GP services as the foundation of an integrated health and social care system centred around the patient and carer

A partnership between:
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups
Foreword

In Bristol, North Somerset and South Gloucestershire (BNSSG) we share a common belief that primary care is, and should continue to be, the foundation of the NHS. We also recognise that it faces unprecedented pressure and so welcomed the publication of the GP Forward View.

We welcome and support the development of this BNSSG GP Primary Care Strategy because, being both clinical leaders of our membership organisations as well as local GPs, we recognise the significant difficulties and challenges facing primary care across BNSSG.

We are serious about change, not for the sake of change itself, but in order to deliver a resilient and thriving primary care service that is at the heart of an integrated health and social care system centred around the patient and carer.

We know primary care is facing significant challenges (changes in workforce; workload; ageing population with complex medical needs; expectations to deliver more ‘out of hospital care’) in the delivery of core primary medical care to patients.

This strategy aims to ensure the sustainability of general practice in light of the challenges, building on existing strengths and ensuring safe, effective and high quality care. We need to future-proof primary care so that our patients and the people of BNSSG are supported to look after themselves and to have access to high quality care when they need it.

This strategy has been shaped by discussions across the area, not only between the clinical commissioning groups member practices, but with the public, GP practices, their area representative bodies and our partner services.

We are very grateful for the constructive feedback that we have received and the enthusiasm of Avon LMC, One Care Ltd and our three community service providers in particular, to develop their own internal ideas and plans to complement and support the delivery of the strategy. We look forward to working with these stakeholders to develop an implementation plan to support this strategy.

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Chair, Bristol CCG

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Chair, South Gloucestershire CCG
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This strategy reflects Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCG) previously published commissioning intentions and the Strategic Plans 2014-2019 and builds on the new opportunities provided by primary care joint commissioning and the General Practice (GP) Forward View. This strategy will inform and align with our Sustainability and Transformation Plan (STP), which is being organised around three broad themes, one of which is integrated Primary, Community and Social Care.

This strategy aims to consider what is important to and for the population of BNSSG using intelligence from primary care patient surveys, local stakeholder events and public health statistics. It considers the challenges facing the primary care system in BNSSG and provides a vision for the future from both a patient and system perspective.

Although this strategy is focused on the role of general practice in primary care, its successful implementation will require not just the support of practices, but

**Our Vision**

A resilient and thriving primary care service which is the heart of an integrated health and social care system centred around the patient and carer;

A responsive system that delivers needs-based high quality, equitable and safe care.

It will also require closer co-operation across the wider healthcare system including nurses, therapists, hospital clinicians and staff, and the voluntary sector. It is presented as a foundation for wider-system reform across BNSSG, which will be delivered through the STP, recognising that general practice is not isolated but is at the heart of the local health system.

Across BNSSG, the CCG GP membership practices support changes to primary care. GPs acknowledge that general practice needs to change so it is best placed to deliver patient-centred, coordinated care, which is as accessible and as close to home as possible.

“The General Practice Forward View [...] sets a new direction and opportunity to demonstrate what a strengthened model of general practice can provide to patients, those who work in the service, and for the sustainability of the wider NHS”

— Dr Arvind Madan, GP, Director of Primary Care NHS England
Overview

Primary care is the entry point for the prevention and treatment of illness. It is the foundation of the NHS, however it faces unprecedented pressure. Nationally, the share of NHS funding for general practice has decreased during the last ten years, workload has increased along with patient expectations, while vacant posts remain unfilled. To address this, the GP Forward View sets out national commitments to stabilise and transform general practice, improving services for patients and investing in new ways of providing services.

Traditionally, primary care has been defined as general practice, community pharmacy, dental and optometry services, all of which are currently commissioned by NHS England. The scope of primary care however is much wider and could also include appropriate self-care interventions, mental health support and community health care teams, which incorporate nursing and other multi-disciplinary care.

Advances in technology will mean that, with the right resources (skill mix, funding, premises, and IT infrastructure), more can be delivered in a primary care setting so that people who have historically gone to hospital to receive their care will no longer need to. This will likely mean the emergence of networks, federations and primary care clusters where a team of healthcare professionals and allied workers can provide innovative and integrated care.

This will not necessarily mean that practices will merge or relocate, although this may be appropriate for some. Where it is more efficient and better value to bring practices together this will be the preferred model for the future, and will be actively promoted, supported and built into our estates planning. More importantly, it is about primary care providers within BNSSG working together, in population based clusters, to keep people healthy and independent, ensuring that those who require treatment or care are treated in the most appropriate place by the appropriate healthcare professional.

It is also important to recognise there are many strengths to our GP primary care service that we don’t want to lose as we make this transformation. These include continuity of care, a real understanding of the family or personal support network that a patient is a part of, and the relative ease of accessibility and delivery of an equitable service.

This will be a transformational journey for building patient-centred, out-of-hospital care, which will be realised over a number of years through a focus on improving outcomes for patients and thinking beyond traditional boundaries and business models.

“The NHS Five Year Forward View recognises the vital role which primary care plays at the heart of the NHS. It also outlines the need for improvement and innovation, including an ambition to improve access and deliver care which is more personalised, proactive and co-ordinated”

— Dr Robert Varnam, PhD, MSc, MRCGP, GP Head of General Practice Development at NHS England
• Integrated service delivery covering a geographical area providing high quality, affordable, ‘out of hospital’ care. This includes self-care, providing alternatives to A&E and hospital admission, supporting hospital discharge, and keeping people well once they return home, as well as general medical services both in and out of hours covering seven days a week.

• Provide a seamless and safe service to patients by defining new community care pathways and sharing a common electronic patient record.

• Local services will be provided by general practice partnerships that have merged, federated or simply co-operate to provide services jointly, working in an integrated way with other providers, such as community services, acute, mental health and social care practitioners.

• Working closely with local authorities, particularly focusing on areas of health inequality and vulnerable patients.

• Clinical teams small enough to retain GP practices’ personal relationship with patients and continuity of care, whilst being part of organisations large enough to assure long-term sustainability and capacity to meet the demands of the wider system.

• A valued and motivated primary and community care workforce with training and development opportunities for a variety of roles including specialists.

• Better health promotion and self-care messages enabling patients to understand when to seek expert advice from a healthcare professional, and when and how to self-care.

BNSSG Sustainability and Transformation Plan Vision
Our population

**South Gloucestershire** is predominately rural although the majority of the population live in the urban areas. The South Gloucestershire population has grown during the past decade by 10% and is projected to rise by a further 17% by 2037. The biggest increases will be in the older age groups. At least 30,000 new homes are planned to be built in South Gloucestershire by 2036.

**North Somerset** faces significant demographic pressures with a population that is both ageing and growing. Long-term projections suggest the population of North Somerset is set to increase across all age groups, reaching an estimated 300,000 by 2030. The largest increase over the next ten years is set to be within the 75-84 age group. The ‘Weston Villages’ are the main strategic growth area for North Somerset and are forecast to deliver 6,200 new homes.

**Bristol** population has grown 11.8% since 2004 (compared to 8% in England and Wales) mainly due to the high number of births relative to deaths. This growth has been mainly concentrated in the inner city. The population is young, with a median age of 33.4 compared to 39.9 in England. Around 16% of the population are from black and minority ethnic (BME) backgrounds but among children it is 28%. There are 58,800 people aged 65 years and over in Bristol. This proportion (13.3%) is lower than the national average. There are projected to be 8,100 additional older people by 2022, a 14.2% rise.

**Case for Change**

The population total across BNSSG is 968,314, with 17.5% of the population living in the most deprived quintile areas of England (IMD2015), this equates to 164,613 people across BNSSG.

The largest proportion of growth in the next five years is expected in older age groups.

<table>
<thead>
<tr>
<th>Age</th>
<th>BNSSG population 2015/16</th>
<th>Five year predicted change</th>
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<tbody>
<tr>
<td>0 to 14</td>
<td>165,737</td>
<td>7.1%</td>
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<tr>
<td>15 to 44</td>
<td>407,959</td>
<td>2.6%</td>
</tr>
<tr>
<td>45 to 64</td>
<td>235,236</td>
<td>2.8%</td>
</tr>
<tr>
<td>65 to 74</td>
<td>86,453</td>
<td>2.3%</td>
</tr>
<tr>
<td>75 to 84</td>
<td>51,234</td>
<td>15.9%</td>
</tr>
<tr>
<td>85 plus</td>
<td>22,605</td>
<td>17.6%</td>
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35.8% increase in the over 65s in the next five years
Recently, Healthwatch England asked people how they want to look after their health in the future. The report provided clear messages from patients in support of developing primary care and shows a growing recognition that patients have some responsibility for their own health.

It’s clear that patients value the personal relationship with primary care, seeing a familiar face and someone that they trust. It’s vital that this personal service and continuity is protected. The challenge is to balance this alongside limited resources, both in terms of primary care professionals and funding.

### Patients said:

<table>
<thead>
<tr>
<th>What is important to the population?</th>
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<tr>
<td><strong>We want to do more for ourselves</strong></td>
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<tr>
<td>• We recognise the NHS is under pressure but we can help by playing a bigger role in looking after our own health and wellbeing.</td>
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</table>

### What would this look like?

**I’ll be in control**
- I won’t have to rely as much on my GP to interpret information for me.
- I’ll be able to access the information and advice I need to make more decisions for myself.

**Services will work better for me**
- My health records will be up-to-date and services that help me will be able to access them.

**I’ll have easier access to the support I need to stay well**
- I won’t have to go to hospital so much.
- Tests such as ultrasounds can be done by my GP.

**My employer will also help**
- I won’t have to leave work to get a health check. My employer will offer these.

**I’ll be able to do more online**
- I won’t have to visit the GP or wait for the post to get my test results.

**More help for mental health**
- Long waiting times for mental health support will be an issue of the past.
- If I need help with my mental health, my GP will be able to offer the right support for my needs quickly.

Find out more: [www.healthwatch.co.uk/bettertomorrow](http://www.healthwatch.co.uk/bettertomorrow)
A review of the BNSSG Joint Strategic Needs Assessment (JSNA) provides a high level summary of the underlying health issues across the area.

**Priorities in local JSNAs – healthcare**

- **Premature mortality**: Reduce premature deaths from cancer, heart disease, stroke, lung disease and liver disease.
- **Inequalities**: Reduce inequalities in healthy life expectancy and quality of life.
- **Prevention**: Tackle harm caused by smoking, rising rates of obesity, diabetes, preventable sight loss and alcohol-related harm. Ensure a focus on prevention and early identification of ill health, in order to manage increasing demand.
- **Mental health**: Reduce the suicide rate, halt the rising rates for self-harm and mental health conditions in children and young people.
- **Ageing population**: Develop services that support the rising prevalence of frailty, dementia, multiple long-term conditions and reduce mortality especially over the winter period.
- **Health protection**: Monitor and review systems to manage anti-microbial resistance, healthcare acquired infections; reduce HIV incidence rates and improve screening coverage; monitor and work to address TB rates.

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3,075 hospital stays per year were for alcohol-related harm.

16.9% (1,396) of children aged 10-11 are classified as obese.

2,373 hospital stays per year were due to self-harm

Life expectancy is between 7 and 9.6 years lower for men and between 5 and 7 years lower for women in the most deprived areas of BNSSG than in the least deprived areas.

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Source: Public Health England Health Profiles 2016 for Bristol, North Somerset and South Gloucestershire.
Case for Change

What is important for GPs and their teams?

GPs and their teams have told us they want:

- To deliver high quality, patient-centred care to all patients.
- To spend more time on those patients with the greatest need.
- Less administration and bureaucracy.
- Time and support to change and/or test new ways of working.
- Certainty of funding that is affordable for the system but recognises the cost of work being done in primary care.
- Funding that follows the patient.
- To be at the heart of care for their patients – a conductor or co-ordinator.
- The freedom to do a job they enjoy and to have work-life balance.
- Support services will be available to patients so GPs have confidence in delivering timely, safe and appropriate care as the patient moves through or around the healthcare system.
- A safe and seamless handback to primary care as soon as is appropriate.
- To provide more appropriately resourced out of hospital care, recognising that primary care is the entry point for patients into the system and that care closer to home can be mutually beneficial to patients, their carers and the system.
- To leave a sustainable legacy – handing the stewardship of the NHS onto a younger generation.

”

High quality, patient centred care

Less administration

A conductor or co-ordinator

Safe and seamless handback to primary care

 Appropriately resourced out of hospital care

A sustainable legacy

”
Case for Change

Where are we now?

Resilient, sustainable and thriving primary care
• There are practices in BNSSG that are identified as being ‘vulnerable’ according to the national approach and have received support from NHS England. Several practices have cited the inability to recruit GP staff as a key contributing factor.
• Work is being undertaken by the CCGs to identify others that are struggling but are not yet classified as vulnerable.
• Nationally the number of those training to be GPs has dropped and more than 17.5% of the GPs working in BNSSG are aged over 55 and 4.3% are over 60. This creates a recruitment and retention challenge in the area.
• While there have been real-term increases in primary care funding each year since 2013, this does not reflect the additional clinical workload expected from primary medical care providers during this period.
• 2.3% of the population is aged 85 and over and this figure is set to grow by 17.6% by 2021. The population of >65s is predicted to increase by 35.8% over the same period creating additional pressures in demand from an increasingly elderly and frail population.
• Some of our healthcare estate needs upgrading to meet modern requirements for primary care including disability access. Some estate appears underutilised, whereas in other places buildings are at full capacity. Often GP premises are owner occupied and they may not be in the right place for the current and future needs of patients and the healthcare system.

The heart of integrated care
• Within each CCG a range of providers deliver excellent care for local people but in the main they have all worked independently, both professionally and geographically.
• Local health and care systems have come together to provide a forum in which health and care organisations work closely. This allows plans to be developed and delivered to help drive genuine and sustainable change in patient experience and health outcomes for the longer-term. This will be reinforced by the development of the BNSSG Sustainability and Transformation Plan.
• Nationally there is a move towards ‘one public estate’ to ensure that state owned infrastructure is used across organisations to maximise value for money and that any obsolete property is sold or reused.

1 in 5 GPs are aged over 55
Where are we now?

Case for Change

High quality, equitable and safe care
- By September 2016, most BNSSG practices have been visited by the Care Quality Commission (CQC) for their inspection and of those visited:
  - 96% were rated as good in the caring domain, with two rated as outstanding and one requiring improvement.
  - However, only 81% were rated as good or outstanding in the safety domain with 19% rated as requiring improvement or inadequate.
  - 90% of practices inspected to date were rated as outstanding or good in both the well-led and effective categories but 5% required improvement in both. 10% were marked outstanding for responsiveness.

Proactive, agile and flexible care
- Analysis of the latest GP Patient Survey data (July 2016 publication, collected during July-September 2015 and January-March 2016) indicates that 86% of the population rate the overall experience of GP surgeries across BNSSG as very good or fairly good; however the range across practices is from 51% to 98%. There are 27 practices scoring below their respective CCG peer group.
- Overall satisfaction rises to 93% of the population aged 65 and above.
- National survey results record 76% of patients were very or fairly satisfied with the hours their surgery is open. In BNSSG this figure is also 76%. However, the range across the practices is from 56% satisfaction rates for the lowest performing practice and 93% for the highest.
- 76% of responders to the national survey stated that their surgery was open at a convenient time. However, of the responders who stated their practice was not open at a convenient time, 74% said opening on a Saturday, and 41% on a Sunday, would make it easier to see or speak to someone.
- There has already been considerable house building in the BNSSG area and this will continue with at least c.43,500 homes either planned to be built, or required between now and 2030. Please see CCG key facts pages for more detail (pages 19-21).

Range of overall GP experience

- Highest Performing: 98%
- Lowest Performing: 51%
Patient centred

- a resilient, sustainable and thriving general practice

We will:

• Support the development of emerging ‘clusters’ where a team of healthcare professionals and workers can provide innovative and integrated care.
• Build on existing patient participation and ensure the role of the patient voice in shaping and developing the locality based service models is strengthened.
• Ensure funding follows services when shifted from secondary to primary and community care, working within an affordable system.
• Ensure the current strengths of the primary care service are not lost and core primary medical services are not diluted through the transformation process.
• Work with other primary care provider groups such as pharmacists to develop sustainable solutions.
• Maximise national opportunities to attract and secure funding in primary care ensure funding follows services.

What will be different for general practice

<table>
<thead>
<tr>
<th>Integrated and collaborative working across localities will deliver economies of scale and increased sustainability</th>
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<tbody>
<tr>
<td>The development of locality based services and centres of excellence will attract ‘portfolio’ and/or specialist GPs into BNSSG</td>
</tr>
<tr>
<td>The development of provider contracts or organisations will position general practice competitively to be able to attract new business/services and income</td>
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<tr>
<td>The primary care workforce will change with a greater role for specialist nurses, mental health workers, pharmacists, physicians’ associates, healthcare assistants and other healthcare professionals</td>
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<tr>
<td>Reduced bureaucracy through the sharing of best practice (protocols, policies and ways of working) across a locality.</td>
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What will be different for patients?

<table>
<thead>
<tr>
<th>Additional skills and capacity in primary care and the development of hubs or centres of excellence will enable more services, including diagnostic and therapeutic care, to be provided in a more local setting</th>
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<tbody>
<tr>
<td>The patient experience will be enhanced through the availability of seamless, integrated services supported by shared access to clinical records</td>
</tr>
<tr>
<td>Patients with complex needs will have improved access to a GP or other appropriate clinician</td>
</tr>
<tr>
<td>Ensuring that the patient’s journey through the healthcare system is as ‘smooth’ and uncomplicated as possible</td>
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<tr>
<td>Patients will benefit from increased availability of clinical time and resources.</td>
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Patient centred

- the heart of an integrated health and social care system

We will:

- Work with other health, social care and voluntary/charity providers to develop integrated models of care focussing on the needs of the patient and carer.
- Establish appropriate and seamless evidence based multi-disciplinary care pathways across a locality.
- Provide primary care with the tools to support patients to navigate their way through care pathways, enabling easy access to appropriate care with access to health, social care, lay and voluntary organisations.

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<thead>
<tr>
<th>What will be different for general practice?</th>
<th>What will be different for patients?</th>
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<tbody>
<tr>
<td>Access to a broader range of clinical skills will enable a multi-disciplinary approach to care for patients and release specialist medical resources e.g. mental health services</td>
<td>Patients will be able to access more care locally from a range of service providers</td>
</tr>
<tr>
<td>Services will be tailored to local needs, with closer integration between providers enabling the provision of more care in a community setting</td>
<td>Availability of a wider range of patient centred services will support accessible care closer to home for the patient</td>
</tr>
<tr>
<td>Access to patient information broadened to support clinical care through the common clinical IT platform to enable seamless, integrated service provision</td>
<td>General practice will remain the ‘gate keeper’ to care but patients will access a broader range of services through their GP</td>
</tr>
<tr>
<td>An integrated approach will ensure that duplication is avoided, eg. tests not duplicated unnecessarily.</td>
<td>Patients will have a simpler journey through the healthcare system.</td>
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Patients will be shown how to navigate the system to access the appropriate care at the right time and through the right services. Patients enabled to be healthy and independent, taking ownership of their own health and wellbeing.

Patients will be educated and supported to be as healthy as possible, be confident and able to self-care or manage as well as knowing when and from whom to seek appropriate advice when required.

Primary care is more accessible through use of technology for those who want to use it.

Shared care records will allow the seamless and safe treatment and transition of patients between health care professionals.

What will be different for general practice?

- Patient demand managed through joined-up, collaborative, multi-professional approach especially for patients with co-morbidities
- Increased access to primary care through the use of technological approaches to communicate with and provide support to patients
- Future demand on services managed through the prevention of ill-health
- GP time released to concentrate on supporting more complex and/or vulnerable patients
- Simple, effective technology used to support the patient pathway throughout the system through the sharing of information.

What will be different for patients?

- Provide continuity of care for those with complex care needs
- Support the development of patients’ capacity and capability to self-care
- Improve and increase routes to access primary and community care
- Develop access to local diagnostics such as local pathology tests, x-rays or scans.

We will:

- Develop patient-centred, out of hospital care thinking beyond traditional boundaries and business models
- Improve information sharing to support seamless 24/7 access to care and safe hospital discharges
Patient centred
- delivering high quality, equitable and safe care

We will:
- Work collaboratively to ensure that primary medical care services are delivered in the most efficient way possible
- Focus on delivering high quality primary medical care services and improved outcomes and experiences for the population of BNSSG
- Develop robust processes to monitor quality across the whole healthcare system/patient journey
- Reduce unwarranted variation, e.g. by use of Rightcare methodology, so that patients know what to expect from their local GP
- Develop services that meet the needs of the population, within and across localities
- Reduce administrative burden on primary care through collaborative working arrangements
- Ensure a focus on the continuity of care for those with complex care needs, those who are particularly vulnerable, in a care home, or are in need of end of life care.

<table>
<thead>
<tr>
<th>What will be different for general practice?</th>
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<tbody>
<tr>
<td>Practice based centres of excellence across a locality/cluster</td>
</tr>
<tr>
<td>All practices achieving good or outstanding CQC ratings</td>
</tr>
<tr>
<td>Sharing of best practice (protocols, policies and ways of working) across a locality/cluster</td>
</tr>
<tr>
<td>Technology used to support long-term conditions management and safe hospital discharge</td>
</tr>
<tr>
<td>Service provided by localities/clusters are tailored to local population need.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>What will be different for patients?</th>
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</thead>
<tbody>
<tr>
<td>Consistency of high quality care across primary care will result in improved outcomes for the population and benefits of economies of scale</td>
</tr>
<tr>
<td>Patients report improved outcomes and experience (PROMS &amp; PREMS)</td>
</tr>
<tr>
<td>Patients benefit from safe and consistent standards of treatment</td>
</tr>
<tr>
<td>Appropriate provision of continuity of care</td>
</tr>
<tr>
<td>Local population has access to services tailored to their needs.</td>
</tr>
</tbody>
</table>
• Active collaboration between healthcare providers and the people they care for will sit at the heart of primary care. This patient-focused, multi-specialty approach will require collaboration between professionals and stronger integrated approach both within and across organisational boundaries to ensure that both personalised and continuity of care is provided and the need to go to hospital is reduced.

• Our model will build on the traditional strengths of our ‘expert GPs’ who will continue to deliver equitable, personalised and continuity of care, proactively targeting services at, and working with, the population with complex on-going needs such as the frail elderly and those with chronic conditions.

• By working at scale primary care providers will ensure consistent, resilient, high quality and safe care with all patients having access to a range of core services but allowing the flexibility to develop services that meet the specific needs of their population. Instead of a ‘one size fits all’ model, we will work to determine the best solution based on local need and circumstances.

• The term ‘at scale’ describes a locality, or a group (cluster) of practices working together across a larger area to produce efficiencies and therefore increase sustainability.

• The primary care teams will become more multi-disciplinary. Increasingly the general practice teams will be supported by specialist nurses, mental health workers, pharmacists, physicians’ associates, healthcare assistants and other healthcare professionals.

• Building on the tradition of hosting services such as the diabetic retinal screening and mental health services, the teams will be capable of offering more services locally.

• An integrated approach will provide the capacity for greater continuity of care through better case management and greater use of shared care plans and a single model of rehabilitation, reablement and recovery. This will benefit those with complex care needs including those who are particularly vulnerable, frail or elderly, the housebound, those in care homes and patients who are in need of end-of-life care.

• General practice teams will work collaboratively with, and be closely aligned to, community services and social care. There will be a general shift of appropriate work and resources from acute hospitals where it can be demonstrated that funding would be freed up, and it would deliver safe, and quality care more efficiently.

• Joint working across providers, such as primary and community care, will expand the opportunities for training and development, the rotation of staff and of joint educational programmes.

The diagram opposite shows how practices will work in an integrated cluster, hub or locality to deliver services across geographical areas.
GP practices working in integrated cluster/hub or locality
- Care co-ordinators
- Specialist LTC nurses e.g. diabetes, COPD
- Shared admin/management
- Social Services
- Allied Healthcare Professionals
- Enhanced support for care homes
- Integrated multi-disciplinary teams including community nurses, emergency care nurses, social services and community mental health
- Case management and shared care plans
- Single model of rehabilitation, re-ablement and recovery
- Voluntary sector support
Building on existing foundations

Building on existing foundations
• Cluster/locality structures within each CCG have formed which group practices together geographically, generally complementing the structure of the community services teams. They present the opportunity for practices to work together across a larger footprint of delivery and to obtain economies of scale through collaboration, accepting that new collaborations may emerge in time.
• Each CCG, NHS England, local authorities and providers have developed a BNSSG Sustainability and Transformation Plan (STP) which will deliver the NHS Five Year Forward View locally. Any developments in primary care will need to align with the STP and GP Forward View.
• Across BNSSG there are a wide range of community services already working with GPs to support patients across the care pathway e.g those with long-term conditions or who have recently been discharged from hospital.

Co-commissioning – opportunities
• Bristol and North Somerset CCG have joint commissioning responsibilities with NHS England, while for South Gloucestershire CCG this is in shadow form. This means the CCGs not only benefit from more proactive consultation and involvement with NHS England but are also party to all decisions about primary medical care services across BNSSG. The contractual responsibility and accountability for commissioning these services remains with NHS England. Further discussions are on-going about taking on delegated responsibilities.
• The current co-commissioning arrangements enable the CCG to play an active role in the re-procurement of Alternative Provider Medical Service (APMS) contracts. Any new contracts will include flexibility to review and refine objectives during the life of the contract to ensure they remain aligned to this and other CCG strategies.
• Since 2013/14 BNSSG CCGs have responsibility for commissioning locally commissioned services from primary care providers. This additional contracting mechanism has enabled CCGs to ensure, where applicable, funding for services (over and above core services) follows the patient to a primary care setting and provides a vehicle to support the commissioning of services from primary medical care providers.

Integrated and partnership working
• Patients are keen to support the sustainability of the system and would welcome education and guidance on options for care or when to expect to see other healthcare professionals beside GPs.
• BNSSG CCGs are proud of their history of working in partnership and collaboration with a number of organisations including, but not limited to, their membership, NHS England, local authorities, community and acute providers, and Healthwatch. There is a strong tradition of hosting services which can be enhanced further. Achieving transformation of out-of-hospital care will require continued effective partnership working to:
  • Understand local nuances and variation in service delivery, healthcare roles, patient needs and behaviours and cultures;
  • Quantify and assess the likely impact on the cost of delivering the service and on primary care sustainability to ensure that, where possible, these risks are mitigated;
  • Align expectations;
  • Ensure effective, quality and sustainability of care.
Common IT platform (EMIS)
- BNSSG benefits from a common clinical IT platform (EMIS Web) in use by practices and the three community services providers, which allows for other providers such as BrisDoc and hospitals to access patient records via Connecting Care enabling seamless transfer of care.
- The development of the IT Digital Roadmap will identify clear goals to leverage maximum benefits from existing systems and deploy new systems to fill identified gaps. These goals should include:
  - Shared records interoperability;
  - Use of patient centred technology such as tele-health;
  - Developing an enabling infrastructure across our whole system and beyond including remote working;
  - Balancing the need for patient confidentiality with an increasing desire amongst many patients to access healthcare via electronic media such as e-mail and Skype;
  - Systems which allow practices to better identify patients with co-morbidities, at risk of developing long-term conditions or requiring particular support or other interventions;
  - Reducing administrative overheads and improving turnaround times.

CCG commitment and leadership
- Good levels of engagement in clinically led commissioning from GPs - membership forum meetings across BNSSG are focussed and very well supported by the membership.
- Our clinical leaders have matured into their roles and are delivering strong leadership around the improvement and future development of services.
- Enthusiasm for trialling initiatives via One Care Consortium and the Primary Care Access Fund continues.
- Practices are embracing the concept of locality working and collaborating to deliver services across a wider footprint and to bid for public health contracts.
- A strong tradition of public and patient engagement and working closely with a number of representative bodies such as Patient Participation Groups (PPGs) and Healthwatch remains across BNSSG.
- Working with One Care Limited as the recently elected voice of primary care across BNSSG practices.
- Working with local professional networks towards aligning and delivering services.

Next steps
- NHS England and BNSSG CCGs are in co-commissioning arrangements for the commissioning of primary care and this will be a key factor in the successful implementation of the strategy.
- Local work plans will be developed and the CCGs will work closely with NHS England to implement the GP Forward View at a local level.
- The BNSSG STP workstreams particularly Integrated Primary Care and Community Care (IPCC) will help drive system change and the development of new models of care.
- Working closely with One Care Ltd., as nominated provider voice of GP practices and also with statutory professional bodies such as Avon LMC to support and implement the strategy and GP Forward View.
Our area

- South Gloucestershire
- Bristol
- North Somerset
Bristol: key facts

- Overall experience of GP surgery 86% very or fairly good – range 51-97%. 14 practices below CCG average. >65s 93% positive
- 77% very/fairly satisfied with opening hours – range 56-91%
- 76% say that surgery is open at convenient time. Of those who said no; Saturday was more convenient for 72% and Sunday 41%

- An estimated 11,400 additional dwellings are required in Bristol. The largest increases will be seen around South Bristol (2,980), City Centre (2,757) and Northern Arc (1,118). The remainder will be provided throughout Bristol or on small unidentified sites.
North Somerset: key facts

- Overall experience of GP surgery 87% very or fairly good. Range 69-98% 8 practices below CCG average. >65s 94% positive
- 77% very/fairly satisfied with opening hours – range 58-93%
- 76% say that surgery is open at convenient time. Of those who said no; Saturday was more convenient for 77% and Sunday 42%
- North Somerset faces significant demographic pressures with a population which is both ageing and growing. Longer term projections suggest the population of North Somerset is set to increase across all age groups, reaching an estimated 300,000 by 2030. The largest increase over the next ten years is set to be identified in the 75-84 age group.
- Historically the growth in population has been across North Somerset with the largest increases seen in certain wards in Portishead.
- The emerging West of England Joint Spatial Plan has identified potential developments of about a thousand new dwellings in Weston-super-Mare, up to 3,600 in Nailsea and Backwell and up to 5,400 at the southern end of the M5/A38 corridor.
• Overall experience of GP surgery 86% very/fairly good. Range 62-97% 5 practices below CCG average. >65s 92% positive
• 75% very/fairly satisfied with opening hours – range 56-92%
• 76% say that surgery is open at convenient time. Of those who said no; Saturday was more convenient for 73% and Sunday 39%
• Significant housing is anticipated to the North and East fringes of Bristol within the jurisdiction of South Gloucestershire. An anticipated 23,000 new homes will be delivered between 2014 and 2027. Most development will take place in new neighbourhoods being developed at Cribbs Causeway, Patchway and Filton (5,700), East of Harry Stoke (2,000), North Yate (2,125) and Thornbury (686).
Connecting Care
The Department of Health project delivered by Lasa (local authority software applications) to help small charitable providers of adult and social care make the most of information communication and technologies (ICTs).

One Care Ltd
One Care’s vision is to create an integrated and effective approach to the delivery of primary care across Bristol, North Somerset and South Gloucestershire, providing seamless seven-day a week care to patients. http://onecareconsortium.co.uk/about/

Patient-Reported Outcome Measures (PROMS)
Patient-Reported Outcome Measures are self-report questionnaires designed specifically to measure the impact of illness/health condition (e.g. quality of life, symptom severity, functional status, health status etc) from the patient’s perspective. They can be helpful in monitoring the progress of a health condition or whether a treatment has been effective, by looking at changes in the questionnaire scores. PROMs focus on the outcomes of a health condition or disability.

Patient Reported Experience Measures (PREMs)
Patient Reported Outcome Experience are questionnaires designed specifically to assess the patient’s view of what happened during health care (e.g. waiting time at the hospital; duration of appointment). They can be used to evaluate quality of health care and monitor improvement in services. PREMs focus on the process of healthcare.

Primary Care Access Fund
Formerly known as the Prime Minister’s Challenge Fund. In October 2013, the Prime Minister announced the £50m Challenge Fund to support practices to trial new and innovative ways of delivering GP services and making services more accessible to patients. GP practices were asked to submit expressions of interest and the first wave of twenty pilots were announced in April 2014. http://psnc.org.uk/the-healthcare-landscape/prime-ministers-challenge-fund/

Joint Strategic Needs Assessment

Rightcare methodology
The NHS RightCare is a three-phase approach (where to look, what to change, how to change) to improvement that provides a systematic, evidence-based methodology to the redesign of services. https://www.england.nhs.uk/rightcare/imp/

• Practice GP list sizes as at April 2016

• HSCIC NHS Workforce Statistics February 2016 (provisional) - http://content.digital.nhs.uk/catalogue/PUB20647


• What patients said: http://www.healthwatch.co.uk/news/What_help_do_you_need_to_look_after_your_health_in_the_future

• West of England Local Enterprise Partnership: http://www.westofenglandlep.co.uk/jsp
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