Healthier Together

Improving health and care in Bristol,
North Somerset and South Gloucestershire

Healthier Together BNSSG Primary Care Strategy

2019 – 2024

‘Delivering excellent, high quality, accessible care for you in a sustainable, joined up way’

20 February 2020

Contents

Executive Summary

> ‘Delivering excellent, high quality, accessible care for you in a sustainable, joined up way’

Our Bristol, North Somerset and South Gloucestershire (BNSSG) Primary Care Strategy has been developed with the help and support of our local population and all our partner organisations in Healthier Together. Primary Care is the bedrock of the NHS. Our Primary Care Strategy focuses on Primary Care sustainability and transformation over the next five years, with the aim of ensuring a high quality, resilient and thriving Primary Care service at the heart of an integrated health and social care system. The community will be our default setting for care for our population.

There are a number of factors leading to the need for a clear strategy for changing the way services are delivered in BNSSG. Some of the key drivers for change are:

- Managing increasing demands and workload in Primary Care with reducing workforce numbers
- Improving access to a wider range of care in a community setting
- Supporting integration of services
- Improving continuity of care
- Addressing variability in Quality and Outcomes
- Decreasing health inequalities and unwarranted variation
- Focusing on prevention of disease
- Shift to integrated, personalised and preventive care

As a system Healthier Together has committed to delivering population health which means we have collectively committed to improving physical and mental health, promoting wellbeing and reducing inequalities in health outcomes for the people of Bristol, North Somerset and South Gloucestershire.

Fundamental to our ambitions for delivering integrated care to the people of BNSSG is our commitment to strengthening Primary Care. All our Primary Care providers within BNSSG will work together collaboratively, keeping people healthy and independent, ensuring that those who require care receive it at the right time, in the right place, by the right person.

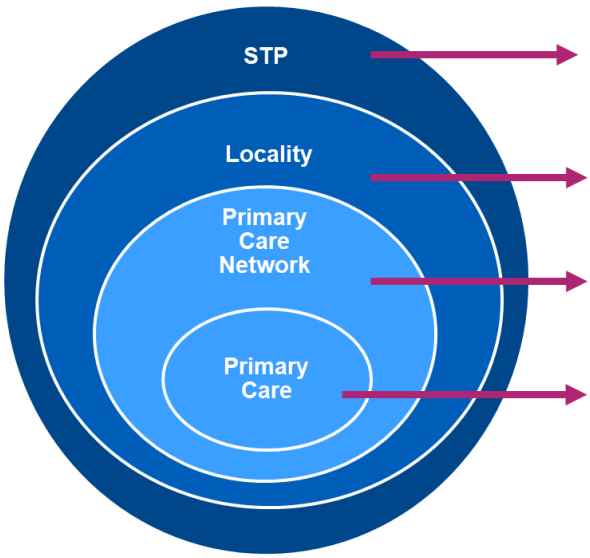
Our Primary Care Providers:

GP Surgeries | Integrated Urgent Care | Community Pharmacy | Dental | Optometry

The Building Blocks of Integrated Care

Our Primary Care model of care is one in which Primary Care Networks (PCNs) are part of integrated working with local community, mental health, social care and voluntary sector partners to develop further co-ordinated care. Our practices in BNSSG have joined together to form 18 PCNs, all sitting within our six established Localities. The aim is for Localities to work together across providers, including our adult community services provider Sirona, to deliver services tailored for their population. Our Primary Care Strategy is designed to be read in conjunction with our other system strategies but in particular our Integrated Care Strategy.

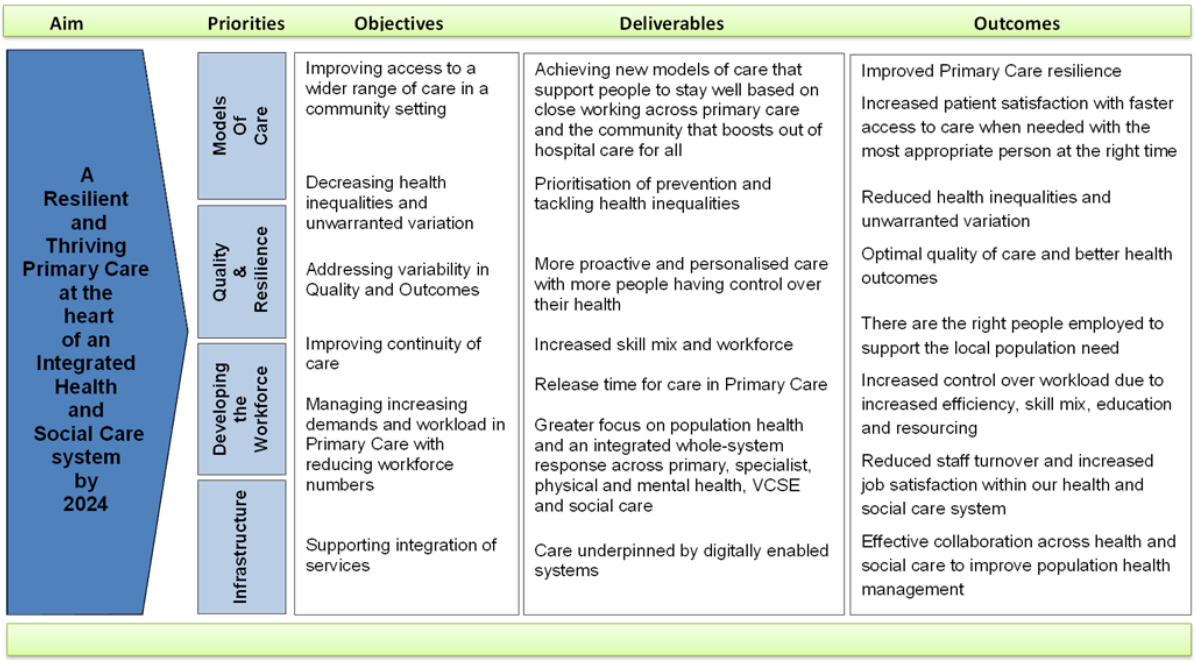
PCNs will become the local "neighbourhood" delivery arm of our locality-wide Integrated Care Partnerships (ICPs) working at a scale to support on the ground transformation. Clinical Directors will be instrumental in driving the implementation of the Primary Care Strategy at practice and PCN level, as well as establishing ICPs.



Long term plan	Function
Integrated Care System (ICS) **(System)**	Strategic Governance Vision Overall Accountability
Integrated Care Partnerships (ICP) Provider Alliance **(Place)**	Planning and coordination across providers
Primary Care Networks **(Neighbourhood)**	Practices working together Resilience Local Delivery Shared Resource
General Practice IUC Community Pharmacy Dental Optometry	Personalised Community Based 24/7 Care

Central to our integrated model is the principle of delivering continuity and proactive care through primary care and integrated teams working at all levels of the community, understanding people, their families and circumstances. Continuity of care will improve patient satisfaction, the ability to influence health behaviours and concordance with treatments and medication regimes, thus reducing hospital use, increasing independence and lowering mortality rates. It can also help staff satisfaction, confidence and efficiency.

Our Priorities



Primary Care Investment

Investment in Primary Care will support our vision for our community to have services delivered as close to home as possible by the right person at the right time. We will ensure continuity of care for our population by: investing in our workforce; supporting the recruitment of new roles across our system; and delivering services tailored for our population. As a system, we will commit to supporting this vision by shifting resource to follow activity either directly or by flexing current arrangements as required; this will all result in the sustainability of our Primary Care services in BNSSG.

We recognise that key to all of this is ensuring stability of General Practice. This is recognised nationally, and has resulted in funding growth in the core General Practice contract as well as the national PCN Directed Enhanced Service (DES). We in BNSSG will continue to commission additional Local Enhanced Services (LES) from General Practice according to population need and are investing GP Forward View (GPFV) funds to support resilience, workforce retention and the roll out of online consultations.

What does this mean for our population and health and social care professionals?

All of our engagement with our staff, patients and the public has told us clearly what a perfect Primary Care system looks like; and this is our ambition for Primary Care in BNSSG.

Chapter 1: Introduction

This strategy is written for our BNSSG population and all the health and social care professionals that work so hard to care for them.

This strategy focuses on Primary Care sustainability and transformation over the next five years, with the aim of ensuring a high quality, resilient and thriving Primary Care service at the heart of an integrated health and social care system.

This strategy considers what is important to and for the population of BNSSG using intelligence from public and professional 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.
There are a number of factors leading to the need for a clear strategy for changing the way services are delivered in BNSSG. Some of the key drivers for change are:

- Managing increasing demands and workload in Primary Care with reducing workforce numbers
- Improving access to a wider range of care in a community setting
- Decreasing health inequalities and unwarranted variation
- To support the integration of services
- Improving continuity of care
- To reduce variability in Quality and Outcomes
- A need to focus on prevention
- Shift to integrated, personalised and preventive care.

The strategy will ensure we deliver the best possible value for our population by maximising health and care outcomes that matter to people and the whole population, within our given resources. This will mean ensuring that we:

- Understand the outcomes that matter to people
- Promote prevention of disease
- Promote wellbeing with supported self-care
- Reduce health inequalities
- Reduce unwarranted variation
- Allocate our resources across the system enabling us to achieve the best possible outcomes we can for our population
- Support people to have fulfilling work within our health and care system

In addition a sustainable, effective and accessible Primary Care, will lead to Bristol, North Somerset and South Gloucestershire Primary Care being a more attractive career choice.

What is Primary Care?

Our Primary Care Services:

GP Surgeries | Integrated Urgent Care | Community Pharmacy | Dental | Optometry

Primary Care is people's entry point for the prevention and treatment of illness. It is the bedrock of the NHS. The strategy is about Primary Care providers within BNSSG working together collaboratively, 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.

> What primary care does best is around undifferentiated illness, anxieties, fears, hopes and expectations. This is not "mental health" and it is not social prescribing and it is not frequent attenders. All these are important of course. This is core general practice which is so difficult to define.
>
> Skills of using time as a tool, holding risk, exploring fears and expectations while at the same time holding extensive medical knowledge and experience. **BNSSG GP**

This quote highlights the importance of recognising that there are many strengths to our

Primary Care services – General Practice, Community Pharmacy, Dentistry and Optometry - which we do not want to lose as we make this transformation.
This will be a transformational process for building patient centred, Primary 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. 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 can receive improved care in the community.

Transformation must not reduce the power of Primary Care to deliver population wide health benefits; it must seek to enhance it. In order to do so it must clearly identify its key beneficial features, understand its core functions and support them.

Key features:

Research (Starfield et al 2005) has identified 5 key features of Primary Care necessary to deliver maximal benefit:

1. Greater accessibility
2. Better person focused prevention
3. Better person focussed quality of clinical care
4. Earlier management of problems (avoiding hospitalisation)
5. The accumulated benefits of the above four features of Primary Care

Evidence demonstrates that better person focussed prevention and clinical care are enhanced by relationship continuity (seeing a clinician that you know and trust – who knows and cares about you) which leads to:

Better health outcomes, more satisfied patients, better cost control, more personalised decisions on appropriate care, more effective care outside hospital, earlier diagnosis, better targeting of expensive interventions to those most likely to benefit, limited use of interventions that have a significant harm rate, better acceptance of self-limiting illness, better medicines usage and adherence, better uptake of screening programmes and immunisations, cost savings in investigations, prescribing, hospital referral, admissions, use of accident and emergency departments and the overall cost of health care.
(RCGP 2020 vision for General Practice)

Enhancing access and relationship continuity of care across all Practices would deliver significant benefits to our patients and the wider system.

Transformational change needs to enhance not diminish the 3 core Primary Care functions:

1. To efficiently and effectively manage large numbers of mainly low risk patients.
2. To risk stratify and identify the few high risk patients for proactive care and

appropriate onward referral. (Cost control)

3. To encourage positive lifestyle change and promote prevention and self-care (demand control). Many people may not have the ability to make these changes; we need to recognise socio-economic determinants of health and address the health inequalities within our system.

Our Vision

'Delivering excellent, high quality, accessible care for you in a sustainable, joined up way'

Our Principles

We will use these principles to guide the commissioning and delivery of efficient, high quality, sustainable services:

1. Ensuring everyone can access services on an equal footing and promoting targeted access for specific groups based on their needs to address inequalities in access to health services and the outcomes achieved.

2. Healthcare starts with supported self-care; from disease prevention to illness management, patients, carers and their families are supported to share responsibility for their healthcare at every point of contact with the care system

3. The value that continuity of care brings in increased patient satisfaction, improved outcomes and cost savings, is considered in all care pathways and all services we develop.

4. Care is provided as close to home as possible by the right person, at the right time and the right place

5. Face to face contact is used where it offers additional value to the patient so that remote working is maximised to reduce stress on our environment and demand on our physical facilities

6. Accepting there is risk and supporting clinicians and patients to work in an environment that is able to manage this risk

7. Only those patients who need ward-based care are admitted to hospital and all other patients are managed and supported in an appropriate community environment

8. We work collaboratively with our entire care community, including patient representatives, to develop and construct the care pathways and services that patients need and that the system can deliver.

9. Deliver value, through informed decision making on the services we provide based on our population need and the resources available

Our Value Goals

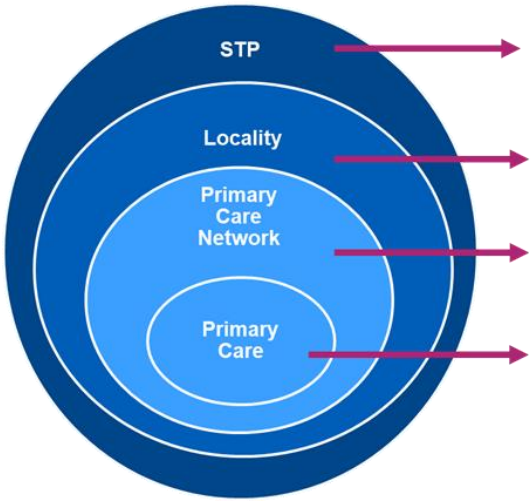
1. Improve outcomes that matter to individuals and at population level

2. Ensure that people receiving care benefit from that care and those that need that care are not missing out

Our Priorities

Our Strategy is designed to be read in conjunction with the Integrated Care Strategy; working with colleagues in the Integrated Care Steering Group we have articulated the relationship between neighbourhood, place and system which is reflected in the diagram below.

The Building Blocks of Integrated Care diagram:



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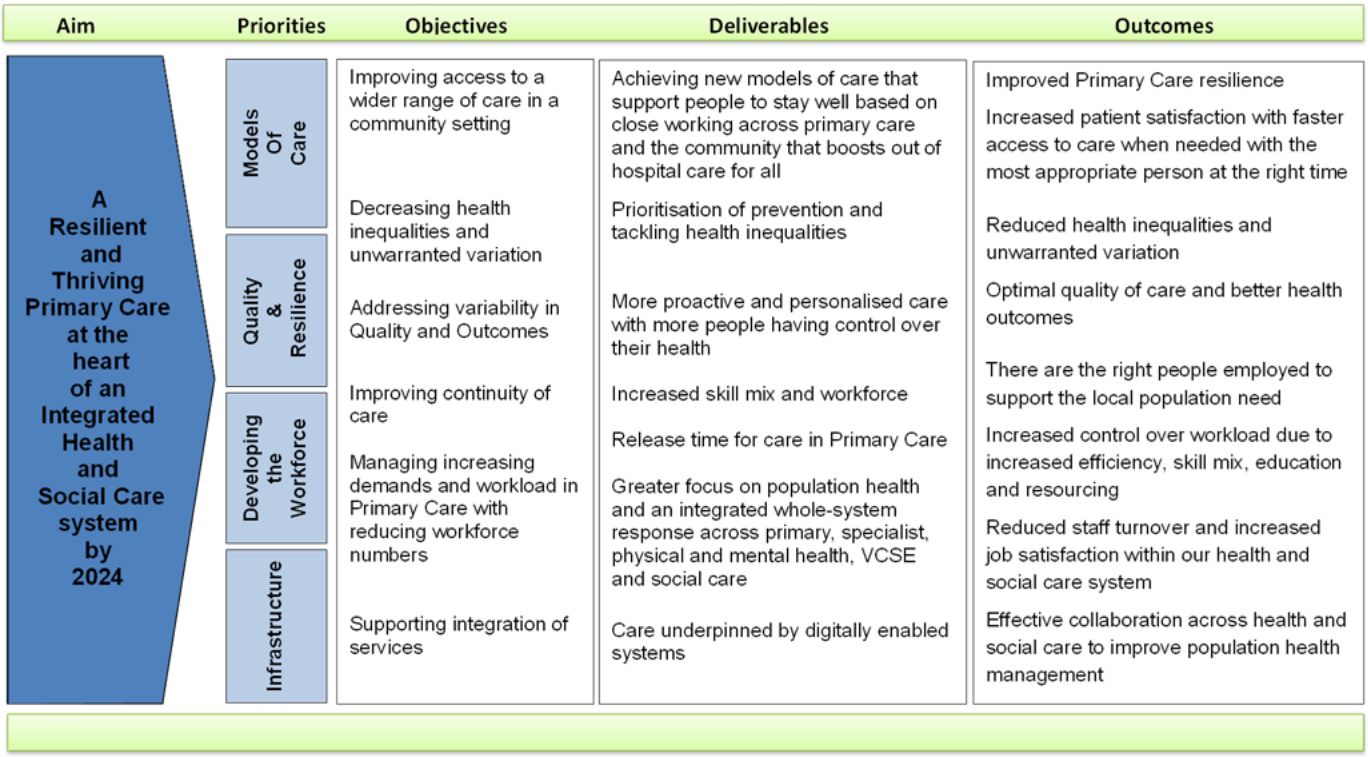
Our Strategy focuses on Primary Care and within that PCNs. As part of our engagement we identified what matters to our population and our Healthier Together system to determine where we prioritised our areas of work. These priorities are outlined in the diagram below:



Chapter 2: National and Local Context

There are a number of key strategies and drivers at national and local level.

NHS Long Term Plan

Published in January 2019 the NHS Long Term Plan (LTP) sets out how the NHS will accelerate the redesign of patient care to future proof it for the decade ahead.

The NHS Long Term Plan focuses on integrating services around the patient more effectively and how the NHS will manage major 'killer' diseases and causes of ill health. The three main ambitions are:

Primary Care Services Contracts

All primary care services have new contracts as of 2019:

General Practice Contract

On 31st January, 2019 NHS England (NHSE) published, **"Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan"**.

The short summary of the key parts of the contract as set out on the NHS England website are:

- Core General Practice funding will increase by £978 million per year by 2023/24.
- A PCN contract from 1 July 2019 as a Directed Enhanced Service (DES). It will ensure general practice plays a leading role in every PCN and mean much closer working between networks and their Integrated Care System. This will be supported by a PCN Development Programme which will be centrally funded and locally delivered.
- By 2023/24, the PCN contract is expected to invest £1.799 billion, or £1.47 million per typical network covering 50,000 people. This will include funding for around 20,000 more health professionals including additional clinical pharmacists, physician associates, first contact physiotherapists, community paramedics and social prescribing link workers. Bigger teams of health professionals will work across PCNs, as part of community teams, providing tailored care for patients and will allow GPs to focus more on patients with complex needs.
- A new shared savings scheme for PCNs so GPs benefit from their work to reduce avoidable A&E attendances, admissions and delayed discharge, and from reducing avoidable outpatient visits and over-medication through a pharmacy review.
- A new state backed indemnity scheme from April 2019 for all General Practice staff including out-of-hours/Integrated Urgent Care (IUC).
- Additional funding of IT which will allow both people and Practices to benefit from the latest digital technologies. All patients will have the right to digital-first Primary Care, including web and video consultations by 2021. All practices will be offering repeat prescriptions electronically from April 2019 and patients will have digital access to their full records from 2020.
- A new Primary Care Fellowship Scheme will be introduced for newly qualifying nurses and GPs, as well as Training Hubs.
- Improvements to the Quality and Outcomes Framework (QOF) to bring in more clinically appropriate indicators such as diabetes, blood pressure control and cervical screening. There will also be reviews of heart failure, asthma and mental

health. In addition there will be the introduction of quality improvement modules for prescribing safety and end of life care.

- Extra access funding of £30 million a year will expand extended hours provision across PCNs and from 2019 see GP practices taking same-day bookings direct from NHS 111 when clinically appropriate."

Integrated Urgent Care (IUC) Contract

IUC is the "marriage" of NHS 111 and GP Out of Hours (GPOOH), together with the clinical assessment service (telephone clinical advice) which aims to deliver consistent, predictable, safe, high quality, patient centred, urgent Primary Care 24/7 to the population of BNSSG. The IUC contract is managed by BrisDoc, with Care UK subcontracted to provide the 111 service.

Key aims of the IUC Service are:

- To provide a consistent response for people and equitable access to NHS services based upon need
- To provide high quality urgent care at all times
- To sit at the centre of the BNSSG Urgent and Emergency care model
- To ensure smooth patient journeys and avoid unnecessary re-triage
- Reduce Emergency Department (ED) attendances following contact with NHS 111
- Ensure all referrals to South West Ambulance Service Trust (SWAST) are appropriate
- To manage the clinical risk appropriately to increase the number of patients who can be safely managed in their own homes
- To work collaboratively with all stakeholders, especially the Patient Reference Group, to ensure joined up and safe care
- To empower patients to manage their own care
- To deliver "Consult and complete" to offer the "right care first time"
- To utilise "Consult and hold" to enable continued longitudinal care where appropriate
- To develop and innovate, including using digital technology

National Community Pharmacy Contractual Framework (NHSE commissioned)

Community pharmacists are highly trained healthcare professionals, committed to providing high quality services to their patients. Community pharmacists have the potential to play a greater role in clinical service delivery, helping people to stay well. Whilst the supply of medicines remains an ongoing and critical part of what community pharmacy provides, there is an opportunity for community pharmacists to expand their role, to focus on minor illness, along with the prevention and detection of ill health. It is expected that Community Pharmacy will be a key partner in local PCNs.

The actions described in the LTP include Community Pharmacy working as an integrated member of a multi-disciplinary team (MDT), built around each PCN. Community pharmacies will support PCNs with planning and implementing population healthcare and patient pathways.

For clarity, community pharmacists are those working in a pharmacy e.g. on the high street or attached to a GP practice. In order for community pharmacists to focus on their more clinical roles there will need to be a strong link with the PCN clinical pharmacists.

A 5 year contractual framework has been agreed for community pharmacies and was published in July 2019. This contract took effect in October 2019 and aims to expand and transform the role of community pharmacies embedding them as the first port of call for minor illness and health advice, and as an integral part of the NHS. Nationally, a commitment has been made that £13 billion will be invested in community pharmacy through its contractual framework: £2.592 billion in each of the next five financial years.

Delivery of this will be supported by an Interim People Plan. The Pharmacy Integration Programme will provide new education and training initiatives, through Health Education England, including new training to support community pharmacy teams to deliver consistent, high-quality care for patients with minor illnesses.

As PCNs develop, NHSE and Local Pharmaceutical Committees (LPC) will support their local community pharmacies in engaging with the network. This will include LPCs working with Local Medical Committees (LMC) to develop and negotiate a structured and coherent community pharmacy offer. To deliver this, community pharmacies will need to work collaboratively and engage with the PCN with one voice.

Optometry

Opticians are highly trained healthcare professionals, committed to providing high quality services to their patients. Opticians in the community have the potential to play a greater role in clinical service delivery. They already undertake local services covering, Glaucoma and Cataract Schemes, holding patient consultations in the community rather than a secondary care setting. Nationally CCGs are already looking at Minor Eye Schemes, referring patients to opticians rather than referring to hospital emergency eye services.

NHSE priorities for the commissioning of optical services for 2019-2020 are as follows:

- Nationally working to review access and work with health partners to ensure that homeless patients are not disadvantaged and have equitable access to optical services.
- Nationally working to review access and work with health partners to ensure that learning disability patients are not disadvantaged and have equitable access to optical services.
- Supporting contractors to prepare and use the new electronic submission forms (eGOS), transforming payment processes, and ensuring timely payments.

In addition to the core contract, the CCG commissions a number of enhanced services from Optometrists for Glaucoma management and post op cataracts care in the community. We are developing plans to further develop the Optometry workforce with more integrated primary / secondary virtual shared care.

Dentistry

The key objective around dental is maintaining and increasing access to NHS dentistry across the region. There is recognition that the availability of services, value for money provided, and oral health outcomes delivered to local populations varies across the STP areas, mirrored in both primary and secondary care.

Effective contract management will deliver value for money and enable treatment of a greater number of people; the national recruitment issues concerning NHS dentists remains the overriding challenge in terms of providers delivering the required levels of access. Contract management remains focused on quality and productivity, however there has been a move recently away from solely the Unit of Dental Activity (UDA) currency approach towards more innovation in commissioning; examples include increasing oral health promotion, new working models, national initiatives such as dental checks by age one, starting well and mouth care matters, and enhanced mandatory services. Working towards incorporating these initiatives into a UDA-based contract will address specific local challenges whilst making the contracts more attractive to prospective staff.

Nationally, NHSE and the Department of Health and Social Care are continuing to test new ways of providing NHS dental care focussed on preventing future dental disease. The overall aim is to deliver a new contract which improves oral health whilst increasing dental access.
Prototype practices participating in the programme are open to seeing new NHS patients, and accepting all categories of patients (adults, children, fee paying, and exempt). Prototyping has enabled Practices to increase the proportion of patients in an area that are registered with a dentist, with a focus on preventive care. The incentives in the contract are designed to reduce dentists regularly reviewing the dentally fit, and to increase access for more patients, to address oral illness, and in turn keep people well.

Dentistry is keen to work with the STP to meet the objectives of the Ten-Year plan and recognises the challenges with dental patients accessing A&E for advice and general

medical practitioners for prescriptions when unable to access a dentist.

Public Health Service Commissioning

The Health and Social Care Act 2012 conferred new duties on Local Authorities to improve and protect public health and in 2013 transferred much of the responsibility for public health from the NHS to local authorities. In BNSSG we have three Local Authorities- Bristol, North Somerset and South Gloucestershire, each with a Director of Public Health and Public Health Team. Local authorities have a number of mandated public health functions including:

- NHS health checks
- Sexual health services
- National child measurement programme
- Health visitors' five universal contacts

Alongside the mandated functions there are a range of other public health services for example: tobacco control, weight management, behavioural and lifestyle campaigns, drug and alcohol services, children's public health nursing (schools nurses and health visitors). The commissioning of these services is discretionary and variable across our 3 local authorities, guided by the local Joint Strategic Needs Assessment (JSNA) and local Health and Wellbeing Board strategies. Some of these public health services are commissioned from Primary Care, others from secondary care, the community and voluntary sector. Some services (e.g. specialist sexual health) are jointly commissioned by the local authorities and the CCG. Analysis by the Health Foundation shows that nationally the Public Health Grant, which funds Local Authority commissioned and delivered public health services, will have reduced by almost a quarter (estimated spending per person) between 2014/15 and 2019/20. There will have been a £700m real-terms reduction in the public health grant in that period.

In addition to commissioning public health services, public health teams work with their respective local authorities to influence and address the wider determinants of health that are affected by a range of council policies and functions (such as education, air quality, housing and economic regeneration).

NHSE alongside Public Health England commissions certain public health services such as national screening and immunisation programmes. There are 20 population immunisation programmes and 11 population screening programmes. These programmes cover the whole life course from antenatal to elderly persons and in any one year approx. 70 % of the population will become eligible for at least one immunisation or screening test. These programmes are therefore a core element of prevention and early diagnosis and offer opportunities for accessing populations to improve wider health and wellbeing.

The NHS LTP and the Prevention green paper highlight a common ambition for an integrated and place based model of prevention and there is now an even greater opportunity for partners to work in an integrated way to maximise efforts to provide high

quality public health functions and services.

Primary Care Investment

Investment in Primary Care will support our vision for our community to have services delivered as close to home as possible by the right person at the right time. We will ensure continuity of care for our population by: investing in our workforce; supporting the recruitment of new roles across our system; and delivering services tailored for our population. As a system, we will commit to supporting this vision by shifting resource to follow activity either directly or by flexing current arrangements as required; this will all result in the sustainability of our Primary Care services in BNSSG.

Guaranteeing investment in Primary Care

Transformation of our health and care services is dependent upon a thriving General Practice service within wider Primary Care. This is recognised nationally as well as locally, and the commitments in the NHS LTP have been translated into a framework for General Practice in the new GP Contract, and Primary Care Network Direct Enhanced Service (DES).

This gives funding certainty for practices and Networks over the next 5 years from 2019-2024, and clearly sets out the direction of travel for practices and primary care for the next 10 years. This is the first time in the history of the NHS that real terms funding for primary medical and community services is guaranteed to grow faster than the rising NHS budget overall.

Much of this flows through the nationally agreed practice contract and its extension through the Network Contract DES, as outlined in the draft expenditure plan below:

Core Contract & Network Contract DES investment 2019/20 – 2023/24

	2019/20 £'000	2020/21 £'000	2021/22 £'000	2022/23 £'000	2023/24 £'000
	Year 1	Year 2	Year 3	Year 4	Year 5
National GP Contract					
Core Primary Care Contracts	84,252	86,767	89,856	92,811	96,035
Designated Enhanced Services (DES)	1,212	1,335	1,371	1,406	1,444
Quality Outcomes Framework (QOF)	12,181	12,668	13,175	13,701	14,250
	97,645	**100,769**	**104,402**	**107,919**	**111,729**
Annual Funding Growth		**3.2%**	**3.6%**	**3.4%**	**3.5%**
Network Contract DES					
Additional Roles	866	4,140	6,704	10,259	14,468
Clinical Director	525	721	740	759	780
Network Participation Payment	1,696	1,711	1,726	1,740	1,755
Extended Hours Access DES	1,500	1,514	1,556	1,596	1,639
Core PCN Funding	1,531	1,567	1,610	1,651	1,695
	6,118	**9,653**	**12,336**	**16,005**	**20,337**
Annual Funding Growth		**57.8%**	**27.8%**	**29.7%**	**27.1%**

The following five additional roles are being rolled out in Primary Care:

2019/20: Clinical Pharmacists and Social Prescribing Link Workers
2020/21: Physiotherapists and Physicians Associates
2021/22: Paramedics

Leading to an additional 381 roles working in BNSSG by 2023/24 using average cost of role reimbursement and indicative funding projection on weighted population:

In 2019/20: An extra 47 additional roles working in Primary Care in BNSSG
By 2020/21: An extra 105 additional roles working in Primary Care in BNSSG
By 2021/22: An extra 179 additional roles working in Primary Care in BNSSG
By 2022/23: An extra 273 additional roles working in Primary Care in BNSSG
By 2023/24: An extra 381 additional roles working in Primary Care in BNSSG

Additional Investments

The NHS LTP Implementation Framework sets out the funding which has been allocated to support the commitments in the NHS LTP and previous requirements from the Five Year Forward View, in addition to the core growth outlined above.

Indicative funding allocation available to BNSSG STP:

	2019/20 £'000	2020/21 £'000	2021/22 £'000	2022/23 £'000	2023/24 £'000
LTP Funding Allocation Summary	2,461	2,592	2,930	3,113	3,027

2a) GP Forward View Funding Streams:

- **GP Resilience programme** - to support GP practices and to build resilience into the system. The purpose of the fund is to deliver support that will help practices to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and secure continuing high-quality care for patients.
- **Clerical & Reception Staff training** - to support the training of practice staff to implement the 10 High Impact Actions, including active signposting and document management and new consultation types.
- **Online consultations** - to deliver the existing commitment that all practices will be offering online consultations by April 2020 and video consultation by April 2021.
- **GP retention -** to support retention of Primary Care workforce
- **Improved Access** - all practices are currently receiving £6 per head of population, which funds additional minutes to be provided between 18:30 – 20:00 weekdays and provision at weekends. This additional capacity aims to help reduce some of the pressure on general practice services and the wider BNSSG system. This is currently subject to a national review.

2b) Primary Care Network Development

We are supporting the organisational and leadership development of PCNs in BNSSG. Through workshops and meetings with our Locality Leads and Clinical Directors we will ensure PCN development enhances service delivery at Locality and Network level. We will use PCN OD funding to support PCNs to grow and mature in line with the PCN maturity matrix.

2c) STP Funding for Workforce

Primary and Community Care Training Hubs will be the link between PCNs and the workforce requirements of the system. The Training Hub will oversee the skills and competencies of staff in Primary Care to ensure PCNs are able to deliver the priorities of Healthier Together.

The following programmes assist in promoting Primary Care and reducing health inequalities in BNSSG:

- Primary Care Training Hubs
- General Practice fellowships

- General Practice Nursing Ten Point Plan (GPN10PP)
- Health Inequalities Fellowships
- General Practice GP Retention Programme
- Additional roles advice for PCNs

Additional Local Investment (Local enhanced services)

In addition to the indicative funding outlined above, we will use Population Health Management (PHM) tools and patient and public engagement to identify where support for services and initiatives tailored to the needs of our healthcare staff and population is required.

Targeted National Funding

In addition to the indicative funding outlined above, budgets have been allocated nationally to fund targeted schemes and for specific investments, where a general distribution is not appropriate, and generally accessible through local bids to NHSE.

This targeted funding is intended to support the elements of the LTP, and for Primary Care specifically, this relates to the:

- Investment and Impact Fund
- Digital First Primary Care support funding
- Estates and Technology Transformation Programme

BNSSG is awaiting publication of the national rules and guidance, including the details of how the CCG will be able to access these funds

4a) Investment and Impact Fund

The purpose of the Investment and Impact Fund will be to enable PCNs to work with the wider BNSSG system in order to address improvements in patient care in the following areas

(i) avoidable A&E attendances

(ii) avoidable emergency admissions

(iii) timely hospital discharge, helped by the development of integrated primary and community teams

(iv) outpatient redesign

(v) prescribing costs

The intention is for the fund to operate on a shared savings principle, where indicators clearly demonstrate a direct link between actions in primary care and the desired outcomes.

4b) Digital First Primary Care Support Funding

The NHS LTP commits that every patient will have the right to be offered digital-first Primary Care by 2023/24. The new five-year framework for GP contract reform describes the areas in which early progress is expected to be made in general practice. For example, by April 2020 all patients should have online access to their full record and by April 2021 all patients should have the right to online and video consultations.

https://www.england.nhs.uk/wp-content/uploads/2019/06/digital-first-primary-care-consultation.pdf

Estates & Technology Transformation Funding (ETTF)

This national funding has been available from 2016/17 and will continue until the end of the 2020/21 financial year to support the following areas:

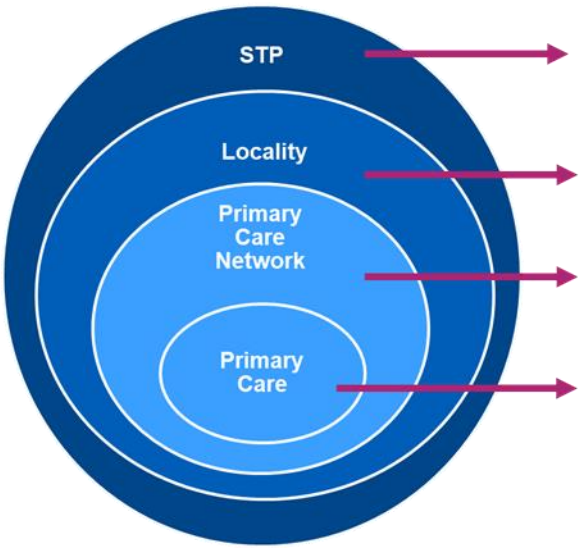
- New consulting and treatment rooms to provide a wider range of services for patients and so more patients can be seen
- Improved reception and waiting areas
- Building new facilities to deal with minor injuries
- Creating better IT systems to improve the way information is shared between health services in the area
- Extending existing facilities to house a wider range of health staff including GPs, nurses and clinical pharmacists.
- Building new health centres which have a greater range of health services for patients in one place.

Our System

The BNSSG Healthier Together Sustainability and Transformation Partnership (STP) will drive how we deliver care in the future in support of the NHS Five Year Forward View and 10 Year Long Term Plan.

Healthier Together's vision is for the health and social care system to progress towards an integrated approach to care, with organisations working together regardless of individual budgets. The geography is an aspirant Integrated Care System. Priorities include redesigning models of care to meet the needs of the population, with care closer to home and ensuring effective infrastructure to enable this.

The Building Blocks of Integrated Care



Long term plan	Function
Integrated Care System (ICS) **(System)**	Strategic Governance Vision Overall Accountability
Integrated Care Partnerships (ICP) Provider Alliance **(Place)**	Planning and coordination across providers
Primary Care Networks **(Neighbourhood)**	Practices working together Resilience Local Delivery Shared Resource
General Practice IUC Community Pharmacy Dental Optometry	Personalised Community Based 24/7 Care

We established Healthier Together as a partnership to improve services, outcomes and experiences for the people we serve by better joining up what we do. In essence this is a simple concept. It means that our organisations are committed to working together as a system to deliver integrated care - an Integrated Care System.

The foundation of our Integrated Care System is a defined population: the places and people that we serve in BNSSG. We have worked together to pool data and insights about our population and this plan now sets out our shared ambitions for improving outcomes.

GP Leadership

We need GP leadership at all levels and in all areas of our system model in order to deliver radically transformed services for our population and to deliver our Primary Care Strategy.

As the General Practice team and the PCN team expands to incorporate additional roles, the practice-based GP role will also need to change to accommodate the needs of our population. Practice-based GPs will be acting as consultants and co-ordinating multi-disciplinary care in the community, working across community, mental health, social care and voluntary sector providers as well as being supported to develop strategic leadership skills within our system.

Locally we have procured a single provider for adult community health services across BNSSG, and similarly for integrated urgent care. This will ensure a truly integrated community and primary care patient centred service for our population. GP leadership roles will be needed to support locality multi-disciplinary working with our new community

provider.

Practice based: The MDT within the practice should have strong medical leadership. This will ensure a focus on services needed for the practice population and identification of those patients more at risk using population health management tools to feed through to PCN level, as well as providing support to the practice team and ensure training and development needs are met. *The RCGP supports this approach in their 2019 Fit for the Future document "GPs will provide leadership, advice, training and mentoring to their practice teams"*.

PCN: The Clinical Director (CD) has strong links with practice leadership teams and is able to pull through the local population needs to the PCN. The CD has leadership responsibilities in establishing and developing the PCN, as well as a strategic leadership role within the Locality.

The NHSE and NHS Improvement PCN Development Support Guidance and Prospectus describes the leadership role of PCN CDs. PCN CDs will provide leadership for networks' strategic plans, through working with member practices and the wider PCN to improve the quality and effectiveness of network services. Key responsibilities include: providing strategic and clinical leadership for the network and supporting implementation of agreed service changes; fostering collaboration and developing relationships across the PCN; working closely with other network CDs, clinical leaders of other health and social care providers, local commissioners and LMCs; and in BNSSG representing the PCN within the Locality and through this our STP/Integrated Care System.

Locality: Locality leadership is needed to form and build strategic provider alliances, also referred to as Integrated Care Partnerships. This will involve leadership to plan how to address population health need, leadership of the development of new care models at locality level and leadership to ensure the co-ordination of resources to mobilise and support these models of care. Locality leaders will need to be skilled in working across organisational boundaries, generating a shared vision and purpose, building teams and developing accountability for meeting and improving health outcomes for their population.

IUC: Severnside IUC has established and experienced medical leadership. The Medical Director and Deputy Medical Directors will build relationships with the Locality and PCN leaders to ensure that care – along with any new innovations – are seamless across 24 hours. This "melded" leadership will respond to the changing needs of the population of BNSSG and will contribute to local system needs and enable changes that deliver improved patient care. Relationships will also be developed with Sirona as the provider of adult community services across BNSSG, and in particular with the Integrated Care Bureau (ICB).
Severnside GP leaders will be active in promoting the "identity" of urgent Primary Care and fostering it as a desirable place to practice primary care within the urgent care model. Our leaders will seek new ways to work and seek opportunities to deliver continuity when a person's own GP practice is closed.

STP: Locality leadership will be needed to provide GP leadership to our STP and the development of our Integrated Care System. This will ensure that the GP voice provides leadership within our STP and that Primary Care is integral to shaping how we plan safe

effective high quality patient led care for our population in BNSSG. Leadership in building strategic partnerships and commitment, shaping direction and managing complexity will be critical to the success of these roles.

How will we support this leadership development?

We will:

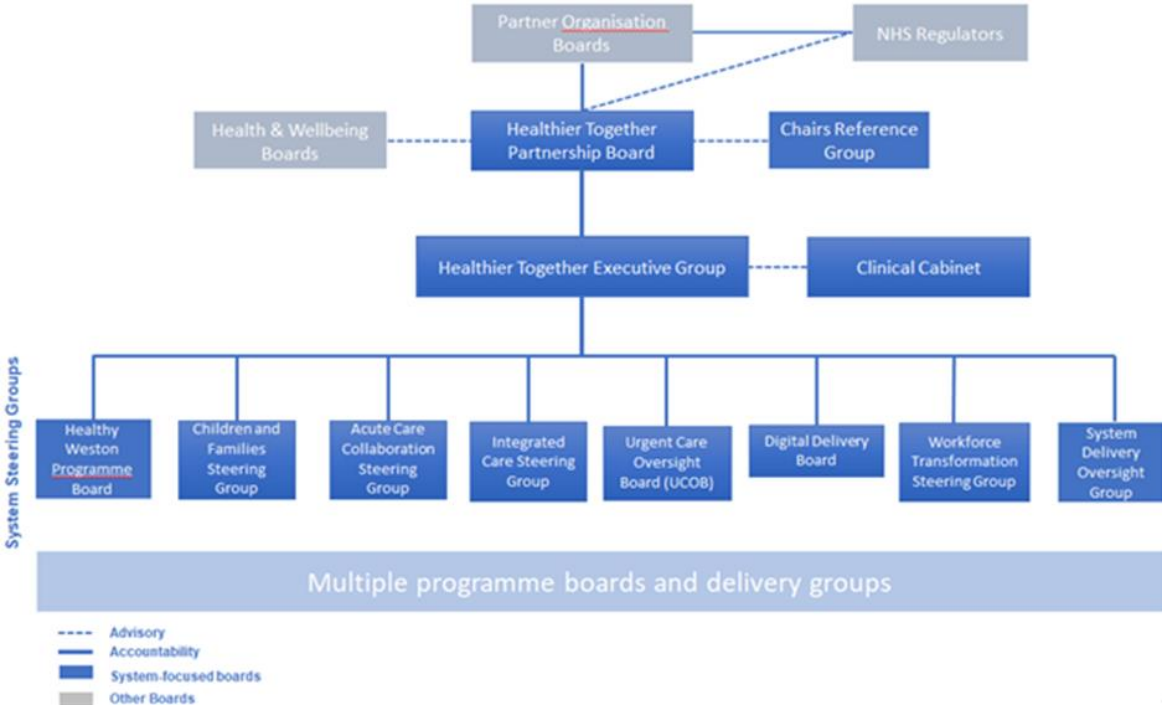
- Maximise the role of the training hub in supporting general practice leadership and co-ordinating the training of all post-graduate education and training
- Develop and invest in a PCN Clinical Director and Locality Leads Leadership Development Programme in 2019/2020 and beyond
- Maximise the opportunity of the Healthier Together clinical leadership programme to support cross boundary working and a common approach to system leadership across our clinical leaders
- Share leadership development and “intelligence” across all sectors

Governance

This strategy has been developed by the members of the BNSSG Primary Care Strategy Group and stakeholders across the wider STP Healthier Together system. ***Healthier Together*** is our BNSSG Sustainability and Transformation Partnership (STP), and consists of 13 local health and care organisations that sit on the Healthier Together board, but the partnership goes beyond just these organisations and includes Local Authorities and other partners.

The BNSSG Primary Care Strategy Group reports in to the General Practice Resilience and Transformation (GPRT) STP workstream, with oversight of the strategy by the Integrated Care Steering Group. Final sign off is through the BNSSG CCG Governing Body and the Healthier Together Partnership Board.

Our System Governance Structure



Partners and organisations that have contributed to and endorsed the Strategy are:

Avon and Wiltshire Mental Health Partnership NHS Trust
Avon Local Dental Committee
Avon Local Medical Committee
Avon Local Ophthalmic Committee
Avon Local Pharmacy Committee
BNSSG General Practice
BNSSG Patient Public Involvement Forum
BNSSG Training Hub
BrisDoc Healthcare Services
Bristol Community Health
Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group
Bristol City Council
CareForum
Community Health Partnerships
Healthwatch
Independent Mental Health Network
NHS England
NHS Improvement
North Bristol NHS Trust
North Somerset Community Partnership
OneCare Ltd
North Somerset Council
Local Authority Public Health Teams
Severnside IUC
Sirona Care and Health
South Gloucestershire Council
South West Ambulance Service Trust
University Hospitals Bristol NHS Foundation Trust
Weston Area Health NHS Trust

Chapter 3: Drivers for Change

How we engaged with people to develop this Strategy

The refresh of the Primary Care Strategy was launched at an event in June 2019, attended by over 150 stakeholders from health and care partner organisations across the system including local authority, voluntary sector, patient and public representation. Following this successful launch our Primary Care Strategy group have been proactive at providing opportunities for engagement and communication with our stakeholders both face to face at established meetings but also through online surveys for both patients and professionals.

As well as engagement with our health and care partner organisations, the BNSSG Patient and Public Involvement Fora membership have supported us in engaging with patients in the development of this Strategy. Our patient engagement managers across the system have facilitated discussions with members of BNSSG Patient Participation Groups, Healthwatch and other established patient involvement groups including the OneCare patient reference group. A significant amount of engagement has been carried out with the many Healthier Together strategies and pieces of work. A big piece of work was carried out to pull all aspects related to Primary Care from the extensive information gathered in these areas. 12 individuals attended the Strategy launch event in June and it is hoped they will form part of a patient reference group during the implementation phase. This Strategy, therefore, sets out our direction for Primary Care and has begun the initial engagement, as plans develop in the implementation stage, further appropriate engagement and communication will be undertaken.

Population Health Management

As a system Healthier Together has committed to delivering population health which means we have collectively committed to improving physical and mental health, promoting wellbeing and reducing inequalities in health outcomes for the people of Bristol, North Somerset and South Gloucestershire.

Population Health is an approach aimed at improving the health of a defined population within a specific geography, whilst reducing unwarranted variation and health inequalities. It includes action to reduce the occurrence of ill-health by focusing on addressing wider determinants of health, and requires working with communities and partners.

A key enabler of this approach is Population Health Management (PHM), which aims to improve population health by data-driven planning, delivery and evaluation of care to achieve maximum impact. Through collaboration with OneCare, GP Localities and the LMC, 80/81 GP practices in BNSSG have agreed to share the data needed to enable this process.

The opportunity for PHM to support PCNs in delivering improved personal and population level outcomes is great but will take coordinated effort to realise. The Healthier Together PHM team will work with PCN leaders to co-produce intelligence that will lead to positive changes within front-line services. This will take the form of an interactive dashboard which allows users to explore connected health data (including General Practice, secondary,

community and mental health data) for patterns and relationships within demographics, disease prevalence and activity recorded in the BNSSG System Wide Dataset. This will be able to be filtered at Locality and PCN level.

Improving Health Outcomes for our Population

Along with all other parts of our system, primary care will take its part in delivering improved health outcomes for our population. Population Health Management, use of risk stratification tools and benchmarking data will support ICPs and PCNs to develop targeted interventions and address health inequalities. We will continue to support parity of access for all of our population and ensure that our most vulnerable patient groups including those with Serious Mental Illness (SMI) benefit from health checks. We will also support access to health and care for other groups of our population including veterans, children and young people, black and minority ethnic groups and people living in areas of deprivation.

Primary care has a key role to play in prevention and detection of illness. We will continue to work with Public Health England to support immunisation and screening programmes for our population and embed giving advice and support on healthy lifestyles in our daily clinical practice. We will ensure that primary care supports national public health campaigns.
Our BNSSG Population

Almost one million people currently live in Bristol, North Somerset and South Gloucestershire. BNSSG has the major city of Bristol at its centre, with the towns, villages and rural areas of North Somerset and South Gloucestershire to the south and north respectively. 90% of the population live in urban locations.

The age profile for BNSSG is very similar to England as a whole with 18% of the population aged 0 to 14 years and 8% aged over 75 years. The population profile of the area is changing dramatically with a rapidly ageing population, and an even faster growing younger population and significant new housing planned across the area.

BNSSG is a relatively affluent area, but there is local variation, with significant areas of deprivation. Nearly one in ten of the population (9.3%) are living in some of the most deprived areas whilst one in twenty (5%) are living in some of the most affluent areas. BNSSG is also an area of cultural diversity, with 87,325 (9.8%) of the population having black and Asian ethnicity.

Understanding the health needs of the population is important for planning services.

There is considerable variation in population health across BNSSG. Whilst average life expectancy is similar to the England average there are some areas of extreme poverty and deprivation with poor health outcomes. The most common causes of premature death in BNSSG are due to cancer, heart disease and stroke, liver disease and injury. Cancers, circulatory and respiratory diseases are major drivers of inequalities in life expectancy we see between deprived and more affluent groups, especially within Bristol. These main causes of early death are often preventable and amenable to preventative interventions.
Health inequalities and the wider determinants of health

It is widely acknowledged that the health of the population is closely linked to levels of deprivation. Health inequalities across the BNSSG population, and between different groups are wide and growing. Health inequalities are unfair and avoidable differences in health that arise because of the conditions in which we are born, grow, work and age. These conditions influence our opportunities for good health and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

Health inequalities pose ethical, service and financial challenges. Tackling health inequalities makes good economic sense. The high burden of disease in deprived areas generates higher use of health and social care services, higher unemployment, and lower productivity which has a cost for local and national economies. If this 'unmet need' is not addressed in those at greatest risk, a large part of the growing burden and cost will persist. Local Authorities and Clinical Commissioning Groups have legislative duties to reduce health inequalities. The impact of health inequalities is also referred to in many areas of public policy including economic growth, housing, educational attainment and action to promote social justice.

The recent Department of Health and Social Care green paper 'Advancing our health: prevention in the 2020s' and the NHS Long Term Plan all create welcome opportunities for ambitious, coordinated, local level action on health inequalities. The commitments outlined in the green paper suggest a new approach for the health and care system with the aim of shifting the health system away from just treating illness, and towards preventing problems in the first place. It recognises the shared responsibility between local and national government, working with the health and care system and also that individuals and communities must play their part too.

We acknowledge that health is about much more than healthcare or the choices we make about our diet or whether we exercise, smoke or drink alcohol. We know that the best way of ensuring a long life in good health is to have a good start in life, a good education, a warm and loving home and an income sufficient to meet our needs and that working with our diverse local communities and neighbourhoods to influence the "wider determinants" of health is vital for improving population health and reducing health inequalities.

The charts labelled figure 15, 16 and 17 show the absolute gradient of inequality (AGI) in unplanned hospital admission for ambulatory and urgent care sensitive conditions (ACSC), e.g. diabetes, asthma or COPD. The steeper the slope from left to right, the worse the level of inequality between the least and most deprived neighbourhoods. Bristol has the greatest inequality within BNSSG with the most deprived neighbourhoods having unplanned admissions at 3.5 times the rate of the least deprived. This is an important measure as it is sensitive to the quality of healthcare provision from community, through urgent and ambulatory care and the outpatient system. Of course this is also influenced by population health characteristics, which are in turn affected by the wider social determinants of health. This data highlights the opportunity to improve the state of health inequalities while simultaneously addressing the current unsustainable demand for acute care.

Figure 15. Bristol AGI for ACSC admissions

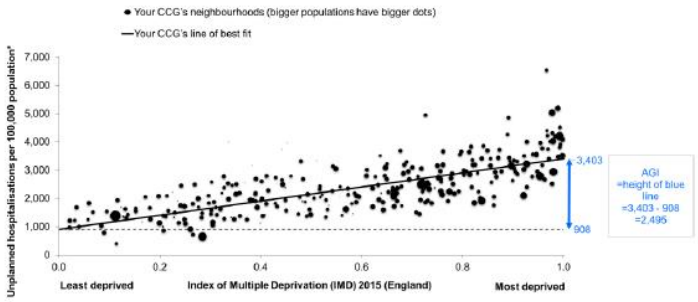


Figure 16. North Somerset AGI for ACSC admissions

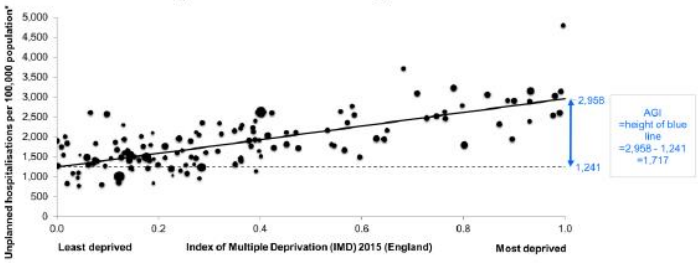
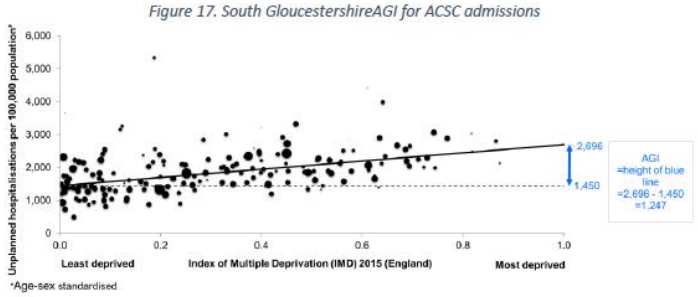


Figure 17. South GloucestershireAGI for ACSC admissions



Individual lifestyle factors

Behavioural and lifestyle factors including smoking, excessive alcohol consumption and poor diets are linked to an increasing number of diseases and conditions. The relationships between socioeconomic factors, health behaviours and health outcomes are complex - those who are most deprived, tend to experience greater exposure to risk factors for disease, so acting on the wider determinants of health as well as health behaviours are essential to improve health and reduce health inequalities in the population.

- Nearly a quarter of the adult population (22.7%) report binge drinking (England 20%)
- The rate of hospital admissions attributable to alcohol is high for BNSSG at 708.5 per 100,000 compared to a national average of 632 per 100,000 (LAPE 2017/18).
    - Bristol: 810
    - North Somerset: 663
    - South Gloucestershire: 667

- Overall one in ten pregnant women are still smokers at the time of delivery.
- Around 1 in 5 reception age children in BNSSG are overweight or obese and this rises to almost 1 in 3 by the age of 11 representing a major strategic risk to the system and their health outcomes. By 2020 it's estimated half of all children will be overweight or obese. Obese children are much more likely to be obese adults, causing significant health risks as well as low self-esteem and body image.
- In 2013-15, 61.3% of adults in BNSSG were estimated to be either overweight or obese.
- The number one cause of years lost to disability is low back pain and neck pain.

Cancer – early diagnosis and screening

- 30% of women do not receive age-appropriate screening and 40% of all people do not receive bowel cancer screening. Disparities exist within ethnic groups with black and ethnic minority groups
- The BNSSG proportion of cancers diagnosed at an early stage is 55%, slightly above the England average of 52.4%
- It is estimated that between 63% and 82% of all deaths require palliative care. However, the numbers of people on the most recent palliative care register represents only 22% - 31% of deaths in BNSSG (BNSSG End of Life Care Needs Assessment).
- Smoking is the biggest risk factor associated with incidence of lung cancer. An estimated 85.6% of cases in the UK are attributable to exposure to tobacco smoke. The prevalence of smoking was highest among the most deprived throughout the UK and Ireland, which explains why the rates of incidence of lung cancer are much higher in the most deprived quintile.

Primary care will be central in the development of Rapid Access Diagnostic Services and supporting screening in specific populations with low uptake.

Long term conditions and complex needs

A key challenge is managing the needs of people with multiple conditions and complex needs.

It is estimated that people with long term conditions make up an estimated 30% of the BNSSG population and have associated needs for ongoing management of their condition as well as responding to urgent problems. Approximately a third of people with long term conditions may have complex needs, requiring multi-agency and specialist input.

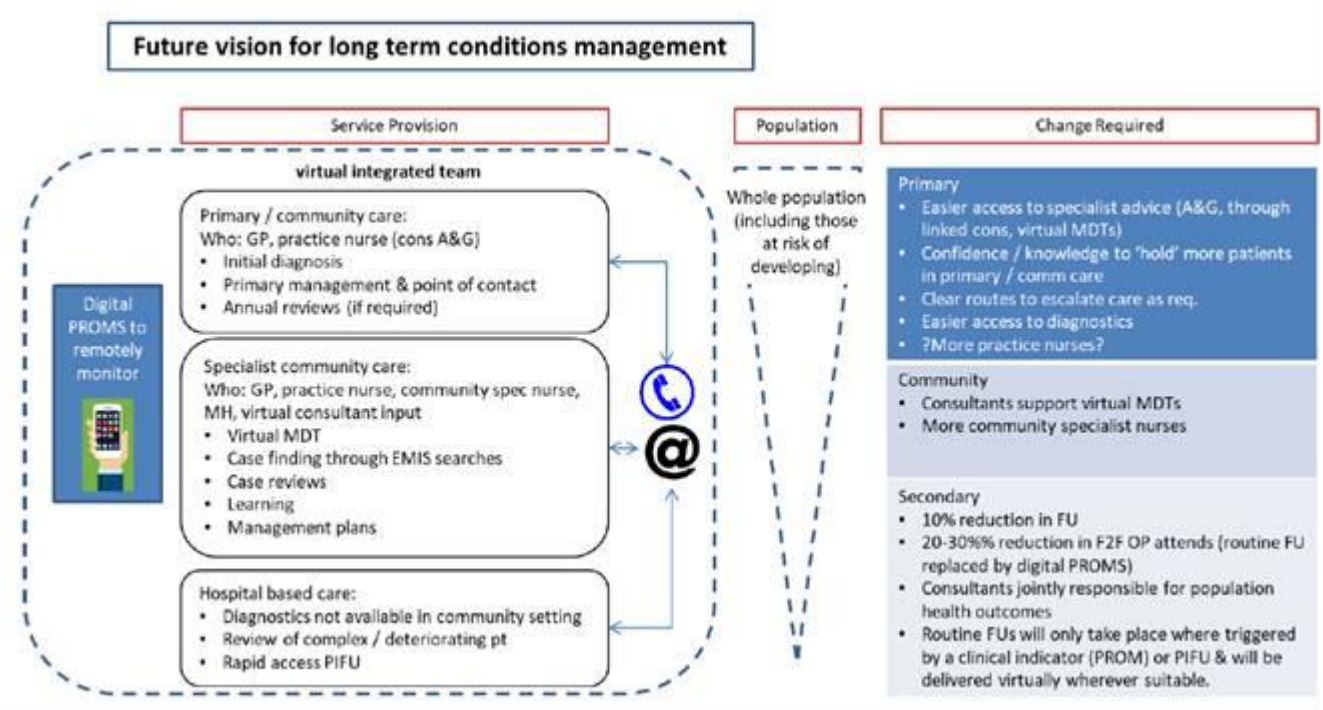
Long term conditions account for about 50% of GP appointments, 65% of outpatient appointments and 70% of hospital admissions as well as significant social care costs. About 40% of people over 40 will have a long term condition, and this rises by 10% every

10 years.
However, much of this disease is considered avoidable. For example, about four out of five cases of heart disease, stroke and diabetes and two out of five cases of cancer could be prevented. Helping people to stop smoking, raising levels of physical activity, ensuring a healthy diet, stopping harm from alcohol and drug misuse and investing in good mental health and wellbeing can all have a significant effect.

The top ten long term conditions within the GP QOF in BNSSG are (prevalence 2018-19):

1. Hypertension (12.6%)
2. Depression (11.7%)
3. Asthma (6.4%)
4. Diabetes (6.0%)
5. Chronic kidney disease (4.9%)
6. Ischaemic heart disease (2.7%)
7. Atrial fibrillation (2.1%)
8. COPD (1.8%)
9. Stroke or TIA (1.8%)
10. Heart failure (0.94%)

Analysis of urgent and emergency care users suggests that complexity and multimorbidity are more important in explaining service use than simply being older. This may reflect a service that currently does not work for this group of people and/or represent unmet need leading to demand on acute services.



Mental health and wellbeing

Mental health conditions are one of the biggest contributors of years lived with disability in BNSSG. They are widespread, often of long duration, and have adverse effects on many areas of people's lives. Anxiety and depression prevalence in BNSSG is estimated at 12.7%. Self-harm is a major concern locally and accounts for over 2,200 emergency hospital admissions annually in BNSSG. The number is particularly high amongst females and is more of an issue in Bristol than other areas.

Mental and physical wellbeing are closely linked; people with poor physical health are at higher risk of experiencing mental health problems and people with poor mental health are more likely to have poor physical health. People with mental health conditions are more likely to smoke, be overweight, use drugs and drink alcohol to excess, have a disrupted education, be unemployed, take time off work, fall into poverty, and be over-represented in the criminal justice system. It is therefore crucial that mental health is given equal priority to physical health in order to improve health and reduce inequalities in the population.

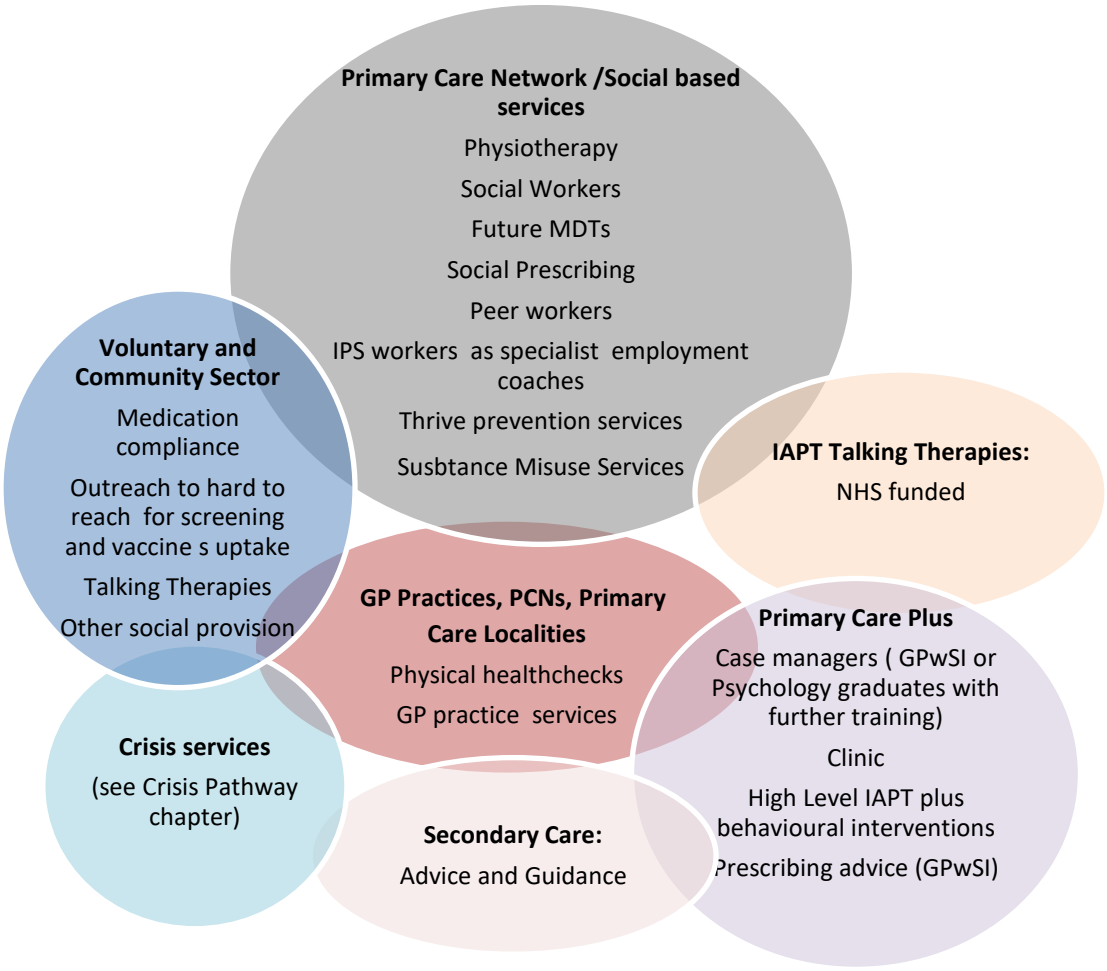
- Premature (<75) mortality in adults with serious mental illness in BNSSG is much higher (3-4 times) than the background population (approximately 1,300 per 100,000 population) but is even higher in North Somerset (approx. 2,100 per 100,000 population)

- Only just over half (51.9%) of people with a learning disability receive a coded annual health check. People in this group experience much higher premature mortality than the background population.

- The BNSSG dementia prevalence is estimated at 4.4%

In seeking to better meet the needs of people experiencing poor mental health, in an accessible community setting, rather than the emergency department value is likely to be improved through improved experience, outcomes and use of resources.

Our **BNSSG Mental Health Strategy** understands the benefits of an integrated service and through developing a fully integrated approach in primary care will offer 'Safe Hands' for those with mental health needs. The finished model will need to go through some further testing, but we are aiming for an approach as per the diagram below, with improved joined up local care for individuals and admission prevention.



The key principles of our model will include:

- A GP/PCN 'menu' of support wrapped around the individual in GP practice, the gaps in appropriate services are defined more systematically so that solutions needed can be quantified and addressed in the wider offer from community mental and physical health services;
- We will extend our well-developed partnership and co-production approach with the VCS and NHS providers to maximise the benefits and streamline integration.

- A mental health workforce more embedded in Primary Care and the community, to act as a first point of contact;
- There will be equal weight given to physical and mental health.
- The Serious Mental Illness (SMI) physical health check approach will include referral/signposting to the appropriate services, some may be bespoke, targeted prevention e.g. smoking cessation;
- The individual is at the heart of integrated mental health in Primary Care, working together with their healthcare professional, with flexibility available to adopt extended appointment times if needed.
- Our model will be based on local population need and clinical profiling, rather than being service-based;
- The approach will be centered on the principles of hope, recovery and resilience.

Learning Disabilities (LD) and Autism

There are significant access, quality and outcome issues for people with learning disabilities (LD) and autistic spectrum disorders, within BNSSG. The prevalence of LD in BNSSG is1.7% (~16,000 people) compared with 1.5% for England.

The 'Learning Disability Mortality Review (LeDeR) Programme', led by Bristol University has found:

- median age at death for people with learning disabilities (aged 4 years and over) 59 years (April 2017-December 2018)
- The resulting life expectancy gap is 23 years for males and 27 years for female
- The medical conditions most frequently cited anywhere in Part I of the Medical Certificate of Cause of Death were:
  - pneumonia (25%)
  - aspiration pneumonia (16%)
  - sepsis (7%)
  - dementia (syndrome) (6%)
  - ischaemic heart disease (6%)
  - epilepsy (5%)
- Completeness of the GP learning disability register: 0.46% of population on a register (6th/11 comparator CCGs)
- Proportion of people with a learning disability on the GP register receiving an annual health check: 51.9% (5th/11 comparator CCGs)

Autism and Autistic Spectrum Disorders (ASD) are lifelong developmental disorders that affect how individuals perceive the world and interact with others. It is not an illness or disease and cannot be cured. There are an estimated 1% of the population, which would mean 9,500 people in BNSSG, with autism/ASD of whom around 1,700 of school age and

known to schools. Both adult and children specialist services have suffered from long waiting times, in some cases waiting for up to close to a year to be seen for a diagnosis. Recent improvements have reduced waiting times at least for adults. Available system level data on autism/ASD is poor, with minimal data on outcomes. We do know that the experience of care for people affected and their families can be very poor.

The LTP committed to improving coverage of health checks for people with a learning disability. NHSE have now agreed with the General Pharmaceutical Council (GPC) to implement a wider package of measures to make faster progress:

(i) Improve the quality of registers for people with a learning disability;

(ii) Concerted effort to increase the number of people receiving the flu vaccine, given the level of avoidable mortality associated with respiratory problems;

(iii) Introduce the QOF Quality Improvement module for learning disability in 2020/21;

(iv) Aim to achieve early delivery of the 75% target for comprehensive health checks, which already attract a £140 item of service fee. We would like to achieve the 75% goal in every PCN and

(v) Later this year launch a national communications campaign to help get the messages across

Improving Health Outcomes for our Population

Along with all other parts of our system, primary care will take its part in delivering improved health outcomes for our population. Population Health Management, use of risk stratification tools and benchmarking data will support ICPs and PCNs to develop targeted interventions and address health inequalities. We will continue to support parity of access for all of our population and ensure that our most vulnerable patient groups including those with Serious Mental Illness (SMI) benefit from health checks. We will also support access to health and care for other groups of our population including veterans, children and young people, black and minority ethnic groups and people living in areas of deprivation.

Primary care has a key role to play in prevention and detection of illness. We will continue to work with Public Health England to support immunisation and screening programmes for our population and embed giving advice and support on healthy lifestyles in our daily clinical practice. We will ensure that primary care supports national public health campaigns.

Primary Care links to the Healthier Together System Strategies and Workstreams

This Primary Care Strategy is one of a number of strategies that collectively describe our future vision for delivering health and care services in Bristol North Somerset and South Gloucestershire. As part of our engagement we are collaborating with the following areas to align and support work. The table below highlights some of the key themes that cross over:

Prevention	Integrated Care	Acute Care Collaboration – Planned Care	Urgent & Emergency Care	Mental Health/ Learning Disability & Autism	Children, Families & Maternity
Explore and highlight opportunities for prevention across all providers of primary care in the following priority areas : **Public Mental Health & Wellbeing** **Healthy Weight** **Alcohol** **Tobacco** **CVD** **Making Every Contact Count** Support improved education and early intervention with the population Expand delivery of MECC training across Primary Care Primary Care based social prescriber's role in delivery.	**Out of Hospital Care including Frailty** **Personalised Care** (Supported self-care, shared decision making, personal health budgets) **Building Healthier Communities** (incl Social Prescribing) **Diabetes** 5 workstreams within the prevention programme. Increased diabetes specialist care by community services **Respiratory** Smoking cessation, Reduction in admissions for community acquired pneumonia. Establishing a community based single respiratory service for BNSSG available seven days per week. **EoL** Locality models of care programme, including the development of the out of hospital model of care and new ways of working, will support the delivery of the EoLC programme.	Community and locality based care established under community service provider supporting prevention of readmission to hospital and reducing hospital LoS through improved out of hospital management of cardiac conditions. **LTC & MSK** -Prevention , Early Diagnosis and Supported Self-Care – Locality Hub working -Roll out of First Contact Practitioners to Primary Care Networks -Work with Sirona to implement the centralisation of MSK Interface services -Implement the new outpatients model in Rheumatology to increase closer working with primary care -Improved access to diagnostics and Heart Failure nursing support through the establishment of PCNs and locality community models -Stroke programme is interdependent on the new community services models of rehab care **Social prescribing** increased through the development of PCNs and locality based care models **Outpatients Transformation** -Referral support. -Interdependency with the Primary Care Strategy and development of Locality Hubs - closer working with primary care to enable them to manage more people and therefore prevent an outpatient appointment -NHS App/ Online Consultations - All patients can book online or through an app -Locality services will be in place to support integrated model of care for respiratory, urology and MSK in 2020. The plans will need to be tested with GP providers and localities **Improved Diagnostics** -Primary Care, the Locality Hubs require diagnostics -Digital, there is a requirement to share images/information across BNSSG. **Ophthalmology** Eye Care Strategy – also see relevant section in PCS **Meds Optimisation** -Improve medicine value and unnecessary harm from medicine – linking to structured medication reviews -antibiotic-multiresistant corynebacteria (AMC) – continue to reduce antibiotic use and healthcare associated infections(HCAI) -pharmacy workforce + system wide network to support training and education -digital capability to improve safety + efficiency	Comprehensive primary and community care services to ensure that only those who need acute care are referred to hospital: -Improved access to Primary Care & MDT working -Same day, community-based urgent care will be available 24 hours a day, 7 days a week -Integrated new models of care for frailty and mental health -Referral-only hospital emergency services used by those who need immediate acute care **IUC** As part of the IUC, a single point of access service for patients, carers and professionals including an Integrated Care Bureau and flow capacity management **Improved Access:** DoS/MiDoS NHS App 111 Direct Booking Online Consultations **Urgent Social Care** **Pharmacy/Community Pharmacy Consultation Service(CPCS)** • Referrals from 111 • Longer term, referrals from IUC • Referral from GP practice • Increase access to medicine, through introduction of Patient Group Direction (PGD) service	-A fully integrated Primary Care and Community service offer to ensure every person who presents with a mental health condition can access the right care in the right place first time -A GP/PCN 'menu' of support wrapped around the individual in GP practice, the gaps in appropriate services are defined more systematically so that solutions needed can be quantified and addressed in the wider offer from community mental and physical health services. -Safe Hands: with Primary Care Plus for Mental Health **Prevention** Agree and implement recording process for physical health checks that take place in primary care in partnership with GPs Improve uptake of physical health checks for people with SMI on practice registers, and develop plan to further improve across LTP period Create single point of access for all crisis services Create NHS111 mental health line Work with Local Authorities to develop an early advice and help model for primary care CAMHS. Implement dedicated system pathway for 16-25 year olds **Access** Improving and delivering high quality and effective support for parents and carers IPS service across BNSSG, embedded with rehab, EIP and Recovery teams – complimenting **Integration** -Integrated initiatives from community, primary and unplanned care delivered through our community services offer and our emerging primary care networks. This will include MDTs that provide wrap around care to provide a more holistic care offer, and a focus on High Impact Users of urgent care services who may have a mental health need. -Design a primary care based mental health service aligned with Primary Care Networks harnessing the capacity and capability of the third sector -Training for clinical roles including GPwSIs **Severe Mental Health Problems.** New and integrated models of primary and community mental health care: psychological therapies and employment support, personalised trauma-informed approaches, self-harm/substance misuse support, new services for people with the most complex needs, addressing racial disparities, greater choice and control and support to live well in communities. **LD & Autism** Increasing access through reasonable adjustments and awareness Working with LAs and providers to have greater awareness of physical health needs, access to Primary care increase of health checks Reduction of deaths increased severity resulting from undetected preventable illness Including preventing admissions to hospital associated with behaviour that challenges as a result of undetected pain or infection for example Access to health checks and screening Early support through reasonable adjustments in accessing IAPT services people with autism	Reduced Health Inequalities: Smoking cessation and healthy weight Design and implement new models of care that are age appropriate and closer to home: Locality Hubs, Social Prescribing Improve pathways between midwifery and GPs, improve transition of care from midwifery to HV Enabling annual GP health check for young people with learning difficulties Role for Primary Care Networks in team-around-the-school models of care and children's palliative and end of life care

What does this mean for our population?

Access/Models of Care

- I can get an appointment when I need one
- I know who I can see for a particular problem
- I get my care delivered where I want it
- I am sure all the people involved in my care talk to each other and me

Developing the workforce

- The health and care professionals looking after me have access to regular training to keep their skills up to date
- The team looking after me have people in it who can help me with the different types of problems I may have and they co-ordinate well together
- I can be sure that the team looking after me is looking to the future and training people up to join, so I can be sure of a consistent service

Infrastructure

- The services offered are helpful to me and my family
- If I can't get what I need locally, I don't have far to travel
- I can access services in different ways
- My care is delivered from a place where I feel safe and comfortable

Quality and resilience

- The care I receive is: up to date; trustworthy; delivered safely; tailored to my situation; high quality; aiming to improve something I care about

Continuity of Care

Continuity of care is a core feature of general practice; it creates multiple benefits for patients, doctors and society. Continuity increases trust, patient satisfaction, disclosure of information, take-up of preventive care, adherence to advice, reduction in socio-economic disadvantage, and reduces deaths. However, the level of continuity is reducing in general practice. About 15 consultations are needed with a patient for a GP to acquire enough 'accumulated knowledge' to develop a sense of continuing responsibility. This fosters GP sensitivity and mutual understanding, which enable GPs to provide 'higher-level' quality of care. **Professor Sir Denis Pereira Gray**

Perceptions of continuity and capability

Continuity is perceived to be particularly important in regard to integrated care, with capability (in terms of system capacity, resources and individual competency) considered an important element for both integrated and personalised care to succeed.

Deliberative Research October 2019

Research shows improved continuity of care is associated with greater patient satisfaction, improved take up of health promotion, increased concordance with treatments and medication regimes, reduced hospital use and lower mortality rates. Improved relational

continuity can also help staff be more confident, more efficient and feel increased job satisfaction due to improved engagement with the patient over a longer period of time. Clear lines of accountability lead to increased patient and staff satisfaction as both groups always know who is responsible for each patient's care. Other benefits include decreasing practice workload and increased efficiency associated with patients telling their story once to someone who knows them. Improving the working environment for team members restores their job satisfaction, promotes health and well-being and improves staff retention.

Chapter 4: Our Priorities

Models of Care

Community Based Model of Care

Our community based model of care supports the vision and priorities set out in the NHS LTP including:

- Achieving a new model of care that supports people to stay well based on close working with networks of GPs and boosts out of hospital care for all
- More people having control over their health, more personalised care and less pressure on high cost emergency services
- Care underpinned by digitally enabled systems
- Greater focus on population health and an integrated whole-system response across primary, specialist, physical and mental health, and social care
- Prioritisation of prevention and tackling health inequalities
- Higher intensity support for people with long term conditions
- Staff wellbeing

'Alicia is 50y old and lives at home with her elderly parents. She has COPD and gets regular chest infections, necessitating visits to the GP frequently especially during winter. Her father's mobility is deteriorating, and he has had a stroke in the past. Her mother has heart disease and her angina is worsening. Alicia is the sole carer for her parents and she is worried about how she will manage her own health needs, as well as those of her parents. She is not sure how she can access help.'

Over 90% of healthcare contacts happen in the community. This Strategy looks to move more care being delivered in the community, increasing patient satisfaction, quality and improving the system capacity as a whole.

Through our community services and integrated locality working we will be providing truly integrated community care, and this will be the foundation of our approach to personalised care for individuals, whilst meeting the needs both locally and of our population as a whole.

What will this mean for Alicia?

Alicia is called for her annual COPD review. The nurse wants to reduce the likelihood of Alicia deteriorating in the winter, so she changes Alicia's inhalers in discussion with Alicia's GP and makes sure she talks through a management plan if things get worse, including whom to call and when. This is recorded and shared digitally across Community Providers through a shared care plan and to other Providers via Connecting Care, so if Alicia worsens all are aware of what has been discussed and agreed with her. The nurse gives Alicia a rescue pack of medication and makes sure she has written information about when to start this. She also refers Alicia to pulmonary rehabilitation, which happens at another location not too far away, and transport is arranged. The nurse asks about Alicia's home situation and records her carer status and signposts her to the Primary Care Network social prescribing link worker for other avenues of support.

Because of the strong links with the community pharmacy, when she goes to her local pharmacy to collect her medicines, the pharmacist makes sure she knows how to use her new inhaler. The pharmacist reinforces the advice given to Alicia on when to use the COPD rescue pack and will be there if she needs to phone/drop in for advice. Alicia realises that she hasn't had her blood pressure done for a while, so gets it checked with the pharmacist and is asked to come back in a month for another check as it is slightly raised. She is given information about lifestyle measures she could adopt to improve her health in general

Integrated Local Services

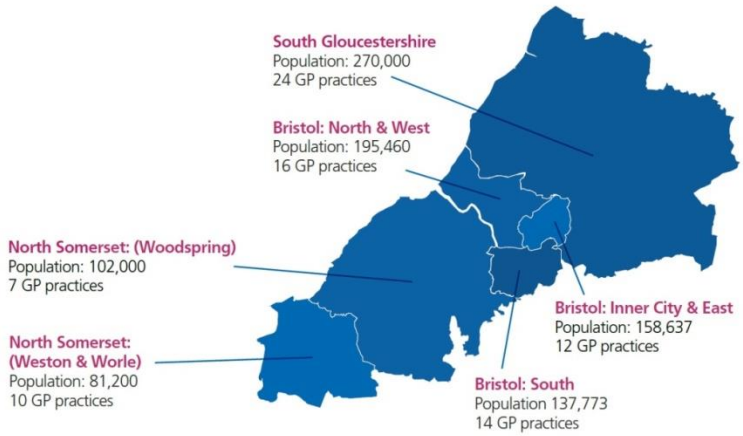
The BNSSG system has begun its journey to address the current fragmentation between the multiple services that exist in the community and the key challenges for our system, including:

- An ageing population, people living longer and with more long term conditions
- Cost and demand pressures
- An over-reliance on hospital and residential care and traditionally commissioned domiciliary services and the need to focus on people's strengths
- A limited focus on prevention and early intervention
- A disconnect between social and medicalised care, and a lack of attention to the whole person
- Fragmented delivery of services leading to duplication, a lack of co-ordination, and gaps in care

Locality Development Approach

We began the journey towards joining-up local services in Autumn 2017 with the establishment of our Locality Transformation Scheme which incentivised Practices to work together in national geographies. Over the last two years, we have established wider

provider partnerships in each locality to oversee the development of integrated local services. These partnerships currently include adult community, mental health and social care and links are beginning to form with the acute sector.



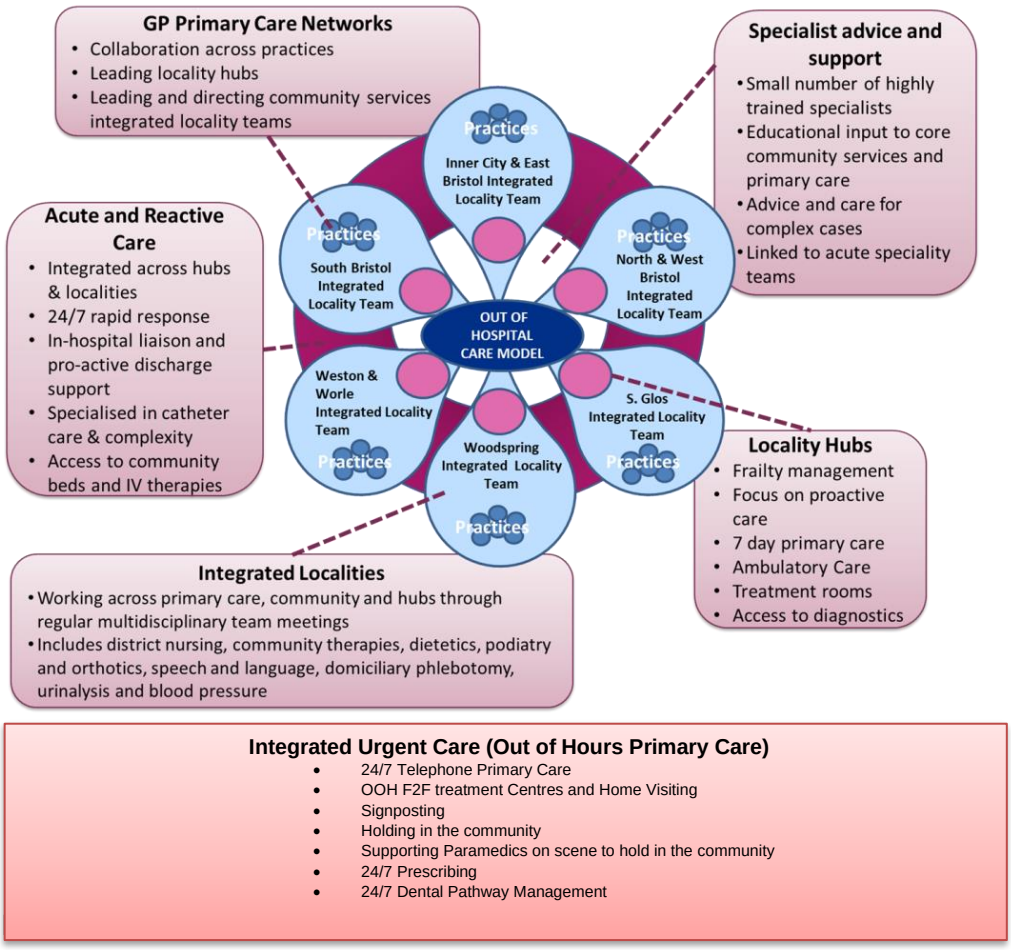
Over the last two years, we have established partnerships in each Locality to oversee the development of integrated local services. These groups have already started working with other providers. Some areas have well established multidisciplinary teams working in each GP practice to bring together a range of practitioners to jointly support people with exceptionally complex needs; others have set up new drug and alcohol clinics based in GP practices; social prescribing services are working with GPs and others to support people in new ways e.g. helping them to have the confidence to take part in activities to prevent loneliness and therefore ill health; in Weston a new mental health crisis café has been commissioned and specialists from our mental health trust are supporting GP practices so they can better treat people with less severe mental health problems in Primary Care.

Our six localities are planning how they will further join up services in the community to become a strong system of care at every level, enabling people to keep healthy, well and independent in the community.

Integrated Care Partnerships (ICPs) are being co-produced by and will bring together our PCNs, community services, local authority services, mental health and the voluntary sector in communities jointly to coordinate services for their populations. They will use Population Health Management data to focus on the specific needs of the people in their communities.

Where more specialist community support is required, the community services delivered by Sirona and mental health services by Avon and Wiltshire Mental Health Partnership Trust (AWP) will be embedded in the management of people's care in the following model:

Figure 1: BNSSG Community Based Model of Care



By October 2020 there will be a new hub in each of our six localities. They will act as the base for a range of new community-based services, making the community the default setting for people's care.

In the Locality Hubs, we will bring together a range of existing and new services that currently sit within different organisations but will work more closely together to deliver joined-up care that considers the whole of an individual's needs. For example, we will develop a new service that will carry out comprehensive assessments for elderly people and identify the support that they need, providing specialist services for people with long-term health conditions and delivering urgent care in the community.

Integrated Network Teams

From April 2020, 18 network teams integrated with our PCNs will be in place to deliver more proactive and joined up care for people with complex needs.

The teams will develop care coordination approaches with Community Matrons, Community Nurses, Nurse Associates, Dieticians, Therapists, Pharmacists, Social Care, Mental Health and other staff coproducing robust care plans for individuals living with complex needs. They will be responsible for identifying people who need proactive care

before their condition worsens and people who need more intensive support to retain their independence and live well.

With Local Authority colleagues embedded within the team, we will maximise the use of technology to support people to live independently and enhance their lives. This partnership will also mean that physical health, mental health, social needs and spiritual needs can be addressed.

Specialist advice and support

New community specialist advice and support services, largely operating within the Locality Hubs, will help the Integrated Network Teams support people with a wide range of needs in a safe and effective way.

Over 2020/21, hospital-based specialist services will either provide virtual or physical input to clinics in the Locality Hubs, for example in the management of dementia, heart failure, diabetes, musculoskeletal disorders, and hospices in end of life care. The specialist services will also work with care homes providing advice and education and with people and their carers in the community to support people to stay healthy and well.

We will strengthen our capability to respond to emergencies within the community without having to send people to hospital, or when they do need hospital, to reduce lengthy hospital stays. For example, we will put in place new Emergency Care Practitioners, frailty assessment units and falls services to work with our Integrated Network Teams so that they can make rapid assessments and mobilise specialist support for people quickly in an emergency.

Building Healthier communities together

Alongside developing services, we intend to find a very different way of working with people and their families. There are large numbers of community led faith, voluntary and social enterprise organisations which already do a considerable amount to keep people healthy, well and independent and our ambition is to work with and through these groups to accelerate community mobilisation in health and wellbeing. Our Local Authority partners are particularly taking forward this work with the VCSE to optimise community assets. We are working with the VCSE, Local Authority colleagues and grant-holding organisations to develop an entirely new way of working with communities.

Our plan is to establish community based VCSE organisations as equal partners in each of our locality partnerships to support thriving communities where people are able to have healthy and fulfilled lives. This will be established in each locality by April 2020.

As a system we support the NHS ambition to embed the Comprehensive Model of Universal Personalised Care by 2023/24 and we are committed to supporting people and their carers to manage their conditions and make informed choices about what is right for them. We are also developing metrics to measure the impact of shared decision-making and personalised care.

The underlying care approach that underpins the community based system is deliberately strengths based, supporting people to have more choice and control over their lives. It

aims to help them acquire the skills they need to manage their conditions and feel confident and in control of their health and their care.

Integrated Care Partnerships (ICPS)

As services in the community become more established in the form of Localities, we will work with them to enable them to form ICPs, able to take delegated responsibility for budgets and the delivery of services based on the needs of their populations. Over time we expect this to cover the majority of commissioned care for local people.

From 2021, we will work with our current Locality Partnerships to consider how we might develop more formal ICPs that will allow us to secure sustainable integrated services, focused on local needs and working with the strengths of communities and individuals.

Prevention

In BNSSG we see prevention as everyone's responsibility. As a system Healthier Together has committed to delivering population health which means we have collectively committed to improving physical and mental health, promoting wellbeing and reducing inequalities in health outcomes for the people of Bristol, North Somerset and South Gloucestershire.

Primary Care already plays an important role in prevention through delivery of NHS Health Checks, stop smoking support, immunisation and screening programmes and contraception and sexual health services. We know that there is further work to do to ensure that prevention opportunities are identified within every pathway and the benefits those prevention opportunities will bring. This should include primary prevention (keeping people well); secondary prevention (intervening to prevent a condition progressing); tertiary prevention (steps to support people to recover or maintain best health following serious illness).

There are opportunities to do this through PCNs. Future PCN service specifications include prevention of cardiovascular disease and tackling neighbourhood inequalities and we will work together to develop these services in-line with NHS England guidance when available,

Making Every Contact Count in Primary Care

Making Every Contact Count (MECC) is about supporting organisations and their staff to maximise the opportunity they have with the public in promoting health and enabling them to make changes to improve their health and wellbeing.

In 2019-20 we have been working to further expand MECC capacity through Primary Care organisations in BNSSG, collaborating with Avon LMC and LPC. The purpose of the project has been to develop and deliver training for Primary Care staff to enable them to maximise prevention opportunities and encourage individuals to consider their health behaviours and any improvements they wish to make.

MECC training focuses on using open discovery questions, which are questions starting with 'what' or 'how'. Open discovery questions allow the conversation to be led by the

person and move the conversation away from staff giving solutions or offering suggestions.
Trainers from the LPC and LMC have been MECC trained, shadowed experienced MECC trainers and supported delivery to become accredited. Over 100 Primary Care staff have already received MECC training in 2019-20. We have also produced an e-learning video to showcase Open Discovery Questions, which compliments the existing e-learning materials. This will be transferred into suitable platforms for general practice and pharmacy staff to readily access.

Further system wide work is planned to develop an integrated approach to maximising prevention, population health and reducing inequality in health in BNSSG by using evidence based tools such as Public Health England's (PHE) menu of prevention interventions and the PHE inequalities place-based approach and toolkit. This approach will be informed by population health management, public health intelligence and evidence as well as citizens' insights and will inform the ongoing development and delivery of the Primary Care Strategy.

A PCN consists of groups of General Practices working together with a range of local providers, across Primary Care, community services, social care and the voluntary sector, to offer personalised, coordinated health and social care to their local populations. Networks are geographically based and, between them, cover all practices within a clinical commissioning group boundary.

Our Practices have already come together in 18 PCNs in BNSSG, and are collaborating to improve services for people in defined geographic areas (see Appendix 2).

Our model of care is one in which Primary Care is part of an integrated network working with local community, mental health, social care and voluntary sector partners to develop co-ordinated care. Working within Localities, PCNs will focus on keeping people well and improving the overall health of their populations, supporting people to care for themselves, intervening early to prevent ill health and working collaboratively with people to plan their care. Through PCNs, practices will work together and with other services to make best use of staff and resources. Our system model has PCNs at its core working within our Localities to form ICPs and develop shared population health management, provide leadership to our Integrated Care System and deliver new models of care at scale.

Our PCNs are working to deliver the following new service areas by April 2020, aligned to national policy:

- Structured medication reviews
- Enhanced health in care homes
- Anticipatory care
- Personalised care
- Supporting early cancer diagnosis

This will be followed by a focus on cardiovascular disease case-finding and locally agreed action to tackle inequalities in 2021.

In addition, we are also working with the Local Pharmaceutical Committee to involve community pharmacies for example, collaborating with PCNs to:

- Deliver consultations and advice
- Become Healthy Living pharmacies
- Support primary care in quality prescribing

Our ambition is for PCNs to:

- Provide greater resilience to Primary Care through supporting investment in practices, growing the workforce in Primary Care and providing an opportunity for formalising collaborative working
- Facilitate the delivery of more joined up working across providers to improve the delivery of care to people in BNSSG and enhance the offer to people by providing more care closer to home
- Underpin our system transformation and work with our localities and our IUC to develop a specific focus on urgent Primary Care, and to deliver our priorities on same day emergency care, frailty and improving mental health
- Deliver high quality and best value care through a focus on population health management, promotion of self-care and prevention of ill-health and pro-active care planning based on shared decision making with patients informed by a common understanding of personal outcomes

What people have told us about PCNs

During our engagement phase we have asked professionals and people in BNSSG to think about the opportunities for PCNs and to identify key challenges or risks. This has been a key part of both our face-to-face engagement events and our online survey which we have promoted to health care professionals and patients.
We have received strong messages about the opportunities for sharing best practice and resources, for providing a population focus and reducing inequalities and health inequalities as well as the opportunity for PCNs to grow and provide a platform for providing more care in the community - accompanied by the resource to support this. There is a consistent recognition that in order for this to work PCNs will need to work with other providers. There are hopes that PCNs can provide better access to specialists within a more local geography balanced with concerns about how continuity of care can be provided and access barriers for some to more centrally located services.

We will know we have made a difference when people tell us that they have better access to a wider range of care in a community setting and that access has not come at the expense of continuity of care. Additional roles will be recruited to and will be providing value to primary care, supporting innovation and an increase in capacity in primary care.

Our local providers will work with PCNs to support workforce development and solutions such as rotations, shared recruitment or portfolio roles to develop an integrated workforce approach. Good ideas will spread and be adopted within and across PCNs. PCN leaders inform our system plans to drive improvements in population health. They deliver care and provide tailored approaches to meet the differing needs of our population. Relationships across providers are trusting and encourage and support shared risk taking. We see better value in the use of our resources in the system. New models of care are adopted across our PCNs and we have a consistent approach to delivering frailty, mental health and same day urgent care, learning from the best approaches being developed and tested across our localities. We can evidence reductions in unwarranted variation and a greater focus on consistent achievement of quality indicators. PCNs actively seek to support improving resilience of all practices within their network. PCNs deliver the ambitions of our Integrated Care Partnerships and support our Locality leaders to lead the co-ordination of community care at scale. There is a cultural shift in our community with primary care taking the leadership of our system transformation, supported by partner organisations. Primary Care Networks become mature and this is demonstrated by year-on-year improvements in their maturity self-assessment over the next 3 years. *All our PCNs self-assess their maturity at Step 3 on the national PCN maturity matrix by 2022.*

Community Pharmacy

A patient story:
A patient with diabetes visited the pharmacy one morning with a prescription for a new type of insulin. I talked to him about the insulin, how to use the injection and how to store it. I engaged him with the 'New Medicines Service' for more information about the drug, expectations and possible side effects. The patient is then followed up at week 1 and 2.These interactions enable the patient to make an informed decision about taking their drugs, improving adherence and results in the patient gaining maximum benefits from their treatment.

The patient was so happy with the advice and support he received that he paid regular visits to the pharmacy to help his diabetic control including looking at his diet and he even learnt about glycaemic values to help his control. I communicated this information with his consent to the diabetic nurse at the surgery.
His HbA1c results had been very poor but after the three months of consulting he came into the pharmacy with a large grin telling me his long term control had massively improved.'**Community Pharmacist'**

Vision:

Over the next five years community pharmacy, as an integral part of the Heathier Together system, will focus on urgent care, prevention and medicines safety to help more people stay well in their community, delivering clinical services as a full partner in local Primary Care Networks using pharmacists' knowledge and expertise.

Community pharmacy will continue to provide a safe and effective supply of medicines to patients as well as focusing on the best possible outcomes and experience for the population.

Pharmacies will also begin to play an important role in early diagnosis of long term

conditions such as hypertension and Atrial Fibrillation (AF) and will be able to refer appropriate patients to their surgery for further examination if appropriate.

The new contract can support our local healthcare system as follows:

Access: Support the urgent care system	• Community Pharmacist Consultation Service – referrals for minor ailments will be sent to community pharmacies from NHS 111 following an assessment by a call advisor. This is part of the national framework. Local BNSSG pilot includes referrals from GP practices to pharmacies. • Urgent medicines supply service to ensure urgent medicines can be accessed in a timely manner. • New Medicines Service continues to provide support for people with long-term conditions newly prescribed a medicine to help improve medicines adherence. • The necessity of protecting access to local community pharmacies will be supported through a Pharmacy Access Scheme.
Models of Care: Support the prevention and long term conditions agenda	• All pharmacies are required to be accredited Level 1 Healthy Living Pharmacies by April 2020 delivering interventions on key issues such as smoking and weight management as well as providing wellbeing and self-care advice. • Introduction of Hepatitis C testing in community pharmacies for people using needle and syringe programmes to support the national Hepatitis C elimination programme. May be delivered in conjunction with local authorities • A number of national pilots will be undertaken, including detecting undiagnosed cardiovascular disease, stop smoking referrals from secondary care and point of care testing to support antimicrobial resistance. National rollout will be subject to pilot evaluation. • Flu vaccination
Quality: Support medicines optimisation, safety and quality	• Pharmacy Quality Scheme – this allows pharmacies to earn payment for meeting certain quality criteria which can include developmental targets and training. • Medicines audits initially include lithium safety, advice on pregnancy prevention to women taking valproate and auditing the use of NSAIDs. • Proactive work to ensure safe prescribing in asthma. • Antimicrobial stewardship

Beyond April 2020, it is expected that there will also be a community pharmacy medicines reconciliation scheme to allow pharmacies to support patients being discharged from hospital back to their own home, or community based supported living.

Medicines Optimisation

Medicines optimisation looks at the value which medicines deliver, ensuring they are clinically-effective and cost-effective. It is about ensuring people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team.
Medicines optimisation will be embedded across all primary care workstreams. While it will be pharmacist led, a multidisciplinary approach will be needed to deliver benefit to patients and the system.

In addition to community pharmacists, there are primary care clinical pharmacists working in GP practice (either employed by GP practice(s), PCN or CCG). There are also CCG Medicines Optimisation Pharmacists working in GP practices and pharmacists employed as part of the community services provider teams.
The roles of the pharmacists differ but should complement each other to best support the local population. It will be important that PCNs work closely with the CCG Medicines Optimisation team in order to monitor prescribing activity and costs for their population, along with ensuring all prescribing is safe, evidence based and financially sustainable.

The role of clinical pharmacists in GP Practices across PCNs as part of a multidisciplinary team, involves them seeing patients in the most appropriate care setting i.e. in the patient's home, care home or GP surgery. They will provide a focal point for collaborative working across different pharmacy providers including hospital, mental health and community pharmacy. They will ensure patients see a professional that is most appropriate for their needs with their role being primarily patient facing and clinical in nature. They will undertake structured medication reviews, improve and ensure good medicines optimisation and patient safety, lead on antimicrobial stewardship in their PCN, support care homes and hold medication review clinics in practice.

We are developing a BNSSG Pharmacist Network, which we will grow over the coming years to provide peer support to pharmacists across sectors, avoid duplication and enhance collaboration

Alongside the development of Primary Care Networks in 2019, in 2019/20 a range of actions will ensure movement towards integrated medicines optimisation:

- Anti-microbial Resistance National Action Plan
- Additional Clinical Pharmacists established in PCNs
- A GP contract Quality Improvement module on prescribing safety
- Low priority prescribing work

- Medicines value programme
- Medicines safety programmes / WHO global challenge
- Launch of foundation pharmacist professional framework
- Strong medicines governance processes and pathways

By 2020/21 there will be General Practice national service which includes Structured Medication Reviews and Optimisation and Enhanced Health in Care Homes. There will also be a national Overprescribing Review report.

Social Prescribing

Social prescribing addresses the non-clinical needs of people/ patients holistically. It is primarily aimed at addressing the wider determinants and social determinants of health and wellbeing such as isolation and loneliness, unhealthy behaviors and lifestyles. It is delivered in local communities often by the VCSE sector.

Social prescribing is designed to support people with a wide range of social, emotional and health needs, for example people with long-term poor mental health, people who are socially isolated and those with long-term health conditions. Schemes aim to help people with their physical and mental health and wellbeing and can offer people a personalised and flexible offer of support back to health at a pace that is appropriate to the person.

Social Prescribing services help people to access support that is already available in their local community, connecting them to activities that meet their needs and helping them to overcome practical barriers as well as the focus on health.

Social prescribing supports the individual, families, local and national government, and the private, voluntary and community sectors to work in collaboration. When done well, it allows people to self-manage their personal situation whilst experiencing physical, emotional and social challenges.

There is emerging evidence (Thomson et al. 2015) that Social Prescribing:

- Improves mental health and wellbeing
- Reduces social isolation, exclusion and loneliness
- Increases people's confidence and independence (including for example people's ability to remain in or return to employment)
- Leads to fewer primary care consultations
- Reduces hospital utilisation

In addition Social Prescribing can reduce medicines waste generated by 'over prescribing' or medicalisation of essentially non-medical problems because there is no alternative.

The Social Prescribing Link Worker role will grow and develop over the next five years in BNSSG through the Primary Care Networks as a result of NHS England's commitment with the additional role reimbursement scheme (https://www.england.nhs.uk/wp-content/uploads/2019/08/network-contract-des-additional-roles-reimbursement-scheme-

guidance-updated.pdf). Primary Care Networks are encouraged to join together to deliver a Social Prescribing Link Worker service at a Locality level, accessing services and support across a wider geographical area, using the skills and experience of voluntary and 3rd sector organisations already embedded in communities across BNSSG.

The BNSSG Social Prescribing Framework agreed on the following core elements:

- Agreed process for **identification and referral** of people who would benefit from a social prescription and complementary non-clinical community-based support, with defined entry points
- **Signposting** to include information and signposting, and triage services for a referral for Social Prescribing, enabled by a shared platform (database)
- **Social Prescribing definitions –** Light, Medium and Holistic levels of service - includes guided support and intensive one to one, delivered by skilled and appropriately trained and accessible staff (link workers).
- A wide range of community based activities and support groups and building of capacity in the community setting, co-designing with the Voluntary and Community Sector and built on an Asset Based Community Development (ABCD) approach.
- Conditions to create a rich, diverse and sustainable range of community support and activities for social prescribing may need to be stimulated and will require planned long term stimulation and support.
- An agreed approach to evaluation and measuring outcomes/ impact that is proportionate to the scale of the service increased shared learning and best practice.

Improved Access

Our priority is to improve access to Primary Care services, so people see the right person, at the right time. Our goal is to improve the quality of Primary Care while taking pressure off urgent and emergency care. We are making a number of changes to improve access to Primary Care and community services, for example:

- Providing an additional 1.5.hours of evening appointments between 18.30 to 20:00 every evening, along with appointments being available on Saturdays and Sundays
- Adding a minimum additional 30 minutes capacity per 1000 population
- Effective advertising of this additional capacity
- Implementation of 111 Direct Booking
- Implementation of online consultations

We will continue to develop our locality based offer for Improved Access, supported by our PCNs, in preparation for the requirement for PCNs to be delivering Improved Access by 2021.

Our priority areas will work on the characteristics for practices delivering good access:

Patients	Workload/ Productivity	Using IT	Skill Mix	Leadership
Education **Signposting** **Supported self-care** **Range of modes of access** **Patient involvement** **Availability of appointments**	**Data driven improvement** **Population Health Management** **Shared records**	**Effective telephone systems** **Symptom checkers** **Text messaging, online services, online consultations**	**MDT working** **Flexible ways of working for staff**	**Fully engaged leaders** **Effective triage systems e.g care navigation** **Practices collaborating to improve access to services**

NHS England has committed to the provision of additional funding, on top of existing Primary Medical Care allocations to enable Clinical Commissioning Groups to commission and fund extra capacity to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet locally determined demand, alongside effective access to other primary care and general practice services such as urgent care services.

When the GP contract was rolled out in 2019, a national access review was announced which is considering how Improved Access and Extended hours DES from April 2021, could best deliver the 7 core requirements:

- Timing of appointments
- Capacity
- Measurement
- Advertising and ease of access
- Digital
- Inequalities

- Effective access to wider whole system services

Locally the CCG will engage patients and stakeholders to ensure any offer is concurrent with patient and local service design across both PCN and Locality footprints. Primary Care will also need to recognise and be responsive to the emerging Integrated Care System when designing these access models.

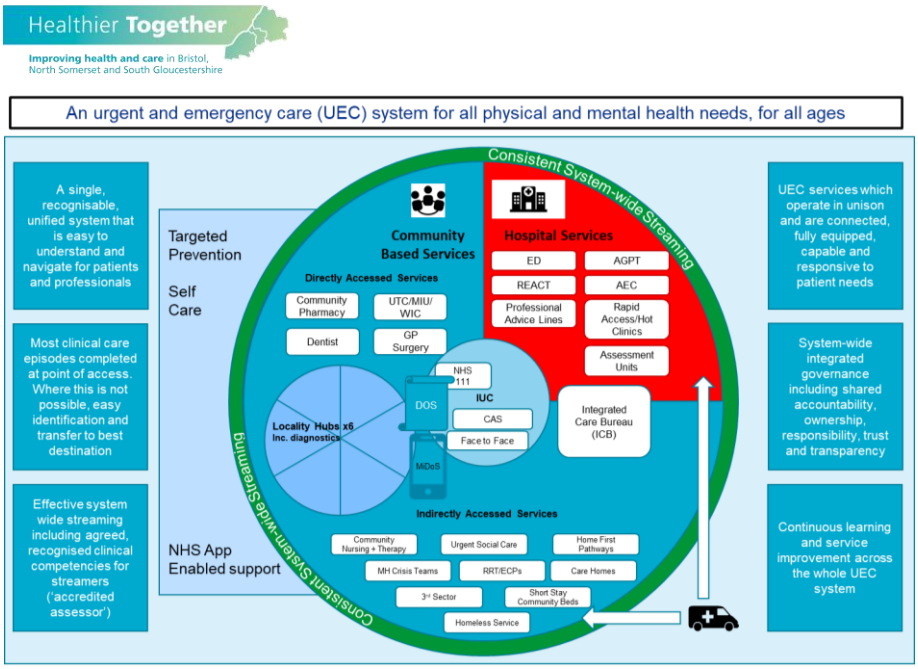
Same Day Urgent Care

"I needed help, I called a service and they helped me to where I needed to go. No waiting, no having to repeat my story – someone helped me first time."

Delivering Urgent and Emergency Care – a vision and strategy for BNSSG, Healthier Together, March 2019

The strategy vision for enhancing integrated urgent care services:

"The immediate focus is on the creation of an organised, co-ordinated and effective primary care provider environment that is seen as the main conduit for meeting a person's health and care needs. This new environment sees urgent primary care, community services, mental health, the ambulance service, the local authority and the third sector working much more collaboratively around a single, person centred care plan. In the longer term, a more integrated model which supports an integrated, care system is envisaged but the priority now is to bring together the currently fragmented community model, including general practice."

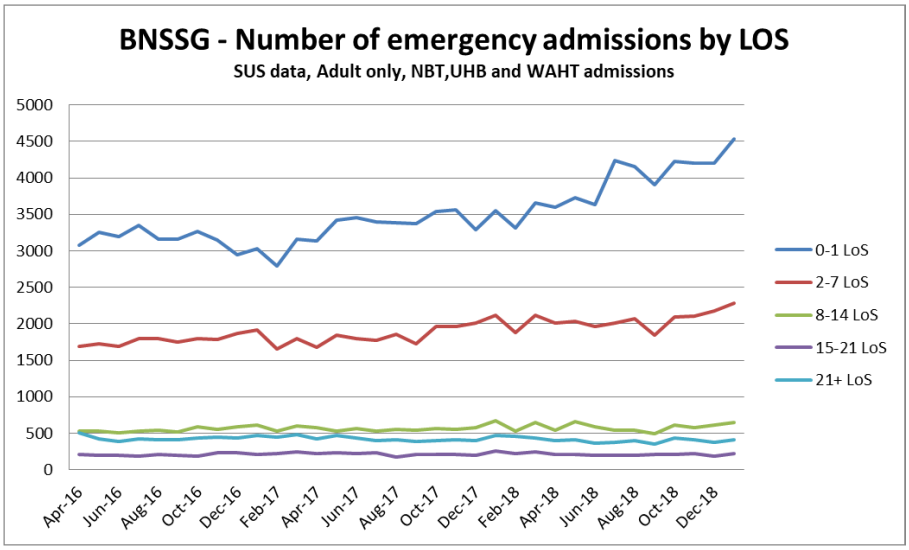


Over recent years, national trends in increasing rates of attendances and non-elective admissions to acute providers have been reflected in our local health system.

Between 17/18 and 18/19 across the 3 BNSSG acute providers there has been:

- 11% increase in 111 call demand
- 7.3% increase in ambulance conveyance to ED
- 4.5% increase in A&E attendances
- 11.8% increase in non-elective admissions
- 9.4% increase in GP referral admissions

Within this general picture of increasing non-elective activity, our system has seen significant and specific growth in admissions of 0-1 day Length of Stay (LOS), plus continued long term trend in growth in non-short-stay:



Further analysis has shown that the increase in short stay admissions is driven by the 20-59 age group and the most common admitting conditions are related to the cardiac, digestive and respiratory systems.

Primary Care, community and acute partners are working to develop **Same Day Urgent Care Services.** Urgent care already represents a significant proportion of primary care activity. Building on the benefits of working at scale across practices and Primary Care Networks, and the opportunities of bringing diagnostic and other services together in Locality hubs in the future, the programme aims to enhance the ability of primary care teams to provide care in or near people's homes, and prevent unnecessary ED attendances and admissions to hospital.

The ambition is to:

- Enable people to stay healthy, well and independent in the community
- Community settings to become the default service for the triage, treatment and assessment for the population
- Provide comprehensive primary and community care services to ensure that no patient attends an Emergency Department due to the inability to access primary care services
- Triage and re-direction of patients to alternative care settings

- Integration with the emerging models of care for frailty and mental health through the provision of same day urgent care components of those pathways
- Enhanced locality services for ambulatory sensitive conditions and pathways to significantly reduce the requirement for patients to attend acute settings for diagnostics and assessment

Integrated Frailty Service

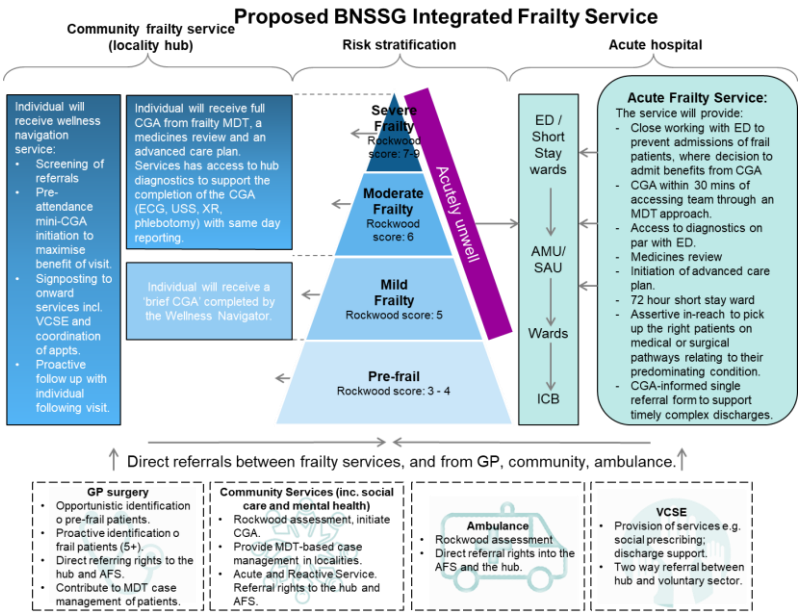
The new model of care for the frail population will comprise:

- High quality, locality-based navigation services in place for all frail individuals, and those at risk of becoming frail, with access to health, care, and social prescription interventions.
- Consistent, practice-level MDT case reviews for moderately frail individuals across all localities.
- 3x community frailty services based at locality hubs for comprehensive geriatric assessment of severely frail individuals by a specialist MDT.
- 3x frailty day assessment units at locality hubs with access to diagnostics, step up beds, complex supported discharge and emergency care practitioner home visits, for severely frail individuals.
- Common core offer of a specialist frailty MDT in all three EDs to support admission avoidance, with access to community and short stay services.
- Pathways developed for accessing services (including IUC and SWAST) and 'pulling' patients from acute spells using the ICB.
- All frailty services underpinned by a consistent approach to care planning and data sharing, population health analytics-informed risk stratification, and holistic assessment.

The Pathways

Five pathways corresponding to the levels of frailty identified in the figure below have been developed to set out the how the integrated frailty service will meet the needs of the cohorts within these 5 levels of risk:

1. Fit and Well
2. Mild frailty
3. Moderate frailty
4. Severe frailty
5. Acutely ill



Healthy Weston

The vision for primary care in Weston is to:

- Deliver general practice at scale, attracting clinicians to Pier Health PCN and crucially retain their skills by developing a multi-disciplined clinical team around GPs to support a managed practice workload

- Provide a sustainable and resilient future for Primary Care. This will be achieved by working closely with local stakeholders such as Weston College to develop an assured health and social care workforce pipeline for the locality. Opportunities for integrated working with community and secondary care partners defined in the Healthy Weston programme i.e. Integrated Frailty Service and Same Day Urgent Care facilitates development of General Practice portfolio roles. On a platform of integrated and portfolio working, Weston locality will become a more attractive prospect for newly qualified general practitioners, or for practitioners to North Somerset

- Develop opportunities to work together as a group of practices, joining up back office functions, creating efficiency – for example the development of a Pharmacy Hub where significant operations may be located 'off-site' enabling the current practice estate to be freed up to provide versatile space for additional primary care workforce i.e. social prescribers, clinical pharmacists, physiotherapists etc

- Improve access to Primary Care through the establishment of Pier Health Group, to deliver joined up working and shared workforce to ensure that the population of Weston has access to the care they need, with the community as the default place to receive health and social care. By integrating provision through the Integrated Frailty Service, pressure on urgent care services at Weston General Hospital will be reduced

- Provide continuity of care to enable improved patient outcomes and support people to manage their long term conditions better by ongoing, consistent management from the same clinician

- Support people in Weston to live healthy lives, preventing people from developing long term conditions and supporting those who have diabetes and long term MSK, COPD and mental health conditions to manage their health confidently with their health professionals. This will be enabled by providing LTC education and self-care support and information, working with partners in Community Pharmacy. A preventative approach, identifying those who are at risk of developing LTCs through population health management will ensure that pro-active services such as social prescribing is offered effectively to people at risk of developing long term conditions

- A new Primary Care facility in Central Weston to re-house the practice population of Graham Road Surgery, with opportunity to co-locate health and social care services provided by partner organisations in Weston and Worle Villages (WW&V) locality, including the voluntary sector. The new facility will support integrated working, with multipurpose clinical areas and in-built versatility to use rooms as community meeting venues – supportive of new models of consultation such as group consultation or hosting social prescribing services

Quality and Resilience

The Ambition

The vision of the BNSSG system is to offer highly quality and consistent care to the population, driving up improvements in population health, reducing health inequalities and developing the personalisation approach working with people to achieve their health goals. The system will ensure that services are safe and effective, making the best use of combined resources. A learning culture that supports continuous quality improvement will be championed which enables excellence in patient care and experience. In order to achieve this vision general practice needs to be resilient, effectively managing current demands and being able to plan and redesign for the future.

Over the next 5 years our ambition is to:

- Develop a continuous quality improvement and learning culture in primary care to support the achievement of our vision

- Reduce health inequalities and develop our personalisation approach by working with people to achieve their health goals

- Drive forward our population health management approach to enable us to plan and deliver care to people that will lead to improvements in health outcomes

- Proactively listen to how people experience primary care and work with them to design better care, including access to services and the pro-active planning and co-ordination of their care

- Support every practice to maintain safe and effective services as evidenced by all practices receiving Good or Outstanding CQC ratings

- Proactively support Primary Care to be resilient through tailored improvement support

- To have in place regular opportunities for the sharing of good practice in quality and resilience improvement, supporting the spread of learning

- Develop our Primary Care Networks to become responsible for the resilience of the care provided for their population

Quality Approach

"The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high-quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients…" NHS 5yr forward view October 2014

We will work with a framework that:

- encompasses the three key aspects of quality (safety, clinical effectiveness and the person's experience)

- recognises the need to use information in a way that encourages understanding and learning before the drawing of conclusions

- encourages the use of quality improvement methods to make changes

- monitors and measures quality improvement so that the system can understand the impact and value of the improvement work undertaken and share best practice.

The way in which we will collate and share information in order to understand and improve the quality of primary care will cover the areas of safety, 'personalised care', i.e. the extent to which people have choice and control over the way their care is planned and delivered, population focus and outcomes.

Patient Safety

July 2019 saw the publication of **The NHS Patient Safety Strategy - Safer culture, safer systems, safer patients.** The emphasis is on creating safer systems providing care in the right place at the right time and learning as much from what works well as from what hasn't gone well.

There are three strategic aims:

- to improve understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**) – including a new safety learning system and

introducing the Patient Safety Incident Response Framework to improve the response to an investigation of incidents

- to equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**) – including the development and roll-out of a system-wide patient safety syllabus
- to design and support programmes that deliver effective and sustainable change in the most important areas (**Improvement**) – targeting a number of different groups in our population to improve their care

In line with these national recommendations, BNSSG will:

- Work together to further foster a culture of openness and transparency that focuses on continuous learning and improvement
- Learn from and share the outcomes of looking at patients' compliments, concerns and complaints, safeguarding, Significant Event reviews and feedback from patients about their experience of care to ensure that we actively listen to our patients, public, carers and other key stakeholders.
- All stakeholders continue to understand their responsibilities to safeguard and promote the welfare of people using national policy and guidance to support this work
- Approaches and actions are put in place to reduce the risk of avoidable harm

Patient Experience

We will broaden out the traditional ways in which we have considered this by including aspects that encompass personalised care. This means that we will:

- Focus on how care is planned and delivered in a way that is based on people's preferences, their and their community's strengths and also their individual needs
- Include the use of both meaningful public and patient engagement to gain insight and co-production to design services as part of our quality improvement efforts

Clinical Effectiveness

We will work together to:

- Establish meaningful clinical and social outcomes on both a population and individual level that can be measured to track and inform quality improvement.
- Share benchmarking information without judgement such that organisations are encouraged to jointly explore the information and take action where there is unwarranted variation. This unwarranted variation means that there may be some people who could be benefiting from care but currently aren't. It may also mean that some people are getting care that might not be effective for them.

- Systematically adopt and spread evidence-informed interventions that improve population health and help to use resources to best effect. We trialled this in the area of some primary care pathology testing and will use what we have learnt from the quality improvement approach we took and the impact we made.

The achievement of these goals will be supported by a **Primary Care Quality Forum** made up of quality leads from primary care providers. Quality Leads are being identified within practices and Primary Care Networks and in other providers across the healthcare community. The leads will be brought together to discuss quality improvement and adopt and spread learning and good practice; foster a culture where incidents, significant events and complaints can be discussed without judgement and used to make improvements. There is also the opportunity to equip Quality Leads with quality improvement skills to support the development and delivery of improvement projects and a culture of continuous improvement in their practice / Primary Care Network / organisation.

A BNSSG Managing Partner Story

'Involvement in the Productive General Practice process enabled us to put quality at the centre of how we work. I have struggled to promote a culture of quality and continuous improvement, but the direct input of Productive General Practice consultants helped concentrate people's minds and junior staff, particularly, engaged fully and proactively. As a result, we have undertaken an organisational review where greater support for me has been found with part of the role to continue the management and monitoring of improvement. Additionally, we are reviewing all our processes and developing a manual to help junior staff.'

Resilience Approach

Resilience can be defined as a general practice being able to continue to operate and deal with challenges, including in the event of a significant internal or external change such as the retirement of a GP partner or a list dispersal of a nearby practice.

A resilient Primary Care provides high-quality care, has a motivated, valued and stable workforce and sound finances and can effectively maintain this status in the face of change. Resilient practices are also aware of and plan for change which is likely in the local system in the future.

Identification of practices which would benefit from support to improve resilience

The CCG has developed a Quality and Resilience dashboard using key metrics to help pro-actively identify practices in most need of support to improve resilience and quality. The dashboard has been developed to support an understanding of quality and resilience at practice, PCN and locality level. This includes the ability to produce practice and PCN reports for quality and resilience including benchmarking.

The dashboard is used coupled with soft intelligence to identify practices which may benefit from support and is used as an indication of the need to have a conversation with a practice or primary care network about their current position and if there is a need for

support. Practices can also contact the CCG or other partners to seek support to improve resilience.

Supporting practices to improve resilience

We currently have 81 GP practices in BNSSG, our strategy aims to ensure they are resilient and thriving. We want practices to collaborate within and across PCNs to develop their resilience and to develop at scale solutions to support their efficiency and sustainability. This may also lead to mergers to improve resilience. Nationally, a number of large-scale super-partnerships have now been developed. We will support our practices which choose to collaborate on a larger scale.

General Practice Resilience Programme

The General Practice Resilience Programme includes working with practices which are in greatest need of support to improve resilience i.e. those identified via the process described above. This can be individual or groups of practices such as a PCN or locality. Practices are approached to secure agreement in principle, a stocktake of the resilience position is completed which informs a resilience improvement plan. The General Practice Resilience programme is supported by non-recurrent funding and accompanying guidance provided by NHS England as part of GP Forward View.

Each practice or group of practices is supported to:

- Undertake a stocktake of resilience which drives the identification of key issues affecting the resilience of the practice.
- Develop a joint resilience improvement plan between the practice(s) and the CCG which is signed as part of a memorandum of understanding along with a description of the individualised support package required to implement the improvement plan. This may also involve support from other organisations across the system. In some instances a more detailed diagnostic is required further to the stocktake and this can form part of the improvement plan which then informs resilience improvement work streams as described below.

Examples of what could be included in a resilience improvement plan are as follows;

- Resilience diagnostic /whole practice review of current model and identification of opportunities for improvement
- Financial health check
- Developmental support for practice partners
- Identify frequent attenders for intense review, reflection and re-education
- Appoint self -care ambassador that will investigate a self-care pilot for a particular cohort of patients
- Review actual demand on the services and perform an analysis of what resource is provided in comparison

- Explore options to reconfigure the service access and delivery model
- Implementation of new access and delivery models

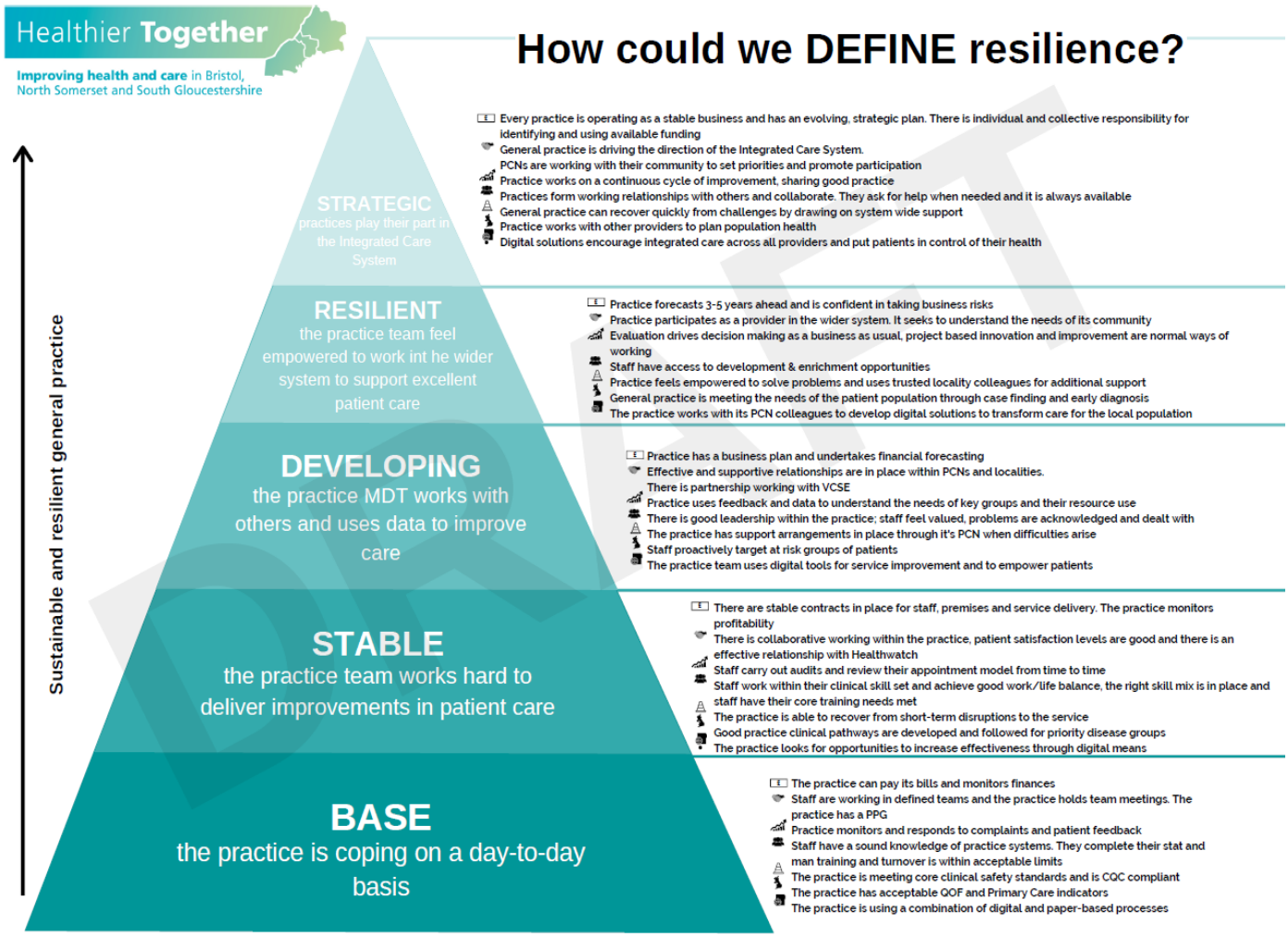
BNSSG CCG and One Care (BNSSG) Limited are working together to provide aspects of support identified in resilience improvement plans, this particularly includes the resilience diagnostic and financial health check functions as described above.

General Practice Resilience and Transformation – thriving general practice is at the heart of excellent care for our community

A system-wide work stream of General Practice Resilience and Transformation (GPRT) brings together key stakeholders to oversee the co-ordination and delivery of a programme of work across system partners including One Care (BNSSG) Limited, the LMC, locality provider leads and the CCG. This group champions the connection of Healthier Together priorities with the development of general practice, within the wider primary care setting.

The GPRT Healthier Together work stream has collaborated to develop a resilience framework and self-assessment tool for use in General Practice and PCNs. This tool has been tested with practices and is now being used as part of the resilience diagnostic which forms part of the work with a number of practices taking part in the GPRT Programme described above. We will use the anonymised findings to create a collective support offer for general practice, using the resources that already exist within our system (the CCG, One Care Limited, the Training Hub and Local Medical Committee), as well as new offers where required.

The resilience definition which has been worked up as part of the resilience self-assessment tool is shown diagrammatically below.



Developing Resilience at Scale

We will apply learning from the 2019 Intensive Support Site working at scale with ten practices in Weston. The project focussed on three key areas:

- Support for individual GPs
- Support for practices
- System wide interventions

Developments included:

- coaching and mentoring for GPs
- change management training for practices
- back office modernisation and improvements
- new practice websites

- new digital appointments system.

The project galvanised all of the practices to work together and find partnership solutions to problems. Some of the other benefits to come out of the project are a solution to managing care homes, a prescription hub, business cases for home visiting and portfolio careers and an intranet capability.

This demonstrates the potential benefits of effective PCNs and how they can work collectively with the appropriate support to ensure sustainability of the local primary care provision. The evaluation of the ISS informed our approach to developing locality and PCN resilience programmes.

Offers for all BNSSG practices

Understanding resilience and developing improvement plans

The GPRT resilience self-assessment tool described above is going to be rolled out to all practices during 2020 to support practices to understand and improve resilience.

Reports which can be prepared from the CCG primary care quality and resilience dashboard as described above are available to individual Practices and PCNs. The CCG is currently working with Practices on how this can be used to be support practice improvement planning.

A practice may wish to access support to understand its opportunities to maintain or improve their resilience. One Care (BNSSG) Limited is developing a practice review offer for practices in BNSSG and local capability to support this. One Care (BNSSG) Limited has provided consultancy support for the following:

- formal Service Change (i.e. mergers and changes in sites)
- practice business reviews
- capacity and demand reviews and associated appointment book analysis
- estates utilisation
- staff culture and engagement
- practice management good practice
- practice financial updates and accounting reviews

The offer to practices can also include:

- full financial review
- support with CQC visits
- support with facilities management

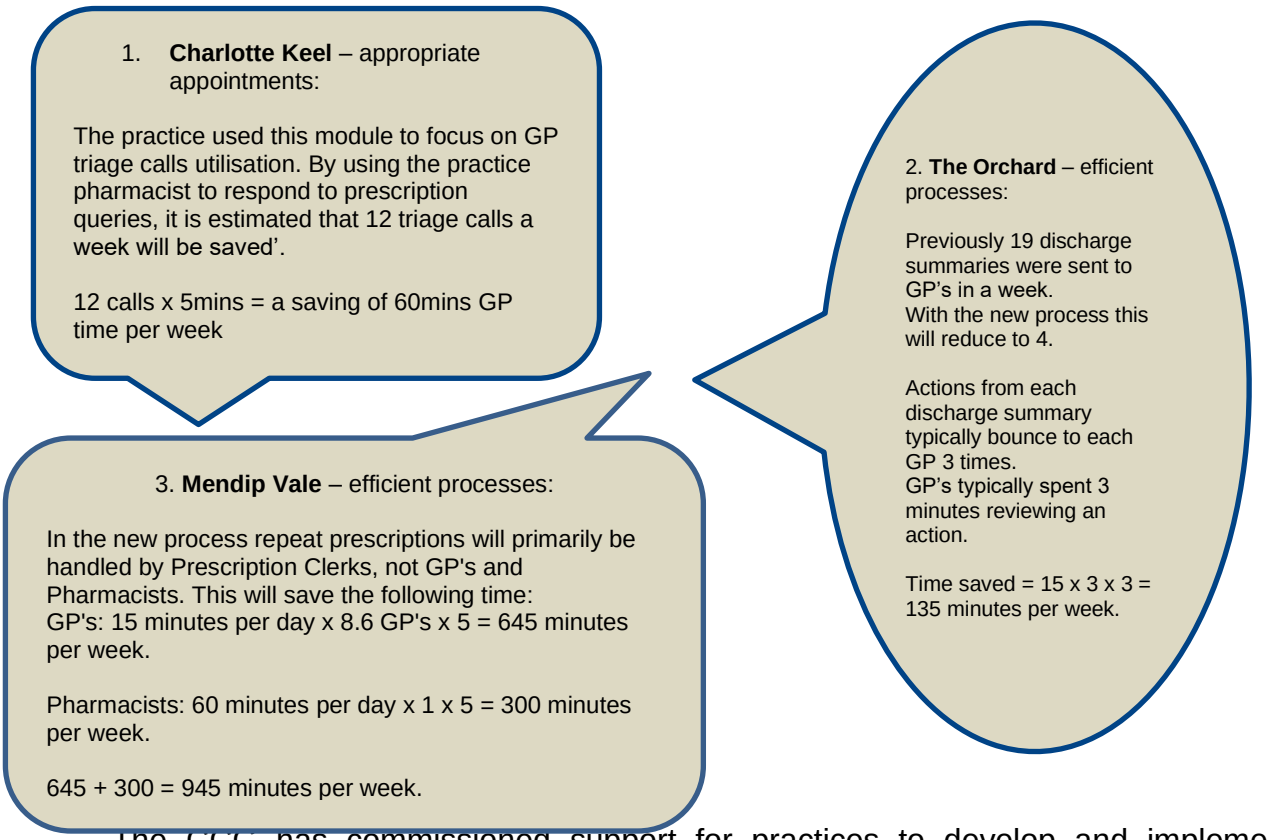
- technical support to maximise utilisation of telephony and clinical systems

The Time for Care Programme

At the heart of the NHS England development programme to deliver the General Practice Forward View is Time for Care, a programme to help practice teams manage their workload, adopt and spread innovations that free-up clinical time for care, and develop the skills and confidence to lead local improvement. This programmes focuses on encouraging practices to adopt the 10 High Impact Actions.

The CCG primary care development team is actively engaged with the Time for Care programme. We aim to provide maximum access for BNSSG practices to Time for Care support and to ensure that the BNSSG offer is tailored to meet the local landscape, requirements and direction of travel. BNSSG has hosted a Time for Care Showcase event, supported over 50% of our practices to participate in the Productive General Practice Quick Start programme and host an Introduction to Quality Improvement workshop. Our next steps are to work with the Time for Care team to access the group programmes for PCNs / localities to work together to release time for care.

Some examples of the outputs achieved by practices which have participated in PGP Quick Start are shown below:



The CCG has commissioned support for practices to develop and implement active signposting. Active signposting provides patients with a first point of contact which directs them to the most appropriate source of help, ensuring the patient is booked with the right person first time or signposted to services in the community, including statutory and voluntary sector services. Our ambition is for all BNSSG practices to be actively signposting patients by 2020. This will support practices in releasing time for care and

managing workload and adds value for patients.

Efficient processes and digital optimisation

One Care (BNSSG) Limited have supported practices with training in workflow optimisation which radically reduces the burden on GPs. This aims to review document management processes within a practice and ensure that only letters which require GP input are sent to a GP to action. One practice reports a reduction from 200 documents per day to 10 documents being managed per day across 3 GPs. Our ambition is that all practices have completed this by 2021.

One Care (BNSSG) Limited is one of our providers who provide EMIS optimisation support to practices including:

- Up-loading EMIS-ready referrals forms to practices that are using Resource Publisher
- Building and releasing searches & protocols e.g. for the 2019/2020 flu season
- Configuration of EMIS and training to support new ways of working – e.g. Inner City and East home visiting pilot (meaning community nurses could carry out home visits on behalf of GPs) and remote consultations for South Bristol Leg club

Developing the Workforce

'As a Paramedic Practitioner working in general practice, I can see first-hand the impact of the role in this setting. I see around 30-35 patients per day, including three home visits. The patients' presenting complaints vary from minor injury/minor illness, to sexual health, or urgent/emergency complaints such as cardiac chest pain. I also take bloods, order bloods, scans/X-rays and analyse my own lab reports. I also do ECGs, the resus training for the practice and attend practice meetings. My practice is particularly supportive and I have an allocated supervising GP for both morning and afternoon clinics. The ultimate aim is to aid with the increasing GP work load and patient demand. An example is when an urgent home visit comes through on the on-call list, which I then attend, enabling the on-call GP to continue managing the list, whereas previously they would have had to go out on the visit themselves.' **BNSSG Paramedic (see Appendix for full story)**

'Over the past 2 years a number of initiatives have contributed to improving my work life balance. It started with workflow optimisation training through One Care and adopting protocols developed elsewhere - over a period of time I went from seeing (on a bad day) over 100 documents and having to do all the coding / activating to much of this being done by others so that now I'm seeing about 10 documents a day - and for the most part they are for my information only.

Next, we followed many other practices and employed a practice pharmacist to address the next biggest headache I had as a GP - medication issues. The burden of reconciling medication changes on discharge from hospital or after outpatient appointments has been taken on by the pharmacist and he deals with all the medication queries from patients or pharmacies. He's a really good member of the team - he does all that stuff as well as his other duties and I get hardly any medication queries and all the reconciliation is done. Not

only does it release time for me, but now I don't have to worry about signing scripts as I have confidence in the systems we have developed.

*The final piece was our move to an online consultation tool. This proved to be the most significant change and the key was embracing total flow - every patient has to use the tool although not necessarily on line. This has produced a really significant change in workload - I now only see about half the number of patients face to face that I used to. It's not that we're keeping them away; it's just that often there is no need for them to come in. This system gives us a really good overview of the complete work of the practice so we can use the team to its best. The cases I see are the cases only I can see and it enables me to make best use of the team and reduces everyone's workload.' **BNSSG GP***

Workforce Vision

In order to deliver our ambitions, we want our workforce thriving not just surviving; we aim to attract, support and develop a primary care workforce that is skilled, committed, compassionate and engaged, enabled to deliver exceptional care every day. We will bravely break down barriers when finding new solutions to workforce through competencies rather than traditional roles, reaching out to low participatory groups in our community through apprenticeships, schools and outreach work. We will have a flexible workforce that can deliver the models of care that meet our current and future demands and needs of our population health.

Why we need to change

The current provision of workforce in primary care services in BNSSG will be unable to meet the future needs of the population it serves. Our current model of care is built on GPs and GP Nurses delivering care to the population of BNSSG with little flex when taking into account the needs of very different populations across BNSSG.

- 6% (2,000 full time equivalent posts) of the Health and Social Care workforce is in Primary Care across approximately 81 practices
- There are 481 registered practice nurses currently working in BNSSG contributing to 325 full time equivalent posts
- Flexible working opportunities in Primary Care are currently limited. As a result, practices find releasing staff for development difficult due to the challenges finding and costs of backfill. Practice Nurses move from practice to practice to gain development, resulting in movement of the same 'pool' of Practice Nurses, with minimal opportunities for newly qualified Nurses and Nurses with little experience of Primary Care moving into this specialist area
- A significant proportion of the workforce in Primary Care is over 50 years of age with some hot spots: nurses 53%; admin/non-clinical 56%; 41% direct patient care (includes health care assistants); 34% GPs
- The numbers of GPs willing to work in the Out of Hours period has declined year on year

- GPs are retiring at a rate of 4 GPs every 3 months in BNSSG
- There are currently 879 people working as GPs in BNSSG, which equates to 586 full-time equivalent posts
- There are lower than national participation rates in BNSSG i.e. higher percentage of part-time working. If someone is working full-time then they would be working 100% of a full-time role. On average every GP in BNSSG is working 67% of a full-time role. This has reduced from 75% in 2018. BNSSG labour market workforce intelligence indicates this is the case across the whole of the BNSSG health and social care workforce

If the above is left unresolved, we would see a reduction in access to Primary Care for patients resulting in an increased dependence on Urgent Care services. This would result in unsustainable GP Practices, and extreme workload pressures negatively impacting on staff retention.

This means we will focus on skill mix, recruitment, retention, education and training and securing a pipeline of new GPs. We will do this through a range of initiatives including:

- Continuing to engage with the NHS England International GP Recruitment Programme, bringing GPs from Europe to work in practices in BNSSG
- Implementing our local General Practice Nursing 10 Point Plan
- Increasing placements for Nurses and Allied Health Professionals in primary care through our work as a national pilot site for the place based tariff
- Developing system wide plans to support the introduction of new roles in Primary Care Networks (PCNs)
- Develop a primary and community staff bank
- Raising awareness of GP Nursing Careers with universities' undergraduate programmes by working with higher education institutions and supporting the development and roll out of the NMC Future Nurse Project, bringing the primary care context to the new NMC undergraduate nursing programme
- Developing new roles and rotational posts for people to work across the system, for example in urgent care, frailty and mental health

Workforce Ambition

In the next ten years our ambition is to:

- Work together to maximise the potential benefit for the population, our patients, our staff and the system.

- Ensure our workforce plan includes sufficient staff with the right skills delivering care in the right place, both now and in the future.

- Have collaborative training and development providing consistent, quality training at scale through our Primary and Community Care Training Hub and Healthier Together Learning Academy

- Develop our Primary Care workforce through multi-disciplinary team (MDT) working at Primary Care Network and Locality level to reduce the burden on GPs

- Ensuring new additional roles in Primary Care e.g. Pharmacist, Paramedic, Physiotherapist, Social Prescribing Link Workers, and Physicians Associate benefit the whole health and social care system for a joined up health and social care workforce with improved career pathways, reduced vacancies and truly integrated services.

We will achieve this by:

- Developing a sustainable pipeline of entry level health and social care workers through the creation of career pathways and frameworks that attract and retain staff.

- Expanding the numbers of registered clinicians both in post and in the pipeline

- Significantly increasing the capacity and capability of advanced practice skills, through the development of a common framework and competences across BNSSG, underpinned by apprenticeship routes to enable career progression

- Ensuring all organisations are enabled to become model employers for recruitment, retention and health and well being

- Workforce planning to ensure that new models of care have affordable, safe and realistic staffing models which align with our career framework, and developing workforce solutions as an integral part of delivering locality plans and primary care at scale planning and implementation

- Passport-ing of recruitment checks, and training and development underpinned by common competences to enable a more streamlined and flexible workforce and portfolio (flexible) working which will stretch across all clinical and non-clinical roles.

Equality and diversity is a theme which runs throughout our goals and vision.

Infrastructure

Developing and Improving our Primary Care Estate

We will make substantial changes to our estate over the next five years to deliver our vision for improved services. Services that should be best delivered in the community are at present delivered at hospital sites; staff who need to work closely together in future teams are currently based in separate services on separate sites. While we have many good facilities, we also have some ageing facilities where it is hard to ensure that people

have a positive experience of care.
There are opportunities to make better use of our estate, improving people's experience of care while reducing costs. For example, we have opportunities to harness digital technology to avoid people travelling for health and care and for staff to work remotely.
As an Integrated Care System, we will work in partnership to make the best use of our estate, wherever possible working together to make better use of existing facilities.
Within our Localities, Practices are working at a scale through Primary Care Networks. We will reconfigure facilities to better support our model of multi-disciplinary team working and deliver integrated care, bringing together staff who need to work more closely. We will establish new community facilities to deliver care closer to people's homes wherever appropriate, using existing estate which will support our plans to increase community-based health and care and reduce pressure on hospitals and residential care.
We have agreed six principles for the development and use of estate in our system:

1. Improve quality and user experience

2. Improve utilisation of the existing estate, creating working environments that are flexible to enable modern and improved service delivery

3. Identify opportunities for disposal, rationalisation, re-purposing of buildings and disposal of surplus land to generate STP capital receipts and additional housing units

4. Reduce overall costs of running the estate, contributing to our system's financial sustainability

5. Invest in estate which is sustainable and supports new models of care

6. Collaborate with partner organisations to gain efficiency and wider community and regeneration benefits

General Practice Premises

This strategy also looks at the wider implications of resilience, efficiency and sustainability drivers. For example, the relationship between health, the environment and the impact provision of healthcare can have on the environment and wider society. We want our practices to access the resources available to support the Green Impact agenda. This is becoming increasingly important as resources are challenged and we need to prioritise what we are able to do and what Primary Care and the wider system can provide.

At present, 81 practices deliver primary care services at 120 different facilities. While some are excellent, others are in poor condition. Some are underutilised while others have insufficient capacity.

Our GPs are leading work with partners across the system to assess the current Primary Care estate and reconfigure facilities to support this and the development of Primary Care Hubs. We have already completed a series of six facet surveys to assess the condition, suitability and utilisation of current facilities. The key findings from the six facet surveys are summarised in the BNSSG Estates Strategy.

The next phase will be to compare this information with our requirements for the new primary and community based system to inform plans for future estate configuration, utilisation, investments and disposals, which we have already begun, but will require further capital investment to deliver this.

Locality Hubs

We have identified six potential locations for new Locality Hubs which will bring together a range of staff and services to support health and wellbeing in local communities.

We have potentially identified five appropriate sites within our existing estate, which will be reconfigured and renovated:

- South Bristol Community Hub (owned by Community Health Partnerships)
- Cossham (owned by North Bristol Trust)
- Clevedon Hospital (owned by North Somerset Community Partnership)
- Yate Health Centre (owned by Sirona care and health)
- Weston Hospital Rowan Ward (owned by Avon and Wiltshire Mental Health Partnership NHS Trust)

We are also exploring the possibility of building a new facility, Southmead Health Centre, under the one public estate programme to become the location for a sixth Locality Hub. We will need to secure capital investment of £3.5 million to be able to do so.

Community-based urgent care

We are reviewing our estate to identify appropriate facilities for same-day, community-based urgent care services. Our plan is to identify appropriate sites within our existing estate, in Locality Hubs, at appropriate sites in local communities and at the front door to hospitals.

Population, Deprivation & Health Needs

One key element of future planning for the estate is to understand the predicted population and housing growth in the area, which is set out in the Healthier Together Estate Strategy. Where possible, the STP, working with the local planning department, has aimed to establish where the areas of high population growth and major housing developments will be. This has a strong influence on how services and estate decisions will be made now and in the future.

Local authorities will be key partners and have a major role to play in impacting upon the social determinants of health and care inequality. By working together and understanding need, ambitions and challenges, we can jointly shape the change in a co-ordinated way to make the most of opportunities.

Utilisation

The system continues to face pressures regarding the allocation and reallocation of space across BNSSG to support clinical, office and general working space. Everyone has an obligation to ensure that the available resources within their control are effectively used and this principle applies equally to the use of the estate.

Outcome: To ensure we maximise the use of resources and space, the CCG will be looking for a minimum occupation of 70% in existing space, rising to 75% by 2023.
It is important to note that although some sites are identified as potentially needing additional capacity to support their patient list, it is possible to increase use and capacity of a site by increasing the hours of usage, relocating back office functions and reconfiguring existing administrative space to help increase clinical capacity, rather than undertaking new build projects.

Digital Strategy for Primary Care

The use of digital technology is an integral element of our system transformation, enabling new models of care and optimising working arrangements for our staff. Digitally enabled Primary Care can improve the value added to the Primary Care system in four key ways:

i) improved access
ii) improved outcomes
iii) improved efficiency
iv) improved work-life balance

Our Aims

- Provide patients with more control over their own health, anticipatory care and personalised care when they need it
- Information sharing to provide care plans and communication across the system to make it easy to provide and manage care
- Insights to understand demand and capacity patterns and pre-empt deterioration of health
- Remote and collaborative working to move care to where it is most needed and make the most of limited resources
- Improved access to appropriate healthcare advice at the right time with the right person

These aims are reflected in our system wide Digital Strategy Priorities:

Priority 1: Citizen Facing Digital Care. Using digital innovation to enable a partnership with citizens to increase their access, control, independence and ability to care for themselves and/or their loved ones.

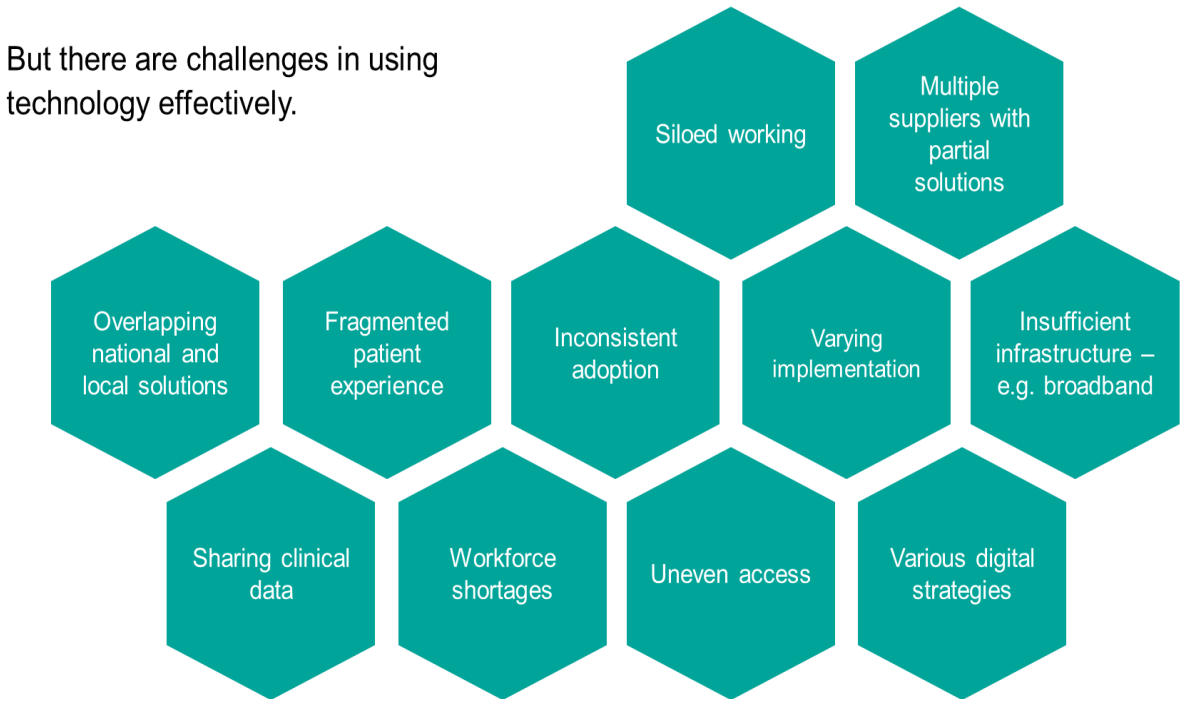
Priority 2: Shared Care Records (our Connecting Care Programme). People have told us that in most cases they want the professionals looking after them to be able to access

their health and care records. We also know that it allows us to provide more responsive and safer care with reduced duplication. Our aim is to make sure that every health and care interaction provides the best outcome for the person by ensuring that the right information is available to the professionals who are designing, defining or delivering care.

Priority 3: Embedding Digital Practice. To improve the day to day experience of staff, providing them with digital tools and skills that ensure they are able to deliver safe personalised care. Enabling the optimisation of how staff use their time to enable greater focus on the person, drive efficiencies and reduce unnecessary tasks, risks and duplication. Through the widespread use of digital technology we will transform how staff are able to make decisions and be more efficient. This will be by reducing the amount of duplication and time spent on tasks currently completed manually, increasing ease of access to the right information when people need it and developing opportunities where the data we need is captured whilst delivering care rather than requiring time and capacity for data inputting.

Priority 4: Population Health Management. To give us the capability to understand the needs of our whole population as well as specific groups. Enabling the use of predictive tools and models to support effective future planning and support the delivery of Value Based Health and Care. To contribute and learn from the One South West LCHR platform across the region.

Priority 5: Digital Leadership and Driving Innovation. To help us create the right environment for digital innovation and transformation across our system.

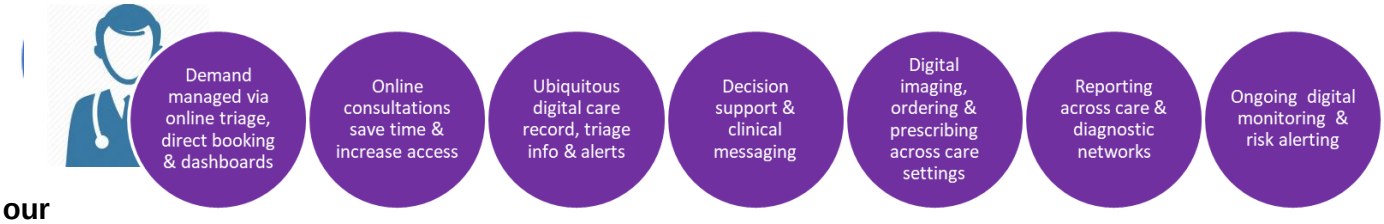


What will the changes we make look like by 2024?

- Electronic prescriptions and electronic repeat dispensing
- Full online access to patient record

- Access to online booking of appointments
- People accessing services online
- Direct booking from 111 into in-hours GP Practices
- Online consultations (by April 2020)
- Video consultations (by April 2021)

For our patients: more digital options to access and manage personalised care throughout their journey.



For our care professionals: providing care more appropriately, efficiently, informed and collaborative.

Chapter 5: Our Outcomes

Improving Health Outcomes for our Population

Along with all other parts of our system, primary care will take its part in delivering improved health outcomes for our population. Population Health Management, use of risk stratification tools and benchmarking data will support ICPs and PCNs to develop targeted interventions and address health inequalities. We will continue to support parity of access for all of our population and ensure that our most vulnerable patient groups including those with Serious Mental Illness (SMI) benefit from health checks. We will also support access to health and care for other groups of our population including veterans, children and young people, black and minority ethnic groups and people living in areas of deprivation.

Primary care has a key role to play in prevention and detection of illness. We will continue to work with Public Health England to support immunisation and screening programmes for our population and embed giving advice and support on healthy lifestyles in our daily clinical practice. We will ensure that primary care supports national public health campaigns.
We also have a responsibility to ensure day to day delivery of services for our population. As part of ensuring Primary Care can respond to major disruption we will develop the primary care aspect of the EPRR.

The work we have done in our priority areas has produced the following high level strategic outcomes:

Strategic Outcome	Priority Area
Improved Primary Care resilience	Quality & Resilience
Increased patient satisfaction with faster access to care when needed with the most appropriate person at the right time	Models of Care Quality & Resilience Developing the Workforce
Reduced health inequalities and unwarranted variation	Models of Care Quality & Resilience
Optimal quality of care and better health outcomes	Models of Care Quality & Resilience
There are the right people employed to support the local population need	Developing the Workforce
Increased control over workload due to increased efficiency, skill mix, education and resourcing	Developing the Workforce
Reduced staff turnover and increased job satisfaction within our health and social care system	Developing the Workforce
Effective collaboration across health and social care to improve population health management	Models of Care Quality & Resilience Developing the Workforce

Further detailed outcomes are outlined in our delivery plan in Appendix 1.

Chapter 6: Implementing our Strategy

Our next steps are to develop an implementation approach for the delivery of the Strategy. We will build on and refine the draft delivery plan and agree governance and responsibilities. The delivery plan is currently far reaching and comprehensive. We will need to prioritise the plan, make it SMART and prepare a programme plan that recognises that a number of key elements of the plan will be led by other parts of the system or organisation and develop an effective matrix approach to oversight of the delivery of the strategy.

We need to be clear about the resources required to address the strategy. There is a high level investment plan within the strategy and as we move into implementation we will need

to prioritise and cost our delivery plan at a more detailed project level.

This will be done through proposals that will be taken to the Primary Care Strategy Working Group in January once the Strategy is approved. This group will be responsible for oversight of work prioritisation and proposals for the according appropriate allocation of resources.

Appendices

Appendix 1 – Delivery Plan

Priority	Deliverables	Outcomes
Models of Care		
Prevention Year 1	• Explore and highlight opportunities for prevention across all providers of primary care in the following priority areas: Public Mental Health & Wellbeing; Healthy Weight; Alcohol; Tobacco & CVD • Expand delivery of MECC training across Primary Care	• Opportunities for prevention across Primary Care pathways are identified and benefits highlighted *to enhance our collective commitment to prevention* • Our professionals are better empowered to help people achieve healthier lifestyles and the number of years people in BNSSG live in good health is increased
Year 2-5	• Implement opportunities identified for prevention across all Primary Care providers • Further expand the delivery of MECC training across Primary Care	• Improved physical and mental health and reduced health inequalities for BNSSG population through: - Healthier lifestyles (including alcohol, drugs, smoking, physical activity, healthy weight, sexual health, mental wellbeing) - Increased support for healthier places and communities (to better address wider determinants of health) - Increased uptake of screening programmes to meet or exceed targets and improve earlier detection of disease
PCNs Year 1	•PCNs authorised and operational from July 2019. •PCN and GP Locality board governance agreed	- Improved vaccination uptake and completion rates to meet or exceed targets and reduce

Priority	Deliverables	Outcomes
Year 2	•Integrated Care Steering Group governance agreed and in place, incorporating PCNs and GP Locality Boards • PCNs recruit to Year 1 Additional Roles • PCN Organisational Development plan formed and offered including PCN Clinical Director and locality leads leadership development programme based on PCN maturity self-assessment • Development of analytics capability to support PCNs including a range of activity and outcomes data to underpin population health management and quality improvement approach at PCN level • PCNs to support 2019/2020 locality improvement programmes on same day urgent care, frailty and mental health • PCNs contribute to system-wide social prescribing plan • PCNs work with new BNSSG community provider to mobilise multi-disciplinary teams and to operationalise the BNSSG approach to frailty, support to care homes, population health management and personalised and proactive care • PCNs to develop partnership with wider primary and community care and VCSE sector including developing closer working relationships with community pharmacy to develop minor illness referral schemes, healthy lifestyle support and support for people with long term conditions in 2020 and 2021 • Implementation of 5 new national service specifications from April 2020: • structured medication reviews • enhanced health in care homes	vaccine preventable disease •PCNs offer Extended Hours to their population from July 2019 •PCNs established, building key relationships and planning their organisational development (OD) needs •PCNs and GP Provider Locality Boards develop BNSSG wide infrastructure to enable General Practice at scale, ensuring capability and governance in place to participate as equal and effective partners at the ICP Boards from April 2020 •Increase capacity and capability for quality improvement in Primary Care •Enhanced skill mix in Primary Care with increase in people supported by Voluntary, Community and Social Enterprise (VCSE) for non-medical needs • Reduction in avoidable admissions from care homes • Increase in pro-active care planning • Optimisation of use of medicines • Increase in early diagnosis of cancer • Increase in people being referred to community support offers and reduction in demand on statutory services

Priority	Deliverables	Outcomes
	• anticipatory care (with community services) • personalised care • supporting early cancer diagnosis • Review of Local Enhanced Service offer in BNSSG • PCNs to expand social prescribing offer with referrals to Social Prescribing Link Worker being made from other agencies including community and secondary care providers, other statutory agencies and the VCSE during 2020/2021 • PCN additional roles expands to include physician associates and first contact physiotherapists • PCNs to review practice resilience and look at opportunities for improving resilience and sustainability as a group of practices including: • Access and workflow • Reviewing approaches to skill mix, sharing workforce and developing common recruitment approaches • Specific focus on urgent primary care in conjunction with IUC • Maximise use of digital innovation both to deliver care and enable care delivery (shared appointment books, digital care plans, provision of online access to patients, remote working, direct booking from NHS 111 and from Emergency departments) • Estates – review local estates and opportunities for maximising estates usage across the PCN group including that of other local providers and inform development of locality estates plans	• Increase in measures of wellbeing as reported by people referred for social prescribing • Increase in people using community pharmacies in support of their health and wellbeing • PCNs increase their understanding of resilience amongst their practices and support the sharing of good practice • Support our system to become a mature ICS

Priority	Deliverables	Outcomes
Year 3	• Shared back office functions and at scale delivery e.g. prescribing hubs. Currently discussions being undertaken with PCNs individually where they have expressed an interest to take this forward. • PCNs to work with other primary and secondary care providers to develop pathway opportunities and support transformation with acute hospital and mental health services e.g. digital first approaches to outpatients and patient initiated outpatient follow up programmes • PCNs support GP Locality Boards to establish Integrated Care Partnerships in 2021 in order to provide place based planning and deliver of care at scale	
Year 4	•PCNs to prepare for and implement the new national improved access offer from April 2021 •Implementation of PCN cardio-vascular disease case-finding and locally agreed action to tackle inequalities specifications in 2021 •PCN additional roles expands to include paramedics •PCNs support Localities to deliver improvement programmes using national and/or local investment impact funds whereby funding flows to follow the delivery of care in the community •Refresh PCN OD plan to support PCNs to achieve and sustain Step 3 maturity	•Increase access to primary care •Reduction in health inequalities targeted to local PCN population needs •Increase the number of people diagnosed with CVD in primary care working closely with community pharmacy •All PCNs to self-assess at Step 2 on the NHSE PCN maturity matrix
Year 5	•Primary Urgent Care works in an integrated fashion 24/7 •PCNs provide support and resources to Practices and	•All PCNs self-assess as Step 3 on NHSE PCN maturity matrix

Priority	Deliverables	Outcomes
	providers within their footprint and have a culture of developing shared resilience and sustainability •PCNs are the default working within Localities to provide new pathways and models of care in the community	•People in BNSSG experience a seamless 24/7 primary care service •PCNs demonstrate significant growth in care in the community and reduction in secondary care •PCNs are driving and delivering system change •All PCNs continue to self-assess their maturity at Step 3 on the NHS England PCN maturity matrix •People in BNSSG experience improved access to a range of primary and community services, they are encouraged to self-care and when they need more intensive support they work with health and care professionals to set their goals and agree a shared care plan
SDUC Year 1	•Improved Access established across all Primary Care Networks and delivered against revised specification. •Collaboration between primary and secondary care clinicians	Patients have access to care delivered as close to home as possible, whether that care is routine or urgent negating the need for Emergency

Priority	Deliverables	Outcomes
Year 3	to develop community based ambulatory pathways and services to replace current hospital based activity for a range of Ambulatory Sensitive Conditions (ASC). Priority focus will be on: ○ Low risk chest pain ○ Acute headache ○ Abdominal pain ○ Respiratory •Locality provider teams are working on options for provision of community same day urgent care services in their areas, and considering which can be delivered during 19/20 in order to support system capacity over the winter period. Sirona Care and Health, as the adult Community Services Provider will be a key system partner in transforming the out-of-hospital care setting, so that services provide proactive care to meet population needs and a “safety-net” to avoid acute hospital admissions. From April 2020, more services will start to be delivered from Locality Hubs across BNSSG, with some designated as Urgent Treatment Centres. Locality providers will continue to work together to use these shared facilities in Locality Hubs to meet a greater range of urgent care demand and provide support to more clinical pathways. In doing so, providers will help people stay healthy, well and independent in their community.	Department attendance.

Priority	Deliverables	Outcomes
Quality and Resilience **Year 1**	• Triangulation of information from both the data, and from regular announced and unannounced CQC visits to practices, and where necessary to escalate any immediate or emergent issues and concerns to maintain patient safety and promote quality improvement • Support and work with practices on any improvements required with individual CQC domains to ensure all are rated as good or outstanding • Develop with practices a workplan to tackle Antimicrobial Resistance and Healthcare Associated infections including Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections, Clostridium Difficile infection and E-coli infections, alongside significant reductions in the use of broad spectrum antibiotics. • Finalise the Primary Care Incident Reporting Policy • Establish the BNSSG Primary Care Quality Forum to be made up of quality leads from primary care including optometry, dentistry and pharmacy • Identify the training needs of the primary care quality leads • Implement leadership programmes for Primary Care Network Clinical Directors to improve the culture of quality improvement and patient safety • Confirm the clinical and social outcomes that are being sought including from the Locality Plans and other plans and strategies that impact the work of primary care • Agree how information that will support the monitoring of progress on achievement of the outcomes will be collected	•Increased positive patient experience ratings and positive feedback •Improved and sustained positive clinical and social outcomes as evidenced by meaningful QoF achievement and personalised care plans •Reduced levels of avoidable harm •All primary care staff have the knowledge, skills and confidence to undertake quality improvement projects. •All relevant Primary Care Services are supported to achieve a CQC rating of Good or above •Practices working together within and across PCNs to understand and compare quality measures that are meaningful and support each other, under the leadership of the Clinical Director(s) •Individual practices and PCNs take responsibility for resilience of the practices in their network and provide mutual support to ensure the sustained provision of primary care services for their population

Priority	Deliverables	Outcomes
By Year 3	and who will collect it • Agree the content and format of a primary care quality dashboard that will align with the Primary Care Network national dashboard that is in development • Agree the content and format of a 'variation report' for primary care to use • Roll out the resilience self-assessment tool and make this available to all practices • Delivering the 2019/20 general practice resilience programme for individual practices identified as requiring support to improve resilience • South Bristol locality is currently undertaking a programme of work to improve resilience across the locality. In year 1 the aim is to have delivered the first set of agreed objectives which relate to the front door of general practice. A further aim is to agree the second tranche of objectives for the South Bristol Resilience Programme. • Continuing to access the Time for Care programme to benefit the practices • PCNs self-assess their resilience and are supported with analytics to help them with this • PCNs are supported with quality and population health management data • Successful delivery of the active signposting contract • All practices to have undertaken work in relation to a minimum of 3 of the 10 high impact actions, enabling time for care to be released by changing ways of working practice. A further aim is to agree the second tranche of objectives for the South Bristol Resilience Programme.	•Practices collaborate within and across PCNs to develop their resilience and to develop at scale solutions to support their efficiency and sustainability – e.g. shared back office functions and centralised prescription hubs. This may also lead to mergers to improve resilience. Nationally, a number of large-scale super-partnerships have now been developed. These have the capacity to bid for and deliver extended services, designed to fit local needs, beyond that which it is possible for any individual practice to offer. The scale and variety of services can help facilitate centralised training and new and flexible employment options. This in turn can help attract trainees and salaried doctors, who in the long term might also be interested in becoming partners. Extended services also offer an opportunity to develop the primary care workforce, drawing on professionals such as pharmacists and physiotherapists, and improve integration with other community services. We will support our practices which choose to collaborate on a larger scale.

Priority	Deliverables	Outcomes
	• All practices to have completed workflow optimisation training •System-wide resilience support menu and toolkit is available to support practices which makes the most of the capability and capacity of local stakeholders and addresses key practice needs • All practices to have adopted at least 5 of the 10 High Impact Actions • At scale work with other PCNs / localities to support improved resilience and quality • Implement the workplan to address Antimicrobial Resistance and Healthcare Associated infections • Implement the Primary Care Incident Reporting Policy • Respond to the requirements set out in the new national Patient Safety Incident Response Framework • Work with the Regional Medical Examiner system by 2021 regarding deaths in primary care which will provide an additional structure for insight • Regular sharing of quality improvement projects takes place across practices and PCNs facilitated by digital platforms and face-to-face learning opportunities • Populate the primary care quality dashboard and use the information to identify trends and themes in order to inform quality improvement efforts • All stakeholders to use the primary care quality dashboard to understand where primary care quality is being achieved and help to understand where we should focus our improvement efforts	

Priority	Deliverables	Outcomes
By Year 5 **BNSSG Referral Support Service**	• Continue to develop Primary Care Network Clinical Directors in their quality improvement leadership role by implementing formal and informal learning • Develop and implement a training programme for the primary care quality leads • Collect and analyse information that will support the monitoring of progress on the outcomes • All stakeholders use the 'variation report' for primary care to understand where variation is warranted and where it is unwarranted in order to help focus our improvement efforts • Gather information on evidence-informed interventions related to the outcomes we are seeking and use this information inform decisions about improvement efforts • Continue to consider opportunities for primary care to inform and participate in meaningful research • Write evaluation plans where relevant • Complete the evaluation of work that is being done to improve quality • Continue with actions to develop skills and training on safety to the whole primary care workforce • Continue with actions to develop a culture of continuous learning and quality improvement within all primary care • All PCNs to have undertaken work in relation to each of the 10 High Impact Actions • Achieve the best outcome and the best quality of care for our patients • Get patients the right care, by the right person at the right	The referral process itself is conducted well Improved referral quality and reduced variation Improved patient experience of referral process Patients are referred as and when necessary, without avoidable delay. Patients are referred to the most appropriate place

Priority	Deliverables	Outcomes
	time and in the right place with minimum delays • Work closely with practices to provide peer review and referral support to BNSSG practices • Work in partnership with local health providers to look at referral processes and pathways and act as a central point to try to establish consistency across organisations. The longer term aim to develop a whole system approach to referral	first time.
Developing the Workforce **Year 1**	**We will make BNSSG 'The Best Place to Work'** • We will work with Primary Care Networks to improve staff retention, e.g. mentorship, portfolio working, fellowships, developing peer networks/learning sets • The Happy App is being piloted in Primary Care in BNSSG; an App that measures how content the workforce are at a given time, with opportunities for staff to highlight any issues to managers, and for successes to be celebrated • We are producing a "how to" guide on portfolio careers in Primary Care • We are developing an outline BNSSG career pathway, agreed across Healthier Together Partners. We aim to embed the career pathway into recruitment, retention and appraisal processes and to create a digital version for access through schools, colleges and potential recruits • We will identify areas of low participation for health care careers across BNSSG, including reasons for low participation We have recruited nine Health Inequalities Fellows in BNSSG	• A Diverse high quality empowered workforce who care for the population they serve • Supporting people to self-care and to be the best they can be • Creating opportunities within PCNs and Localities for staff training and supervision to ensure estates are used effectively • Primary Care will be a supportive training environment for health care professionals, with opportunities for portfolio careers across clinical and non-clinical roles, enabling staff to work flexibly, benefitting the whole BNSSG health and social care system. • Career pathway advice accessible for all health

Priority	Deliverables	Outcomes
	working with Public Health focusing on reducing health inequalities in BNSSG • We are working with schools in areas with low participation rates in Health and Social Care to market career opportunities • We are engaging with health and social care BTEC students to attract them into hard to recruit roles • We are creating opportunities for GP Nurses to engage in education, strategy and student outreach projects • We are testing the Paramedics in Primary Care project within BNSSG, testing the viability of developing newly qualified Paramedics into system aware clinicians who can manage their own portfolio career **We will continue to support and improve leadership in Primary Care by** • Continuing to deliver leadership opportunities to GPs • Promoting leadership opportunities to BNSSG's GP Nurses through the GP Nursing 10 Point Plan • Promoting leadership development in Primary Care Networks, including leadership in multi-disciplinary teams **We will release time for care in Primary Care by** • Developing an operating model and process for a staffing bank across community, primary care and social care • Piloting of E-consultation to help improve workload levels for GPs and practice staff • Introducing Social Prescriber Link Worker models in Primary Care Networks • Developing the Clinical Pharmacist role across practices in	care professionals, schools, colleges, and potential health and social care recruits • Primary Care workforce will be equipped to reduce health inequalities across BNSSG • General Practice Nursing will be a career of choice for newly qualified nurses • General Practice Nurses will be able to return to practice through a well sign posted accessible route • Health Care Professionals working in Primary Care will be developed to deliver the service required for the population they serve • Happy, engaged and fulfilled Primary Care workforce

Priority	Deliverables	Outcomes
	PCNs • Building on our existing work with the national Time for Care programme, referenced in the quality and resilience section • Making every contact count **We will address urgent workforce shortages by** • Increasing placements for Nurses and Allied Health Professionals in Primary Care • Using a consistent approach to 'return to practice' to maximise uptake and impact • Piloting the 'New into Practice' module for newly qualified Registered Nurses and Registered Nurses working in other areas of the system in BNSSG wanting to work in Primary Care • Developing preceptorships in Primary Care and implement Nursing fellowship schemes • Continuing to engage with the NHS England International GP Recruitment Programme, bringing GPs from Europe to BNSSG and place in practices in BNSSG • Developing system wide plans to support the introduction of new roles in Primary Care Networks (PCNs) • Supporting PCNs with new roles to ensure they operate in effective multi-disciplinary teams (MDTs) • Promoting 'group consultations' in Primary Care to reduce demand on clinicians, and improve patient experience through peer support • Introducing fellowships to attract GPs, General Practice Nurses (GPNs), and AHPs in hard to fill areas • Raising awareness of GP Nursing Careers with Universities' Under Graduate programmes by working with higher	

Priority	Deliverables	Outcomes
	education institutions and supporting the development and roll out of NMC Future Nurse Project, bringing the Primary Care context to the new NMC Under Graduate nursing programme • Promoting GP Nurses as 'first choice' career at point of registration • Supporting the upskilling of staff in social care particularly in care homes and domiciliary care to identify deterioration in residents and to improve communication with GPs and community services • Supporting the development of a school to practice career information platform for use by schools and developing clinicians within BNSSG **We will optimise skills by:** • Increasing the use of apprenticeships in Primary Care in clinical and non-clinical routes, supported by the remaining levy from acute trusts • Work with PCN's to support new roles, embedding and developing the roles within the PCNs • Implement Nurse Preceptorships in Primary Care to support Nurses moving from Secondary Care to Primary Care using an NMC led skills/knowledge passport. • Offering direct support to new Primary Care Network Social Prescribing Link Workers, co-designing a package of support for link workers that may include, for example, peer network meetings, action learning sets, co-mentoring • Deliver mental health first aid training in Primary, Community and Social Care to include care workers and volunteers • Developing and facilitating peer groups networks and action	

Priority	Deliverables	Outcomes
By Year 3	learning sets and conferences across PCNs, for example, Social prescribers, Paramedics, Pharmacists and Nurses • Supporting portal development for a single point of reference for training and education across BNSSG • Changing back office functions in Primary Care to improve workflow • Offering active signposting to ensure patients see the right person in the right place at the right time • Supporting PCNs to develop links across the voluntary sector through development of social care and voluntary sector task and finish groups • Developing training for volunteers in identifying frail at risk patients and communicating with community and primary care to support social prescribers and PCNs • Launching the Advance Clinical Practitioner apprenticeship • Supporting the Paramedics in Primary Care Project at practice level, offering placement support and continuing to grow the Paramedic Forum • Developing a Physiotherapist Forum, understanding training needs and aspirations • Supporting Primary Care Placements for Physicians Associates by creating a UWE Role Guide and continue to promote the role in practices • Work with local providers to ensure there is a sustainable pipeline of Pharmacists for additional roles in primary care through portfolio careers, rotations and training of sufficient Pharmacists for primary care • Develop and support better use of administrative and management apprenticeships in Primary Care to develop a sustainable Primary Care workforce	

Priority	Deliverables	Outcomes
By Year 5	• Develop motivational interviewing skills in the Primary Care workforce to assist patients with long term conditions set goals and engage with their care • Offering direct support to new Primary Care Network Social Prescribing Link Workers, co-designing a package of support for link workers and building a team of community volunteers to support the link worker • Supporting Primary Care placements for Physicians Associates by creating a Role Guide and continue to promote the role in practices • Continue to develop portfolio working in Primary Care • Digitalised career framework model – embedded into recruitment, career development • Assess the impact assess of schemes reaching out to areas where there is low participation in health and social care careers and develop further, targeted programmes • Next Generation GP leadership programme • Leadership Development for MDTs • Implement a GP nurse bank across primary care and community • We will have an embedded approach for schools to improve our workforce pipeline numbers • Physios, physicians associates and paramedics recruited in significant numbers by PCNs • As part of Healthier Together, we will have a system wide recruitment passport which will be used in every organisation for all inter-organisational transfers to ensure processes are	• A single, integrated system wide bank • Reduce unspent apprenticeship levy from 75% to

Priority	Deliverables	Outcomes
	more efficient and reduce duplication in HR processes • Subject to national pilot site outcomes, embed place based placement scheme across BNSSG • Embed nurse preceptorship schemes across PCNs • Implementation of apprenticeship strategy • Primary & Community Care Using Training Hub to develop links across the voluntary sector to ensure appropriate training is available to the voluntary sector primary care interface • Rotational roles will be developed across Primary Care, the Acute Trusts, and the Community providers • A motivated GP Nurse team will be embedded in education, schools and colleges outreach and Primary and Community Care Training Hub strategy building • Development of a workforce management/deployment hub – to include rotational programmes • Have a career framework recognised by all staff, used for appraisal, recruitment, and in schools and colleges • Continue to develop leadership roles in Primary Care in GPs, GP Nurses and Practice Managers to ensure PCNs are well led and effective models of care Support PCNs with a system wide approach to developing and embedding new roles in primary care	0% • MDT working at scale across PCNs and Localities • More registered Nurse starters than leavers each year • Reduce registered nurse vacancies from 12.6% to 5% • Increase Primary Care placements by 20%

Priority	Deliverables	Outcomes
Digital **Year 1-3**	People empowered to take control of their own health and care, anticipatory care, supported self-care and personalised care when they need it, through secure online access to health records personalised health information, digital tools and solutions Telephony for automated appointment booking systems such as patient partner – giving 24/7 access to telephone appointment booking	Patients, carers and families better able to manage their conditions Personalised care with shared decision making Digital solutions for all including people with visual + hearing impairments Patients being able to contribute to their own health record and choose who to share it with
	Reduced local health inequalities and unwarranted variation Insights to understand demand and capacity patterns and pre-empt deterioration of health	A population health solution - identifiable, pseudo-anonymised and de-personalised data is shared to ensure wider population health planning, management and development of pathways Effective risk stratification tool in place
	Staff across the *Healthier Together* partnership are able to access the digital information and services they need to do their job, regardless of location including: - Health and social care records - Test requests – in particular ICE - Test results - Care Plans - Discharge information - Decision support - Easy access to information about local health and social care services	Shared care record with read and write capability where appropriate Care planning - information sharing to provide care plans and communication across the system to make it easy to provide and manage care Staff enter information directly in to digital system do not enter the same information into multiple IT systems Single, fully functioning requesting system for cross

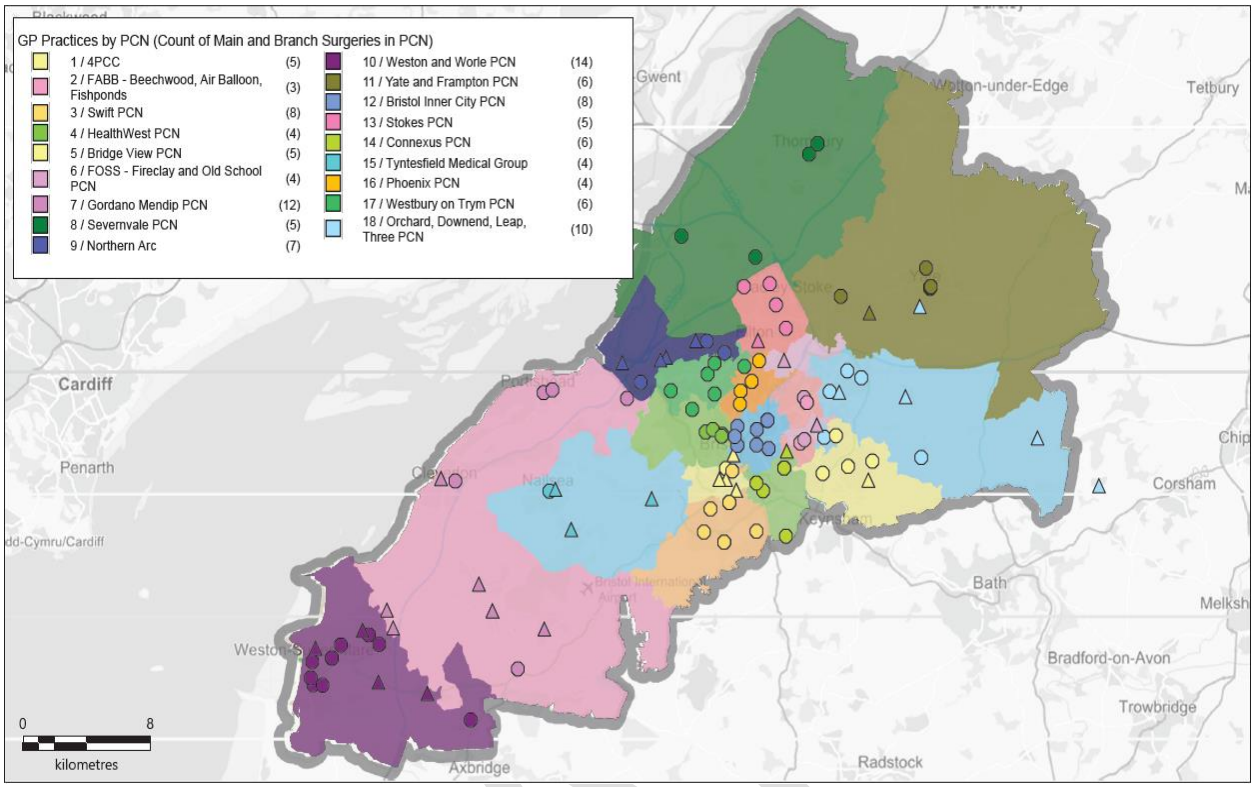
Priority	Deliverables	Outcomes
	Implementation of read/write access to Connecting Care care plan with write back into local systems Sunquest ICE – review local configuration to improve functionality for cross organisational working or consider testing the market for alternative solution Cross organisational appointment booking.	organisation ability to order and take samples/tests Infrastructure in place to support collaborative working for patient care and MDT working Continuity of Care Improved staff health and well being Improved recruitment and retention - BNSSG primary care a more attractive career choice
	Real time sharing of information between health and social care settings, organisations and geographies, as well as between professionals and patients Structured messaging using FHIR standard between organisations, improving efficiency, data quality and improving medicines reconciliation Connecting care patient held record NHS App / Patient Access / Evergreen giving patients access to their up to date information	Improved access to appropriate healthcare advice at the right time with the right person Optimised patient outcomes and quality of care One digital solution - all information will be digital, structured in appropriate coded formats and shared electronically as structured data by default Medicines reconciliation on transfer of patients between organisations to be facilitated by electronic structured messaging to improve patient safety and efficiency Continuity of care Patients empowered to engage in the management of their health by having access to their up to date

Priority	Deliverables	Outcomes
		health information
	All staff are appropriately and regularly trained to make best use of digital technologies	All digital solutions are used to maximum capability – patient outcomes and experience is optimal
	Clinicians and patients can communicate with each other using a shared digital record that is be easily accessed by patients and clinicians alike, using mobile technology Use of systems such as Consultant Connect to facilitate access for primary care to specialist advice Use of advice and guidance systems for quick access to advice for primary care clinicians	Remote and collaborative working to move care to where it is most needed and make the most of limited resources Patients, carers and families will have remote/virtual clinical consultations and receive clinical advice using tools such as online meetings, videoconferencing, email or instant messaging Health and care professionals can contribute remotely to discussions about patient care with colleagues across the system Improved delivery of care home and housebound care Continuity of care

Priority	Deliverables	Outcomes
	Improved access to appointments when needed to the appropriate person within the appropriate timeframe. - Patient Access - Care navigation - Mi-Dos - Online consultations - NHS App - High speed internet	IT solutions interoperable with EMIS Patients, carers and families can access healthcare advice when they need: - Supported self-care - Signposting - Appointments when appropriate, with the right person, at the right time with the right service Patients, carers and families could have remote/virtual clinical consultations and receive clinical advice using tools such as online meetings, videoconferencing, email or instant messaging Professionals can electronically refer and book patients directly into appointments, including but not limited to professionals from Community Services, 999, acute, Primary Care, integrated urgent care clinical assessment service, social care, voluntary services and mental health Reduced workload for practices.
	Assistive technology to remotely monitor patients	Supported self-care, independence and social participation Improved delivery of care home and housebound care

Priority	Deliverables	Outcomes
	Partnership working – Office 365, EMIS X, Resource Publisher, FHIR Messaging, cross organisational record access, cross organisational test requesting	IT solutions interoperable with EMIS Infrastructure in place to deliver 24/7 primary care Data is recorded consistently across PCNs and integrated Localities Infrastructure in place to support collaborative working for patient care and MDT working Infrastructure in place to deliver locality priorities across PCNs and Integrated Localities: - Same day urgent care - Frailty - Mental Health

Appendix 2 – BNSSG PCN Map



Appendix 3 - Engagement Findings

Summary of PCS Public and Patient Eng

BNSSG Primary Care Strategy Survey anal

Summary of Clinical Engagement 271119.

Shaping the Primary Care Strategy Works

Appendix 4 – Glossary of Terms

A&E	**Accident and Emergency**
AF	Atrial Fibrillation
AFS	Acute Frailty Service
AGI	Absolute Gradient of Inequality
AHC	Annual Health Check
AHP	Allied Health Professional
AMR	Antimicrobial resistance
APMS	Alternative Provider Medical Services
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
BNSSG	Bristol, North Somerset and South Gloucestershire
CCG	Clinical Commissioning Group
CCIO	Chief Clinical Information Officer
CD	Clinical Director
CGA	Comprehensive Geriatric Assessment
CHP	Community Health Partnerships
CIO	Chief Information Officer
COPD	Chronic Obstructive Pulmonary Disease
CPCS	Community Pharmacist Consultation Service
CQC	Care Quality Commission
CVD	Cardiovascular Disease
DES	Directed Enhanced Service
DoS	Directory of Services
ED	Emergency Department
eFI	electronic Frailty Index
eGOS	electronic submission forms used in optometry
EOLC	End of Life Care
EMH	Enduring Mental Health
EMIS	Digital provider for General Practice
ETTF	Estates and Technology Transformation Fund
FTE	Full Time Equivalent
FFT	Friends and Family Test
GPFV	General Practice Forward View
GPIT	General Practice Information Technology
GPRT	General Practice Resilience and Transformation Programme
HbA1c	Clinical measure used in diabetes care
HCA	Health Care Assistant
IA	Improved Access
ICB	Integrated Care Bureau
ICE	Integrated Clinical Environment: The system enables pathology and other departments' requests to be made from wards, clinics, and GP surgeries
ICP	Integrated Care Partnership
ICS	Integrated Care System
IFS	Integrated Frailty Service
IMHN	Independent Mental Health Network
IPB	Integrated Personal Budget
IUC	Integrated Urgent Care
JSP	Joint Spatial Plan
KPI	Key Performance Indicator
LA	Local Authority

LDC	Local Dental Committee
LeDeR	Learning Disabilities Mortality Review
LGA	Local Government Association
LMC	Local Medical Committee
LOC	Local Ophthalmology Committee
LOS	Length Of Stay
LPC	Local Pharmaceutical Committee
LTC	Long Term Condition
LTP	Long Term Plan
MDT	Multi-Disciplinary Team
MECC	Making Every Contact Count
MiDoS	Local Directory of Services
MSK	Musculoskeletal
NHSE	NHS England
NHS PS	NHS Property Services
NMC	Nursing and Midwifery Council
NMS	New Medicine Service
NSAIDs	Non-Steroidal Anti-Inflammatory Drugs
OD	Organisational Development
ONS	Office for National Statistics
OOH	Out of Hours
OP	Outpatient
PCN	Primary Care Network
PCS	Primary Care Strategy
PGDs	Patient Group Directions
PGP	Productive General Practice
PHB	Personal Health Budget
PHE	Public Health England
PHM	Population Health Management
PPIF	Patient and Public Involvement Forum
PROMs	Patient Reported Outcome Measures
PQS	Pharmacy Quality Scheme
QoF	Quality and Outcomes Framework
QI	Quality Improvement
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RCGP	Royal College of General Practitioners
SDUC	Same Day Urgent Care
SMI	Severe Mental Illness
SNOMED	Codes for EMIS
STP	Sustainability and Transformation Partnership
SWAST	South Western Ambulance Service NHS Foundation Trust
UDA	Unit of Dental Activity
UEC	Urgent and Emergency Care
UWE	University of the West of England
VCSE	Voluntary, Community and Social Enterprise
WHO	World Health Organisation
WTE	Whole Time Equivalent

Appendix 4 – References

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