering care and are enthusiastic for new styles of GP consultation – including Skype video consultations.

Some online respondents were concerned about our how we will implement the vision. We intend to address this concern through the implementation plans that we put in place to support delivery of the Strategy which will include mechanisms for identifying and addressing risks to delivery. Seven day working was seen as beneficial overall, though many of those in favour felt that Sundays should not be used for routine appointments.



The following table summarises the key themes identified through all of the engagement activities we have undertaken as part of the development of this Strategy (including the online consultation above), and how these are reflected in the final document. A full report is available on the CCG websites.

Key themes identified through patient engagement	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 and they are supported to navigate the care system. 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. These patients most value continuity of care. IT systems should ensure confidentiality of data. Technological solutions should not be a substitute for good face-to-face care but respondents did recognise the potential of wearable technology.	• 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. Other elements of our IT programme will ensure we maximise the potential of self-care and monitoring apps and gathering data from wearable devices. • Wokingham and NWR CCGs are piloting voluntary sector co-ordinator roles which will support patients to navigate the system. Learning from these pilots will be shared across Berkshire West.

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, or would be willing to access another surgery at these time. Others felt that good access in-hours with an ability to see their own GP was as important as extended opening. There is limited appetite for Sunday opening. Appointments could also be different lengths according to patient need. People are generally positive about accessing their GP surgery in new ways (email, Skype etc) although some said they would need support to do this and others expressed concerns that it must be voluntary and shouldn't substitute face-to-face care.	• 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. This now applies to all patients; addressing the concerns expressed by some around this previously being limited to Over 75s. • GP practices will make best use of technology such as email, texting, online services such as repeat prescriptions and consultations. Information and support will be available for patients from practices to enable then to get started. • NHS 111 will play an integral role for patients to be able to access the NHS locally out of hours.
People recognise that there is a need to promote self-care and to ensure that patients access services appropriately. There is general support for the concept of the NHS 111 service.	• 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. • As part of implementing the Strategy the JPCCC will work with the Urgent Care Programme Board to consider the future potential of NHS 111 to respond to on-the-day demand for primary care 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 roles 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. Staff should be supported to understand the needs of particular groups attending practices such as those with learning disabilities. GP practices should work with and support carers; signposting them to other services where appropriate.	• 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). Specific action will be taken to ensure GP practices support carers effectively. • We intend to continue to work closely with practices around continued professional development. This could include providing training around the needs of particular groups.
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	• 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

other organisations to enable early intervention and prevention of more complex health issues. Some patients also indicated that they would welcome more general health advice and health checks.	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. Patients feel that this is appropriate as they recognise that they do not always need to see their GP but do want to be assured that appropriate leadership arrangements are in place and there is clarity of roles. Most people were positive nurses and pharmacists in particular taking on enhanced roles. Generally people welcomed the idea of more services being available in their GP surgery from a mixed skill-set team and it was felt that this would also make primary care careers more attractive.	• The workforce sections of this Strategy describe how different professionals such as Physicians' Associates, pharmacists and emergency care practitioners may increasingly become involved in the delivery of primary care, with a wider practice team working to support the specific needs of different groups of patients. We will support practices to diversify their teams with clear lines of accountability and information for patients about different professional groups. • The Strategy describes how practices will in future work differently with secondary care consultants and other professionals to provide a much broader range of services in primary care.
People want more planned care for long-term conditions, including continuity of care where possible. Having substantive staff in post supports this.	• 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. • The Strategy sets out a range of actions that will be taken to support practices to address difficulties in recruiting to substantive posts. We recognise that recruitment is a key challenge for the primary care system and that we need to work as proactively as possible to address this.

People want to understand how the Strategy will play out in rural areas and for smaller GP surgeries which may not be able to host multidisciplinary teams.	• The CCG elements of the Strategy above starts to set out how the vision might be implemented at a local level. This may include smaller practices working together to provide some services, thereby ensuring that patients in all areas have access to the same range of services and supporting practice sustainability. Practical considerations such as a rurality would be taken into account in any such approaches.

We recognise that engagement with the public should be an ongoing process. Going forward we intend to undertake specific engagement around key workstreams resulting from the implementation of this Strategy. This will be in addition to any formal consultation required with regard to service changes. We will build upon our successful approach of combining public meetings, focussed discussions with key groups and online publications and surveys to engage with as broad a range of patients as possible; also working through established mechanisms such as our Patient Voice and PPG Forum groups, the Berkshire Health Network and practice-based participation groups. If you would like to know more please contact the CCGs Patient and Public Involvement Team on 0118 9822709 (8.30am-4.30pm, Monday-Friday) or on ppiteam.berkshirewest@nhs.net. Information about how to register with the Berkshire Health Network is also available at https://www.healthnetwork-berkshire.nhs.uk/consult.ti/system/register.

Appendix 2: IM&T investment plans