NHS
Bradford City
Clinical Commissioning Group

NHS
Bradford Districts
Clinical Commissioning Group

Primary Medical Care Commissioning Strategy

2016 – 2021

Version Control

Version Number	Date	Editor	Purpose/Change
v1	**20th May 2015**	**Karen Stothers**	
v2	**8th June 2015**	**Karen Stothers**	Comments from LP, HH and AH.
v3	**23rd July 2015**	**Karen Stothers**	Comments from AW and joint GB/CB chatter
v4	**15th September 2015**	**Karen Stothers**	Comments from VW, GT
v5	**15th September 2015**	**Karen Stothers**	Clean copy removing GT comments – requirement to revisit comments in v4. CC comments – new self-care section, amendments to Access, LTC, Workforce and IT GF comments. Inclusion of commissioning for quality primary care section (MT comments)
v6	**20th October 2015**	**Lisa Pope**	Textual revisions
v7	**5th November 2015**	**Karen Stothers**	Clean copy following LP revisions
v8	**26th May 2016**	**Liz Allen**	Districts v7 and City v6 combined and updated to reflect publication of GP Forward View (NHSE, April 2016), formation of the Bradford Care Alliance, steps towards an accountable care system and the development of the Bradford District and Craven Sustainability and Transformation Plan
v9	**5th July 2016**	**Vicki Wallace**	Further additions regarding STP, GPFV, removal of out of date information, altered layout and included feedback from general practice engagement event on 30th June and email comments
v10	**20th July 2016**	**Vicki Wallace**	Additions following joint (BC and BD CCGs) Governing Bodies and Clinical Boards strategy session on 13th July
v11	**8th August 2016**	**Liz Allen**	Revisions and additions following meeting of CCG Clinical Chairs, Directors of Strategy, Head of Commissioning and Contracting (Primary Care) and senior representatives of YORLMC Ltd.
V12	**7th December 2016**	**Vicki Wallace**	Revisions and additions following engagement process with stakeholders

Record of Stakeholder Engagement

Stakeholder Group	Version number	Date
Bradford Districts Governing Body	Districts - v3	11th August 2015
Bradford City Governing Body & Clinical Board	City – v6	9th December 2015
City and Districts member practices and YORLMC Ltd	v8	30th June 2016
Bradford City and Bradford Districts Joint Governing Body and Clinical Board session	v9	13th July 2016
Bradford City and Districts CCGs and YORLMC Ltd	v9	29th July 2016
People's Board	v11	18th August 2016
Public and Stakeholder engagement (included Governing Bodies, Joint Clinical Board, YORLMC)	v11	5th September 2016 – 14th October 2016
Integration and Change Board	v11	28th October 2016

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Foreword (Still to be drafted for/written by Helen, Andy and Akram)

Executive Summary

This document sets out the primary medical care commissioning strategy for NHS Bradford City Clinical Commissioning Group and NHS Bradford Districts Clinical Commissioning Group. It sets out the commissioning aspirations for the next five years to enable primary medical care services within Bradford to:

- Be delivered via primary medical care at scale by a mixture of independent practices, networks and federations as part of an accountable care system operating out of hubs, co-located and collaborating with other relevant services 7 days a week. As well as NHS and social care providers this will also include VCS organisations.
- Regularly use technology for all elements of patient care including access, consultations, telehealth and telemedicine.
- Have established new roles and new ways of working, including 'virtual primary medical care', shifts in traditional roles and responsibilities and that Bradford is 'The place to be'.
- Have better demand management, as patients are empowered and experienced in self-care and preventative services are embedded within the accountable care system.
- Have strong embedded relationships with education, paving the way for increased levels of self-care and a workforce who choose to work and live in Bradford.
- Have equality of care for the whole population. Wherever people live or are registered within Bradford, they can access the same services.

To attain our end state we will focus on the following 6 key areas and deliver our 'We will' statements:

1. Improve access
2. High quality
3. Workforce
4. Self care and prevention
5. Collaboration
6. Estates, finance and contracting

To enable the Clinical Commissioning Groups to facilitate this we will change the way we commission, contract and pay for services as part of our move to accountable care. This will include funding federations of primary medical care providers, rather than the traditional route of individual primary medical care providers.

1. Introduction

The health and care delivery system of Bradford District & Craven comprises of three Clinical Commissioning Groups (CCGs), two local authorities and four main NHS providers. Although each are statutory organisations in their own right, the three CCGs have a strong commitment to working collaboratively. This primary medical care commissioning strategy relates only to Bradford City and Bradford Districts CCGs. We will continue to work closely with our partners to secure the best possible integrated and efficient health and care services for people in the Bradford District and Craven area.

In October 2014 Simon Stevens, Chief Executive of NHS England, published the 'Five Year Forward View' (FYFV)[1] for the future of the NHS. He put patient experience, care closer to home and moving care out of hospital settings at the heart of plans for transforming the NHS. In the Bradford District and Craven health and care economy we have interpreted this challenge in our own Five Year Forward View[2] and more recently our Sustainability and Transformation Plan (STP), to enable the transformation required to deliver our shared vision: *"To create a sustainable health and care economy that supports people to be well, healthy and independent".*

Since April 2015, both Bradford City CCG and Bradford Districts CCG have held delegated responsibility to commission primary medical services on behalf of NHS England. This provides the opportunity for the CCGs as local commissioners to have greater influence in the use of resources and shape services for the future. It is a key enabler in developing seamless integrated out of hospital services around the diverse needs of our populations and in delivering the aspirations of both the local and national five year forward views as well as those described in the 'General Practice Forward View'[3] published by NHS England in April 2016.

Delivery of our system wide vision is led by the Integration and Change Board (ICB) which is collectively accountable to the Bradford Health and Wellbeing Board. Its role is to provide system wide leadership and accountability for securing the delivery of a sustainable health and social care system within the Bradford health and care economy, implementing the vision and direction for delivering the best outcomes for the population as set out in the Five Year Forward View and Sustainability and Transformation Plan, as required by the Bradford Health and Wellbeing Board.

Within the wider Bradford health and social care system there is an ambition to move towards an Accountable Care System (ACS) to achieve the triple aim of improved population health outcomes, high quality experience of care and at a good value per capita cost. We expect to be operating within an ACS by 2020/21 and we are planning major steps in the design of this in 2016/17. We believe that by establishing an accountable care approach, we will be able to commission holistic care for our population, taking into account the care they will need for their whole life, and for the whole person, rather than commissioning separate services. We will commission services that 'wrap around' them, to provide co-ordinated consistent and high quality services across organisational boundaries.

This approach will be outcome based. We are not interested in merely counting activity and inputs, rather, we want to know that the care received by our population is of high quality, safe and of best value and that we commission interventions that improve the population's overall health outcome. We believe, for this to succeed, primary medical care services must be the bedrock of our system. It is clear that without total primary medical care involvement, a fully functioning ACS would not be

possible. Therefore this strategy clearly sets out our ambition to ensure primary medical care services play a full part in the development and move towards an ACS.

Primary medical care services are the underpinning bedrock of the whole health and social care system and this strategy is a key driver of the delivery of the Out of Hospital Programme. The Out of Hospital Programme has interdependencies with other ICB programmes, and achievement of our system wide vision is dependent upon all programmes delivering.

The scope of this strategy covers the entire service element of primary medical care. This includes all services deliverable under core General Medical Services[4] and Personal Medical Services[4]. It also includes Enhanced Services, the Quality and Outcomes Framework, vaccinations and immunisations and locally commissioned services. The scope includes services delivered at both individual practice level and delivery at scale. The scope does not include services delivered by community providers e.g. district nursing. This does not mean that there will be no interaction or influence over the commissioning of community services and this interaction with be managed by the Out of Hospital Programme Board. The delivery of the strategy relies on all elements of the primary medical care workforce, not just General Practitioners. This includes, but is not limited to, Advanced Nurse Practitioners; Practice Nurses; Practice Managers; Receptionists; Health Care Assistants, practice-based Pharmacists and practice volunteers.

It is unlikely that the future model of primary medical care will look exactly like the service that exists today. Over the next 5-10 years the service must transform, adopting new ways of working and of delivering care to the population of Bradford. To do this we will learn from what we have done well, look to local, national and international examples of best practice, and will establish a culture that facilitates innovation, to enable new ideas to be tried and tested.

The term 'general practice' is often used interchangeably when describing three related yet different concepts:

- The current model of delivery (including, but not limited to, independent contractor status)
- The wider members of the primary health care team who work in and/or for the practices
- The skills of GPs that are unique to the profession

It is important that our strategy addresses all of the above. It is also important to note that throughout this strategy, where we refer to patients we are referring to both patients and their carers as we recognise that not all patients are able to access care or manage their conditions independently. We recognise the importance of engaging with carers as part of our service transformation. It is also imperative to acknowledge that the primary medical care services included in this strategy relate to both physical and mental health needs. This strategy recognises the need to ensure that mental health illnesses are treated with the same parity of esteem as physical health needs and will support the delivery of the mental health strategy to guarantee this occurs in Bradford.

1.1 National context

NHS England's Five Year Forward View (2014)[1] sets out a vision for the NHS, based on new models of care. Primary medical care is recognised as *"one of the great strengths of the NHS"* and further investment is planned, specifically relating to:

- stabilising core funding;
- greater influence over the NHS budget for CCGs;
- increased numbers of GPs;

- increased funding for infrastructure development;
- initiatives to tackle health inequalities; and
- awareness of roles and resources to support self-care.

The environment for further investment and development is challenging, complicated by recruitment and retention issues; transformation shifting care closer to home; lower relative funding; increased activity in acute services (e.g. A&E); the development of new primary medical care models e.g. federations; increasing demand and financial pressures; and pressures from increasing performance targets.

Government policy continues to move services into the community, placing yet more pressure on overstretched GP services struggling to provide enough appointments, with consequential delays to see a GP.

In April 2016, NHS England (NHSE) in partnership with The Royal College of General Practitioners (RCGP) and Health Education England (HEE) published the General Practice Forward View[3]. This document can be seen as primary medical care services' own FYFV – highlighting the key challenges which face primary medical care currently and the changes and developments which NHSE, RCGP and HEE identify as being key priorities in ensuring a high quality and sustainable primary medical care service is in place in the future.

The General Practice Forward View[3] (GPFV) focuses on five main areas:

1) Investment
2) Workforce
3) Workload
4) Practice infrastructure
5) Care redesign

Against each area, the GPFV outlines what NHSE plans to implement to support those areas, and the detail set out in this strategy outlines what Bradford CCGs will also be doing locally to interpret and implement the GPFV in order to make it real for Bradford people.

Some of the plans and concepts outlined in the GPFV have also been evidenced in earlier documents which inform this strategy. The Royal College of General Practitioners previously set out a vision suggesting that primary medical care in 2022[5] should be based on shared decision making; increased community self-sufficiency; coordinated care; collaboration across boundaries; and greater use of information and technology. The NHS Alliance[6] has also prepared a vision for primary medical care , focused on developing a "community of care" using a restructured workforce; improved premises; increased coordination; social prescribing; effective use of technology; a review of funding; and increased self-care and prevention.

The BMA's discussion paper "General practice and Integration"[7] states that initiatives to reduce service fragmentation and align organisational interests for the benefits of patients through the development of collaborative working should be welcomed. The current arrangements of competing providers and at times, rigid separation between primary medical care, community providers and social care are having a detrimental effect on patients, with disjointed service delivery, duplication, increased transaction costs and flows of funding which create perverse incentives that do not reflect patient needs. Our CCGs agree with this, and the work we are doing on ensuring

primary medical care is the bedrock to the accountable care system is our main approach in eliminating these issues in the future.

The Equality Act 2010[8] unifies and extends previous equality legislation and we have also taken this Act into account when developing this strategy. Nine characteristics are protected by the Act; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

To ensure that NHS Bradford City and NHS Bradford Districts are meeting their equality duties, improving health and reducing health inequalities we will:

- Adhere to the 'Brown principles'[9]
- Ensure any changes to services will include local engagement with patients, public, carers and wider stakeholders and ensure that this includes involvement of protected characteristic groups and that equality monitoring is undertaken for all engagement activity.
- All service reviews undertaken as part of this strategy, will undertake an equality analysis.
- Service contracts and service specifications will reflect the need for equality monitoring and ensure that providers demonstrate and report on how they are meeting their public sector equality duty.
- Any decision making resulting from this strategy will give consideration to any identified 'impact' on protected characteristic groups and where appropriate identify and implement mitigating actions.
- Adhere to the accessible information standard by ensuring that patients and service users, and their carers, can access and understand the information they are given. This includes making sure that people get information in different formats if they need it, for example in large print, braille, easy read or via email. We will also ensure that people get any support with communication that they need, for example support from a British Sign Language (BSL) interpreter, deafblind manual interpreter or an advocate.

1.2 Sustainability and Transformation Plan

The national FYFV[1] also sets out the aim of closing three gaps in health care:

- The health and wellbeing gap
- The care and quality gap
- The funding and efficiency gap

The NHS planning guidance for 2016/17[10] outlined the importance of closing these gaps, and locally this would be enacted via each area producing and delivering a Sustainability and Transformation Plan (STP). The planning guidance made it clear that a STP is not just about writing a document, nor is it a job to be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting.

In common with the other CCGs across West Yorkshire, it has been agreed that our footprint for local delivery of the STP is to remain as the Bradford District and Craven locality, embracing the understanding of a place-based and population-based plan, whilst being a sub-set of the West Yorkshire STP. Along with the other West Yorkshire CCGs we fully recognise and have included in our plan the need to work across our footprint boundaries in order to create sustainable services.

The Healthy Futures group has identified that there is still a substantial financial and efficiency gap that must be closed if health and care services are to be sustainable in the future. The financial efficiencies that have to be achieved are extremely challenging and need to be met at both a local (CCG) and sub-regional (West Yorkshire) level. Five areas are being targeted across the whole of the West Yorkshire footprint. These are: Mental Health; Urgent and Emergency Care; Cancer; Stroke; Specialised services. This work will take into consideration the impact on protected groups regarding access, experience and outcomes.

Primary medical care services in Bradford play an important role in delivering the STP as the majority of care is delivered in primary or community settings. In Bradford we recognise the importance of primary medical care, it is the bedrock of our whole system, the foundation on which the rest of the health and social care system is built. This is because the majority of care delivered in the NHS is delivered by primary medical care teams. They are often the first port of call for patients and are the gateway in many instances to acute care via the referral system. Unless high quality safe care is delivered by primary medical care, the number of patients presenting acutely within secondary care increases, access issues result in high A&E attendances and early diagnosis of conditions is reduced.

This strategy outlines the main steps that will be taken to improve the quality, reduce the variability in care, and deliver long term sustainability of services in primary medical care, thereby contributing to the closure of the three gaps outlined above.

1.3 Local context

Primary medical care services in Bradford are in a different position currently to many other areas nationally. The concept of a GP with Special Interest (GPwSI) was established in Bradford, and there has been a long history of investment within primary medical care. Developments and investment have meant that there has been an acute care to primary medical care shift taking place over the last 20 years, so many of the changes taking place elsewhere in the country have already happened in Bradford. These changes did not take place systematically over Bradford, for example, the practices in the city centre area were more focussed on attracting new GPs to this under-doctored area, while the specialisation took place in areas which now predominantly fall under the remit of Districts CCG. Once more, we need to look to new and innovative ways of working to guarantee the benefit of our long history of investment in primary medical care is felt by all patients.

Here in Bradford there are significant transformational and enabling programmes in place. The primary medical care commissioning strategy will sit alongside and will support, drive and respond to other Bradford initiatives including (but not limited to):

It is important to note that not all of the actions and intentions outlined in this strategy will be the responsibility of the Out of Hospital Programme to deliver. Some aspects will be delivered by other programmes of work, e.g. self-care and prevention programme, Bradford Digital 2020. This strategy is about the role of primary medical care in the whole system – it is just one element of the health and care system in Bradford, albeit a very crucial element. This strategy outlines the primary medical care transformation which will support the wider transformation of health and social care services in Bradford.

1.3.1 Health Challenges in Bradford

The health needs of the population of Bradford are challenging. The different profiles of our two CCG's are outlined below.

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Health challenges

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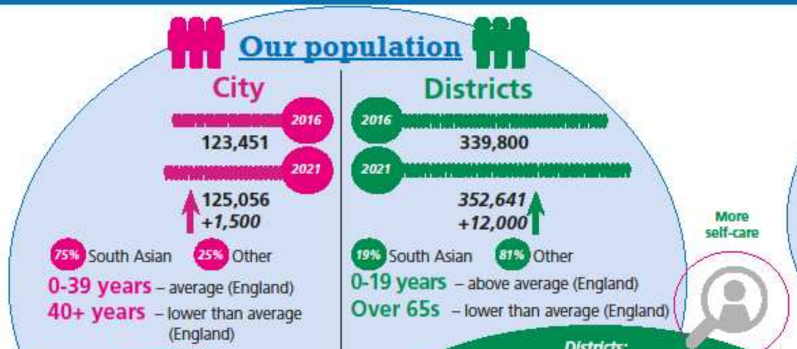


More self-care

Districts: What this means for services: This huge growth massively impacts on primary care, so we need to develop more sustainable services that can support patients to self-care. With already high demand and little spare capacity, an increase of people with two or more conditions will stretch the resources further. We need to look at how we use resources differently.

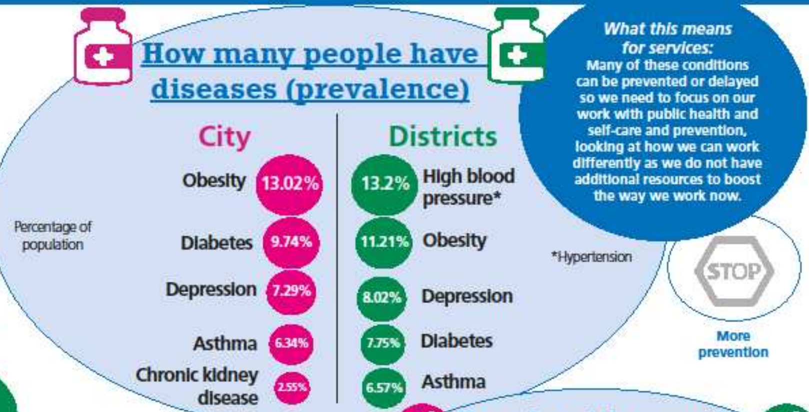
City: What this means for services: Our services need to be appropriate to younger and older people. It's likely that the way people use services will change, particularly as younger people use technology regularly and expect to continue doing so.

More technology

More social media

City: What this means for services: To improve how men use services, and so improve their health, we need to consider using social media, peer support and taking services to where men are. Whilst increasing life expectancy is positive, it also increases pressure on services, so we need to look at how we use our resources differently as we cannot continue to provide care the same way as we do today.

Districts: What this means for services: Despite this positive outcome, we must continue to improve by focussing on screening and preventative services. As our growing population ages, our resources are put under further pressure, so we must adapt and be creative in our service delivery as we cannot continue to provide care the same way as we do today.



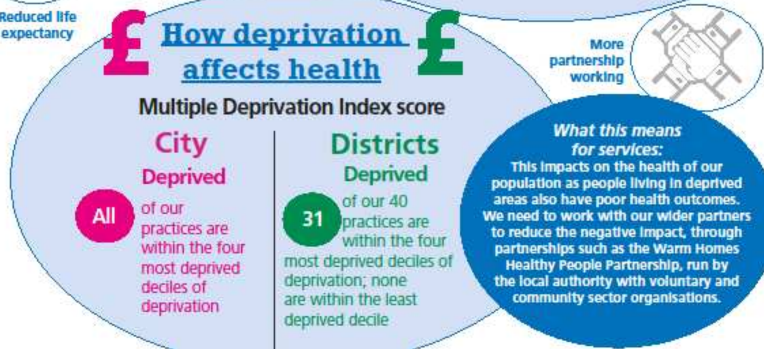
What this means for services: Many of these conditions can be prevented or delayed so we need to focus on our work with public health and self-care and prevention, looking at how we can work differently as we do not have additional resources to boost the way we work now.

More prevention

What this means for services: People with mental health problems are more at risk of worse physical health than those who do not experience them. The life expectancy of people with severe and enduring mental illness is 15-20 years less than the general population. The most common physical health problems amongst those with serious mental illness include high blood pressure, diabetes and asthma.

15-20 %

Reduced life expectancy



More partnership working

What this means for services: This impacts on the health of our population as people living in deprived areas also have poor health outcomes. We need to work with our wider partners to reduce the negative impact, through partnerships such as the Warm Homes Healthy People Partnership, run by the local authority with voluntary and community sector organisations.

1.3.2 The primary medical care provider landscape in Bradford

The two CCGs in Bradford have two differing provider landscapes. In Bradford City CCG there are 27 separate primary medical contract holders providing care for 124,000 patients, of whom 75% are of South East Asian origin with an average list size of 4571. The majority of the population live in the 20% most deprived areas of England.

While in Bradford Districts CCG, 43 separate primary medical contract holders provide care for 328,000 patients, of whom 19% are of South East Asian origin. 41% of the population live in the 20% most deprived areas of England with an average list size of 8288.

Bradford City CCG, with the agreement of the Council of Members, and Bradford Districts CCG, with agreement of the Council of Representatives, became delegated commissioners of primary medical care services in April 2015. We believe that by accepting these delegated responsibilities we are now enabling local commissioners to have greater influence in the use of resources and the shaping of services in the future. One of our key objectives is to manage the provider landscape in primary medical care in order to enable the development of seamless integrated out of hospital services around the diverse needs of the population. Eventually this will progress into fully local and responsive place based commissioning via the ACS.

Contract types and values:

There are 7 GMS contracts (4 City, 3 Districts), 56 PMS contracts (19 City, 37 Districts) and 7 APMS contracts in place (4 City, 3 Districts). These contracts currently provide services to patients during core hours (8.00am to 6.30pm Monday to Friday) providing services over 86 sites (17 branch surgeries). APMS contracts are time-limited contracts, when contract terms end national guidance dictates that these are fully evaluated against key criteria for value for money, needs assessment, impact assessment and consultation proposals.

The majority of these contracts outlined above are held by individual practices. However, we have a number of practices who hold multiple contracts across the district (e.g. one partnership holds 5 contracts) and often in these situations patients are able to access services at any of those sites. The list size across our practices also varies, in Bradford City CCG they range from 1573 to 9360, while in Bradford Districts CCG the numbers are 2933 to 25,110.

Since becoming delegated commissioners, both CCGs have undertaken negotiations with PMS practices and the Local Medical Committee around the equitable funding review. The implementation of the PMS equitable funding review (EFR) came under the terms of the national policy for PMS reviews set by NHS England. In summary the amount of PMS funding classed as a 'premium' i.e. anything over £79.99 per weighted head of population is being redistributed to practices within the CCG area in a way that demonstrates the principles of equity, fairness and value for money. Locally we have agreed to an offer of equitable distribution. The national requirement was for the review to be completed by 1 April 2016 and implemented within four years and the CCGs are on track with achieving this.

Practices that are likely to suffer hardship as a result in the changes can make a request for further transitional support funding. The decision to grant further transitional funding will be one for each Governing Body to make and will be done in an open and transparent way, with YORLMC oversight to ensure fairness and equity. Practices will have to demonstrate why the change in policy has resulted in hardship. All practices with a high premium should have been planning to manage a reduction so it will be necessary to demonstrate why the shortening of the premium recovery period

cannot be managed without threatening the viability of the practice. Each Governing Body was clear that it did not want to see any practice's viability threatened as a result of the change of pace arrangements. To support this, the CCGs have provided financial support to practices to allow them to manage the changes.

Our approach to APMS contracts and practice mergers is becoming established, both of which will have an eye to sustainability and quality. The move to 7 day service provision will include a review of the existing extended hours Directed Enhanced Service, with the aim to enable practices to work flexibly to meet the needs of our population, especially in regards to the needs of children, which is especially pertinent in Bradford City CCG. The work behind the EFR supports the CCG to improve the offer of services to patients by ensuring that all patients have access to enhanced services and local diagnostics via local arrangements even if their own GP practice is not directly able to provide these. Bradford City CCG, through the EFR, has an opportunity to work with practices to develop new models of delivery, encouraging practices to look at innovative ways of managing demand within primary medical care. This will benefit practices by giving them the opportunity for meaningful community engagement and the development of members of the practice team to make links deep in to the community, using appropriate language and cultural norms, promoting health and wellbeing.

As well as core provision which is set out within the contract, primary medical care services also deliver enhanced service provision as we have deliberately chosen to increase the primary medical care offer across both CCGs in Bradford. Enhanced services can be seen to be 'over and above' day to day services, including:

- A directed enhanced service for extended hours provides an opportunity for practices to offer extended hours opening to patients. This service is delivered by 90% of Bradford practices, offering a range of early morning, late evening and Saturday morning appointments.
- A local enhanced service on a list basis for diagnostic testing for ECG, spirometry, and 24 hour BP monitoring. This is offered by all practices.
- The local community enhanced dermatology service went out to Any Qualified Provider (AQP) at the beginning of 2015 and contracts were awarded in July 2015. There are currently 9 practices delivering this service.
- Using a process of 'structured collaboration', commissioners and providers are working with the public, patients and service users to co-design a transformed end-to-end integrated diabetes pathway that incorporates primary prevention of the condition as well as better management for those who have diabetes and secondary prevention of related complications. The current diabetes services delivered in primary and community settings (described as Levels 2 and 3) are part of this redesign work, all of which serves as the first part of our journey towards an accountable care system. The structured collaboration process is implemented through a series of workshops, with the objective of agreeing a service specification before the end of 2016 and the two Bradford CCGs offering a single accountable contract for implementation from April 2017.

1.3.3 The emerging primary medical care landscape in Bradford:

Nationally there is growing consensus for primary medical care to be delivered at greater scale. New models of working are emerging within primary medical care in Bradford and developing a strong, sustainable and continuously improving primary medical care infrastructure is a key priority for the Bradford CCGs. We have acknowledged that there is work still to do to establish primary medical care as the strong foundation upon which the new models of care delivery for the future can be built and see one of the enablers as being the development of a new model of primary medical care.

This new model includes practices working as an individual organisation, collaboratively with each other, within the wider primary medical care arena and within the overall health system with services being commissioned across bigger footprints. There is no 'one size fits all' rule in Bradford, we believe that each of the elements below will be needed in the future system and practices are likely to play a role in all elements:

The Bradford Care Alliance (BCA), a community interest company, was established in June 2016. This represents the provider voice of the vast majority of member practices across Bradford. This will facilitate engagement in service redesign and service delivery, as the individual voices of primary medical care are channelled through the BCA. This is a definitive step for primary medical care

services in Bradford which the CCGs recognise and therefore will work with the BCA to deliver this strategy as well as with YORLMC Ltd, the statutory body that represents general practice providers.

1.3.4 Accountable Care System (ACS)

As outlined in the introduction, our wider Bradford health and social care system wishes to commission an ACS by 2020/21. A future with a functioning ACS should enable:

- Care to be delivered seamlessly that is personalised to meet individuals' goals, taking into consideration their cultural needs.
- Person centeredness at the core of all solutions – embracing the tenet that the patient is a valuable member of the care team.
- Individuals to be engaged in a way that is appropriate and accessible to them (care is co-designed) and jointly accountable – that care happens with them not to them.
- Primary medical care to operate at scale with sufficient infrastructure to support delivery of the ACS.
- The population to be segmented by the type of care that they need as well as the level and frequency of care provision so that it is clearly identifiable to all stakeholders, including the relevant providers and the individuals comprising of the population. This will contribute towards reducing health inequalities.
- Risk stratification and predictive modelling tool is embedded in operations as a core enabler to ongoing planning, targeting interventions and monitoring impact. This work will also help to identify protected groups who may not access health care.

As part of our journey towards establishing an accountable care system across Bradford by 2020/21, during 2016/17 the CCGs are testing the capability of our health and care system (commissioners and providers) to work collaboratively to achieve a common purpose. We are undertaking a *structured collaboration* approach to procure transformed diabetes services and the prevention of diabetes. Structured collaboration is a process where CCGs as commissioners work with existing providers, patients/service users and the public to establish a new approach to the delivery of transformed services. This means that we expect the providers to work together collaboratively, rather than in competition with each other. Such collaboration between commissioners, providers and patients/service users and the public is being conducted with the aim that, over time, the emphasis can shift away from secondary prevention of disease and delivering services to meet acute care needs towards primary prevention and self-care We want to enable and empower our population to make decisions around their illnesses and, where possible, to support them to prevent or delay the onset of some diseases altogether.

This work is being taken forward via the CCGs and the Bradford Provider Alliance. The Bradford Provider Alliance (working title) is a partnership of all of the main stakeholders across Bradford and includes: Bradford Teaching Hospitals NHS Foundation Trust; Bradford Care Alliance; Bradford District Care Foundation Trust, and Bradford Metropolitan District Council. They in turn are working with wider partners, including the independent sector (e.g. care homes) and Voluntary and Community Sector organisations as well as the public, patients, service users and carers.

The CCGs have recognised that it would be extremely difficult to go from the current commissioner and provider arrangements to a whole accountable care system in one step, which is why in 2016/17 we are concentrating on diabetes. We believe this will support the overall aim to achieve an ACS by 2020/21. Using the same structured collaboration process, we are also progressing the work of the Out of Hospital Programme in order to transform services for a much broader population – starting with those with multiple long term conditions and/or complex care needs. The services will be redesigned to provide proactive care and/or a reactive response to the changing needs of these

patients and service users. This will range from people who are able to self-care to those who are in a stable condition managed in primary and community services to those who have escalating needs, are unstable or have acute care requirements.

New care models such as these will promote the development of the provider landscape and the embedding and progression of a new commissioning approach over the next 5 years to facilitate the realisation of an ACS across Bradford.

Given the vital role that primary medical services play in out of hospital care, it makes sense for the implementation of this strategy to be a key part of the Out of Hospital Programme – recognising the interdependencies with other transformational and enabling programmes (e.g. Urgent and Emergency Care, Self-care and Prevention).

2. Case for change

The case for change covers both the need to change the way care is delivered and factors which impact on the future sustainability of the service.

Wider system changes
As already discussed, the development of an ACS within Bradford will focus the need for change within primary medical care services to facilitate the sector in continuing to play a major role in the delivery of care. As commissioner of the services, we want primary medical care together with the voluntary and community sector to be the foundation to the accountable care system. Therefore we are undertaking investment and actions to facilitate this.

Planning – homes and workplaces
Bradford Metropolitan District Council is preparing a new Local Plan for the District (2015-2030). The Plan will shape the decisions such as where new homes, jobs and infrastructure are located and which areas such as greenspaces are protected. The strategy of the new Local Plan is contained within the Core Strategy while the details of which sites will be identified to deliver that strategy will be contained in several separate plans – Area Actions Plans for the City Centre and Canal Road Corridor areas and the Allocations Development Plan Document (DPD) for the rest of the district.

The Core Strategy sets out the strategic policy for the District and the targets for new development, including the amount of land which will be required for new employment development and the number of new homes which different parts of the District will be expected to accommodate. Four key geographical areas have been defined and three of these relate to our CCGs geography:

- Regional city – 27750 new homes
- Airedale – 8450 new homes (includes Bingley and Baildon)
- Pennine Towns – 3400 new homes (includes Queensbury, Thornton, Denholme and Wilsden).

The CCGs will need to work closely with the Council to understand where new developments will potentially put pressure on existing primary medical care resources.

Demand and variation
There is a large and increasing gap between the workload demands on practices and their capacity to deliver essential services to their registered patients. GPs and their teams report feeling overwhelmed by rising workload, particularly from a growing and ageing population with complex health needs, increasing patient expectations and rapid shifts in work from secondary to primary medical care. It is also generally recognised that there is unwarranted variation in the quality of primary medical care. We have developed systems and processes where these variations can be highlighted and we need primary medical care providers to come together to understand these and work to pathways and policies to ensure care is more equitable and efficient across the district. As well as increasing the efficiency of services, we aim for this work to increase the quality of services delivered across Bradford and reduce health inequalities relating to these.

Workforce challenges
At the same time, there is an emerging workforce crisis with shortages of GPs leaving, many practices unable to recruit doctors, and evidence that some experienced GPs are considering leaving primary medical care altogether. Bradford is not always seen as a positive place to work – not all GP

training places are filled and people choose to work elsewhere. There are different levels of GP shortages across Bradford, with the most significant problems in the City area. The CCGs also have a significant number of practice staff approaching retirement age which will put further pressure on the system over the next few years. The accuracy of the information that we have on our workforce also creates problems, as not all practices complete the workforce returns which creates problems for future succession planning. Through the district wide workforce programme, as well as a local CCG approach, we need to undertake staff development and succession planning, taking a joined up approach with local partners to reduce the number of staff moving around the system. This must be supported by NHS England and Health Education England. We need to show that Bradford is an exciting place to work, with lots of opportunities for work satisfaction and professional and personal development.

Finances

In addition to the quality and safety drivers for change there is a strong financial case for change as the current funding model is not affordable in the long term. Without change we will not be able to deliver a financially stable health economy or provide sufficient resource to deliver the essential improvement in clinical standards that is required to deliver sustainable high quality care primary care consistently.

> "There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long-term conditions - for example, heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS."[11]

The national planning guidance outlines the need to shift resources from secondary to primary care through transformational working to enable sustainability of the system and the CCGs will continue to focus on this as a key part of this strategy[10]. We have seen a higher level of investment in primary medical care in Bradford than in other areas nationally as many of the services traditionally delivered in secondary care has already shifted to primary medical care. This puts increased pressure on us to change as many of the service developments that are taking place in other CCGs have already taken place in Bradford.

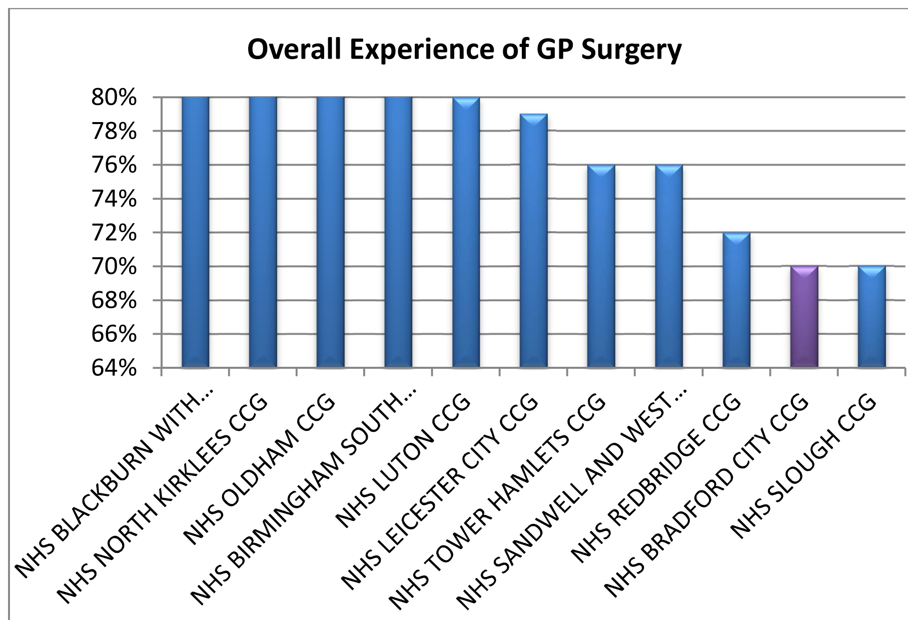
Patient experience

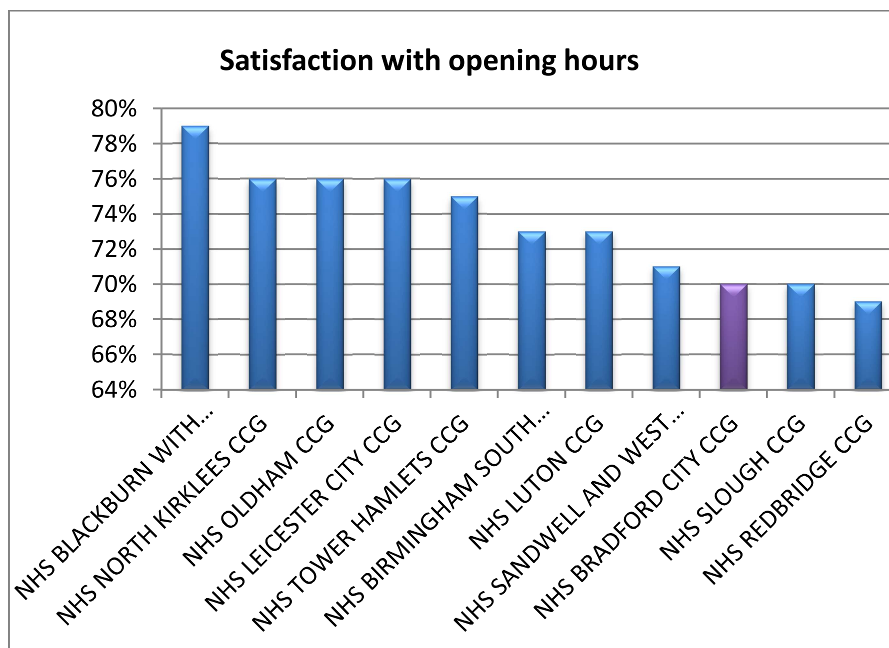
The way in which primary medical care is measured in relation to patient satisfaction and experience is through a national GP survey. The survey has its limitations in terms of the demographic and cultural mix of respondents compared with people registered at individual practices but it is a nationally recognised measure against which some conclusions can be drawn and benchmarked. The two main areas commonly used to understand how patients are feeling in regards to their practice are;

- Overall experience of their GP practice and
- Satisfaction about opening hours.

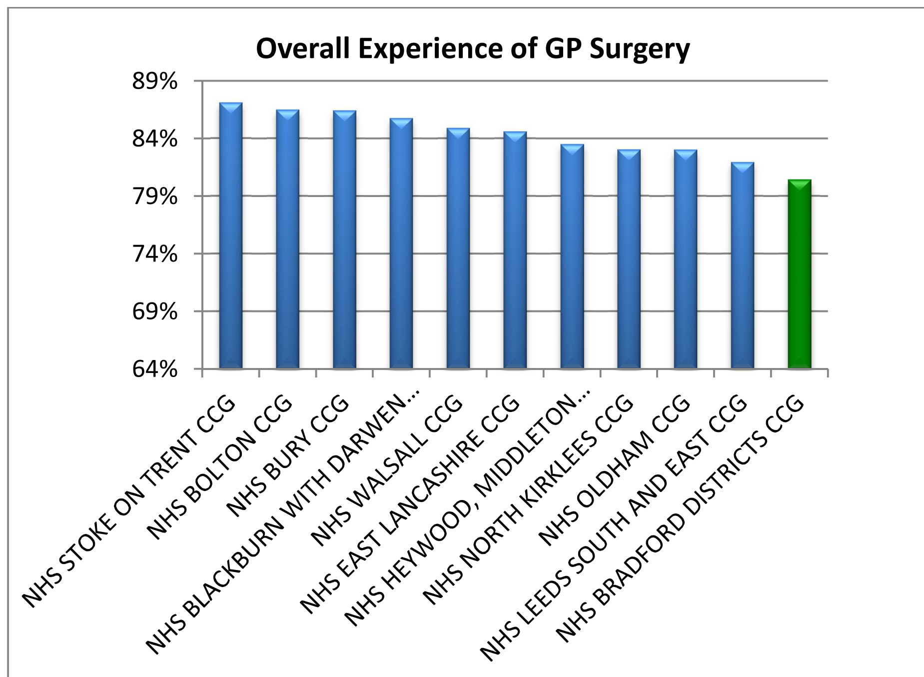
Each CCG is benchmarked against comparator CCGs, i.e. other CCGs that have similar populations so comparisons can be drawn. As seen in the graphs below, both CCGs in Bradford have improvements to make and improving patient experience is a key challenge for us.

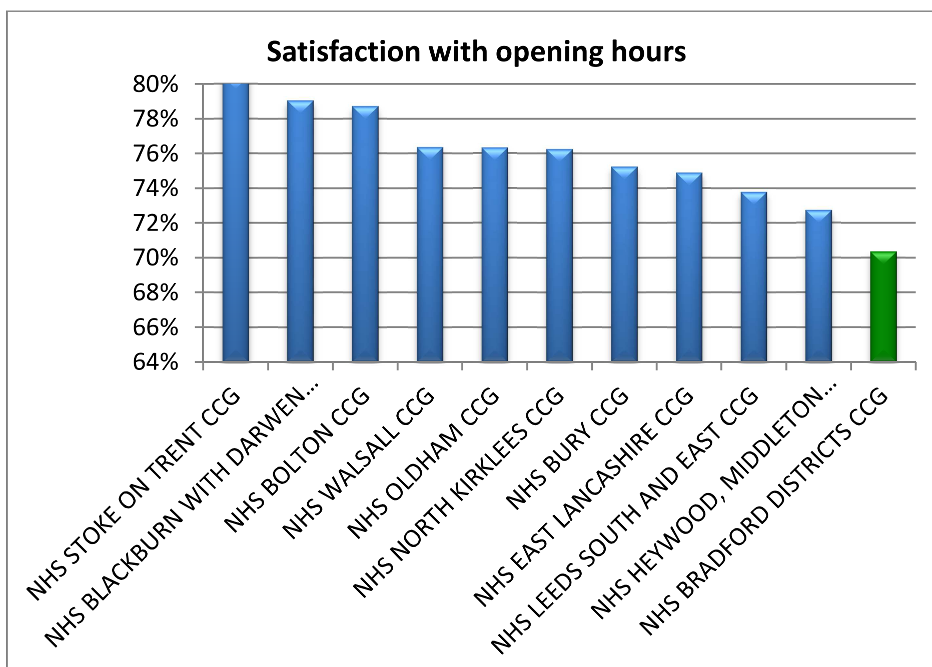
Bradford City CCG:





Bradford Districts CCG:





This focus on patient experience is key, as this is what will allow our system to change and adapt. Until patients experience a positive change in the way they use and experience services they will not

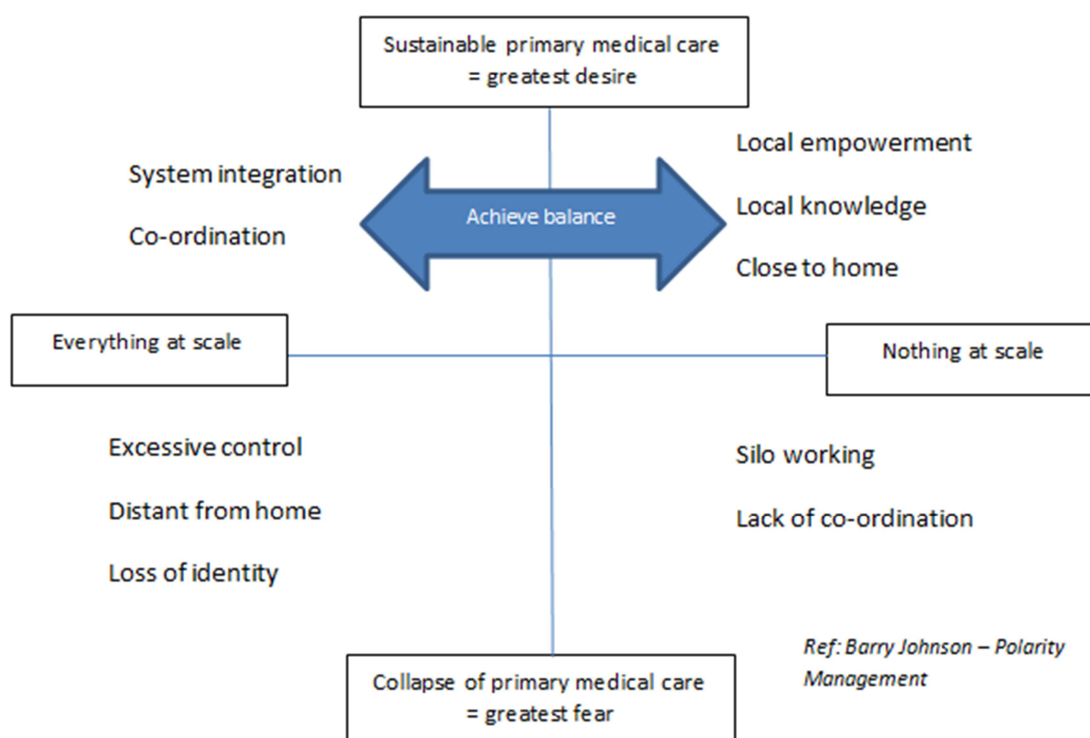
make any changes to the way they access and utilise services. We need to ensure that their experiences of the changes we are embedding are positive, so they continue to use them as they were commissioned, this experiential behaviour will be what facilitates a lot of the transformational change within the system.

3. End state

All of the information above highlights that we need to change our current system. If we do not, there is a very real risk that primary medical care will not exist in 2021 – that it will have collapsed. This is currently a possible future state due to increasing levels of demand, reducing numbers of professionals wishing to work in Bradford, unsuitable estate, financial pressures and an increasing number of complex patients all putting stress on a system that was designed over half a century ago.

Although this has not yet been seen across the full spectrum of primary medical care, there have been pockets of failure within the NHS where quality of service has severely deteriorated and systems fail. National examples include large acute trusts and although these are not primary medical care examples they are large systems of care and it is possible that similar failures could occur in Bradford if changes are not enacted.

To ensure future sustainability of primary medical care and therefore the wider health and social care system, we need to develop a model that will better meet the needs of the population of Bradford whilst at the same time be efficient and able to deliver high quality care. We need to do this via shared learning and use of best practice evidence, using both comparator sites nationally and local experience. As shown in the diagram below, there is a fine balance to be found between sustainability and failure and how healthcare is both delivered and received.



The CCGs want to establish a system that is efficient and has a collaboration of services, whilst keeping people at the centre with holistic care wrapped around them and a population that feels empowered. There is more work to be done in exploring the future model of primary medical care, in partnership with Bradford Care Alliance and YORLMC as the representative organisations of our

local providers. As commissioners, the CCGs wish to see by 2021 a delivery model of primary medical care that will:

- Build on the strengths of current services and deliver primary medical care at scale from individual and/or networks of practices so all patients have equity of service. Care delivery will continue to be based around the practice list but services delivered across aggregated list sizes of a minimum of 7500 will enable depth and sustainability to the workforce delivering the care. Networks will vary depending upon the service delivered, with some working across footprints of 30,000 – 50,000 while other, more specialised services being delivered across wider population numbers. For example, individual practices will continue to deliver long term condition management, while 7 day services and complex care services may be delivered across networks of 50,000.
- Be the bedrock of the ACS as we increase the breadth of primary medical care. Learning from American models[12] stress that primary care is the lynchpin of the model, with a focus on prevention and ability to manage long term conditions effectively.
- Include workforce roles that are not currently in place via local and national initiatives, including physician associates and medical assistant roles. This will be enabled through the establishment of a Bradford Primary Medical Care Academy (or similar). This will be supported by strong retention and skill development of all staff roles including increasing the number of professionals working in Bradford by providing a positive working environment.
- Deliver care from a reduced number of sites across Bradford as services will only be delivered from fit-for-purpose estate that also enables hub working. Hub working will be embedded and this will involve primary medical care delivering services together as well as working with other providers, e.g. community services, so seamless and holistic care is provided to the patient.
- Transform the role of GP as the sole referrer to other services. Many services will be commissioned so other health care professionals can refer patients and, where appropriate, patients will be able to refer themselves.
- Deliver care and enable access via technology which will be part of our core offer. This will be widespread across the system and will not just be operated in silos. All patients will be able to communicate with a member of the primary medical care team either face to face, over the phone, via video conferencing or via text messaging. This will offer patients the choice of how they wish to interact with primary medical care and create a flexible and adaptive service. The use of technology for self-care will also be the norm, as tools and telemedicine will be widely available.
- Be commissioned for outcomes, not for activity.
- Be sustainable via local and where appropriate national investment via a shift in resources to primary care.

Our end state has to include an improved experience for patients. Using direct patient feedback from a variety of sources (patient networks, complaints, People’s Board, Survey Monkey) we want to move from the current patient experience to the future position, both outlined below.

Patient perspectives – current		
I need to call at 8am to make an appointment on the day	When you have family, caring responsibilities or young children, trying to make a morning call for an appointment is impossible	I don't feel I can plan ahead and get good advice so I wait till I am really ill
I'm not sure what the role of other practitioners are so I prefer to see the GP	I see a different person each time so I don't build a relationship or trust – this means I always opt to see a GP or even go straight to A&E	I will see a different doctor or nurse each time and have to explain my long term condition again or go through different treatment options because they don't understand my condition, my history and my circumstances and what support I really need.
I feel like I call NHS111 and then still need to go to my doctor for reassurance	The pharmacist is usually my last port of call	My GP practice does not feel welcoming
I second guess advice given by health professionals	If I can't see a GP, my only option feels like it is to go to A&E and wait	I don't think the professionals have time to communicate
I don't feel like the GP practice treats me with respect	I don't really understand why I receive the medication I receive	

Patient perspectives – future		
I can have the information and resources to understand my own health needs	I can manage my own appointments	I can see a practitioner who is familiar with my long term condition treatment and care plan
My family and carers are recognised as being key to my good health	I understand my treatment, condition and care options.	I feel confident and assured in the advice and care offered by my GP practice
I know in advance where I am going, what support and treatment I will be provided with and who will be my main point of contact	There will be friendly and welcoming people within the practice who can guide me to the best place to receive information and care	There will be more peer support options available

I will feel confident about the treatment and care given to me	My local pharmacist can offer more care and treatment options	The help, care and treatment I receive is given to me in a timely way
The service I receive is consistent and of high quality	There are wider choices to access help when I need it	My GP practice is linked to other health and social care services that I interact with – e.g. hospital care, school nurse and care homes.
There are opportunities for me to share my experiences and help other people at my practice through volunteering and getting involved	I can have access to the best person to help treat a minor or acute illness	When I move between practitioners for my care, the service can respond in a joined up way
I can access activities and services that support my well-being and good health		

We have tried to capture the varied and diverse nature of our population but we recognise that we will always need to check our engagement processes reflects our diversity as our population is always changing with new migrants, asylum seekers and moving population groups.

4. Vision, outcomes and key themes

To meet the case for change outlined above the **vision** for the Bradford CCGs' Primary Medical Care Commissioning Strategy is:

We will commission and deliver excellent primary medical care for all of the people of Bradford

The intended **outcome** of the strategy is:

To deliver a sustainable model of primary medical care which is fully integrated within the wider health and care system and ensures that Bradford people have timely access to high quality safe services

The vision will be realised through the following key themes:

Theme	Description
Improve access	• Accessible and appropriate primary medical care services for all patients both in and out of hours
High quality	• Consistent, high quality and safe care delivered to all patients
Workforce	• Sustainable, motivated, integrated and with the right skills
Self-care and prevention	• Empower and support people to take responsibility and control of their health and wellbeing
Collaboration	• Collaboration, across practices, with patients and with partners
Estates, finance and contracting	• Effective estates, finance and contracting models to enable integration and positive health outcomes

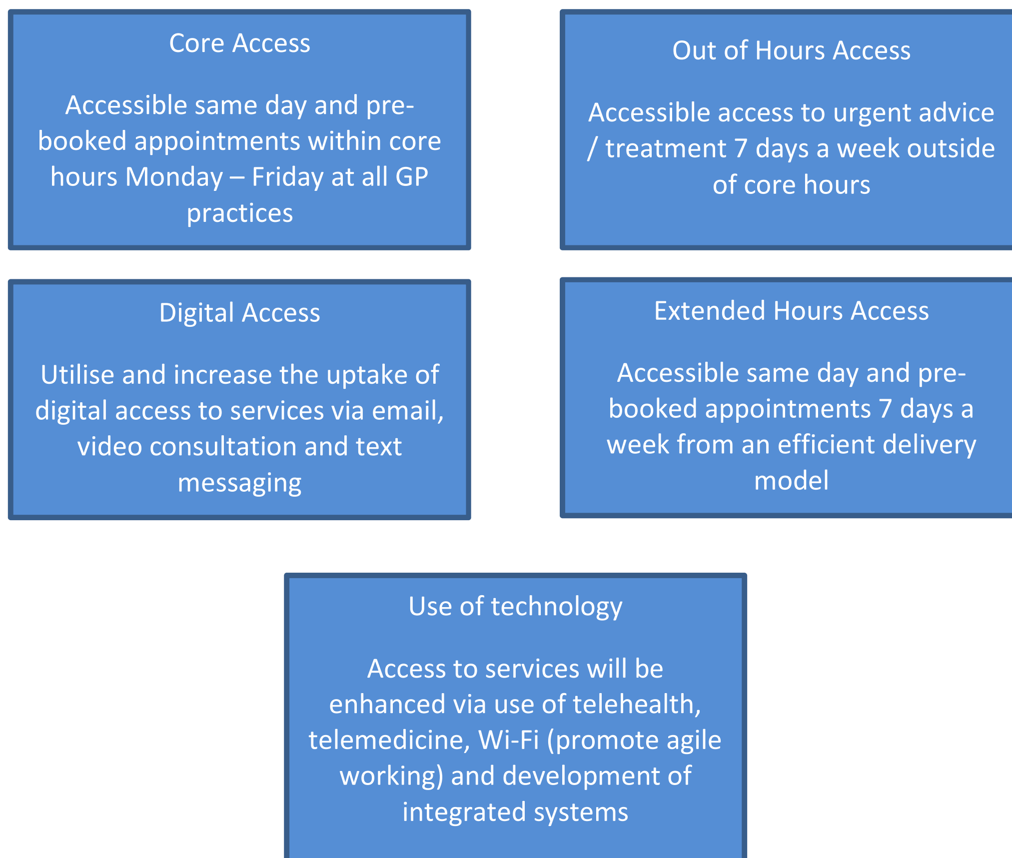
The challenge for primary medical care in the future years will be to work in collaboration with each other and also with other sectors to lay the foundation for total service transformation and the move to accountable care. We will need to break down existing boundaries and service models to deliver patient centred care regardless of the provider. We will need to explore new and innovative ways of delivering services whilst having a relentless focus on improving the quality of care for patients via reviewing, supporting, implementing performance management and shared learning, with the ultimate aim of continuous improvement.

5. Priority themes and key elements

This section describes the priority themes which will need to be addressed if the primary medical care elements of the out of hospital care system are to be transformed. Under each theme there are a number of key elements that will be addressed to deliver the vision of this strategy. Each theme will address how we will transform primary medical care services in the Bradford CCGs. It will aim to deliver this against a range of challenges from: unwarranted variation in quality, an ageing population, increase in co-morbidities, funding constraints, workforce changes, declining patient satisfaction and variation in the utilisation of secondary care. It is apparent that there are areas of overlap between the priority themes, so we need to implement the totality of the strategy to achieve our goals.

5.1 Priority Theme One: Improve access to primary medical services

Accessible and appropriate primary medical care services for all patients both in and out of hours



People should be able to easily access appointments both in and outside of core hours. (Core hours are Monday to Friday, 8am to 6.30pm). They should not notice the difference in quality or access to care depending upon the time or day that they need it. There should also be equity of access. In the future it will not matter where our population live or are registered within Bradford, they will have access to all of the same services. We will support this by working differently with our partners, especially the voluntary and community sector, that can provide relevant and needed services to patients outside of the medical model, thereby improving access to primary medical care services. This has become clearer in Bradford following the work undertaken on the Community Assets approach and published report. Work is ongoing to allow us to better realise the benefits and outcomes from this way of working. Improving access is seen as a key enabler to deliver other parts of service transformation such as the Keogh recommendations around urgent care[13]. To support this we will look at the additional elements of funding beyond core GMS/PMS to see whether this can be used differently to support access.

The current contract for our GP out-of-hours service will end in March 2019. Currently this is jointly commissioned across West Yorkshire, led by Greater Huddersfield CCG. Yorkshire Ambulance Service provides the service and sub-contracts the GP face-to-face element to Local Care Direct. The CCGs need to decide whether we will continue to work with the other CCGs in West Yorkshire to develop a sustainable commissioning model for future provision of the service or whether the development of an accountable care system will include this service for Bradford alone.

The CCGs want to ensure that an effective extended hours service is put in place which will support the implementation of the 7 day services agenda and meet the needs of patients, while at the same time it must be an efficient and sustainable model to run. Therefore we will explore the development of a collaborative hub model which will add resilience to smaller practices in the district while offering choice to patients which is in line with the direction set out in the GPFV[3]. This is not all about more GP appointments, but other healthcare professionals or partners, including nurses, mental health workers, clinical pharmacists, voluntary and community sector organisations. However, as well as offering patients choice and ensuring access is improved, we also need to work with patients around expectations as we are measured on how patients view services. We need to maintain high quality and accessible services, whilst sharing with patients what is possible within our resources. This may mean that patients may not always get what they want so we need to work with our populations regarding community and individual responses to health.

In order to support wider access to primary medical care, adoption of digital ways of working will be supported and will become part of our core offer. This will include digital access to prescription ordering, appointment booking, telephone and digital consultations (e.g. video consultations), and text messaging. We have already started this journey as all Bradford primary medical care practices have Patient Online enabled for use. This allows repeat prescriptions to be ordered online, online access to detailed information in patient records and appointments online. We will also access the national funding which is going to be made available from 2017/18 to support the adoption of online consultation systems.

Currently there is a discord between access and being seen (face-to-face). Through the use of technology the CCGs will embed a culture that doesn't equate access to being seen. Access can also be met virtually, by navigation, or the provision of information. This will take into account the accessible information standard, ensuring what we use is appropriate to the wide ranging needs of our population. The use of technologies will also improve access to services via the use of Wi-Fi to promote agile working of partner agencies and the use of telehealth and telemedicine to allow patients to better self manage their own conditions. This will not evolve without changes to the way we commission services, so we will explore the necessary models needed to commission 'virtual primary medical care services' and implement these over the next 5 years. The adoption of technology will allow flexibility to be built into the system as at the moment in many cases it is 'one size fits all'. In the future we will have a range of choices for our population, for example, a reminder text to take medication, a 2 minute phone call, or a 15 minute face-to-face appointment.

We also need to work with our primary medical care providers to reduce any unnecessary bureaucracy within services to increase the amount of time spent delivering patient care. For example, with the move to outcome based commissioning we could reduce some of the activity counting which currently takes place. This will not be easy, but we must establish what we can stop to enable more effective use of time.

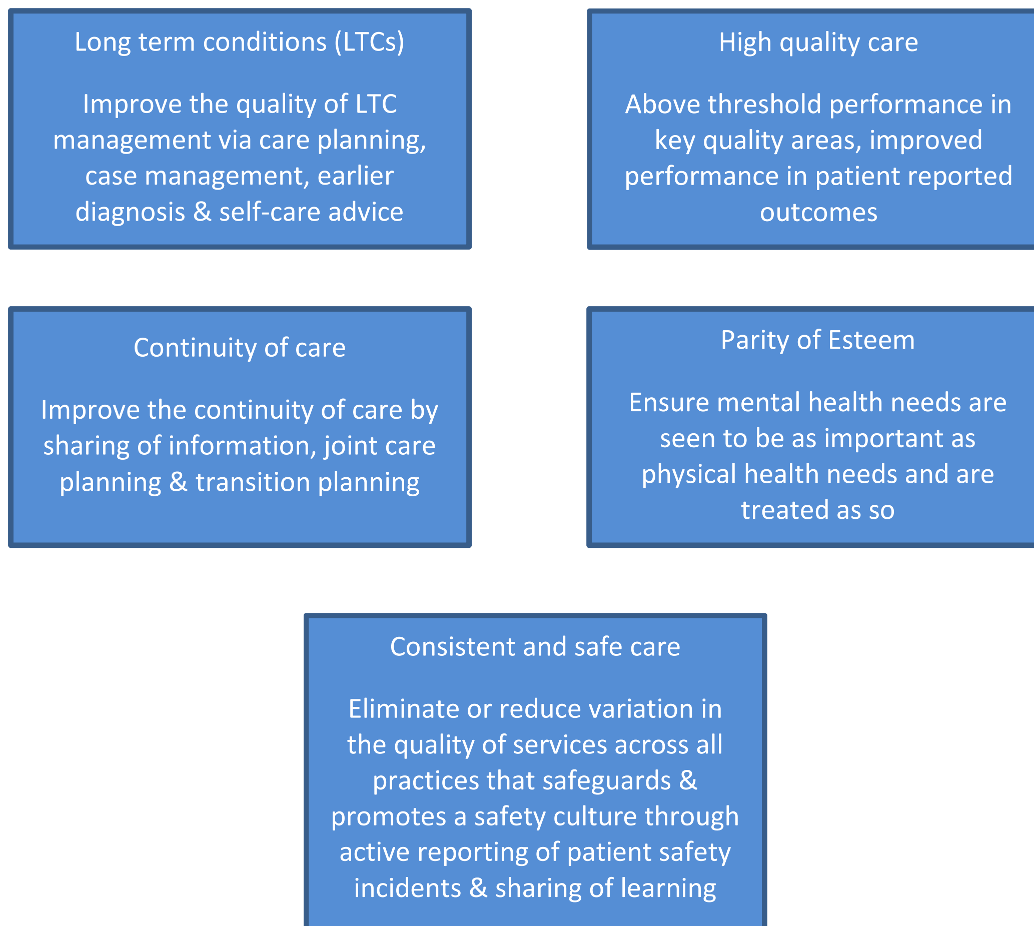
What we will do:

- **Develop an effective and efficient approach to extended access through collaborative hub working**
- **Increase the number of practices offering online booking of appointments and repeat prescriptions**
- **Support the roll out of email and video consultations by exploring and commissioning the concept of 'virtual primary medical care '**

- **Work with NHS 111 and Local Care Direct to improve access to GP out of hours in the short term, exploring direct booking into GP practices in hours and extended access appointments**
- **Establish the future of the out-of-hours service model post March 2019**
- **Ensure all patients have access to the same services, even if their own practice does not offer them**
- **Ensure that the primary medical care estate in Bradford has access to Wi-Fi to enable agile working from partner agencies**
- **Utilise technology to support people to manage their own conditions and maintain independence**
- **Ensure our providers maintain the Directory of Services to enable patients to be signposted to the right service at the right time**
- **Review the extended hours directed enhanced service and use of other funds (e.g. primary medical care element of system resilience funding) to support access to practices.**
- **Commit to reduce transactional bureaucracy to increase time available for patient care.**
- **Access national funding which will facilitate the adoption and spread of technologies.**

5.2 Priority Theme Two: High quality primary medical care

Consistent, high quality and safe care delivered to all patients



We want primary medical care providers to consistently provide high quality and safe care to the whole of our population. There have been huge improvements made in regards to improving quality over the last 10 years and this needs to continue. This will include ensuring the continuity of this care, especially in relation to working with other providers; patients who are transitioning between services and end of life care, ensuring patients' wishes are actioned whenever possible. We expect practices to participate in incident reporting to improve patient safety outcomes and be engaged in peer review to support a culture of continuous improvement.

Primary medical care is seen to be the cornerstone of health support for people with long term conditions (LTC). Not only in terms of its role in supporting people to manage their conditions, through personalised care planning, but also earlier diagnosis of LTCs; identifying health needs of their community ('risk stratification'); and ensuring that there are services in place to manage those needs (the commissioning role). The CCGs will work with practices and other providers to ensure appropriate pathways are in place which are commissioned based on outcomes and take into account our diverse populations and their cultural needs, care planning is embedded and training and development needs are met to reduce variation in delivery across Bradford.

High quality primary medical care requires medicines optimisation. This is a robust plan to integrate safe, cost effective medicines use into the commissioning of all services from development to

monitoring of outcomes in order to secure best possible benefits for patients from finite NHS resources. Medicines optimisation is defined as 'a person centred approach to safe and effective medicines use, enabling people to obtain the best possible outcomes from their medicines.'[14]

Medicines optimisation differs from medicines management in a number of ways but most importantly it focuses on outcomes and patients rather than processes and systems. This focus on improved outcomes for patients should help ensure that patients and the NHS get better value from the investment in medicines. It relies on a multidisciplinary team to work with the person to deliver the best possible outcomes.

Within Bradford this will require a shift in responsibility from the paternalistic approach of the former PCTs to a more interactive approach of the CCGs, working with all key stakeholders to develop and deliver the strategy.

From research it is clear that:

- Only 16% of patients who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need
- 30-50% of medicines are not taken as intended and that ten days after starting a new medicine 30% of patients will be non-adherent
- Sub-optimal use of medicines leads to extensive waste in the system and lost opportunities in improving health and morbidity
- Medication errors occur in up to 11 per cent of prescriptions, mainly due to errors in dosage
- Around 6.5% of all hospital admissions have been attributed to, or associated with, adverse drug reactions, with up to two thirds of these being preventable
- Adverse reactions are particularly common among vulnerable groups, such as, frail older patients in nursing homes
- In hospitals, the General Medical Council's EQUIP study demonstrated a prescribing error rate of almost nine per cent.
- Over half a million medication incidents were reported to the NPSA between 2005 and 2010. 16% of them involved actual patient harm.

High quality care for all means that we must close the health gap between people with mental health problems and those with physical health needs. Addressing mental health and psychological needs will improve the quality of life for the individual, and may also reduce the impact and costs related to 'physical' long term conditions, e.g. from chest pain, chronic obstructive pulmonary disease and diabetes. The cost of managing a patient with diabetes and co-morbid depression is 4.5 times higher than the cost of managing a patient with diabetes alone[15]. People must be assessed and treated holistically for their health problems, rather than providing separate services for physical and mental disorders. Psychological therapies are crucial to this. Contemporary western medicine is based on a tradition of treating mental health separately from physical health – a tendency to assume that diseases occur independently of social context. When mental health is treated as separate from physical health, the healthcare experience is often stigmatized and the care process is fragmented. Depression, the most common mental health condition seen in general practice, often occurs with, and compromises, care of other chronic illnesses; yet stigma and secrecy often cause depression to go undetected, undiagnosed, or under-treated. We will ensure that the outcomes defined as part of an ACS take account of individuals physical, psychological and care needs and mental health is equally as important as physical health. Through the delivery of the GPFV[3] we will take advantage of the extra 3000 mental health therapists which the document outlines will be in

place by 2020. The aim of these is to support localities to expand the Improving Access to Psychological Therapies programme.

Throughout our work to deliver the primary medical care strategy we will maintain close linkages with the mental health strategy for the district, as many of the actions taking place under its remit impacts on primary care. For example, the mental health strategy outlines that they will improve the knowledge and awareness of mental health within the primary care workforce to enable a more holistic approach to patient management. They also plan to develop a model of integrated physical and mental health services whereby people can have their care needs met at the same location as part of an agreed pathway of care, which will involve primary medical care services.

The CCGs will work with the Care Quality Commission to ensure that our primary medical care service providers meet their contractual and regulatory requirements. An open approach will be taken from the learning from this process and through the CCG's GP Joint Quality Group we will develop work plans for improving the quality of care delivered by primary medical care.

High quality care can only be delivered if the right information regarding patients is available to the right people. The need for a summary care record is imperative to this, providers either using the same system or ensuring interoperability between patient systems has to happen to enable this to occur. The Bradford Digital Roadmap outlines the key elements to this and this strategy will support the roll out.

The move towards an ACS will focus attention on high quality safe care, as this will be the most efficient and effective model. Primary medical care services are essential to this development and must engage to ensure the right outcomes for their patients are met through the new delivery model.

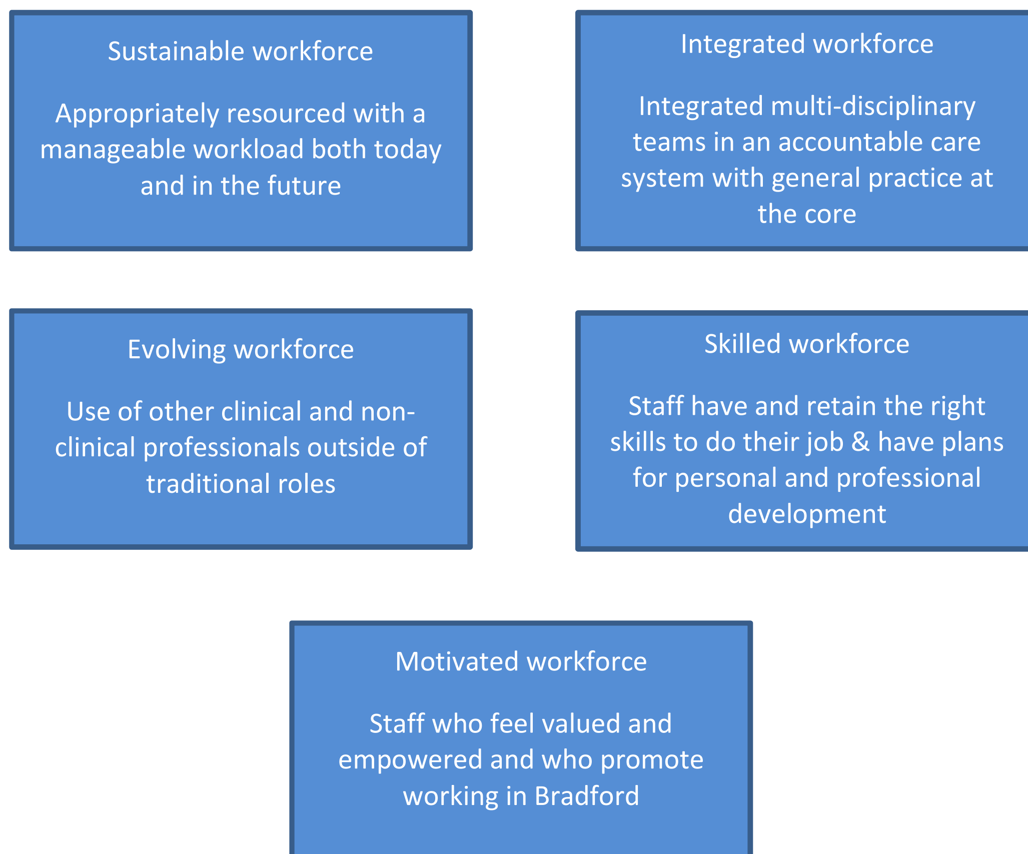
What we will do:

- **Provide opportunities for peer review and learning from other services**
- **Provide medicines optimisation opportunities within primary care, focussing on LTC**
- **Ensure all patients with an identified need for a care plan have one**
- **Commission pathways which support system approaches to the management of and early diagnosis of conditions and self-care management strategies**
- **Support the delivery of Parity of Esteem by commissioning services which ensure people are treated holistically for their health problems, linking closely with the delivery of the Mental Health Strategy**
- **Commission services which are outcomes based on evidence-based clinical guidelines/best practice**
- **Through the GP Joint Quality Group, develop a work plan to deliver against areas which need greatest improvement and/or have the highest unwarranted variation**
- **Use the contract assurance process to support reductions in variation and quality improvements, ensuring equality monitoring data informs this work**
- **Use the contract assurance process to support reductions in variation and quality improvements within prescribing**
- **Promote and establish a patient safety culture to ensure all practices report patient safety incidents and learning from incidents is transparently shared, including those of medicines safety**

- **Commission evidence-based support tools to use in primary medical care (e.g. Map of Medicine) to drive and support consistent, high quality care to deliver the best outcome for patients using the service.**
- **Maintain strong links with the mental health strategy and embed the actions relevant to primary medical care services.**

5.3 Priority Theme Three: Develop the primary medical care workforce

Sustainable, motivated, integrated and with the right skills



Workforce planning in the NHS states[16] that there are large data gaps on key areas of the workforce, particularly in primary and community care. This is in part due to the reluctance of many GPs to share workforce data with commissioners and workforce planners but, through our GP Joint Quality Group, we will encourage more practices to complete this tool to allow for more accurate succession planning in the future.

The total number of GPs in England has increased by 2.3 per cent, from 31,356 in 2010 to 32,075 FTEs in 2013, but modelling by NHS England and the Royal College of General Practitioners (RCGP) has demonstrated that this rate of increase will not even come close to meeting future demand (Health Education England 2015). To ensure a comprehensive picture is developed and to plan effectively for the longer term, the anticipated impact of retirements from service also needs to be taken into account. As part of our contract management, we will encourage all member practices to submit a full suite of workforce indicators so that we can plan more effectively for the future.

The Centre for Workforce Intelligence[3] has said that there is likely to be a significant undersupply of GPs by 2020 unless immediate actions are taken to redress the imbalance between supply and demand, as well as increasing training numbers for longer-term sustainability. Over the longer term, the rate of increase in the number of GPs has also been dramatically outstripped by increases in the medical workforce in secondary care. An indicator of this locally has been heavy reliance on locum GPs because substantive vacancies have not been filled which is especially the case with Bradford City CCG. Bradford Districts CCG has above the national average (England) of GPs per 100,000

population (53.21 compared to 51.20). However, Bradford City CCG is much lower with 43.81 GPs per 100,000 population. We have to make sure that our processes and pathways recognise the high locum use within Bradford. Often implementation of new pathways can be negatively impacted upon as we do not communicate these changes appropriately to locums. We need to work with our primary medical care providers to understand how we mitigate the risks around this. We need to understand how we improve our communication links from both the CCG and also internal mechanisms within primary medical care providers to ensure all staff groups are aware of our pathways and processes.

At face value, these workforce trends outlined above are at odds with the ambition of future care models to deliver more care in the community. To meet the CCGs' ambitions outlined in this document, the workforce strategy for primary medical care needs to be developed in the context of the wider health and social care system and in light of expectations of a greater use of community assets, workforce and role re-design to ensure the most effective use of the skills within the primary medical care team. This work also needs to take into consideration how we attract a workforce which reflects the diversity of our population.

One key challenge is to identify the best person to do the job, and this will not always be a GP. This can go against the expectations of patients, which is why the CCGs and the wider system need to work on the messages shared with our populations. We need to be clear that it is the right care that counts, not who is delivering it. This will be facilitated by some of the national initiatives outlined in the GPFV[3] including the mental health therapists and clinical pharmacists. The CCGs need to ensure that any relevant processes that are necessary for this are in place to take full advantage for Bradford.

The current way of working has been partly established as the GP is often the sole referrer to other forms of care e.g. outpatients. To facilitate better use of resources the CCGs will commission services in a way which unblocks this, for example via patients directly referring themselves, or for services to accept referrals from other health care professionals when appropriate.

We need to recognise that our workforce is the best resource we have available to us in Bradford and look to pioneering ways to attract, retain and develop it. This may need to be innovative, for example the establishment of a Bradford Primary Medical Care Academy and through apprenticeships, as Bradford is not always perceived as a positive place to work. The CCGs will explore the recruitment and retention opportunities outlined in the GPFV[3] including the NHS GP Health Service to support GPs and GP trainees who have mental health issues. We will also include bursaries to attract GP trainees and financial incentives for areas of greatest need. Skill development of new and existing staff is also key. The CCGs will continue to offer existing opportunities whilst utilising the national resources for reception and clerical staff, practice managers and practice nurses.

Our children and young people need to be aware of the variety of roles available to them, within primary medical care and the wider health and social care economy that are not only medical or nursing. We will also need to support and where necessary drive forward new models of primary medical care provision, beyond the list-based, practice-centred model which has predominated in the NHS since 1948. This is explored further under Priority Theme Five: Collaborative Working.

To achieve this, the CCGs and wider system will need to put more emphasis on leadership development and succession planning. The delivery of the strategy needs strong leadership to break down the silo working between organisations and inspire people to make the necessary changes to get the best out of our workforce.

What we will do:

- **Work as an active member of the Integrated Workforce Programme for Bradford District and Craven, taking a long term strategic view of workforce planning to ensure a primary medical care workforce that is fit for purpose for the future.**
- **Be ambitious and challenging about what the future primary medical care workforce should look like; developing a population centric model where the workforce is planned around the needs of the population and predicted demographic and disease management changes**
- **Take a long term view to raise the aspirational levels of young people to both want to train to work in the health and social care system, including primary medical care and to want to work in the Bradford District through schemes such as work experience and apprenticeships**
- **Develop the existing workforce to work in a system wide integrated way, across organisational boundaries**
- **Enable greater flexibility within primary medical care through recognising the unique skillsets of each profession within primary medical care whilst developing people to take on roles/tasks that can be carried out by others with the appropriate training. This may include working with our local training establishments to introduce new roles in primary medical care or the establishment of a Bradford Primary Care Academy**
- **Ensure staff and patients have the right skills to maximise and enable the use of digital technology to ensure the most effective use of time, people and finances**
- **Link with NHS England and Health Education England to benefit as much as possible from the national resources which are to be deployed on the back for the General Practice Forward View**
- **Where resources permit, commission and/or facilitate training and development to support the primary medical care workforce to develop their skills and knowledge in order to promote safe, effective, high quality service delivery**
- **Commission services and interventions which promote self management interventions to empower patients to become active in the management of their own care to reduce the need to see a health care professional**
- **Promote existing schemes that support recruitment e.g. training practices and retainer schemes**
- **Promote Bradford as a positive place to work, live and stay**
- **Encourage/incentivise practices to complete the Health Education England Workforce toolkit to provide reliable workforce data**
- **Commission services which unblock the role of GP as sole referrer to other services where appropriate.**
- **Put resources into leadership development for current leaders and succession planning**
- **Work with our primary medical care providers to establish better links with our locums to ensure pathways and processes are enacted fully across Bradford.**

5.4 Priority Theme Four: Promote self-care and prevention

Empower and support people to take responsibility and control of their health and wellbeing

Self care and prevention is about people doing more for themselves, either with support or individually. The Self Care and Prevention programme works across all health and social care partners to promote the health, wellbeing and independence of people in Bradford using an asset based approach. To make this happen we plan to:

- Give people the right tools and resources to self care and live a healthy life
- Support health and social care staff with the skills to empower people they work with
- Make self care and prevention a priority across organisations and programmes

General Practice is overstretched and demand is growing with high numbers of patients seeking advice on social and emotional issues rather than medical problems. The Citizens Advice Bureau survey of 1000 GPs in February 2016[18] estimated that the financial cost to the NHS from non-health demand on GPs is at least £395m representing more than 5% of the NHS England budget for general practice and equivalent to the salaries of 3,750 full-time GPs and 19% of GPs consultation time. The report also shows that three-quarters of GPs say that the proportion of time they spend dealing with non-health issues as part of consultations has increased over the past year and this affects their workload and quality of life. Self Care and Prevention work can support General Practice to deal with some of this demand with solutions like social prescribing.

Bradford City and Districts CCGs have a number of innovative projects listed below which will transform how we deliver the self care and prevention agenda in Bradford:

1. **Social Prescribing** – a means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. 'co-produce' their 'social prescription'- so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary and community sector (VCS). We plan to

commission a new service in General Practice to support people with their social and emotional needs which will reduce pressure on General Practice.
2. **Workforce** – to deliver a range of learning opportunities to support staff to empower patients to self care. For example, motivational interviewing training and new training for reception staff and health care assistants on self care and active signposting.
3. **Self Care Hubs** – we plan to co-design and transform underutilised health and community centres to offer a wider range of holistic health and wellbeing activities and services. The Hubs will work with the voluntary and community sector, local people and self care initiatives such as social prescribing to connect health and care services together.
4. **Self Care Digital Solution** – develop a new tool to provide the public, patients and the health and care workforce with a simple and accessible online digital platform (app and website) to promote self-care and support people to manage their own health and wellbeing.
5. **Practice Health Champions** – creating a 'community centred practice' through volunteering and patient involvement. We have commissioned a further ten practices to implement the practice health champion model, which means we have a total of 21 practices delivering community centred practice and now Bradford is the largest City in the UK to deliver the practice health champion model.

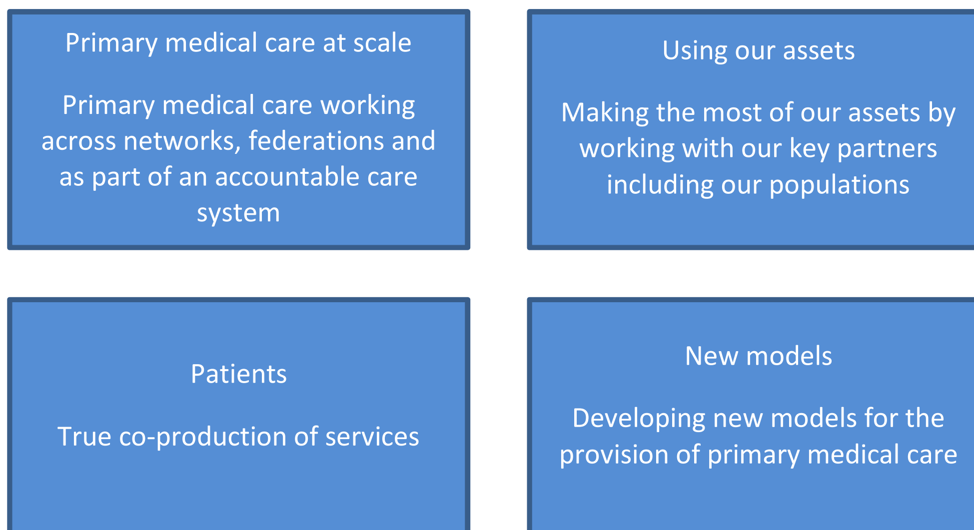
The full responsibility for self-care, health promotion and disease prevention does not solely rest with primary medical care, but it does have a key role to play. Every contact made by a member of the primary medical care team could include self-care advice and health promotion messages and appropriate risk assessments. Self-care empowers patients and allows them to take an active role in their own decision making, make informed choices, able to challenge and ask questions of health professionals supporting them with their care and to take responsibility for their health. The CCGs will also link in with the national programme to help practices support people living with long term conditions to self-care, as outlined in the GPFV[3].

What we will do:

- **Work with the Self-care and Prevention Programme to ensure that we align to the wider work happening across health and social care and to provide consistent messages about self-care to local people.**
- **Provide our workforce with the tools needed to promote self-care and accelerate positive behaviour change towards prevention and self-care in the population. This will include E-learning, self-care and active signposting and intensive motivational interviewing and behaviour change techniques.**
- **Ensure that self-care is embedded within care pathways which are delivered in primary medical care.**
- **Support the self-care and prevention elements that are driven from our strategic priorities and programmes.**
- **Support the development of primary medical care staff being advocates for well-being by providing key healthy lifestyle choices, including smoking cessation, weight management and reduction in alcohol consumption.**
- **Promote screening programmes – cancer and general health checks, to encourage earlier presentation and earlier diagnosis**
- **Commission preventative services**
- **Review the delivery of immunisation programmes, looking for gaps in provision and promoting centres of excellence.**
- **Promote self-care principles and techniques as the first choice of action for many health care concerns.**

5.5 Priority Theme Five: Collaborative working

Collaboration, across practices, with patients and with partners



Despite the strong worldwide reputation of UK primary medical care we need to support and where necessary drive forward new models of primary medical care provision, beyond the list-based, practice-centred model which has predominated in the NHS since 1948. This is because we – and many other NHS partners in England – do not believe that the traditional model is sustainable in the long term. We recognise that the future for primary medical care needs to be about collaboration, be that formally working together, or more informally, for example, sharing specific functions and reducing silo working. This is often described as primary medical care at scale.

This strategy is not promoting one single model for this, but is promoting a move away from the current establishment of small independent businesses working out of multiple sites, so we will work with our practices to support the evolution of a new primary medical care model. This does not mean that there will one model for primary medical care in Bradford in the future, but we have to ensure the sustainability of primary medical care. We will retain the list based model but we will commission services from single or aggregated lists of 7500 and above, to allow for depth and sustainability of practice. Practices will also work within networks and federations. Federations and other collaborative networks are an important way of enabling primary medical care organisations such as GP practices to provide a wider range of services, while at the same time offering the benefits of a smaller organisation, such as convenient location and continuity of care. For example, we will commission locality services across networks of 30,000 – 50,000 patients and more specialised services will be commissioned over wider footprints of 100,000 and above. Services such as extended access and GPs with specialist interest services will be commissioned at scale.

The above principle will be considered in relation to the CCGs' use of APMS contracts. In the past, when a provider has ceased working (for a variety of reasons) the CCGs have often re-contracted the service via APMS, but in the future the strategic aim of primary medical care at scale will be considered when the CCGs are considering the procurement of an APMS contract. This may include different contracting arrangements.

To ensure a model that is better placed to meet the needs of our local populations, both now and into the future, we will explore options for delivering primary medical care services in the most

effective and efficient way that best addresses the current and predicted workforce and demographic challenges we face. This needs to take into consideration the role of primary medical care in the development of an ACS in Bradford. We need to ensure that primary medical care is the bedrock to the ACS otherwise the system will not work. Primary medical care has to be able to collaborate to fulfil this. An ACS would not work if practices were disengaged or insisted on being represented as sixty plus separate voices as through accountable care the CCGs will be awarding single contracts through alliance agreements. We know that work is already underway in Bradford in regards to working differently with each other within primary medical care. Federations of practices are already providing services to their populations of patients, and the development of Bradford Care Alliance allows our federations to come together as 'one voice' when appropriate. This is happening as primary medical care providers are aware of the need to make their service sustainable in the long term and the CCGs need to support this as part of the move to accountable care.

A step within this will involve delegating resources to primary medical care providers operating at scale, therefore we will continue to work with our primary medical care providers in the development of the 'at scale' model. The CCGs believe the development of Bradford Care Alliance will support this and want to ensure that this is sustainable in the future. To support this primary medical care funding flows will change. For example, some of the national funding pots outlined in the next section could be delegated to either Bradford Care Alliance or federations rather than individual practices. This will change relationships with how providers of NHS services work together. It will reduce the need for competition and will allow an increasing focus on prevention and self-care, providing patients with the choice of how they manage and receive their care. This should also impact on workforce and demand, as the GPFV[3] states that 27% of appointments could potentially be avoided if there was more co-ordinated working between primary medical care and hospitals.

The CCGs have already invested resources into the development of the federated model within Bradford and to ensure that this model embeds into the system, resources will still need to be targeted towards supporting collaborative working. This will involve staff resource, as the CCGs move towards the ACS model, the way our staff work will also change, taking up provider facing roles as we take on tactical commissioning. There is also a need to support leadership development within the community, enabling grassroots development and change.

To support collaboration we will need to explore the issue of indemnity which has held back developments in the past. We will gain a legal understanding and solution to ensure any future service provision is not hampered by increasing indemnity costs of professionals seeing patients either out of hours or from other practices, whilst developing new contract models to support this process. The CCGs anticipate that the work being undertaken nationally to look at indemnity will support this but recognise that it may not cover all of the areas that we need as part of new models of delivery.

Primary medical care practitioners do not only need to collaborate with each other, they also need to collaborate with patients and patient representatives. We want to establish a true culture of co-production with patients and patient participation groups. We do not want to blame patients for living in high levels of deprivation, or having lower levels of educational attainment. Our populations are strong, cohesive and resilient and we want to build on this with the development of our health services. Getting true patient buy-in will be one solution to our issues and building the relationship between the practice and patients is key to this.

Our steps towards this have already commenced, but we have a long way to go. The CCGs have established The People's Board, an 18 member group of people with varied and significant experience and representation of our CCGs' populations who have a strategic and quality remit. This group has real influence over the CCGs' plans and proposals, which we aim to strengthen over time.

We want to move to a model where patients are involved in large decisions (e.g. service redesign), but also smaller scale change (e.g. practice appointment changes). This happens in pockets across Bradford currently, with some practices heavily bought into co-production involving their patients in all elements, even the colour of their walls. However, others have yet to arrive at this point. We want to support practices and patients to get the most out of their Patient Participation Groups (PPGs), we want them to see them as something they want to do, rather than have to do. (They are a contractual requirement).

As well as the individual patient voice which is represented well through PPGs and other sources of patient feedback (e.g. NHS Choices, complaints and compliments) we need to better engage our populations and communities. A strong way to approach this is for primary medical care and the CCGs to work more collaboratively with our voluntary and community sector (VCS) providers. VCS organisations have a great and in-depth understanding of the communities and populations that they work with. They are able to represent the 'whole' of these groups, rather than individual voices which often come through our other channels which has become more apparent through the recent community assets work. This is a significant asset and over the next few years we need to establish new ways of working to ensure that we hear these voices and engage with VCS organisations as we change. This will be aided by the funding provided to the VCS sector by the CCGs to support their organisational development towards an entity that can offer one voice across the sector.

Another relationship we need to develop and collaborate with in the future was highlighted clearly by our member practices at engagement events – that of schools and education. As well as encouraging our youth to become the future workforce of health and social care in Bradford, we need to work with our children and young people to promote self-care, resilience and prevention. We believe that starting this education at an early age would be one of the most effective ways to reduce pressure on our services in the future and result in the most appropriate use of our resources. We will work with our Local Authority and Public Health partners on this.

It is important to note that collaboration itself is not an end state – it is an enabler to allow transformation to happen.

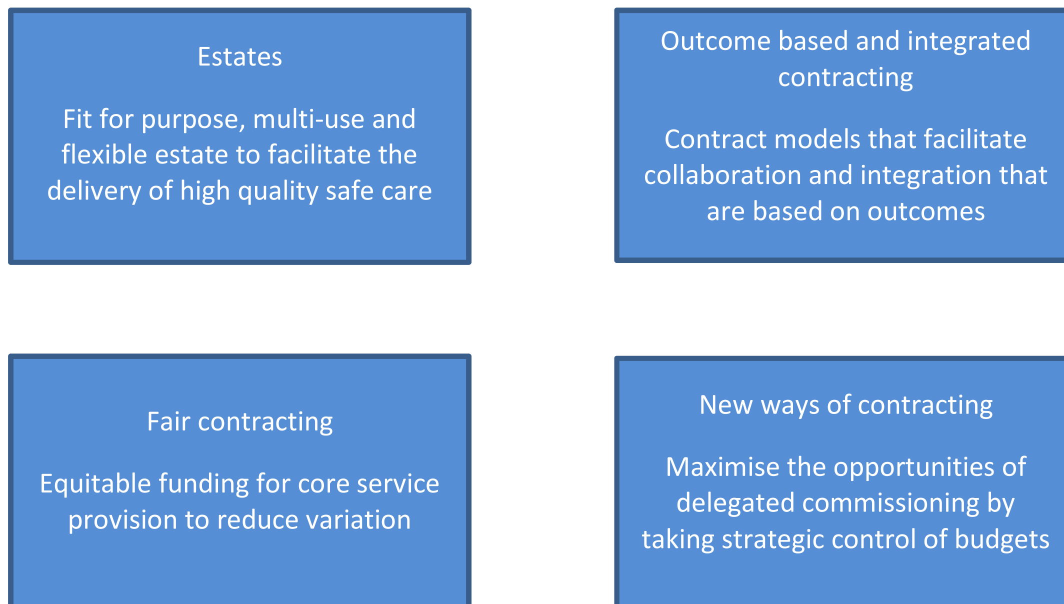
What we will do:

- **Through our commissioning processes we will increase the level of patient engagement in service design and primary medical care decision making which is inclusive and reflects our local population**
- **Put in place processes (including funding) to actively support the delivery of primary medical care at scale**
- **Have commissioning strategies that positively encourage networks of practices and stakeholders as providers**
- **Consider this strategy in the future of primary medical care contracts**
- **Ensure primary medical care services are the foundation of an accountable care system**
- **Support the development of the Voluntary and Community sector to engage as one voice across the system to support improvement**

- **Through a thorough understanding of relevant regulatory and legal frameworks, provide solutions relating to indemnity in respect of working outside of core hours and providing care for patients registered at other practice**
- **Working with the Local Authority and Public Health, establish formal links with education providers and others to bring health messages and health education into schools and colleges to encourage children and young people to consider future working in the health and social care sector of Bradford**

5.6 Priority Theme Six: Estates, finance and contracting

Effective estates, finance and contracting models to enable integration and positive health outcomes



To enable primary medical care services to deliver high quality safe care now and in the future, the infrastructure supporting these services needs to be right and fair. Having fit for purpose estate is key to this, and this strategy sits alongside the Bradford District and Craven Interim Estates Strategy which highlights the importance of ensuring primary and community care estate meets the needs of the population. We must stop investing funding in estate which is no longer fit for purpose or provides identical services within a very small geographic area, but instead we will look to rationalise our estate, investing in buildings and infrastructure that can support high quality service delivered at scale. This will involve reducing void and underutilised space, and will see the closure of some of our estate, either as services change or we move services into more suitable estate. This will not just be limited to primary medical care services. We will look to closer working through hub development with other services through better use of our estate. We recognise that this may go against the wishes of our population, as many people look for convenience in regards to accessing primary medical care. However, the CCGs believe in the importance of having estate that has the facilities to enable the delivery of high quality care and will continue to follow processes to access national funding as it becomes available.

This will be further facilitated by the widespread adoption of technology. As outlined in Priority Theme One, the use of technology will alter the way our populations access services and the way staff across the health and social care system deliver care. For example, installation of Wi-Fi in practices will enable patient access to their own records and staff to work flexibly across sites. These changes will benefit both our populations and our staff, improving the experience of both the delivery and receipt of primary medical care.

To undertake real transformational change we will look to different ways of contracting and commissioning. We will maximise the opportunities placed before us via delegated commissioning, with primary medical care leading the way and shaping the new models of care that we plan to deliver. This will be key in the accountable care system, where a new contracting model can provide

the opportunity to work collaboratively around workforce, service delivery and the holistic care of patients. Through delegated commissioning we can use primary medical care resources differently, focussing on the delivery of our strategic priorities and to build in the sustainability of primary medical care. We will use our delegated responsibilities to ensure that practices are treated fairly in regards to contracting discussions. We will follow agreed policies regarding list closures, list reassignments and boundary changes. We will make sure no patient or patient group is disadvantaged, ensuring patients always have a choice of where they register to receive primary medical care services.

As well as primary medical care contracts, we need to ensure that benefits from other contracts are being utilised. For example, the changes to the NHS Standard Contract for hospitals will reduce workload within primary medical care. This will be seen via reduced referrals back to GPs when hospitals undertake internal referrals or 'do not attends' and ensuring patients have a minimum of 7 days medication (unless a shorter period is clinically appropriate). Primary medical care providers should inform the CCGs if they feel these processes are not being followed.

The CCGs will stop commissioning short term projects which cease when the funding runs out. Instead we will commission with conviction, building exit strategies into contracts in case they are needed, but have contracts that will allow time for new services to embed and deliver. We need to have the confidence to invest where we believe the greatest improvement in outcomes for our population will be and put in place the systems to show the impact and outcomes of the services.

We will continue the drive towards outcome based commissioning. This is an important aspect of improving the quality of care delivered to our patients. We need to know what the impact is on the services we deliver and, if they are substandard, we must either build in service improvements or decommission and re-procure a service that will deliver the outcomes we need. Gone are the days of activity counting in primary medical care. The CCGs expect high quality outcomes from our services and our future contracting approach will be a vehicle to deliver this. We will also use our delegated commissioning powers to ensure high quality and safe core primary medical care services are delivered. Where resources permit, we will work with practices to support the delivery of great care through commissioning and/or facilitating education and training, but if there are quality or contractual concerns these will be managed via the Contract Assurance Group. Practices will be supported to improve, but if it is found that this is not possible then contractual levers (e.g. breach notices) will be utilised as high quality care for our patients is paramount.

We will implement the outcomes of the equitable funding review without destabilising primary medical care, whilst improving the service offer. We will ensure that the resources we have are fairly distributed to reduce unwarranted variation and health inequalities. To further support practice sustainability, the General Practice Forward View assumes additional investment from CCG allocations into primary care over the period to 2020/21. Taken together with increases in allocation for primary care and central investment in general practice, it is expected that the overall share of the NHS budget going to primary care will increase over the period to over 10%.

As outlined in the GPFV we are planning to spend approximately £3 per head (totalling £1.4m non recurrently locally) across 2017/18 and 2018/19 for practice transformational support, set out in the General Practice Forward View. The investment will be used to support the roll out of extended access across both of the Bradford CCGs. As part of the West Yorkshire Urgent and Emergency Care Acceleration Zone the roll out will be accelerated and the £1.50 in 2017/18 will be used to commission services (likely via hubs) across the patch. Initial delivery will be from April 2017 and this will be expanded in 2018/19 with the use of the £3.34 from national funding, plus the £1.50 from

the CCGs. Both CCGs have already provided financial resources to support the development and maturing of the federated approach being taken forward by practices in Bradford.

The detail behind these plans has yet to be established, as this is not new funding so the CCGs need to identify the service areas that this money will be taken from. It is anticipated that some of this may come from reducing activity in the acute care sector, but final plans have not yet been established and this work is underway. It must be recognised that this will not be easy in Bradford, as primary medical care services in Bradford are in a different position currently to many other areas nationally. The concept of a GP with Special Interest (GPwSI) was established in Bradford, and there has been a long history of investment within primary medical care. Developments and investment have meant that there has been an acute care to primary medical care shift taking place over the last 20 years, so many of the changes taking place elsewhere in the country have already happened in locally which will make further change more difficult.

The CCGs also plan to access and utilise national funding streams:

- Vulnerable practice scheme: We are in discussions with NHS England in regards to 5 practices which we feel would benefit from access to the vulnerable practice funding currently. We recognise that this funding allocation has now been committed so there will be no further opportunities to access this.
- Online general practice consultation software systems: Bradford Districts CCG expects to receive £88,661 in 2017/18 and £118,104 in 2018/19 to support the role out of this work. Bradford City CCG expects to receive £32,025 in 2017/18 and £42,618 in 2018/19. The CCGs will be clearer on the detail of the work to be done on publication of the national specification and monitoring arrangements but expect this to be non-recurrent.
- Training care navigators and medical assistants: Bradford Districts CCG expects to receive £59,107 in 2017/18 and £59,052 in 2018/19 to support the role out of this work. Bradford City CCG expects to receive £21,350 in 2017/18 and £21,309 in 2018/19. The CCGs will be clearer on the detail of the work to be done on publication of the national specification and monitoring arrangements but expect this to be non-recurrent.
- General practice resilience programme: We recognise that this funding will be delegated to local teams. A number of our practices have self referred against this funding pot and we will work with NHS England to identify those who will receive support as we believe there is a great need for this investment within Bradford. We would like to see West Yorkshire wide work being taken forward around workforce, including baseline information collection. On a local footprint we would be keen to utilise this funding to support the development of local sustainability initiatives, such as a local locum bank which all practices could utilise.
- Estates and Technology Transformation Fund (ETTF): Bradford Districts CCG submitted 8 schemes against the ETTF, 7 of these are being taken forward into the next stage. All 7 of these relate to improving GP premises to allow for better patient experience and improving patient access. The technology bid aims to provide the public, patients and the health and care workforce with a simple and accessible online digital platform to promote self-care, support people to remain independent and to manage their own health and wellbeing. Bradford City CCG submitted 6 schemes, 3 of which have been taken through to the next stage. These are a mix of estate and technology proposals, and go beyond improvements to GP estate. These include the establishment of self care hubs and the roll out of WIFI in GP

practices to support both patients and flexible working for community staff. We will work with the national team to undertake the work needed to further all of these proposals.

- Reception and clerical staff training and online consultation systems: The CCGs have received the first allocation of this funding and we have plans are in place to roll out training from January 2017. The plans for the existing and future allocation have been developed in conjunction with general practice and in the first instance are looking at 'signposting with confidence' training for receptionists.
- International recruitments: Bradford City CCG looks forward to receiving further information this year regarding international recruitment as the CCG would benefit from the recruitment of new doctors. The national average (England) of GPs per 100,000 population is 51.20, while this is much lower in Bradford City with 43.81. Therefore, the CCG will look to work with NHS England to benefit from the international recruitment that they lead.
- Additional roles in general practice: Both CCGs will work with NHS England in regards to establishing additional clinical pharmacists and mental health practitioners in general practice and will await the production of further information.

What we will do:

- **Reduce the amount of void and underutilised primary medical care estate across Bradford.**
- **Stop investing funding in primary medical care estate that is no longer fit for purpose and facilitate the relocation of these services to underutilised estate elsewhere in Bradford.**
- **Explore and adopt new contracting approaches to support the integration of services**
- **Adopt outcome based commissioning to ensure our patients receive high quality services**
- **Manage any primary medical care contract concerns via the Contract Assurance Group, supporting practices to meet the terms of their contract.**
- **Use contract levers where required to ensure high quality care for their patients, ensuring primary medical care providers are aware of how they can feedback to the CCGs if the changes to the NHS Standard Contract are not being delivered.**
- **Implement the outcomes of the PMS equitable funding review and ensure that the extra contractual service offer is made to all patients**
- **Access national funding where possible to support primary medical care sustainability**
- **Identify £3 per head investment over 2016/17 and/or 2017/18 to support practice transformation**

6. Expected benefits and local metrics

It is anticipated that the strategy will deliver the following benefits:

- improved patient experience and outcomes;
- improved access to primary medical care;
- equality of service;
- improved quality of services;
- better health outcomes within a sustainable workforce and financial envelope;
- improved ability to meet and sustain nationally and locally agreed targets;
- reduced health inequalities; and
- enhanced patient engagement.

To determine whether the strategy is delivering the expected benefits a number of local metrics will be used as key indicators of success, they are the 'measures that matter'. The proposed key metrics to monitor the achievement of the strategy can be seen in Appendix 2.

We also need to understand the impact of the changes implemented through this strategy on the wider health and social care system. Work is underway across all of the CCGs' transformational programmes to explore how this can be done. The CCGs need to be sure that the impact of, for example, any workforce decisions, is not to the detriment of another service area. The development of the accountable care system should support this, as any changes elsewhere should be easier to identify when working as one system.

The delivery of this strategy will also support the achievement of our STP and the local delivery of the GPFV[3]. The different areas of focus outlined in this strategy all align with elements of the GPFV[3] and support the closure of the health and wellbeing gap, care and quality gap and the finance and efficiency gap, as seen in Appendix 3.

7. Enablers

To ensure the roll out and success of this strategy there are a number of enabling factors which are outlined below.

Enabler	Expected strategic benefit
Whole system commissioning	Contracting decisions that support integrated working and delivery of services across networks and promotion of outcome based provision Local incentive schemes that promote economies of scale Assessment of APMS contracts , outcomes to support delivery at scale and flexible workforce models Local enhanced service provision that improves the offer to patients, that are list based and reduce the variability of offer.
Better use of IT	Widespread adoption of modern technology to make health and care services more convenient, accessible and efficient. For example increasing the uptake of telehealth, telecare and telemedicine.
Engagement and co-production	Making the most of our community and population assets by involving them in decision making
Optimal use of medicines	A strategic shift from medicines management towards medicines optimisation with the patient at the centre of all discussions. Reduction of waste within the system, and focus on high quality cost effective prescribing.
Quality and assurance	To ensure the delivery or safe, effective cost effective care, the setting and monitoring of quality standards in healthcare must be underpinned by an effective partnership between CCG and providers.
Leadership	To ensure delivery of this strategy we will need strong leadership to drive it forward. This is not only strategic leadership at CCG level, but leads within primary medical care and within other partner agencies. There has to be a drive and desire to want to change.

8. Governance and Engagement

Governance

This Primary Medical Care Commissioning Strategy will be owned by the Clinical Boards of Bradford City CCG and Bradford Districts CCG respectively. The Out of Hospital Programme Board will oversee the delivery and the Out of Hospital Engine Room will be responsible for its implementation.

Engagement

There has been continuous engagement with our stakeholders throughout the development of the Primary Medical Care Commissioning Strategy via the:

- Governing Body (City and Districts)
- Practice Quality Improvement Group (City)
- GP Performance and Quality Improvement Group (Districts)
- Primary Care Commissioning Committees (City and Districts)
- Out of Hospital Programme Engine Room/Programme Board
- Learning and Development Groups (City and Districts)
- The People’s Board
- Healthwatch/Patient Networks/Practice Participation Groups
- YORLMC Ltd
- Bradford Care Alliance (CIC)
- Health and Social Care Overview and Scrutiny Committee
- Integration and Change Board
- 4 week public consultation and engagement exercise

GP Practice Engagement

As providers of primary medical care and members of the CCG, it was vital to get good engagement from all GP practices in Bradford City and Bradford Districts. A number of approaches were taken to ensure that GP practices in both CCG’s had opportunity to have their say, including: -

- Clinical Board discussions
- Chatter Group discussions
- Council of Representative discussions
- Council of Member discussions
- Joint Clinical Board and Governing Body discussions
- GP engagement events
- Clinical Commissioning Forums

This engagement with member practices will continue through the implementation of the programmes of work that are defined within this strategy predominantly through the Out of Hospital Programme, but also via other programmes, including Self-care and Prevention, Planned Care and Urgent and Emergency Care.

Patient and Public Engagement

The Bradford CCGs have fully committed to engaging patients and the public in all aspects of our work priorities. This has been embedded within our various engagement programmes so that patients, service users, carers and the public are involved in developing future service models through a range of engagement activities, from individual patient stories to patient networks and events. We will focus on ensuring that this engagement continues and is representative of our local populations and is provided in a variety of formats to ensure we meet the accessible information standards.

A variety of different approaches to engaging patients and the public have been taken. These included:

- Using existing patient networks and groups, using feedback from previous events
- Healthwatch Report – Invisible at the desk[19]
- Patient participation groups
- Grassroots process

As with member practices, engagement with patients and public will continue through the future implementation phases and structured collaboration. Where there are potential service changes patients will be engaged in the process and be involved in co-production of key work priorities. Consideration will be given to the impact on patients and our populations in regards to any changes made, especially relating to protected groups.

9. Summary

By 2020/21 via the delivery of this primary medical care strategy we envisage the primary medical care services in Bradford will:

- Be delivered via primary medical care at scale by a mixture of independent practices, networks and federations as part of an accountable care system operating out of hubs, co-located and collaborating with other relevant services 7 days a week. As well as NHS and social care providers this will also include VCS organisations.
- Regularly use technology for all elements of patient care including access, consultations, telehealth and telemedicine.
- Have established new roles and new ways of working, including ‘virtual primary medical care’, shifts in traditional roles and responsibilities and that Bradford is ‘The place to be’.
- Have better demand management, as patients are empowered and experienced in self-care and preventative services are embedded within the accountable care system.
- Have strong embedded relationships with education, paving the way for increased levels of self-care and a workforce who choose to work and live in Bradford.
- Have equality of care for the whole population. Wherever people live or are registered within Bradford, they can access the same services.

10. Appendices

Appendix 1 – Glossary

ACS	Accountable Care System	Care system to improve health of a whole population across community and hospital care, physical and mental health. Focus is on outcomes and joined up health & social care services that simple, accessible and responsive to needs. Care is personalised using community assets and agreed payment schemes to support joint commissioning.
ADPD	Allocations Development Plan Document	The ADPD supports the delivery of the Core Strategy. It allocates specific sites to meet needs for housing, employment, education, shopping and open spaces in Bradford District.
ANP	Advanced Nurse Practitioners	An ANP makes autonomous decisions for which they are accountable and receive patients with undifferentiated and undiagnosed problems, make an assessment of health care needs and prescribes accordingly.
APMS	Alternative Provider Medical Services	A contracting route available to enable CCGs to commission or provide primary medical services within their area to the extent that they consider it necessary to meet all reasonable requirements.
AQP	Any Qualified Provider	CCGs determine the services to be commissioned as AQP; the intention is to increase patient choice. All providers must meet the qualification criteria set for a particular service and once qualified their service will appear on choose and book for patients to select.
BCA	Bradford Care Alliance	A Community Interest Company (CIC) established in June 2016. Represents the provider voice of the vast majority of member practices across Bradford.
BBB	Bradford Breathing Better	A CCG programme to raise awareness about respiratory issues such as asthma, COPD etc.
BDCfT	Bradford District Care Foundation Trust	Provider of mental health, learning disabilities and community health services across Bradford, Airedale and Craven.
BHWB	Bradford Health and Wellbeing Board	The Health and Social Care Act 2012 established Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. As a result, patients and the public should experience more joined-up services from the NHS and local councils.
BMDC	Bradford Metropolitan District Council	Provider of social care, reablement and rehabilitation services, public health services across Bradford and Airedale.

BPA	Bradford Provider Alliance (working title)	Formal group of providers who are working together under the BPA title. Group includes BTHFT, BDCFT, BCA, BMDC and VCS organisations.
BPMCA	Bradford Primary Medical Care Academy	BPMCA or something similar to be developed to help workforce roles that are not currently in place via local and national initiatives, including physician associates and medical assistant roles.
BSL	British Sign Language	BSL is a visual means of communicating using gestures, facial expression, and body language. Sign Language is used mainly by people who are Deaf or have hearing impairments.
BTHFT	Bradford Teaching Hospitals NHS Foundation Trust	Hospital trust made up of Bradford Royal Infirmary (BRI) and St Luke's Hospital. Key provider of hospital services locally.
CAB	Citizens Advice Bureau	Provider of free independent advice and advocacy services.
CB	Clinical Board	Responsible for leading and setting the vision and strategy, developing commissioning plans and overseeing the commissioning process across the CCG.
CCF	Clinical Commissioning Forums	GPs and Practice Managers attend these meetings and get involved in the work of the CCG.
CCG	Clinical Commissioning Group	Established in 2013 with Clinicians at the heart of decision making. CCGs responsible for commissioning health services: - Bradford City CCG made up of 27 member practices and 124,000 registered patients - Bradford Districts CCG made up of 40 member practices and 339,000 registered patients
CIC	Community Interest Company	A CIC is a type of company introduced in 2005 under the Companies Act 2004 and is designed for social enterprises that want to use their profits and assets for the public good.
CoM	Council of Members (Bradford City CCG)	Main GP forum within the CCG and is responsible for agreeing the vision, values and overall strategy of Bradford City CCG.
CoR	Council of Representatives (Bradford Districts CCG)	Main GP forum within the CCG and is responsible for agreeing the vision, values and overall strategy of Bradford Districts CCG.
CQC	Care Quality Commission	Independent regulator of health and adult social care in England. The CQC makes sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve
DES	Directed Enhanced Service	Directed Enhanced Services (ES) require an enhanced level of provision above what is required under core GMS

		contracts. Commissioners taking part in the ES ensure they have read and understood the requirements in the Directions and NHS England service specifications, as well as the guidance provided.
EFR	Equitable Funding Review	In January 2014, NHSE agreed that the current funding arrangements for General Medical Services (GMS) and Personal Medical Services (PMS) practices would be reviewed with a view to addressing the wide variation in core funding per patient and to ensure that funding.
GB	Governing Body	Responsible for ensuring that the Clinical Commissioning Group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically.
GMC	General Medical Council	Regulator of the medical profession. Its purpose is to protect, promote and maintain the health and safety of the community by ensuring proper standards in the practice of medicine.
GMS	General Medical Services	The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. NHS Employers leads negotiations with the General Practitioners Committee (GPC), which is part of the British Medical Association (BMA) on changes to the GMS contract.
GP	General Practitioners	A Doctor who works from a local surgery or Health Centre. Most are independent contractors providing services to patients through a contract with the NHS.
GPFV	General Practice Forward View	NHS England document which represents a step change in the level of investment and support for general practice. It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to accelerate transformation of services.
GPPQIG	General Practice Performance and Quality Improvement Group (Districts)	The GPPQIG is a sub-committee of the Primary Care Commissioning Committee and contributes to ensuring the achievement of the CCG strategy and fulfilling the duty of the CCG in relation to the quality of primary medical services. (Also see Primary Care Commissioning Committees - City and Districts)
GPwSI	GP with Special Interest	A GPwSI supplements their role as a GP by providing an additional service while still working in the community as a GP.
HCA	Health Care Assistants	HCAs are a vital part of any practice, hospital or care setting nursing team.
HEE	Health Education England	HEE was established to support the delivery of healthcare and health improvement to the patients and public of England by ensuring that the workforce has the right numbers, skills, values and behaviours, at the right time

		and in the right place.
HF	Healthy Futures	The CCGs of West Yorkshire and Harrogate and Rural District have agreed to work collaboratively under the Healthy Futures banner. Initially work is focussed on cancer, urgent and emergency care and mental health.
ICB	Integration and Change Board	Partnership between health, social care and the VCS to promote integration. The ICB oversees a portfolio of programmes.
JCB	Joint Clinical Board	Combination of the Clinical Boards for Bradford City & Bradford Districts CCGS.
LCD	Local Care Direct	A community owned healthcare provider delivering a wide range of NHS services 24 hours a day, 365 days a year. Current provider of out-of-hours services across West Yorkshire.
LES	Local Enhanced Service	Schemes agreed by CCGs in response to local needs and priorities, sometimes adopting national service specifications.
LMC	Local Medical Committee (also see YORLMC)	A LMC is a statutory body in the UK. LMCs are recognised by successive NHS Acts as the professional organisation representing individual GPs and GP practices. The NHS Act 1999 extended the LMC role to include representation of all GPs whatever their contractual status.
LTC	Long Term Condition	Long Term Condition is defined as a condition that cannot, at present be cured but can be controlled by medication and other therapies. Examples of Long Term Conditions are diabetes, heart disease and chronic obstructive pulmonary disease. There are 15.4 million people living with a long-term condition in England.
NHSE	NHS England	NHSE leads the National Health Service (NHS) in England and sets the priorities and direction of the NHS. It also encourages and informs the national debate to improve health and care.
NPSA	National Patient Safety Agency	The NPSA leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector. It is an Arm's Length Body of the Department of Health and through its divisions covers the UK health service.
OHP	Out of Hospital Programme	New programme that has embarked on a structured collaborative approach for services outside of hospital (community services). It's vision is "*I can plan my care with people who work together to understand me and my carer, allow me control, and bring together services to achieve the outcomes that are important to me'*
PCCC	Primary Care Commissioning Committees (City and Districts)	On 1 April 2015, the CCGs accepted full delegated responsibility from NHS England to commission GP primary care services. The PCCC make decisions on the

		review, planning and procurement of primary care services.
PG	Protected Groups	Nine groups covered by the Equality Act 2010 - Age - Disability - gender reassignment - marriage and civil partnership - pregnancy and maternity - race - religion or belief - sex - sexual orientation
PMS	Personal Medical Services	Locally agreed alternative to General Medical Services (GMS) for providers of general practice, which offers greater flexibility for the GP. PMS agreements aim to improve access to and the quality of services within primary care, recruit and retain GPs in areas of greatest need, develop new ways of delivering services, and help integrate services.
PQIP	Practice Quality Improvement Group (City)	PQIG was established in September 2013. The role of this group is to support our member practices in improving the quality of primary medical services that they deliver through leadership and skills development. (Also see Primary Care Commissioning Committees - City and Districts)
PSED	Public Sector Equality Duty (Equality Act 2010)	The Public Sector Equality Duty requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.
QOF	Quality and Outcomes Framework	The QOF is part of the General Medical Services (GMS) contract for general practices and was introduced on 1 April 2004. The QOF rewards practices for the provision of 'quality care' and helps to fund further improvements in the delivery of clinical care.
RCGP	Royal College of General Practitioners	The RCGP is the professional membership body for GPs in the UK and overseas. The RCGP is committed to improving patient care, clinical standards and GP training.
StC	Structured Collaboration	Commissioners, providers, patients, service users, carers and the public working in partnership to define outcomes and agree the scope prior to awarding and mobilising services.
SCP	Self-care and Prevention	Self-care is a way for people to look after themselves (with support as required) in a healthy way.
STP	Sustainability and Transformation Plan	Introduced in December 2015 as part of the NHS Shared Planning Guidance 2016/17 – 2020/21. Every health and care system in England will produce a multi-year

		Sustainability and Transformation Plan (STP) showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.
U&EC	Urgent and Emergency Care	Urgent & Emergency Care services provide life-saving care so patients get safe and effective care whenever they need it.
VCS	Voluntary and Community Sector	Not for profit organisations
YAS	Yorkshire Ambulance Service	Provider of Ambulance services across Yorkshire
YORLMC	YOR Local Medical Committee (also see Local Medical Committee)	Local Medical Committee for Bradford GPs.

Appendix 2 – Measures that matter

Metric	Impact
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	Maintenance or reduction in number of patients admitted
Patient experience of primary care - GP services	Increase in number of patients reporting ‘good’ or ‘very good’ Experience of making an appointment
Patient safety incidents reported	Increase in number of patient safety incidents reported (short term) Longer term reduction as learning is embedded
Primary medical care: Management of LTCs	People with a LTC who feel supported to manage their condition Reduced / no increase in admissions to hospital for people with a LTC Reduced / no increase in admissions to hospital for conditions which should not require a hospital admission
Primary medical care: Primary care workforce	Increased number of professionals working within primary care
Cancer screening coverage	Increase in percentage of patients screened Early diagnosis One year survival rates
Population vaccination coverage	Increase in percentage of patients vaccinated
Health-related quality of life for people with a long term mental health condition	Increase in quality of life reported
Anti-microbial resistance: Appropriate prescribing of antibiotics in primary care	Reduction in number of antibiotics prescribed

Appendix 3 – Alignment with STP and GPFV

Key areas outlined in Primary Medical Care Commissioning Strategy	**General Practice Forward View**					**Sustainability & Transformation Plan Gaps**		
	Investment	**Workforce**	**Workload**	**Practice Infrastructure**	**Care Redesign**	**Health & Wellbeing**	**Care & Quality**	**Finance & Efficiency**
Core access	√	√	√	√	√	√	√	√
Out of hours access	√	√	√		√	√	√	√
Digital access	√	√	√	√	√	√	√	√
Extended hours access	√	√	√	√	√	√	√	√
Use of technology	√	√	√	√	√	√	√	√
Long term conditions	√	√	√		√	√	√	√
High quality care		√		√	√	√	√	√
Continuity of care		√			√	√	√	√
Parity of esteem	√	√	√	√	√	√	√	√
Consistent and safe care		√	√		√	√	√	√
Sustainable workforce	√	√	√			√	√	√
Integrated workforce	√	√	√		√	√	√	√
Evolving workforce	√	√	√		√	√	√	√
Skilled workforce	√	√	√	√		√	√	√
Motivated workforce		√	√			√	√	√
Prevention		√	√		√	√	√	√
Self-care skill development	√	√				√	√	√
People power	√		√	√	√	√	√	√
New models of self-care	√	√	√	√	√	√	√	√
Primary medical care at scale	√	√	√	√	√	√	√	√
Using our assets		√	√		√	√	√	√
Co-production		√	√		√	√	√	√
New models of primary medical care	√	√	√	√	√	√	√	√
Estates	√			√	√		√	√
Outcome based and integrated contracting		√	√		√		√	√
Fair contracting	√	√					√	√
New ways of contracting	√	√	√		√	√	√	√

Appendix 4: Policy Documents and References

1. NHSE Five Year Forward View - https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
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11. NHS England Call to Action https://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/
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16. Kings fund – workforce planning in the NHS http://www.kingsfund.org.uk/publications/workforce-planning-nhs
17. Centre for Workforce Intelligence file:///Z:/Documents/Downloads/CfWI%20GP%20in-depth%20review%20summary_July%202014.pdf
18. A Very General Practice Report https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/CitizensAdvice_AVeryGeneralPractice_May2015.pdf
19. Invisible at the desk http://www.healthwatchbradford.co.uk/news/invisible-desk-healthwatch-publishes-report-gp-services-0