Oxfordshire
Clinical Commissioning Group

OXFORDSHIRE PRIMARY CARE COMMISSIONING COMMITTEE

Date of Meeting: 4 June 2019	**Paper No: 7**

Title of Paper: BOB STP Primary care Strategy

Paper is for: (please delete tick as appropriate)	**Discussion**	✓	**Decision**		**Information**	

Conflicts of Interest (please delete tick as appropriate)	
No conflict identified	✓
Conflict noted: conflicted party can participate in discussion and decision	
Conflict noted, conflicted party can participate in discussion but not decision	
Conflict noted, conflicted party can remain but not participate in discussion	
Conflicted party is excluded from discussion	

Purpose and Executive Summary:
As part of the NHS Operational Planning and Contract Guidance 2019/20[1], STPs/ICSs must include a primary care strategy as part of the system strategy that will be developed in Autumn 2019 in response to the Long Term Plan which sets out how they will ensure the sustainability and transformation of primary care and general practice as part of their overarching strategy to improve population health; and which engages CCGs and primary care providers in its implementation.

This should include specific details on:

- local investment in transformation with the local priorities identified for support;
- PCN development plan; and
- local workforce plan which supports the development of an expanded workforce and multidisciplinary teams and sets out the strategy to recruit and retain staff within primary care and general practice

The 3 Heads of Primary Care across BOB have been working with the STP GPFV SRO and Transformation Lead to produce this strategy which draws from existing CCG documents.

This paper brings an early draft of the strategy for comment. A submission is expected at end of June and as such an early draft is presented for comment. This strategy is being overseen by the BOB STP

Discussion is taking place at CCG executive on 28 May 2019 and an update will be provided to the meeting.

[1] https://www.england.nhs.uk/wp-content/uploads/2018/12/nhs-operational-planning-and-contracting-guidance.pdf

Engagement: clinical, stakeholder and public/patient:
Discussion at CCG Executive on 28 May 2019

Financial Implications of Paper:
For 19/20 this funding is allocated to the STP. The STP has agreed that the resilience funding will be shared across the CCGs. The spend on the other components will be agreed across the STP.

From MOU between STP and NHS E Budget = £1,429,141

Proposed STP breakdown for 19/20
Receptionist and Clerical Training = £420,000
Online consultation = £429,000
GP retention = £245,000
Resilience = £335,141

Action Required:
CCG executive is asked to provide feedback on this draft before it is presented to OPCCC in June and then agreed by BOB STP Primary Care Programme Board in middle of June for submission at the end of June.

OCCG Priorities Supported (please delete tick as appropriate)	
✓	Operational Delivery
✓	Transforming Health and Care
	Devolution and Integration
	Empowering Patients
	Engaging Communities
✓	System Leadership

Equality Analysis Outcome:
This strategy considers extended access to primary care services

Link to Risk:
AF26 – Delivery of Primary Care Services

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Date of Paper: 20 May 2019

Buckinghamshire, Oxfordshire & Berkshire West Sustainability & Transformation Partnership

Primary Care Strategy

Document information

Creation Date	26.04.2019
Latest Update	20.05.2019
Team	GPFV BOB STP
Author	Rachel Thompson
Owner	Rachel Thompson
Project	BOB STP Primary Care Strategy
Title	BOB STP Primary Care Strategy
Description	This paper sets out the vision for Primary Care within the BOB STP.

Version Control

Version	Author	Summary	Date updated
0.1	Rachel Thompson, GPFV SRO Transformation Lead, BOB STP	Outline framework for the Primary Care Strategy	26.04.2019
0.2	Rachel Thompson, GPFV SRO Transformation Lead, BOB STP	Detail added on Health profiles, deprivation, extended and improved access and detail for Pharmacy, Optom and Dental	17.05.2019
0.3	Rachel Thompson, GPFV SRO Transformation Lead, BOB STP	Clinical Advisor comments included. PCN detail added.	20.05.2019

Circulated to

Name & Role or Team name	Version	Date latest version shared
Ginny Hope, Head of Primary Care, NHSE HTV Helen Delaitre, Associate Director of Primary Care, Bucks CCG Julie Dandridge, Deputy Director of Delivery and Localities. Head of Primary Care and Localities, Oxfordshire CCG Helen Clark, Director of Primary Care, Berks West CCG	0.1	26.04.2019
Ginny Hope, Head of Primary Care, NHSE HTV Helen Delaitre, Associate Director of Primary Care, Bucks CCG Julie Dandridge, Deputy Director of Delivery and	0.2	17.05.2019

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Forward

The vision for Primary Care, as described in this document, has been developed using key publications, notably the Five Year Forward View (October 14), GP Forward View (April 16) the Next Steps 5 Year Forward View (March 17) and The NHS Long Term Plan (January 19) learning from involvement of the Berkshire West and Buckinghamshire in the National ICS Development Programme, networking and learning events put on by the GP Forward View Team across the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Partnership (STP) and engagement with clinicians and managers from across the STP. To sustain and transform Primary Care (which includes General Practice, Pharmacy, Oral and Eye Care and other independent practitioners and community services) needs to become more integrated and work at scale. This will require full utilisation of the ideas and initiatives within the GP Forward View together with a parallel transformation of community-based services. General Practice needs to support an integrated community care service, this will help with the management of increasingly complex cases with more patients managed out of hospital care. Primary Care Networks (PCNs), integrated multidisciplinary teams covering 30-50,000 registered populations, are the operational building blocks of the new care models. PCNs can be networked together to form the basis of larger scale models such as Multi-Disciplinary Community Providers, Primary and Acute Care Systems and Accountable Care Systems. PCNs provide a route for a ground up transformation in health and care provision that engages front line staff in a new care model design as never before. We are already seeing GPs, Dentists, Opticians and Pharmacists and community staff enthused and revitalised by being involved in PCN development. Once in place, the potential for PCNs and associated new organisational models could start to radically redesign services to provide; better care for complex illnesses and multi-morbidity through longer GP appointments, integrated and extensivist care to manage people in the community, workforce re-alignment in terms of an upskilled unified team, better acute “on the day” care 24 hours a day, and improved administration and better use of information and IT. This will create systems and organisations that are attractive for health and care staff to work in with improved job satisfaction and work life balance with a stronger focus on population health and prevention.

Contents

The Vision for Primary Care

General Medical Services

Primary care needs to transform in order to provide a service that is sustainable, integrated and attractive to work in. The vision is that it will play a central role in primary and community care operating at scale to close the three gaps identified in the 5 Year Forward View (i.e. health and wellbeing; care and quality; finance and efficiency).

This vision is in development and will progress as the evidence and learning builds from local and national developments.

Primary Care in this context includes General Practice, other independent practitioners and all community health and care services. The following is a list of some of the key principles and components of a transformed primary care system;

- Primary Care working at scale in Primary Care Networks will form the operational building block for larger system delivery and progression towards Accountable Care Systems.

- The 4 characteristics of Primary Care Networks are;
    - Provision to a defined registered population of approximately 30 – 50,000.
    - An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care
    - A combined focus on personalisation of care with improvements in population health outcomes
    - Aligned clinical and financial drivers

- For GPs to diagnose earlier and to manage complex disease including multi-morbidity, they need be able to spend more time with complex patients. This will require longer consultations, potentially up to 20 minutes and increased support from a wider clinical and administrative team. GPs will play a leading role in community based extensivist services providing the medical oversight for their registered patients.

- Every patient who clinically requires a same day intervention will be able to access one. This intervention will not necessarily be face to face and with a GP, with online access and advice, telephone consultations and alternate practitioners increasingly available. Some larger practices have already integrated to improve productivity and quality, some larger practices and integrated systems have separated acute from routine care to ensure patients are seen by the most appropriate health care professional and to minimise disruption of core primary care.

- All professionals involved in a patient's care will be able contribute to an electronic shared care record, with access appropriate to their role. All Providers will commit to sharing their data for direct care and ensure their systems are interoperable with the shared care record. Patients will be informed about information sharing and given choices about how their data is used.

- Patients will be able to access their electronic shared care record and use a range of online tools for managing aspects of their care.

  All services that can be delivered safely and according to best practice in the community will be provided within a neighbourhood or network, thereby ensuring that patients can access care closer to where they live, avoiding the need to attend hospital unnecessarily. This includes both elective and non-elective care.

- Prevention will be a central feature of primary care and indeed be a golden thread throughout the Accountable Care Systems. This includes primary, secondary and tertiary prevention and also education around self-care and promotion of wellbeing.

- Social prescribing and community empowerment will be a key feature of primary care delivery which will enable more self-care and more resilient communities.

- The primary care workforce will have expanded to include a number of new roles such as care navigators, clinical pharmacists, medical assistants and physician associates and all staff will be up-skilled to work at the "top of their licence".

- The important interdependencies between mental health, cancer and urgent and emergency care will be addressed through more integrated working within primary care networks.

Pharmacy Services

- Community pharmacy will act as the facilitator of personalised care and support for people with long-term conditions, maximising the pharmacy integration fund to work more closely with and reduce the workload of General Practice. Cardio Vascular Disease Clinical Network is working with Community Pharmacy representatives on the collating of blood pressure readings data and identification of patients that need referral to their GP, across the BOB STP and wider into the Frimley STP.

- Community pharmacy will become a trusted, convenient first port of call for episodic healthcare advice and treatment; and will be integrated with NHS 111 building on the success of the New Urgent Medicines Supply Service in Thames Valley.

- Community pharmacy will become an integral part of the neighbourhood health and wellbeing services provided by Primary Care Networks, building on the Healthy Living Pharmacy Programme

Oral Health Services

- Dental care services will be accessible, clearly signposted, supporting prevention and daily patient care. Pathways from primary care to specialist dental services will be clear and easy for practices and patients to navigate.

- Dental and oral health services will be integrated with wider primary care systems working in neighbourhoods and emergency care systems ensuring benefits to patient's oral health, also linking to wider health and social care provision where appropriate.

- Through these developments, practices will be able to transform and enhance their services for example “Starting Well”, increasing patient satisfaction and making maximum use of their staff skill mix.

- Local Dental Network operating across the STP in developing this approach, strategy and commissioning.

Eye Health Services

- NHS England commissions NHS General Ophthalmic Services (GOS) as specified in the GOS regulations of 2008. Ophthalmic practices apply to NHS England for an NHS Contract this can be either a mandatory contract (bricks and mortar premises) or an additional services contract (domiciliary). The NHS contract covers the provision of NHS Sight tests. The issuing of an NHS Voucher towards the cost of spectacles or contact lenses is monitored by NHS England, issuing vouchers are not part of the NHS contract. Developments in the use of technology i.e. online forms and submission of claims will improve the efficiency of processing GOS claims and integrating the ophthalmic providers into the wider health care system improve the time frame for patients accessing services.

- Patients will be able to access a consistent and integrated Primary Eye Care Service within each Primary Care Network across the STP. The evidence-based schemes in terms of improved outcomes and cost effectiveness are;

    - Glaucoma Referral Refinement
    - Pre and Post Cataract Service
    - Minor Eye Conditions Service
    - Children’s post screening eye test service
    - Low vision service

- Further community-based eye care services in primary care will be developed within each Accountable Care System to shift secondary care activity closer to home.

- There should be a STP wide Optometry Connectivity Project (IT) so the Optometrists can access the patients’ single care record to facilitate the above proposals.

1. Transformed Primary Care Service through a Patient and Clinician Lens

What will it be like to be a patient in the new model?

- As a patient, I trust my health service and only access it when I cannot manage to care for myself or my family.
- I feel that I am in control of my own health, with the support of my doctors and their team and I can receive appropriate community care where it is safe to do so. This includes the majority of diagnostic test and specialist appointments.
- I can directly access my medical records and through school and on-going education I am able to self-diagnose and manage most common illnesses myself. If necessary with support from all the appropriate health and care professionals within my community including, pharmacy, dental and eye care.
- I use online resources for support or the telephone if that does not work for me and if needed I am navigated to the most appropriate service for my health needs.
- I can use technology if appropriate, to help me manage aspects of my care in my own home
- I now have access to a wider multidisciplinary team and appreciate that I do not always need to see a doctor. I have received information and education around my illnesses and will be able to optimise my care to fit in with my lifestyle and needs and I know what to do and who to call if my condition worsens.
- It is easier for me to access services; either online, telephone or even via email and I know I will be seen the same day if clinically appropriate. However I also appreciate that where I need continuity of care, I can see my own doctor or nurse at an appropriate time and venue.
- I am grateful now that if I ever get cancer I will have an improved chance of being diagnosed rapidly in the early stages of the disease rather than as an emergency.
- Equally I am reassured that I have access to a range of mental health care services so I am able to seek support where required.
- I know that following detailed discussions and the sharing of appropriate clinical information I can make an informed decision to refuse treatment and be supported in that choice
- I can be involved, with clinicians, managers and other members of the community in planning and if needed rationing of services and I can sit on the Integrated Care systems Governing Body that leads our new Health and Care System.

What will it be like to be a Doctor/Clinician in the new model?

- Whilst I am busy my work is now more fulfilling - being able to concentrate on diagnosing and managing complex illnesses, mainly in the community, working with a skilled, multidisciplinary team, including hospital consultants.

- I am part of a much wider team and have access to a greater range of services and options for patients, many of which are socially prescribed and provided by the community itself.

- All the acute "on the day" work is more appropriately managed and supported e.g. centralised service

- There is a recognised and reliable triage service that patients and clinicians are confident in so that appointments can be made directly into relevant services and I feel in control of my workload, which means that I also feel clinically safe.

- I am able to work in a range of locations with clinical access to IT systems and tools that I need, including in the patient's home.

- I now have access to dedicated time for education and development.

- I have my own personal list of patients and I am part of team of skilled staff that work well together.

- I share relevant information with my colleagues through the electronic shared care record and use online tools to interact with my patients where appropriate.

- We have a competent Primary Care Network (PCN) leadership team that listens to us and helps us to make a difference and I feel a sense of ownership for the PCN and system I work in and I am proud to work here.

- I am now content in my work and my family appreciate the fact they see more of me and I am not stressed. I am also reassured that as I get nearer to retirement, that I can still work in those clinical areas that still interest me and that I can make a difference to my patients."

- Local and district level organisational/governance systems support this positive future by aligning Community Nursing, Mental Health, Social Care and Third Sector around PCNs and General Practices' registered lists. In this scenario, GPs working with a joint management arrangement would help decide where investment and support is required so that more complex and frail patients can be cared for in the community rather than the hospital.

- The improved organisational system at PCN and District level would release time through allocating clinical and administrative work to the most appropriate person. To realise the full potential of this scenario also requires practices themselves to reorganise, so they can contribute to and benefit from the consolidation and sharing of resources.

2. Introduction

The Five year forward view describes General Practice as the bedrock of NHS Care with GPs having one of the highest public satisfaction ratings of any public service, at over 85%, but we know improving access to primary care services is a top priority for patients.

“General practice provides over 300 million patient consultations each year, compared to 23 million A&E visits. So if general practice fails, the NHS fails. Yet a year’s worth of GP care per patient costs less than two A&E visits, and we spend less on general practice than on hospital outpatients.”

Primary Care services including dental, eye care and pharmacy and general practice are central to bringing care closer to home, managing long term conditions, preventing unnecessary hospital admissions and helping people stay well and healthy. Our patients want better access to GP and wider primary care services; to be better informed about self-care and health services generally and wrap around joined up care when needed.

We have seen a steady rise in demand with patients increasingly relying on general practice services for themselves and their families. Whilst demand for appointments and complexity has increased, patients rightly expect: high quality, locally designed services in settings that are accessible and convenient; delivered by healthcare professional who are known to them who provide continuity of care. Aside from organisational changes managing demand also means partnering with patients and carers in new ways. Equipping them with the knowledge, skills and confidence to provide a better patient experience and take more responsibility for their health and care.

Alongside this has been a growing shift of work from secondary care to primary care, and all of these factors have placed unprecedented pressure on community services. The model of Primary Care must therefore transform to meet these challenges and deliver the triple aim: to improve and/or maintain quality of care, reduce variation and be financial sustainable and increasingly it is recognised that there is a fourth aim, to increase primary care staff satisfaction.

Strengthening the capability of General Practice, securing greater integration with wider primary, community, third sector and mental health care services, will be critical to the wider transformation of our health and social care system, as these services provide far and away the largest point of integration that patients have with the NHS.

This primary care delivery plan sets out a detailed, costed package of investment and reform for primary care now through to 2021 reflecting each of the primary care strategies of the 3 Clinical Commissioning Groups culminating in an aggregated STP plan that delivers a sustainable shift in care and activity out of hospital. The plan utilises the funding and resource available within the GP Forward view in addition to additional local investment in primary care from commissioners across the STP which will mean improved access to care, a stronger focus on population health and prevention, more GPs and a wider range of practice staff, operating in more modern buildings, and integration with community and preventative services, hospital specialists and mental health care.

We need to think about all the components included within this Delivery Plan in an integrated way so that they not only complement each other but support a whole system transformation. When we think about the recruitment of 5000 more Doctors, 800 more clinical pharmacists and 1500 mental health therapists in primary care, we need to create a coherent picture of what this will mean for the future of primary care, its impact on urgent and emergency care, and moving patients’ treatment from hospital based services to community based services.

We will miss the point if the impact of all these programmes is not greater than the sum of their parts.

3. Background

The NHS Five Year Forward View was published in October 2014 and describes a new shared vision for the future of the NHS to improve health and wellbeing, transform quality of care and deliver sustainable finances.

In subsequent years, policy and planning guidance were developed to reflect the ambitions set out in the Five Year Forward View outlining a new approach to help ensure that health and care services are planned by place rather than around individual organisations. This included a requirement for every health and care system, for the first time, to work together to produce a Sustainability and Transformation Plan to meet the triple aim, a separate but connected strategic plan covering the period October 2016 to March 2021.

Supplementing the Five Year Forward View, the GP Forward View was published in April 2016, in response to the increased workload and pressures being experienced in General Practice. The GP Forward View provides a programme of investment and resource to help stabilise and transform primary care services in line with the new models of care described within the Five Year Forward View.

Finally, in 2017 the Next Steps of the Five Year Forward View was published outlining the key deliverables for the NHS to 2020/21 and identified four priority areas with STPs as the delivery vehicle:

1. Urgent and Emergency Care
2. Primary Care
3. Cancer Services
4. Mental Health Services

BOB STP therefore needs to incorporate the above four priority work streams into its delivery plan as the local system moves towards and integrating care locally bringing together NHS commissioners, providers and local authority partners in formal partnerships that over time will develop as Integrated Care Systems.

The purpose of this document is to outline the primary care delivery plan for the BOB STP.

4. Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Partnership (STP)

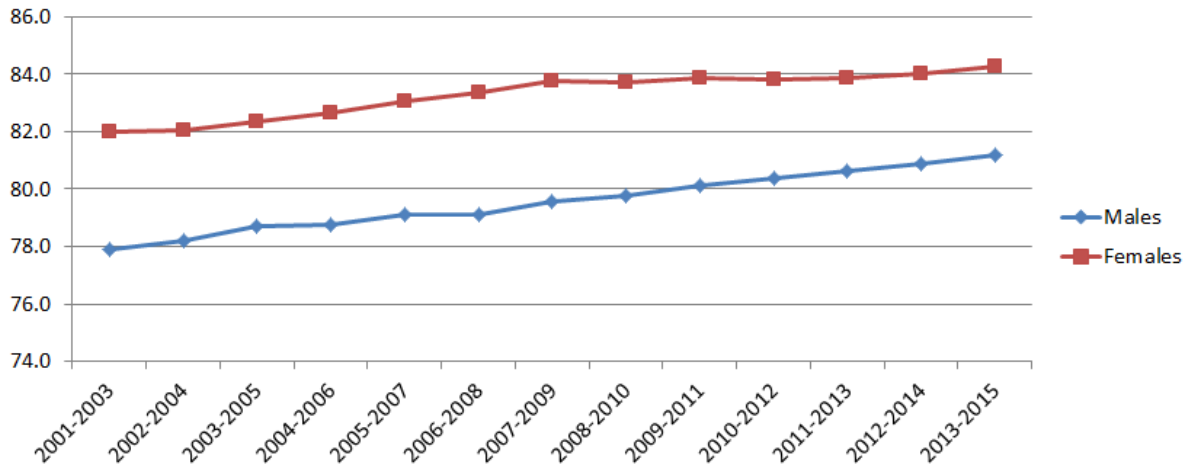
The Health Profile

The most recent set of 3 year Life Expectancy data shows that, between 2012-14 and 2013-15, Life Expectancy for males and females in Buckinghamshire, Oxfordshire and Berkshire West each increased.

- Male Life Expectancy increased from 80.9 to 81.2 (+0.3 years)
- Female Life Expectancy increased from 84.0 to 84.3 (+0.3 years)

Between 2001-03 and 2013-15, the gap between male and female Life Expectancy decreased from 4.1 years to 3.1 years.

Figure 1 Change in Life Expectancy in BOB – males and females to 2013-15



Source: ONS, Crown Copyright 2016; Figures are based on the number of deaths registered and mid-year population estimates, aggregated over 3 consecutive years. Note that scale does not start at 0

The change in Life Expectancy has contributed to an increase in the proportion of men in the older age groups.
For people aged 65 and over: Males made up 44% of the population in 2005, increasing to 46% in 2015.
For people aged 85 and over: Males made up 30% of the population in 2005, increasing to 36% in 2015.
Health expectancies can be used to measure the proportion of life spent in "good" health or the proportion of life spent without disability.
Males at birth are expected to spend 84% of their life in good health (compared with 80% in England), for females it is 82% (compared with 78% in England).
Data for Middle Layer Super Output Areas (MSOAs3) shows geographical differences in the proportion of life spent in good health of between 80% and 89% for males and between 74% and 88% for females. The gap between highest and lowest areas is narrower than the gap for the South East region and England as a whole.
The working age population in BOB (and nationally) is ageing. Earnings remain relatively high for Oxfordshire residents and (for the first time in the past 15 years of data), median earnings for residents was statistically above the South East average.
Poverty and deprivation remain an issue in BOB affecting 24,000 children and 23,500 older people. People claiming Employment Support Allowance made up the majority of working age benefits claimants in May 2016. The top health condition of ESA claimants was Mental and Behavioural disorders.
House prices in BOB continue to increase at a higher rate than earnings and Centre for Cities ranks Oxford as the least affordable UK city for housing. In Oxford city, social rents in 2015 were 18% above the national average.
Buying a family home now requires 2-3 times a median income (i.e. 2-3 earners per household) in each district.
Cancer was the leading cause of death in BOB. The proportion of GP-registered patients with a cancer diagnosis in BOB has remained above the national average.
Between 2007 and 2015, the number of deaths of older people (aged 75 and over) from circulatory diseases declined by 15%, while deaths from dementia more than doubled.
BOB continues to have a significantly higher rate of people killed or seriously injured on roads per head of population than average. The rate of people killed or seriously injured on roads as a proportion of vehicle miles was just below (better than) the national average.

National survey data shows that, over the past 15 years, mental health disorders have been increasing in women and young women have emerged as a high risk group. One adult in six had a common mental disorder (depression or anxiety), about one woman in five and one man in eight. Since 2000, the rate for women has steadily increased.

Deprivation Levels

National statistics show that, over a 30 year period, improvements in life expectancy have been greatest for those in higher socio-economic groups.
BOB has a higher than average proportion of people in Higher Managerial and Professional occupations. The working age population in BOB (and nationally) is ageing.
Unemployment remains relatively low in BOB. The increase in claimants of employment-related benefits in the older age group was above average.
Earnings remain relatively high for BOB residents and (for the first time in the past 15 years of data), median earnings for residents was statistically above the South East average.
Despite relative affluence, income deprivation is an issue in urban and rural areas.

- 24,000 children in Oxfordshire were affected by income deprivation (IMD 2015), 81% living in urban areas and 19% in rural Oxfordshire.
- Snapshot HMRC data (Aug14) shows almost 1 in 5 children aged 0-15 in Oxford were living in low income families.
- 23,500 older people in Oxfordshire were affected by income deprivation (IMD 2015), 68% living in urban areas and 32% in rural Oxfordshire.

People claiming Employment Support Allowance made up the majority of working age benefits claimants in May 2016. The top health condition of ESA claimants was Mental and Behavioural disorders.

The Primary Care Landscape

The majority of NHS care is provided by general practice. One of the public's top priorities is to know that they can get a convenient and timely appointment with a GP to support their healthcare needs. That means having enough GPs, with resources, support and other professionals required to enable them to deliver the quality of care they need to provide. However, this is not achievable within the current model of primary care.
As people live longer lives the NHS needs to adapt to their needs, helping frail and older people stay healthy and independent, avoiding hospital stays where possible. To improve prevention and care for patients, as well as to place the NHS on a more sustainable footing, primary care needs to be delivered at scale with better integration of GP, community health, mental health, third sector and hospital services, as well as more joined up working with home care and care homes. This will be supported through the implementation of Primary Care Networks serving populations of 30-50,000 as described in chapter 6 of this plan.
Furthermore we have begun to reverse the historic decline in funding for primary care. Over the next two years the ambition is to deliver 168 GP recruits, with an extra 63 clinical pharmacists and 34 more mental health therapists working alongside them.
However before the system can transform it is acknowledged that support is required first to stabilise and sustain general practice and provide a platform to transform. The Local GP Resilience Programme offers support to Practices in need and will continue to be delivered to provide rapid packages of support to stabilise general practice:

Case for Change in the BOB STP

- Over 2000 FTE working in BOB primary care

- 19.6% of workforce are over 55- Ageing GP and GPN workforce across BOB
- Only 6% nurses under 35 choose primary care
- More part time working requiring increased headcount
- Housing increases and an ageing population with co-morbidities

Overview of BOB STP, GP Practices, Primary Care Networks and CCGs

5. General Practices at Scale

Primary Care Networks (PCNs)

CCG	Number of PCNs	Practice Coverage	Number of Practices not in a PCN
Buckinghamshire	12	98%	1
Oxfordshire	19	95.71%	3
Berkshire West			

Maturity Matrix

The journey of development for primary care networks in a health system – maturity matrix

Our learning to date tells us that primary care networks will develop and mature at different rates. Laying the foundations for transformation is crucial before taking the steps towards a fully functioning primary care network. This journey might follow the maturity matrix below.

Foundation	*Step 1*	*Step 2*	*Step 3*
Plan: Plan in place articulating clear vision and steps to getting there, including actions at network, place and system level. **Engagement:** GPs, local primary care leaders, patients' representatives, and other stakeholders believe in the vision and the plan to get there. **Time:** Primary care, in particular general practice, has the headroom to make change. **Transformation resource:** There are people available with the right skills to make change happen, and a clear financial commitment to primary care transformation. The network is taking the opportunities that GP network contract affords There is a **clinical director** for the network. The clinical director may serve multiple networks where that is agreed locally.	**Practices identify PCN partners** and develop shared plan for realisation. There is joint planning underway to improve integration with community services as networks mature. There are arrangements for PCNs to collaborate for services delivered optimally above the 50k footprint **Analysis on variation** in outcomes and resource use between practices is readily available and acted upon. **Basic population segmentation** is in place, with understanding of needs of key groups, their needs and their resource use Integrated teams which may include social care are working in parts of the system. **Plans are in place to develop MDT ways of working**, including integrated rapid response community teams. Standardised end state **models of care** defined for all population groups, with clear gap analysis and workforce plan Steps taken to ensure **operational efficiency** of primary care delivery and support struggling practices. Primary care has a **seat at the table** for system strategic decision-making. PCNs are **engaging directly with population groups**, and with the wider community	Providers within the PCN are embedding **shared population health models** identified at Step 1 that supports a significant maturity for integrated care. Functioning **interoperability within networks,** including read/write access to records, sharing of some staff and estate. All primary care clinicians can access **information to guide decision making**, including risk stratification to identify patients for proactive interventions, IT-enabled access to shared protocols, and real-time information on patient interactions with the system. Early elements of **new models of care** in place for most population segments, with **integrated teams** throughout system, including social care, mental health, the voluntary sector and ready access to secondary care expertise. Routine peer review. **Networks have sight of resource use and impact on system performance**, and can pilot new incentive schemes. Primary care plays an **active role in system tactical and operational decision-making,** for example on Urgent and Emergency Care Networks are developing an extensive culture of authentic **patient partnerships**	**PCN population health model** fully functioning for all patient cohorts, working with other PCNs and local agencies in a provider alliance or similar collaborative working approaches. **Fully interoperable IT, workforce and estates** across networks, with sharing between networks as needed. **Systematic population health analysis** allowing PCNs to understand in depth their populations' needs and design interventions to meet them, acting as early as possible to keep people well. **Fully integrated teams throughout the system**, comprising of the appropriate clinical and non-clinical skill mix. MDT working is high functioning and supported by technology. The MDT holds a single view of the patient. Care plans and coordination in place for all high risk patients. **New models of care** in place for all population segments, across system. Evaluation of impact of early-implementers used to guide roll out. PCNs take **collective responsibility for available funding.** Data is used in clinical interactions to make best use of resources. **Primary care providers** full decision making member of ICS leadership, working in tandem with other partners to allocate resources and deliver care. The PCN has built on existing **community assets** to connect with the whole community.

6. Oral Care, Eye Care and Pharmacy Services at Scale

The pathways in place for Oral Surgery, Restorative Dentistry, Orthodontics, Special Care and Paediatrics are all primary care services at scale. Primary Care Dentistry and these services are all commissioned under the NHS (General/Personal Dental Services) Regulations 2005. In contractual terms these are mandatory and additional services. There are care pathways in place following development by the Managed Clinical Networks. These pathways are vital to minimise pressures on hospital services in terms of waiting times to access care ensuring hospitals focus cases that require treatment in that setting.
As a next stage of development NHS England is looking at more integrated working can achieve improved oral health. This will require multi-agency both within NHS Dentistry and between Dental and other sectors.

7. Primary Care Delivery Plan Components

Operational plans for 17/18-18/19 placed a requirement on CCGs to develop GPFV plans to demonstrate how the funding and resource allocated in the GPFV would be utilised to invest stabilise, sustain and develop primary care services to deliver new models of care that will address the triple aim. However, it is recognised that funding and opportunities within the GPFV sit across the health and social care system including Health Education England. Therefore, the STPs role and through the development of this plan is to connect all the resource and coordinate a system wide plan to harness the funding and resource within the GPFV to deliver a coherent plan that closes the financial gap in BOB whilst improving the quality of services and reducing variation.

Common to all Local Delivery Plans within the STP are the delivery of 6 components that make up this plan. These include:

Component 1: Building sustainable and resilient general practice

Component 2: Extending access and enhancing services offered to patients in a primary care setting

Component 3: Increasing the primary care workforce

Component 4: Increasing investment in primary care

Component 5: Development of “at scale” primary care organisations

Component 6: Ensure effective communications of STP primary care delivery plans

These components are not separate from each other but are mutually supporting to enable a new model of provision and to transform care offered.

Whilst there is a strong focus on transforming General Practice Services within this plan it must be acknowledged that this is a primary care plan and includes a focus on Oral care, Eye care and Pharmacy Services. The transformation of these wider primary care services are being spearheaded by the Local Professional Networks that represents each profession.

The plan reflects the Strategic Data Collection Service reports populated by each CCG on a quarterly basis which will continue to be assessed to track progress on implementation of this plan. The plan however goes beyond delivery of the 6 components to ensure that primary care aligns with the STP ambition to establish One Integrated Care Systems that deliver the quadruple aim and the vision as described in section 1 of this plan.
Add Long Term Plan elements

8. Sustainable and Resilient General Practice

The BOB STP GP retention programme seeks to support GPs working across BOB (Buckinghamshire, Oxfordshire and Berkshire West). The programme is divided into 3 project areas. Each project provides its own individual focus and combine together to provide a cohesive range of services to support GP Retention across BOB. The programme will also complement and refer to other National and Local initiatives aimed at supporting the GP workforce. The projects are summarised below:

Project 1:	Locum Chambers	The development of a new Locum Chambers IT platform integrating with the NASGP LocumDeck platform. This will provide the infrastructure to develop a new type of locum chamber which integrates Training Hubs, GP federations, Practices and the locum workforce, to create a tangible "home" for flexible GPs and other potentially other clinicians.
Project 2:	Flexible Career Programme	The creation of a holistic and flexible programme will enable GPs at different stages in their careers access information and opportunities to develop portfolio careers and access career development, training or support where needed.
Project 3:	Mentorship and Support	This service will provide access to a 'faculty' of trained Mentors for GPs requiring extra support at any stage in their career due to a variety of reasons. A secure IT platform will be used to streamline the matching of Mentor and Mentee and support administration and documentation

Project 1: Locum Chambers

The Locum Chambers project incorporates the development of a new scalable IT platform that will provide the infrastructure needed to establish supportive, caring, nurturing professional networks, develop professional communities (Locum Chambers) with shared learning, capability to spread best practice, integrate clinical governance structures and simplify engagement between clinicians, practices and services and ultimately, improvement in patient care. The platform will be tested initially in Oxfordshire, then rolled out across BOB STP.

OTN are currently finalising the contract for the IT platform development with NASGP. Once this contract is signed, NASGP will be able to start developing the platform which will take around 3 months. During this time the project team will be working with stakeholders including local Locum Groups and Training Hubs to understand the specifics of each region across BOB to ensure platform content and structure is fit for purpose for each area. Setting of Milestones and work-streams is set as an agenda item for the GP Retention workshop on 10th May.

Project 2: Flexible Careers Programme

The Flexible Careers programme will develop the framework and infrastructure to deliver a flexible careers programme across BOB. The Flexible Careers programme will offer support in four key areas:

- General Practice Roles
- Added Value Roles
- Education and Coaching
- Mentoring (dovetailing with the Mentoring project)

Flexibility will be offered to enable GPs to choose which areas are supported and what that support looks like. GPs may require support in one, two, three or all four areas. The programme coordinators in each area will work with the individual GP to tailor the support and understand their specific needs. The Flexible career opportunities will offer GPs an alternative to Locuming and support to those who would otherwise be considering leaving the profession.

Milestones and work-streams development is planned as part of the workshop in May 2019.

Project 3: Mentorship Programme and GP Support

The mentorship programme aims to provide and establish a sustainable mechanism, via an online portal by which GPs who are struggling can access mentoring / support services. The pilot duration is 6 months including planning and roll out. Following Pilot evaluation, roll out of the service will be rapid across the BOB STP area. The service portal is designed to streamline administrative needs, materials, evaluation, monitoring, reporting and analytics needs. Work in progress includes portal evaluation; development of materials and resources, mentor selection and agreements.

The launch meeting for the Mentorship pilot with selected Mentors is being held on May 21st. with a hold go live for the pilot of the 6th June 2019. Update and outline set as part of the agenda for the May workshop.

9. Sustainable and Resilient Oral Care

Access to NHS Dentistry has continued to improve over the last decade with a 30% increase in the number of patients accessing NHS Dentistry over that time. The current position is that nearly 52% of the local population has attended an NHS Dentist over the last 2 years. There are growing pressures on the system due to population and housing growth. The local office is reviewing areas of housing growth considering whether the demand can be met via current providers or new practices will be required.

There are pathways in place for primary care dental practices to refer to the following specialties:

- Oral and Maxillofacial Surgery
- Orthodontics
- Restorative Dentistry
- Special Care and Paediatrics

For each of these pathways there are arrangements in place for patients to receive community and hospital-based support. These services are commissioned in line with the relevant NHS England Commissioning guides with local pathway oversight provided by Managed Clinical Networks bringing together primary, community and hospital-based clinicians. All these pathways have been subject to review in recent years with procurements of new community-based arrangements to take effect at the following times:

- Orthodontics – April 2019
- Restorative – September 2019

- Oral Surgery – April 2020
- Special Care and Paediatrics – April 2021
- Unscheduled Care – April 2021

These pathways will continue to play a vital role in ensuring patients can access timely treatment in the most appropriate setting.
During 2019, the Wessex and Thames Valley local offices will procure a Dental Electronic Referral System (DERS) with the aim of a go-live date of early 2020. The aim is for all dental referrals to be web-based by 2021.

10. Extended Access for General Practice

The Extended Access DES and the Improved Access to General Practice programme will, over time, have the funding and responsibility for delivery of both moving to PCNs. The commissioned service, IAGP, will see its funding remain as it currently stands until April 2021, at which point the funding will move into PCNs. The Extended Access DES will remain unchanged from 1 April 2019 until 30th June 2019. At that point, it will cease and the Network Contract DES will commence, requiring 100% patient coverage for the existing requirements of the Extended Access DES, along with increased funding.
The new Network Contract DES will require the following for what was previously the Extended Access DES:

- Completed Network Agreement signed by all PCN member Practices
- All Practices have entered into sufficient data sharing (and data processing) to permit delivery of extended hours access services from 1st July 2019
- PCNs will need to deliver additional clinical sessions outside of PCN members' core contracted hours to all registered patients
- Extended hours access appointments take place at times that take into account patients' expressed preferences
- Additional 30 minutes of appointments per 1,000 population per week
- A "reasonable number" of face-to-face appointments, supplemented by telephone, video and/or online consultations
- Extended hours must be communicated effectively to patients, including any change to existing patterns of appointments
- Any PCN offering Out-of-Hours services must ensure Extended Hours is additional to their Out-of-Hours service

Improved Access to General Practice requires the following:

- Additional 30 minutes of appointments per 1,000 population per week
- Patients are able to access appointments between 8am and 8pm during the week, as well as access appointments at some point on a Saturday and at some point on a Sunday
- The above gives an indication of the minimum required; commissioners should procure more than this if necessary to meet the population needs
- Advertising of the service should be clear on all Practice websites
- Access should be available to 100% of the population and inequalities in ability to access considered and actions taken where necessary
- 111 services should be able to directly book Improved Access appointments
- Demand and Capacity tools have been installed into clinical systems to help Practices measure Access.

11. Extended Access for Oral Care, Eye Care and Pharmacy Services

100 hours pharmacies across BOB STP provide extended access to pharmaceutical services. These pharmacies open early mornings to late evenings Monday to Saturday and Sundays. Optical practices provide services on Saturdays, access to urgent care is provided by hospital eye clinics evenings, Sundays and bank holidays.

Patients are encouraged to have a continuing care relationship with their Dentist (they are not registered). This ensures their oral health is monitored on a regular basis; they can receive relevant health promotion advice and required treatment can be provided at an early stage. Some people, for a variety of reasons, do not have this continuing care relationship. This may mean that they tend to present to the system when they experience pain. These patients access the NHS via NHS 111, who will then assess their need for urgent dental treatment. These patients represent about 4% of all calls made to NHS. They may also present at a GP Surgery. In these cases, the patients should also be advised to phone NHS 111. NHS 111 refers patients to a network of dental practices who will see these patients on the day during surgery hours, if the patient need is identified as urgent.

Urgent access is also available to patients in the evenings up to 10pm and on weekends and bank holidays.

These services are currently subject to review with new arrangements to be procured from April 2021.

The NHS is also looking at how its role in preventing oral health problems can be improved. The national Starting Well programme is being rolled out across the NHS. The aim is to encourage more children to attend NHS services with the aim of preventing extractions. Childhood extractions remain a challenge for the NHS, particularly in more deprived communities. The Starting Well approach involves multi-agency working to promote the benefits of good oral health and regular attendance at dental practices.

12. Growing the Workforce

Workforce Trajectories as of 31.03.2019

			Headcount							FTE						
			2018/19 Inflows Jan-Mar	2019/20 Inflow				2019/20 Planned inflow	Participation rate	2018/19 Inflows	2019/20 Inflow				2019/20 Planned inflow
				Q1	Q2	Q3	Q4				Q1	Q2	Q3	Q4	
Inflow	GP	New Fully Qualified GPs	5	15	17	19	21	72	0.76	3.80	11.40	12.92	14.44	15.96	54.72
		Induction & Refresher scheme	2	2	2	2	2	8	0.75	1.50	1.50	1.50	1.50	1.50	6.00
		International recruitment	2	0	3	3	6	12	0.85	1.70	0.00	2.55	2.55	5.10	10.20
		GP Retention Scheme	8	2	2	2	2	8	0.40	3.20	0.80	0.80	0.80	0.80	3.20
		Other GP retention initiatives	15	3	3	3	3	12	0.76	11.40	2.28	2.28	2.28	2.28	9.12
		Other	0	1	1	1	1	4	0.76	0.00	0.76	0.76	0.76	0.76	3.04
	Clinical	Nurses	0	15	15	15	17	62	0.67	0.00	10.05	10.05	10.05	11.39	41.54
		Direct Patient Care staff (excluding physician associates and pharmacists	0	15	20	25	15	75	0.67	0.00	10.05	13.40	16.75	10.05	50.25
		Physician Associates	4	1	2	2	3	8	0.65	2.60	0.65	1.30	1.30	1.95	5.20
		Pharmacists	4	20	10	8	7	45	0.68	2.72	13.60	6.80	5.44	4.76	30.60
	Non Clinica	Admin Staff	0	50	55	55	60	220	0.67	0.00	33.50	36.85	36.85	40.20	147.40

			Headcount							FTE					
			2018/19 Outflow Jan-Mar	2019/20 Outflow				2019/20 Planned outflow	Participation rate	2018/19 Outflow	2019/20 Outflow				2019/20 Planned inflow
				Q1	Q2	Q3	Q4				Q1	Q2	Q3	Q4	
Outflow		Retirement	27	10	8	8	7	33	0.65	17.55	6.50	5.20	5.20	4.55	21.45
	GP	Other	0	9	8	7	6	30	0.76	0.00	6.84	6.08	5.32	4.56	22.80
		Nurses	39	12	12	12	12	48	0.67	26.13	8.04	8.04	8.04	8.04	32.16
		Direct Patient Care staff (excluding physician associates and pharmacists	20	12	12	13	10	47	0.67	13.40	8.04	8.04	8.71	6.70	31.49
		Physician Associates	0	0	0	1	0	1	0.65	0.00	0.00	0.00	0.65	0.00	0.65
	Clinical	Pharmacists	0	2	2	3	2	9	0.68	0.00	1.36	1.36	2.04	1.36	6.12
	Non Clinica	Admin Staff	106	55	60	60	65	240	0.67	71.02	36.85	40.20	40.20	43.55	160.80

			Historic Trend								Forecast Plan					
			17-18 Q1	17-18 Q2	17-18 Q3	17-18 Q4	18-19 Q1	18-19 Q2	18-19 Q3	2018/19 Net Flow	2018/19 Forecast	Q1	Q2	Q3	Q4	2019/20 Plan	Growth
Rolling Total	GP	Excluding Registrars	0.00	0.00	933.01	0.00	0.00	906.92	897.87	4.05	901.92	905.32	914.85	926.66	943.95	943.95	4.7%
		Nurses	0.00	0.00	450.58	0.00	0.00	438.07	436.13	-26.13	410.00	412.01	414.02	416.03	419.38	419.38	2.3%
		Direct Patient Care staff (excluding physician associates and pharmacists	0.00	0.00	350.94	0.00	0.00	359.00	364.57	-13.40	351.17	353.18	358.54	366.58	369.93	369.93	5.3%
		Physician Associates	0.00	0.00	1.81	0.00	0.00	2.59	4.81	2.60	7.41	8.06	9.36	10.01	11.96	11.96	61.4%
	Clinical	Pharmacists	0.00	0.00	25.90	0.00	0.00	34.09	36.76	2.72	39.48	51.72	57.16	60.56	63.96	63.96	62.0%
	Non Clinica	Admin Staff	0.00	0.00	1809.96	0.00	0.00	1814.22	1827.74	-71.02	1,756.72	1,753.37	1,750.02	1,746.67	1,743.32	1,743.32	-0.8%

Workforce Strategy
Oxon doc from JD/HSR
Recruitment

Retention

International GP Recruitment

Clinical Pharmacists Programme

Mental Health Therapists

Physician Associates

General Practice Nurses

Physiotherapists

Other Workforce Requirements

13. Workforce: Oral Care, Eye Care and Pharmacy

The key elements of commissioning dental services:

- Access for all patients, wishing to attend, either on a routine or urgent basis
- All services playing a role in prevention, early intervention and treatment
- Effective care pathways to ensure patients receive timely clinically effective treatment

The providers are responsible for the recruitment and monitoring of their staff. In primary care, this responsibility is shared with NHS England via management of the NHS Performer List. NHS England also works with providers on the development of services and the appropriate staff to support them. This particularly relates to staff working in tier 2 services designed to prevent referral to hospital with treatment provided by Dentists with Enhanced Skills. The review of the Starting Well programme also involves joint work with Health Education England on the development of the Oral Health Improvement facilitator role, enabling the NHS to work on a multi-agency basis to improve oral health.

14. Primary Care Investment for General Practices

15. Estates and Technology Transformation Fund (ETTF)

Mat Chilcott/Peter Redman

16. Primary Care Investment for Oral Care, Eye Care and Pharmacy Services

Pharmacy - The Pharmacy Integration Fund has launched a new advanced service (National Urgent Medicines Advanced Service (NUMSAS)) to enable patients who need repeat medication to go to a pharmacy rather than use the GP out of Hours service. The aim being to

free capacity in the GP OOH service. This service has been a pilot since 2016 and a positive evaluation of the service will result in this service becoming a standard advanced pharmacy service. NUMSAS has been successfully introduced in BOB and Frimley STP's. NHS England continues to work on further expansion of the service.
Locally NHS England South East has invested in an electronic platform that will facilitate the recording of clinical and non- clinical data.
Key areas for dental investment in the period 2020 – 25

- Maintaining and improving access to NHS Dental services
- Pathways to ensure patients can receive timely access to referral services
- Services to promote and improve oral health, with a particular focus on the more deprived communities

17. Communication

Corrine Yates

18. Local Dental Network Vision

- Maintaining and improving access to NHS Dental services
- Pathways to ensure patients can receive timely access to referral services
- Services to promote and improve oral health, with particular focus on the more deprived communities
- Reviewing and improving the quality of services provided

19. Local Eye Health Network Vision

Improve access for vulnerable groups including learning difficulties and BME groups.
To use the recommendations from the Eye Health Needs Assessment to form an action plan.
To support the implementation of new models of care- Wet AMD review
To support the improvement of referrals and feedback pathways.

20. Local Pharmacy Network Vision

The Pharmacy LPN is not active at present, the initial areas identified as priorities were also being taken forward by the Oxford Academic Health Science Network. The areas identified in 2018/19 are: - clinical innovation adoption, patient safety and clinical improvement and strategic and industry partnerships.

21. Conclusion