NHS
Airedale, Wharfedale and Craven
Clinical Commissioning Group

Delivering the Forward View for General Practice (GPFV)

Airedale, Wharfedale and Craven CCG

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Introduction:

The following plan is intended to provide assurance to NHS England of the CCGs approach to delivering the Forward View for General Practice.

The content is set in the context of our local and West Yorkshire Sustainability and Transformation Plans (STP), our Operational Plan and the National Forward View for General Practice. It is aligned to the agreed ***system wide vision*** for Airedale, Wharfedale and Craven which has been agreed with strategic partners:

Our Vision:

To deliver the *system vision*:
Our aim is to establish a place based 'system of care' in which provider organisations collaborate to manage the common pool of limited resources available and work together as one system to improve the health and care for the whole population, through this delivering 'Accountable Care Airedale'.

Commission one system of high quality care, through a single outcomes based contract focused on improving the whole populations' health and well-being and is financially and clinically sustainable

Our Plan for delivering the GP Forward View:

Sustainability and Transformation Plan (STP) and Operational Plan:

Our plan for delivering the GPFV is aligned to our local and the West Yorkshire Sustainability and Transformation Plan (STP) and our 2017/19 Operational Plan. Through this approach we will continue to focus on ensuring delivery of the NHS Constitution Standards, the triple aims identified in the STP, and on commissioning safe, high quality and effective care.

Example indicators in the 2017/19 Operational Plan which support delivery of the STP triple aim and the GPFV:

- Train 10% of the health and social care workforce to support people to better self-care
- Improved population outcomes through the implementation of new contracting models
- Commission new models of primary medical care that ensures 7 day access is achieved for 100% of our population by 2021
- 90% of people who access Psychological Therapies will engage through direct self-referral
- By 2018/19 we will have modelled additional schemes to shift transfer of resources equivalent to £1.8m to primary care

Area of GPFV plan	Description
Vision Narrative	A clear narrative on the vision for and delivery of sustainable general practice that reflects the ambition set out in the General Practice Forward View

The 2020 ***vision for general practice*** in Airedale, Wharfedale and Craven is:

General Practice will operate as equal partners in an Accountable System of Care, using a resilient workforce to deliver innovative and proactive healthcare improving the wellbeing for all our population

Aims and Intended Outcome

- General Practice operates as equal partners in the (future) delivery of healthcare for our population in the AWC CCG area
- Our approach to care is innovative, integrated, proactive and holistic
- We promote and increase uptake of self-care and self-management
- General Practice understands the health care needs and lifestyle factors of our patients and communities within AWC and tailors care delivery accordingly
- Where appropriate General Practice is delivered at scale in locality hubs, maintaining continuity of care with equitable distribution of services through smaller 'spoke/satellite' services
- The locality hub and smaller spoke/satellite service model will facilitate meaningful collaborative partnership working in an Accountable System of Care

This vision has been co-produced by the CCG in partnership with representatives from General Practice, Yordales Health Federation and YOR LMC.

An accountable care system will not succeed without general practice at its heart. A strong sustainable accountable care system needs strong sustainable primary medical care.

At Pace and Innovation:
Airedale, Wharfedale and Craven is a National Pioneer site and is one of few national Accelerator sites. Through our programmes of work we are designing, developing and testing New Models of Care and progressing at pace towards an Accountable Care System. Our ambition is to run an Accountable Care System in shadow form in 17/18, live in 18/19.

General Practice is the cornerstone of care and an integral and critical stakeholder within any such system; General Practice has been a key stakeholder in designing and testing the New Models of Care which have been commissioned, in particular Enhanced Primary Care. 2016/17 is the second year of delivering Enhanced Primary Care, through these arrangements we have made available up to £5 per head additional investment in General Practice. Up to 2017/18 this funding has been non recurrent (during the pilot phase). In November 2016 the Governing Body accepted a recommendation that this funding is confirmed for two years to enable longer term planning and evaluation. Please see Investment Plan section for more detail. For different reasons (changes in partnership, missed deadline and non-engagement), 3 of our 16 practices did not participate in 16/17.

Building on progress to date and incentivising engagement through utilisation of available PMS Premium funding we anticipate that all practices will engage in enhanced care in 2017/18 and 2018/19. The investment will also encourage pro-active care and through this the opportunity to test and expand a range of new roles which will support delivery of the overall vision.

Accountable Care Airedale:
We will also continue on our journey as an Integrated Care Pioneer and use this as a vehicle to accelerate delivery of Accountable Care Airedale. Through this programme we will develop, commission and test New Models of Care such as complex care, enhanced primary care, community based 'wrap around' services, and we will promote and embed approaches to self-care and self-management. We have also established brief task and finish groups to develop and deliver improvements in services and pathways where Commissioning for Value packs have provided us with information on an opportunity to reduce variation and improve outcomes for our population.

The Accountable Care Airedale Programme and Programme Board have been established and through this mechanism we will ensure a joined up approach to delivery of the STP, Operational Plan and GPFV Plan.

Accountable Care Airedale: Degree of integration and primary care contractual arrangements:
As expressed earlier in this document our aim is to commission one system of high quality care, through a single outcomes based contract focused on improving the whole populations' health and well-being - which is financially and clinically sustainable.

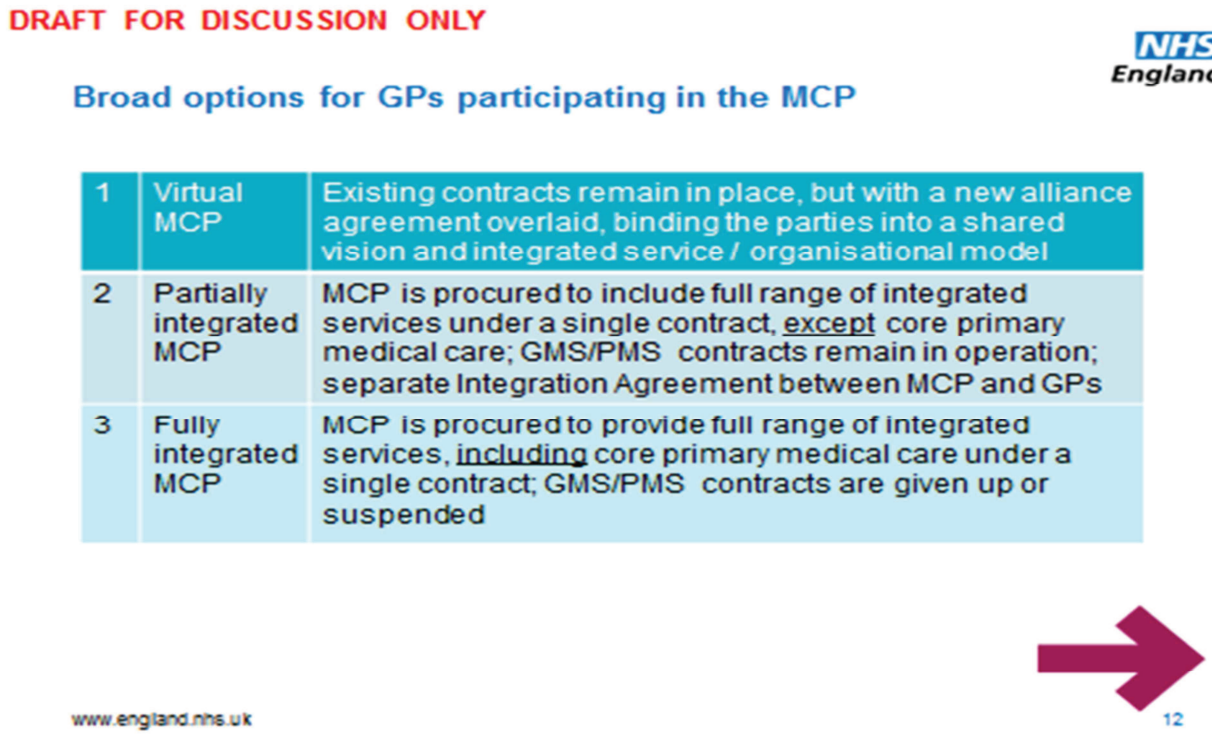
An accountable care system will not succeed without general practice at its heart. A strong sustainable accountable care system needs strong sustainable primary medical care.

As equal partners in an accountable care system there is currently no opportunity for general practice to genuinely commit to being part of the accountable care system and deliver care through one single outcomes based contract. Currently practices within Airedale, Wharfedale and Craven hold GMS, PMS or APMS contracts which, with the exception of the one APMS contract, have no end date. It would be a radical move to review and implement different contractual arrangements for general practice and would require NHS regulatory change. In view of this it is more likely that general practice will integrate as part of the system through an integration agreement. However the National Pioneer team are working with

regulatory bodies to explore how general practice might fully integrate in future and there may be an option to suspend GMS/PMS contracts (with right of return) allowing general practice to deliver care through the one single contract. This would allow general practitioners to operate as salaried doctors as part of a larger system of care with less personal accountability than a general practitioner with a GMS/PMS contract has. This may be attractive to some who are experiencing significant resilience issues.

In recognition that there are a range of options and degrees of integration for general practice as part of the accountable care system dialogue has commenced regarding the future ambition of General Practice.

Example options are set out in the diagram below, this refers to a MCP however it could equally apply to a PACS or Accountable Care model



Locally we need to explore general practices preferences. We expect the outcome to be partial integration unless there is a desire to test full integration. We believe this to be unlikely however there could be a mixed economy with some choosing to integrate and agree an Integration Memorandum of Understanding which will join them as part of the Accountable Care System (ACS) and some may be interested in pursuing the option to suspend GMS/PMS contract and be a fully integrated part of the ACS. There will be no attempt to impose any model on practices this must be driven by General Practice as an integral and key partner in 'Accountable Care Airedale'.

This work will be progressed through the Accountable Care Airedale Programme Board and the National Pioneer Programme.

It is important to note that the CCG is level one co-commissioner so it is not currently responsible for commissioning general medical care hence any agreements, as suggested above, would need to be supported by NHS England, or full delegation of commissioning responsibilities agreed. An expression of interest in delegated commissioning was submitted 5th December 2016 so it may be that the CCG becomes

responsible with effect from April 2017.

General Practice 'Stabilisation, Sustainability and Transformation' Plan:
The CCG in partnership with General Practice and YOR LMC have co-produced a vision for General Practice and are developing a General Practice Stabilisation, Sustainability and Transformation Plan which aligns to the Five Year Forward View. Delivery of the vision will be through this plan.

To deliver our 2020 vision for General Practice within Airedale, Wharfedale and Craven and our vision for the system we must have strong, high quality, accessible, resilient and sustainable general practice. General practice is the foundation of care and the bedrock of any health and care system. An accountable care system will not succeed without general practice at its heart. A strong sustainable accountable care system needs strong sustainable primary medical care.

A critical component is culture and engagement so alongside supporting general practice stabilisation and sustainability we must also encourage and nurture a culture of innovation and ambition which in itself will engender transformational change. The establishment and renewed interest in Yordales Federation provides a mutually beneficial opportunity and a vehicle through which we can achieve greater involvement and engagement of general practice, in turn strengthening its ability and opportunity to operate as an equal and integral partner in the accountable care system. Yordales Federation now has 7 clinical directors and 2 managerial directors representing all three CCG localities, along with YOR LMC involvement in the Accountable Care Programme and joint CCG/Federation working our ability to deliver the ambition within he GPFV is optimised.

The plan also supports delivery of AWC CCG strategic objectives and principles:

STRATEGIC OBJECTIVES:
Reduce reliance on reactive emergency and urgent care through more planned and proactive model of services
Change the mind-set of professionals to promote active participation in health and wellbeing of the individual
Change the mind-set of the public so they become an active participant in their health and care
Deliver the pledges as set out in the NHS constitution
PRINCIPLES:
No one in hospital unless their care cannot be delivered safely in the community 24/7
No one discharged to long term care without the opportunity for a period of enablement
24/7 access to and delivery of co-ordinated care, which is needs driven and not about age, condition or location

The plan has been co-produced with representatives from General Practice, Yordales Health Federation, YOR LMC and the CCG. It is informed by the outputs of a joint development session which was held on 23rd September 2016. There are four themes within the action plan which align to the General Practice Forward View

- Workforce
- Access
- Infrastructure (Technology and Estates)
- Care Redesign and Workload

Please refer to pages 33 and 34 for the Plan on a Page and our Initial Roadmap to progress this work

Further development will be undertaken in partnership with member practices and YOR LMC through the new general practice engagement network as an iterative process as the Accountable Care System within Airedale is developed and implemented.

Investment in primary care	The investment plan (revenue and capital) in primary care to deliver all aspects of the General Practice Forward View, locally. Including: 1. High level modelling that provides evidence of: - The shift of activity from hospital to out of hospital care - Total spend trajectories for the shift to primary care 2. Clarity on the resource shift so the STP can be clear on the new out of hospital /primary care expenditure plan –per capita shift to primary care and total spend reflecting the direction of travel for increased investment in primary care 3. The CCG's proposed on-going investment plans and timescales for making this investment in-line with delivery of the service offer above (including where CCGs require access to supporting additional non-recurrent transformation resources)?

The General Practice Forward View and associated planning requirements set out additional investment from CCG allocations into primary care over the period to 2018/19 along with additional funding allocations to CCGs or NHS England teams. 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%.

Future investment plans for AWC:

	17/18	**18/19**	**19/20**
Transformational Support	£785k. £5 per head of population to commission enhanced primary care and establish and test extended access through a hub model Requirement is circa £471k over 2 years (£3 per head)	£1m. £6.50 per head of population to commission enhanced primary care Requirement is £471k over 2 years (£3 per head)	**TBD as part of an accountable care system**
Access Improvement	Part of £5 per head to test extended access through a hub model	£539k (£3.34 per head) to roll out locality hub model	£ 965k possibly £1.5m (£6 per head extra ? plus the £3.34)

	Enquiry made re whether any additional funding available through WYAZ for General Practice extended access £100k NR in 2016/17 to support infrastructure change to establish hub through WYAZ	This may be incorporated with enhanced primary care funding, to be determined by patient engagement regarding 'local need'	
General Practice Consultation Software	£41k New CCG allocation	£55k New CCG allocation	New CCG allocation
Training Care Navigators & Medical Assistants	£27.5k Devolved to NHSE AT or CCG	£27.5k Devolved to NHSE AT or CCG	
General Practice Resilience Programme	Held centrally do not factor into plan	Held centrally do not factor into plan	Held centrally do not factor into plan
Reception & Clerical Staff training	£14k in 16/17 Plan will be agreed with practice managers		
Funding for new roles and functions to support general practice resilience and integration			
Physician Associates in General Practice (Utilising Quality Premium Funding)	£45k		
Quality Improvement in Care Home Services (Practice provided)	£105k plus £64k	£105k plus £64k	TBD as part of an Accountable Care System
Personal Support Navigators in Complex Care (Age UK provided) CCG & Local Authority Funded.	£90k CCG Funding	£90k CCG Funding	TBD as part of an accountable care system
Personal Support Navigators in Enhanced Primary Care (Age UK provided. Funding request submitted to National Pioneer	TBC		
Wellbeing Pilot (Primary Care part of provider partnership)	£100k	£100k	
Complex Care (Primary Care part of provider partnership)	£690k	£690k	TBD as part of an accountable care system
Integrated Diabetes and Specialist Podiatry Service (Primary Care part of provider	£1.39m	£1.39m	£1.39m

partnership)			
Local Enhanced Service	£828k (includes £425k non-rec PMS premium allocation transfer from NHSE)	£971k (includes £567k non-rec PMS premium allocation transfer from NHSE)	
Estates and Technology Transformation Fund	Bid for options appraisal and business case leading to capital funding bid for Keighley submitted, categorised as Phase 3. Alternative funding sources being explored		

Investment Plan:
In 17/18 and 18/19 we intend continuing to invest in Enhanced Primary Care (EPC) and giving practices more certainty of funding so they can plan and deliver transformational change. The value will increase by a further £1.50 per head of population in 2018/19. This will require annual review of schemes in the context of the forward view, New Models of Care and the developing Accountable Care System. This includes ensuring integration with the complex care model, cultural change, changes in clinical practice and ways of working building on the move from a purely medical model of care, ensuring continuation of outcomes focus delivering pro-active care for those at risk.

We recognise that to deliver a change in culture and mind set, self-care, self-management, prevention and a new model of pro-active care it will be necessary to invest in general practice. Enhanced primary care presents an opportunity to 'pump prime' and allow time for benefits to be realised following which there is the ability to move funding around the system and invest more in the 'front end' of care i.e. general practice. The financial envelope to support accountable care is the financial envelope, in time the system will determine where the funds are best invested until then commissioners are committed to supporting investment in general practice wherever possible without destabilising or having a detrimental impact on other areas of the system of care..

As party to the West Yorkshire Acceleration Zone (WYAZ) the CCG is working with practices to determine 'local need' and ensure patient participation in the design of extended access for our population. This work will be undertaken in Q4 2016/17 to inform rapid establishment of a hub model of extended access to test in 2017/18, funded as part of the £5 per head investment. We will utilise the PMS Premium funding made available in 2017/18 to secure general practice engagement in a range of activities, bringing forward engagement activities to Q4 2016/17 to ensure we are prepared to implement schemes from 2017.

The CCG requires robust engagement and general practice leadership in areas such as :

- Development of a General Practice strategy which includes broader primary care (Co-design)
- Development of New Models of Care for General Practice
- Development of New Models of Care within Accountable Care Airedale
- Engagement in Accountable Care and delivery of the Forward View for General Practice
- In particular the model for delivery of accelerated extended access in 2017/18
- Patient engagement to determine 'local need' for weekend extended access
- Clinical engagement in all communications & engagement activities associated with New Models of Care, GPFV & Accountable Care Airedale

Options appraisal to determine the optimum method of securing this engagement has been undertaken and we are consulting with general practices regarding their preferences. This robust approach to engagement will ensure true co-design and involvement in delivery of the GPFV, most likely through a new general practice engagement network.

Working at scale and Enhanced Primary Care (EPC):
For avoidance of doubt our ambition is that where it is appropriate General Practice is delivered at scale in locality hubs, maintaining continuity of care with equitable distribution of services through smaller 'spoke/satellite' services. This includes 'core' general practice, enhanced services, enhanced primary care all building to a new model of general practice with self –care and self-management embedded as a new offer to individuals – as part of an accountable system of care. This approach will create efficiencies and will support resilience and sustainability of general practice.

The locality hub and smaller spoke/satellite service model will facilitate meaningful collaborative partnership working in an Accountable System of Care. General practice at scale and operating as a federation through Yordales Health also strengthens the ability of general practice to operate as an equal partner, speaking and contributing with one voice influencing new models of care. Without this approach 16 separate independent voices would inevitably dilute general practices ability to influence the accountable care system.

Working at scale and through hubs is a relatively new concept locally however over the last two years models of working at scale and delivering a new model of care have been tested through enhanced primary care. For instance in 16/17 one scheme covered the whole of Craven, a population of 50k involving 4 practices located within a large rural geographic footprint.

Learning from the 'at scale' schemes delivered through enhanced primary care demonstrates that bringing together disparate practices with different cultures and systems over a new footprint is not an easy task. We recognise that to deliver general practice 'at scale' through locality hubs the CCG will need to offer support and facilitation by way of clinical and managerial leadership and dedicated time. We have also submitted bids to the National Pioneer Programme and are considering a bid to the GP Resilience Scheme to support this approach financially. If successful funding will be used to secure an expert change agent and backfill for practice clinical leadership time, to accelerate a 'proof of concept' within Keighley and establishment of Keighley Medical Group, bringing together 5 practices working as one locality hub. The learning from this is intended to encourage others and build confidence in the ability of general practice to operate 'at scale' and also realise significant benefits from this approach. .

To progress these new models of 'at scale' locality hub working will also require significant consultation with a range of stakeholders, not least GPs, practices and the public.

EPC:
The development of EPC schemes in 16/17 for delivery 17/18 will focus on delivering pro-active care, new roles, working at scale, improving access (through reducing demand & churn) and as part of the WYAZ. When agreeing the approach for 17/18 we will work with our enhanced care reference group to evaluate what has worked well and realised benefits and adopt as best practice in 17/18.

Members are reviewing the 10 high impact change areas and targeting efforts at those most likely to realise benefits. It will be necessary to secure commitment to free up GP time to engage in change programmes which stabilise and sustain general practice - whilst also testing innovation and transformation. The approach to utilising PMS premium funding will support this work being undertaken.

EPC Evaluation:
As part of the national pioneer programme we have engaged with the Policy, Innovation, Research Unit (PIRU) in order that independent evaluation of the impact of New Models of Care is undertaken. This includes benchmarking with other national pioneer sites the impact of new care models on a range of health and social care indicators. This will support review over a longer term of the impact of additional

investment in general practice on the system and support and build an evidence base.

Engagement and dialogue with general practice representatives has commenced through the enhanced care reference group (ECRG) and the Operational Development and Delivery Group which includes provider representatives from Accountable Care Airedale.

Reduce Bureaucracy:
Our approach to outcomes based commissioning has enabled a move away from activity based reporting, counting, and payment. For example our Local Enhanced Service specification has three domains, diagnosis, shared care and treatment. Practices are paid based on a population and are not required to report activity numbers but are assessed on outcomes delivered. This principle has also been applied to Enhanced Primary Care (EPC)

Activity Modelling:
An exercise to undertake modelling and calculate the impact of investment in pro-active enhanced primary care (EPC) could have on the system has been undertaken and has been used as a basis for calculating impact. This has informed contract negotiation in 16/17 for 2017 - 2019 contracts. To invest £5 per head in general practice it will be necessary to adjust contract activity and values and this presents some risks to the CCG:

a) In year one 14/15 despite £5 per head investment into general practice to delivery enhanced primary care the impact required to demonstrate return on investment through a reduction in A&E, Non Elective admissions and ambulance activity at a population level has not been achieved
b) The preliminary findings for year 2 do not suggest that return on investment will be realised in year 2 either
c) In view of this it is important to recognise the potential destabilising effect a reduction in contract value could have elsewhere within our local system as indications are that investment in schemes such as enhanced primary care may not actually reduce overall activity levels ***in the short term***
d) In order to robustly quantify the impact of investment in enhanced primary care schemes we need to be able to evaluate at cohort level (the target population receiving pro-active care through these schemes and whether ROI is demonstrated at cohort level). We are currently experiencing difficulty with information governance issues which are preventing analysis of anonymised data, we are working with our CSU provider to resolve these issues and are taking advice from the national Accelerate team to unblock these barriers to evaluating the impact
e) We have also received support from PIRU and hope to have independent evaluation of these new models of care
f) It is this level of evaluation that will give confidence that investment realises system benefits
g) To deliver pro-active care which in turn delivers the anticipated outcomes **takes time**; it requires a significant culture change both from a system, professional and patient engagement perspective

Example Modelling

2015-09-10-B AWC NMoC EPC.pptx

Approach to Funding Formulas:
Recognising the increasing demographic growth (see Population Projections Table), variation in deprivation indices and as a result different health inequalities and associated opportunities it is critical that we progress and develop innovative initiatives to meet increasing demand and reduce health inequalities within finite resources. This is likely to mean taking into account deprivation and health inequalities when

designing and implementing funding formulas. This approach has already been tested with our methodology to redistributing the PMS Premium funding.

With regard investment we will:

1. Agree with member practices and NHSE an approach to justify investment and redistribution of PMS premium by way of securing meaningful engagement and clinical leadership to support co-design and delivery of extended access, the GPFV and Accountable Care Airedale

2. Agree a plan with practice managers and support them to commission training to the value of the £14k allocation for signposting and document management

3. Review and implement national specifications and additional requirements relating to investment made available; such as training care navigators and medical assistants

4. Consider taking into account health inequalities when designing funding formulas

Support and grow the primary care workforce	A baseline assessment of workload, demand and supply side numbers. A plan to: - Develop initiatives to attract and retain GPs and other practice staff, and - Develop expanded multi-disciplinary primary care teams

Workforce Strategy:
A Bradford and Craven Integrated Workforce Strategy has been developed and agreed. Work streams to support delivery have been established, these are key enablers to the Accountable Care Airedale and Accountable Care Bradford Programmes. A summary of the strategy is embedded.

IWP Workforce Strategy.pptx

Predicted Population Growth:
An analysis of expected population growth within AWC over 5, 10 and 15 years has been undertaken by Public Health Analysts in the City of Bradford Metropolitan District Council.

Calculation method - applying ONS CCG resident population projections 2014 to registered practice populations (April 2016). Please see table below

The predicted population growth overall in the next 15 years is not significant, rising from 158,000 to 168,000, this equates to a 6.6% growth in the next 15 years. However the majority of this expected growth is in the over 65's hence the models of care and workforce model needs to meets the needs of older people, particularly frail elderly.

The impact of broader determinants of health, social care circumstance and levels of social care service provision is also a contributing factor to be taken into account. Local Authorities are planning and preparing for more people to have access to assisted living facilities and for packages of care to support people to remain at home. This will in turn increase demand on health services as less people move to long term nursing care and remain in local communities. Models of Care and workforce make up needs to reflect changing population demographics and offer different response through enhanced skill mix and new roles, including generic roles which take account of individuals physical, psychological and social care

needs, through this reducing reliance on GPs.
The predicted population age profile has been used to inform future workforce requirements. By breaking down further into localities we can also plan for hub working. Through the accountable care system there will be the ability to flex the workforce to target areas of most need, through this contributing to addressing health inequalities. Interestingly, whilst the Airedale locality has the largest population, over the next 15 years the predicted growth in population is fairly equally distributed within each locality. This is due to the younger makeup of the Airedale locality and predicted reduction in growth in up to 65's in the next 15 years. So, whilst currently the largest proportion of our population resides in Airedale, the growth rate is proportionately less than predicted in the other localities. This doesn't however take into account health inequalities so whilst the growth in population may be predicted to be proportionately less in Airedale, the need for services is likely to remain constant or increase as people in deprived areas are known to become sicker sooner and so demands on local practices are likely to continue to grow.

When determining workforce needs, in particular the GP workforce, we fully recognise that practices in AWC will be competing not only locally but regionally and nationally to secure the limited emerging GP workforce. In view of this we have taken as innovative an approach as we are able to, at this time, to predict our future workforce model. We are already testing the effectiveness of different skill mix and roles, for example extensivist roles, personal support navigators, physicians associates, as well as more tested roles such as psychologists, physiotherapists and nurse practitioner. We are assessing receptiveness of patients to alternative professionals being the first point of contact and will build on public and patient engagement activities, linked to self-care and self-management initiatives to support mind-set change so people understand that the GP isn't always the best or right professional to meet their needs. We will use feedback and learning to adjust plans as outcomes and benefits of these new approaches are realised.

Practice Population Projections - 2016-2031

		0-19 yrs				20-64yrs				65+ yrs			
Practice code	**Practice Name**	**2016**	**2021**	**2026**	**2031**	**2016**	**2021**	**2026**	**2031**	**2016**	**2021**	**2026**	**2031**
Craven													
B82007	Townhead	1,799	1,815	1,846	1,821	4,977	5,005	4,965	4,912	2,687	2,958	3,270	3,608
B82020	Crosshills	2,618	2,633	2,657	2,624	6,798	6,807	6,748	6,698	2,705	2,968	3,282	3,634
B82028	Fisher MC	2,731	2,747	2,767	2,734	7,810	7,839	7,772	7,704	3,556	3,912	4,335	4,810
B82053	Dyneley	2,397	2,411	2,433	2,403	7,024	7,048	6,989	6,931	2,438	2,682	2,963	3,290
Wharfedale													
B83002	I&W	834	841	848	838	2,343	2,355	2,337	2,317	1,191	1,308	1,451	1,615
B83620	Addingham	472	473	475	470	1,423	1,436	1,425	1,408	1,006	1,108	1,234	1,365
B83008	Ling House	3,226	3,241	3,260	3,221	6,625	6,618	6,558	6,523	1,617	1,774	1,976	2,192
B83019	Grange Park	1,586	1,598	1,607	1,587	3,644	3,653	3,628	3,594	1,414	1,555	1,719	1,910
B83624	IG Medical	3,699	3,729	3,764	3,717	9,619	9,627	9,527	9,450	4,844	5,355	5,990	6,680
Airedale													
B83023	Holycroft	2,647	2,657	2,675	2,643	5,694	5,690	5,628	5,597	1,755	1,923	2,134	2,369
B83027	Haworth	1,868	1,878	1,890	1,866	5,473	5,485	5,436	5,387	1,964	2,138	2,369	2,609
B83033	Kilmeny	3,455	3,469	3,493	3,451	7,813	7,797	7,713	7,673	2,056	2,253	2,499	2,760
B83061	Oakworth	704	707	711	703	2,107	2,108	2,088	2,070	692	760	841	923
B83602	North Street	2,710	2,729	2,746	2,713	3,609	3,601	3,578	3,579	391	426	479	533
B83006	Silsden	2,278	2,285	2,303	2,276	6,491	6,512	6,457	6,405	2,552	2,802	3,108	3,428
B83021	Farfield	3,181	3,196	3,219	3,180	7,367	7,377	7,304	7,255	2,249	2,465	2,731	3,021
	Total	**36,205**	**36,408**	**36,696**	**36,244**	**88,817**	**88,959**	**88,153**	**87,503**	**33,117**	**36,387**	**40,380**	**44,747**

Workforce Plan – understanding the current situation:
HEE report Q2 2016/17 (15 out of 17 practices input to HEE tool) shows that there is much variation across practices in AWC in terms of number of patients per GP, age of GP partners and the spread of other roles in general practice. It highlights that AWC faces challenge in years to come with a significant proportion of workforce roles currently undertaken by staff that are nearing retirement age. 15% of GPs are aged 55 and over and 28% of practice nurse over 55 and 37% of practice management staff over the age of 55.

GP workforce in AWC is consists of 67% GP partners, 30% salaried GPs and 3% GP registrars.

Based on current GP & Nurse establishment as reported through HEE GP Workforce Q2 July - September 2016 (NB tool has only been completed by 12 out of our 16 practices and therefore only includes data relating to these) as demonstrated in the tables below which show Full Time Equivalent (FTE) per 1,000 patients per practice, there is considerable variation across AWC both in types and number of health care professionals within practices.

Three Graphs have been extracted from the most recent HEEE Workforce Report for AWC CCG (Q2 2016/17)

Graph 1 demonstrates that overall there is a healthy ratio of clinical input per 000 patients when combining GP, ANP, Nurses and Direct Patient Care. It also demonstrates a move towards using more nursing input to complement GP care with one particular practice operating on a mainly ANP model of care.

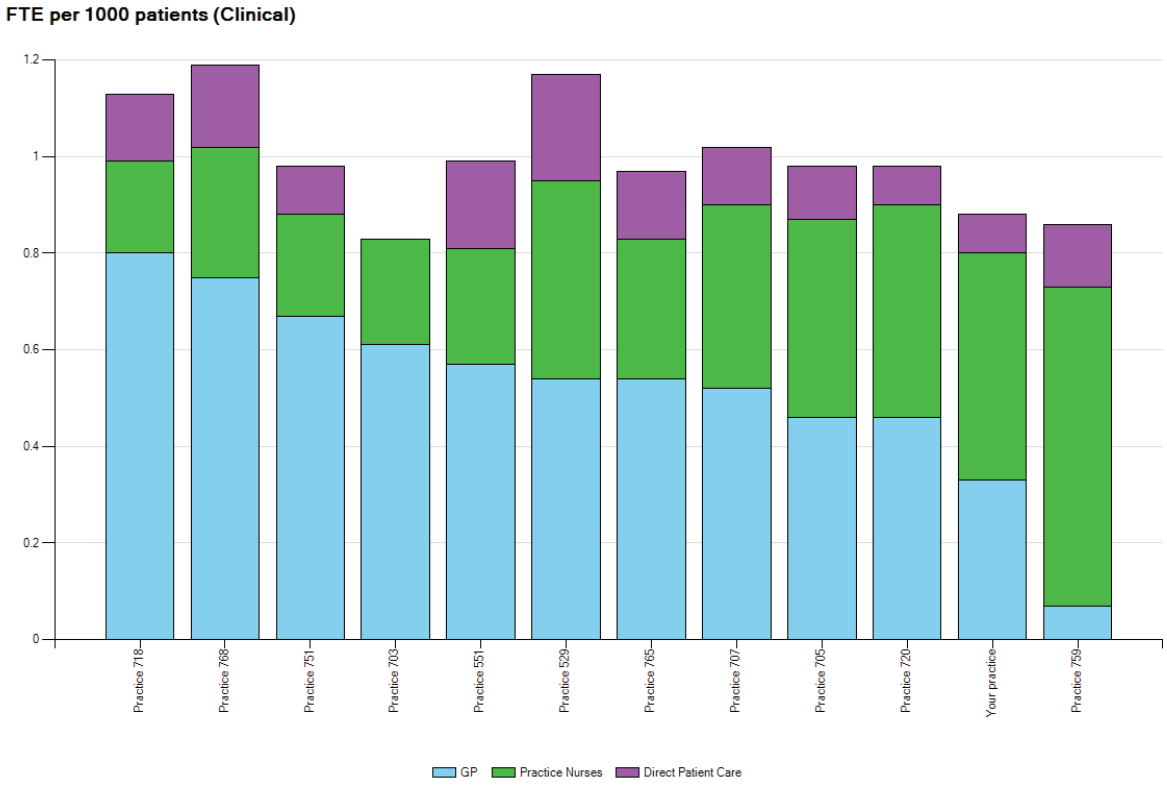
Graph 2 shows that 7 practices are providing more GP clinical sessions per 000 patients than the Yorkshire & Humber (Y&H) average, the CCG average being in line with Y&H average.

Graph 3 compares CCG practices favourably with all bar 2 practices having a higher ratio of clinicians per 000 patients than the Yorkshire and Humber average.

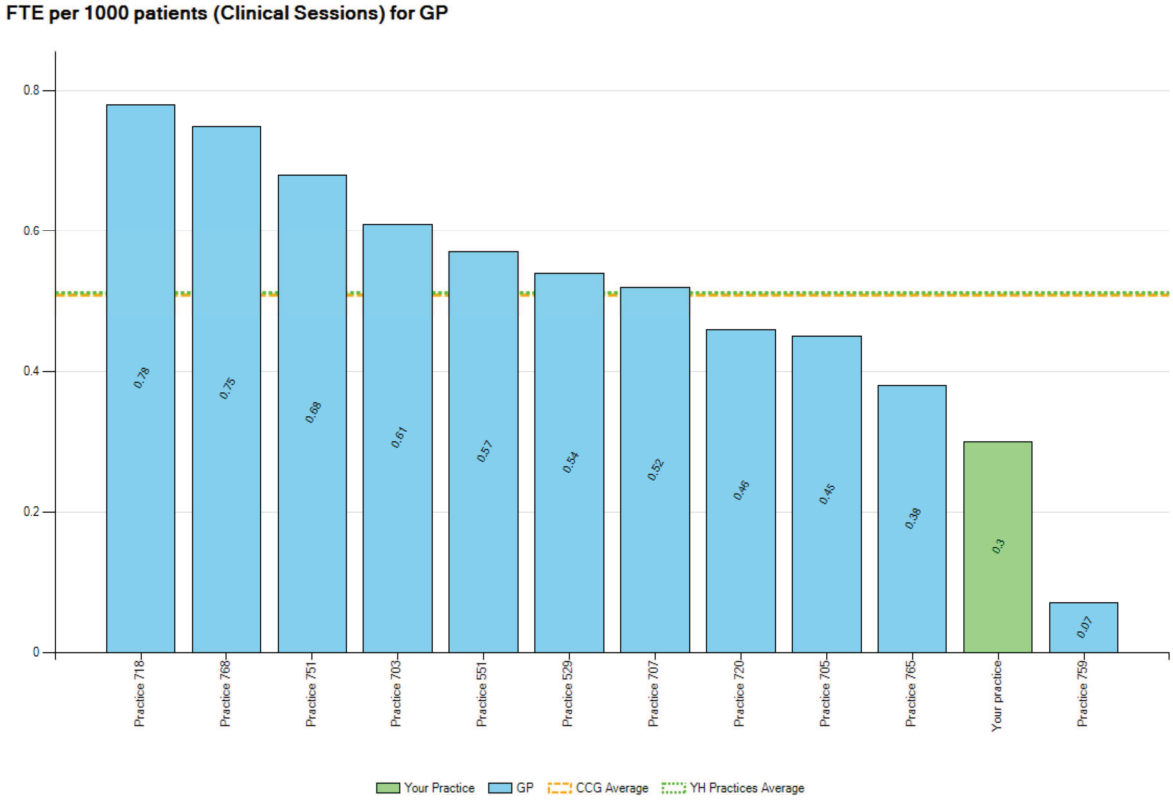
However please note the anomaly in the third graph which reports practice 759 as having 4865 patients per GP/ANP. We believe this to be inaccurate and have queried this with HEEE. This does pose some question about the quality of the data analysis in the HEEE report or practice inputting, for example the practice with an ANP model may be reporting ANP time as nursing time which may explain the anomaly.

To sense check the accuracy of the GP/patient ratio assumed from the HEEE data (excluding practice 759 as a significant anomaly) a report published by GP Online in December 2014 portrayed AWC CCG area favourably as one of the highest GP to patient ratio (1426 patient per GP) the worst in the country being 2237 patient per GP

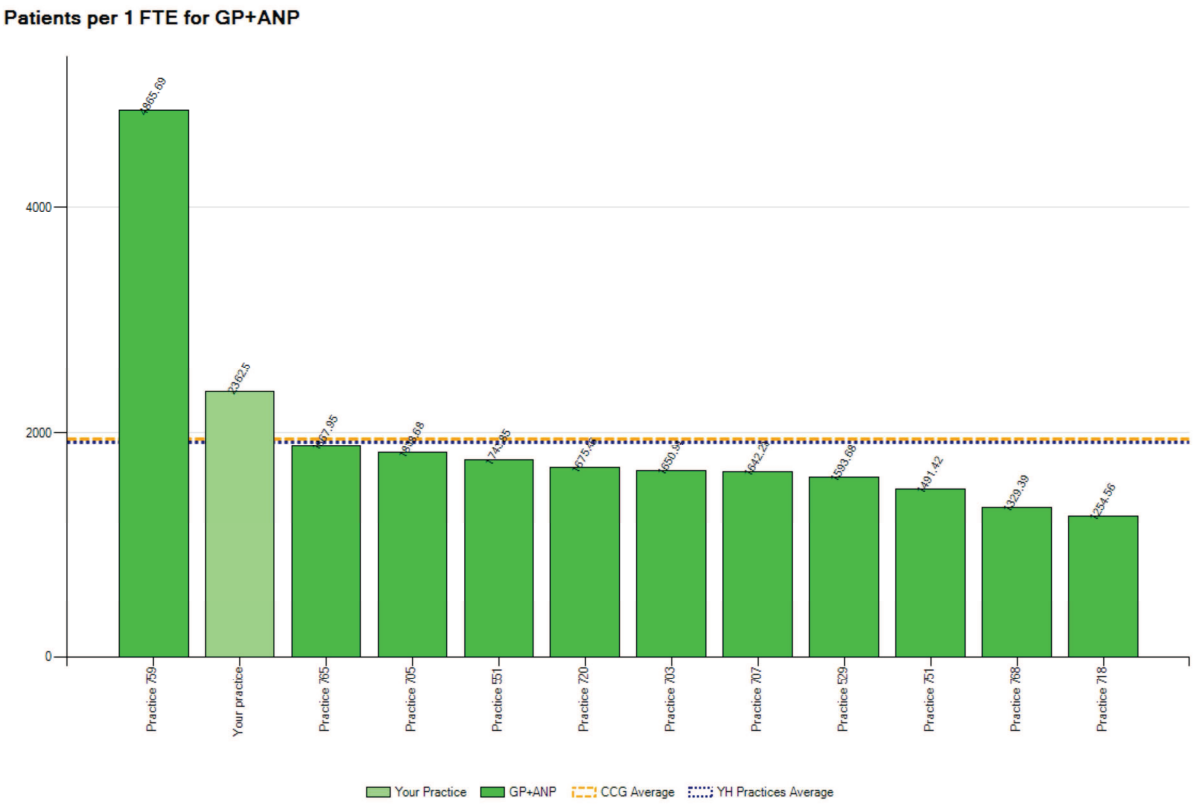
Graph 1



Graph 2



Graph 3



Future Workforce:
To deliver a system of accountable care with General Practice at the forefront the workforce strategy for primary medical care will 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.

With regard other practice staff and expanding multi-disciplinary primary care teams, the CCG has funded a clinical lead for practice nurse development on a sessional basis and has encouraged uptake locally of student nurse training placements. This experience will help encourage nurses, once qualified, to choose practice nursing as a vocation

15 of the 16 member practices are also training practices and dialogue has taken place with GP trainers who have affirmed that they and are amenable and in fact positive in contributing to support delivery of the GPFV through identifying efficiencies and opportunities to review and change the way training is delivered by them as a collaborative rather than individual practices. These individuals are potential future leaders within an ACS

Nursing Workforce:
With over 28% of practice nurses over the age of 55 the balance of recruiting new Nursing staff to be ready to fill this gap is essential. We provide training facilities/placements for pre-registered nurses to allow them to gain an interest in developing a career in Primary Care, also places for postgraduate nursing staff in Masters level Practice Nursing courses in Primary care. Funding is available within each GP practice to

recruit General Nurses to develop skills in Primary Care by career development through the HEE modular courses which are run over a 2 year period, with further funding streams being explored to encourage this investment.

The expansion of the Practice Nurse role will be undertaken using the AWC Framework for Practice Nurses which provides them with a detailed picture of the role of the General Practice Nurse. As already stated this role is wide ranging and it may take time to acquire all the competencies, but the framework will ensure a flexible, gold standard workforce that integrates into the wider MDT.

Recruitment of Health Care Assistants (HCA)by using an apprenticeship scheme to ensure extended roles, using HEE approved training courses and development of educationally robust HCA; also the development of Assistant Practitioners, sometimes known as Associate Practitioners who are a growing part of the healthcare workforce. They would take on more responsibilities than the Health Care Assistant and be under the supervision of registered colleagues.

Multi-disciplinary primary care teams:
A range of new roles such as health promotion manager (range of health promoting activities), health navigators (signposting to VCS), personal support navigators (first point of contact addressing lower level health & social care needs) and care navigators (coaching/buddying) roles are being tested locally to inform future workforce requirements. These will continue to be assessed and tested through New Models of Care. When the specification relating to the care navigators and medical assistants referred to in the GPFV is made available we will review and commit to utilising the CCG allocation to build on the roles which are working locally where this fits and deliver the requirements of the specification.
Given the predicted population growth, impending retirement of GPs and nurses and national shortage in availability of GPs and Nurses we recognise the changing workforce will require a range of roles and professionals with less dependency on GPs. In view of this we continue to design and test a range of roles to complement to general practice workforce

Examples of range of new roles being tested:

	2016/17	**2017/18**
Extensivist	2 In complex care service	Expand to 3 or 4 as role develops
Physicians Associates	In 2 practices	Expand to 5
Physiotherapy First	In 3 practices	Share learning and expand via EPC
Personal Support Navigators	5 in complex care service	Expand to EPC & Primary Care Wellbeing (subject to Pioneer Funding)
Care Co-Ordinators	In 2 practices	Expand via EPC
Wellbeing Practitioners	In 1 pilot practice	Expand via EPC
Community Pharmacy practice based	In a range of practices	Expand funded via EPC

Possible Future Workforce Model, in practice and locality hubs as part of an Accountable Care System:

The expected population growth equates to 6.6% over the next 15 years, mainly in the over 65 age range. This has been used to estimate the future workforce model and numbers; this takes account of those who may retire over the next 15 years, gaps addressed through succession planning. This model does not constitute a definitive workforce plan, it is an estimate based on the data and information available at the time of writing.

Role	2016	2021	2026	2031
GP	66.52	68	70	71
Nursing	41.92	42	43	44
Extensivist	**2**	**4**	**5**	**6**
Physicians Associate	**2**	**5**	**8**	**12**
Therapists (Physio/OT)	**2**	**3**	**4**	**6**
Personal Support Navigators / Care Co-ordinators	**5**	**10**	**12**	**15**
Wellbeing Practitioners/psychologists/MH therapists	**2**	**4**	**5**	**6**
Clinical Pharmacists	**2**	**3**	**4**	**5**
Generic Health & Social Care	**0**	**3**	**6**	**9**

A baseline assessment of workload, demand and supply side numbers:
AWC CCG and member practices do not routinely hold or collect this type of information. An assessment of patient satisfaction with access, availability of next appointment, activity levels at GP OOH, GP centre co-located with A&E and A&E attendances all give an indication of workload, demand and supply. Until there is a consistent approach across West Yorkshire and a toolkit to support collection, collation and analysis of data local approaches to ascertain this are unlikely to be meaningful or comparable.

We acknowledge that the Centre for Workforce Intelligence 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. That 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 anecdotal reporting by GPs and reliance on locum GPs because substantive vacancies have not been filled. There are several local examples of this within Airedale, Wharfedale and Craven, although some practices are reporting being successful in recruiting and retaining GPs.

Examples of practical actions were articulated in the output from the recent joint CCG, practice, LMC workshop: The plan requires further refinement. However we will:

1. Support General Practice so that is has an equal voice and is recognised as an equal partner in the developing accountable care system, This in itself will present more opportunities for development

and establishment of an innovative workforce with the right skills and expertise in place to support GPs. The GP role may become a consultative role using their expertise in the most appropriate place for the most appropriate people utilising colleagues within the primary care team as an alternative initial point of contact thereby reducing pressure on GPs

2. 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.

3. Continue to develop new roles as explain previously, and take account of the care navigator and medical assistant specification and implement

4. In partnership with Bradford 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 and Craven District through schemes such as work experience, training placements and apprenticeships

5. Through the Bradford and Craven Digital 2020 programme 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

6. In partnership with Bradford 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

7. Where resources, both financial and people, 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

8. Progress at pace our self-care and prevention programme and continue to build into specifications provider requirements to promote and implement 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

9. Review and promote the new GP Retainer Scheme

10. Tap into GP trainers as potential advocates and future leaders within the ACS, support collaborative approach to training delivery

11. Commit to developing and delivering different roles and approaches to skill mix of primary care teams. The vision is to have multi-disciplinary practice teams working across larger population areas (see super practices/ hub and spoke model) delivering a wide range of primary care services

12. Build on work to date and support practices to work together and expand and develop a range of different roles to become part of practice MDT's. These will include use of care navigators, health promotion, Physicians Associates, physio therapists and ANP's as well as GP's and GPwSI's

13. Review the range of roles being tested in the CCG through New Models of Care and build on learning, delivering the requirements of the care navigator and medical assistant specifications when made available

14. Support practices to enable additional commitment to training and development programmes, this will include development of new roles, and expansion of existing roles and will consider the role of pharmacist and physio therapist working in different ways – embedded and becoming part of general practice teams

15. Address difficulties in recruiting GP partners and heavy reliance on locums through a pro-active recruitment campaign, shared approaches to recruitment, development and promotion of local website advertising opportunities, reducing reliance on recruitment companies and associated costs of recruitment. The intention is that Yordales Federation will take an active role in this. We recognise that this may require practices contributing to the cost albeit overall reducing cost of recruitment. Through the Bradford & Craven workforce programme we will support practices, the federation and LMC to work in partnership to develop robust recruitment and retention policies which extend beyond individual practices. Advertise and plan recruitment as a system

16. Encourage practices to complete the Health Education England Workforce toolkit to provide reliable workforce data

17. Explore wider issues and reduction in number of medical students choosing general practice as a career. To be progressed through the Bradford and Airedale Workforce programme

18. Utilise 17/18 PMS premium funding to secure clinical leadership and engagement in consulting, and designing care models and access improvements through hub approach - to be delivered through partnership working and care model design group.

19. Build consensus around direction of travel for development of super practices (also see above). Progress has been made with recent mergers and we anticipate further local changes over next 12-18 months with smaller practices working more collaboratively and merging some functions with other practices

20. Support further development of a super practice approach and establishment of Keighley Medical Group. There is an appetite for this within Keighley with a likely timescale of 2 years. The intention would be to have one super Keighley practice – from one purpose built site in Keighley. A proposal has been submitted to ETTF and full business case will be worked up based on outcomes of specialised options appraisal. It may be necessary to consider progressing this without support from ETTF

21. Support the federation in developing more shared back office functions and efficient use of primary care estate

22. Evaluate and utilise learning from the Primary Care wellbeing service – Kilmeny Surgery in Keighley has established this service for their patients with long-term illnesses or chronic diseases; and who frequently visit their doctor with physical and mental health problems. The team, working in partnership with Bradford District Care NHS Foundation Trust, includes a consultant clinical psychologist, occupational therapist, physiotherapist, advanced nurse practitioner and a consultant psychiatrist. Staff work with patients to better support the patient's long-term condition or illness and improve the quality of care

23. Extend the Complex Care – Funding has been secured for a further 2 years to 2019. This service alleviates pressure on general practice through addressing complex care needs as part of our new models of care work. . The team, from Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust and Yordales (a federation of local GPs), will provide treatment wrapped around

patients' needs, in or closer to their homes to reduce their need for emergency hospital care. A unique addition to this team will be the personal support navigators (PSN) role delivered in partnership with the local authorities and voluntary and community services. The PSN will be a dedicated point of contact for these people and an integral part of the team

24. A funding request has been submitted to the National Pioneer team to secure addition Personal Support Navigator roles to expand the workforce associated with the enhanced primary care and primary care wellbeing service. Testing the added value of this role will inform future workforce requirements

25. Intermediate care hub – This was launched at the end of 2014 and has continued to be supported and developed during 2015/16 and 2016/17. The hub provides a single point of access for GPs, hospital staff, community staff and other health and social care professionals to refer patients to intermediate care services. This includes short-term hospital beds, respite care and services that give patients support in their own homes

26. We work closely with our local authority colleagues through a range of forums such as health and wellbeing boards and Accountable Care Programme Board to ensure joint strategic need assessment and to ensure plans are aligned

Improve access to General Practice in and out of hours	A baseline assessment covering local variation in access, in-hours and out of hours plus an assessment of current extended hours practices A plan to implement enhanced primary care in evenings and weekends – with a clear trajectory for delivery by 2020 A description of how wider primary care (dental, optometry, community pharmacy) will contribute to this plan A description of how the plan for access to general practice is linked into the wider integrated urgent care system including 111

In Airedale, Wharfedale and Craven through the national patient experience survey (CCG July 2016 slide pack) local people report satisfaction level in line with or indeed exceeding national levels. So we have a strong foundation upon which to improve. Satisfaction levels vary by practice and the CCG uses a quality dashboard to monitor and support quality improvement. We will continue to develop this approach.

Core hours are Monday to Friday, 8am to 6.30pm; additional capacity is available during extended opening hours and GP services co-located with the local emergency department out of hours. This includes additional GP capacity commissioned by the local acute provider as part of system resilience.

The CCG is not currently responsible for commissioning core services in core hours but it is responsible for commissioning extended services and services beyond core hours (apart from the national DES). The CCG is committed to commissioning pro-active care which is expected to reduce demand and care which meets the needs of the population through core and enhanced primary care and an effective extended hour's service. This will support the implementation of the 7 day services agenda. As part of the West Yorkshire Accelerator Zone we will design and test extended access through a locality hub approach in 2017/18 and use the learning from this to inform trajectories for 100% coverage - expanding to further locality hub models. Likely locality hubs are: Keighley Health Centre; Coronation Hospital/Springs Medical Centre & Skipton Hospital as these sites have the necessary infrastructure and access to SystemOne.

Experience from previous extended general practices service provision over weekends suggests less interest locally in weekend appointments with uptake less than expected. We therefore need to ensure public engagement and that the model of care, location and timing of future weekend provision meets need and is an efficient and sustainable model to run.

Further work will be carried out in Q4 16/17 to ascertain the needs of our patient population and to offer choice of appointments both in terms of times and skill mix on offer as part of care redesign work. We will explore delivery through locality hub/s rather than individual practices; this will offer choice to patients which is in line with the direction set out in the GPFV. General Practice is a key partner in any future accountable care system and as part of this the development of more super practices such as Keighley Medical practice across our patch will support a hub type approach, partners in accountable care delivery will contribute to the design and development of extended access to general practice through the care model design group so the scope of service may be further enhanced through this approach. At the centre of this will be commitment to deliver high quality sustainable general practice services that meet the needs of our patients.

In order to support wider access to primary medical care, adoption of digital ways of working will be supported. This will include digital access to prescription ordering, appointment booking, digital consultations (e.g. video consultations) and text messaging. 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.

Self-Care and Prevention continue to be a key programme of work. This includes social prescribing; workforce awareness and training in motivational interviewing techniques to support a culture change in the mind-set of staff and individuals; use of Community Health maps to signpost to supporting VCS services and resources; Self-Care digital solutions and personal support navigators.

What we will do:

1. Engage with our population through the New Models of Care communication and engagement programme and ascertain views and desires regarding extended general medical practice provision including extended hours over 7 days

2. Utilise 17/18 PMS premium funding to secure clinical leadership and engagement in consulting, and designing care models and access improvements through hub approach - to be delivered through partnership working and care model design group

3. Through the Accountable Care System care model design group develop an effective and efficient approach to extended GP access through collaborative hub working

4. Build on the pro-active outcomes focussed enhanced primary care and complex care models to support reduction in demand for GP appointments

5. Engage in the West Yorkshire Acceleration Zone and deliver an extended access hub using this to inform trajectories for 100% coverage

6. Work with NHS 111 and Local Care Direct to improve integrated working with the GPs co-located within A&E and primary care streaming from A&E

7. Market test and prepare for procurement of extended GP services should this be necessary

8. Establish the future of the out of hours service model post March 2018

9. Ensure that the necessary estate in AWC has access to Wi-Fi to enable agile working from partner agencies

10. Promote use of technology to support people to manage their own conditions and maintain independence

11. Increase complex care and enhanced primary care caseloads and accelerate delivery of outcomes through robust contract management

12. Ensure our providers maintain the Directory of Services to enable patients to be signposted to the right service at the right time

13. Commit to continue to reduce transactional bureaucracy to increase time available for patient care; examples of this are our outcomes focussed approach to our local enhanced service bundle

14. Access national funding which will facilitate the adoption and spread of technologies

15. Continue with the Self-Care and Prevention programme of work

Transform the way technology is deployed and infrastructure utilised	A map of current estates and technology initiatives A plan to deliver the requirements set out in the GP IT Operating Model 2016/18 A clear primary care estates and infrastructure strategy linked to the wider strategy for integrated out of hospital care Confirmation that primary care requirements have been included in Local Digital Roadmaps

There are no current estate initiatives although Keighley has been agreed as the foremost estate priority and a bid has been submitted to the ETTF for an options appraisal, business and leading to a capital finding bid. We recognise that it may be necessary for the CCG to consider funding the first 2 elements of this. We will definitely require support to progress our estate strategy and deliver locality hubs and to ensure 'fit for purpose' estate as the CCG does not have capital or recurrent funding to invest. The CCG is level one co-commissioner.

The exploitation of IT in support of General Practice has remained a constant within the district for many years now. We enjoy a unique position where all of our GP practices are using the same Clinical System (SystmOne), share the same modern central infrastructure and Community of Interest Network (COIN). Records are shared extensively across the district in Healthcare as all of our local Community Services (e.g. District Nursing, Health Visiting and School Nursing) also utilise SystmOne.

Our Local Authority has recently implemented the SystmOne Social Care Module, for Adult Social Care, and whilst this information is not shared at present we are currently undertaking a series of activities that will see the safe and appropriate two way sharing of health and social care data. This will be a huge step for the district and there is a great deal of national interest in this element of our transformational journey.

We are confident that our vision and desires will deliver the 4 key digital proposals for the NHS as laid out by Martha Lane Fox:

Reaching the 'furthest first' – making sure those with the most health and social care needs who are often the least likely to be online, are included first in any new digital tools being used across the NHS

Free Wi-fi in every NHS building

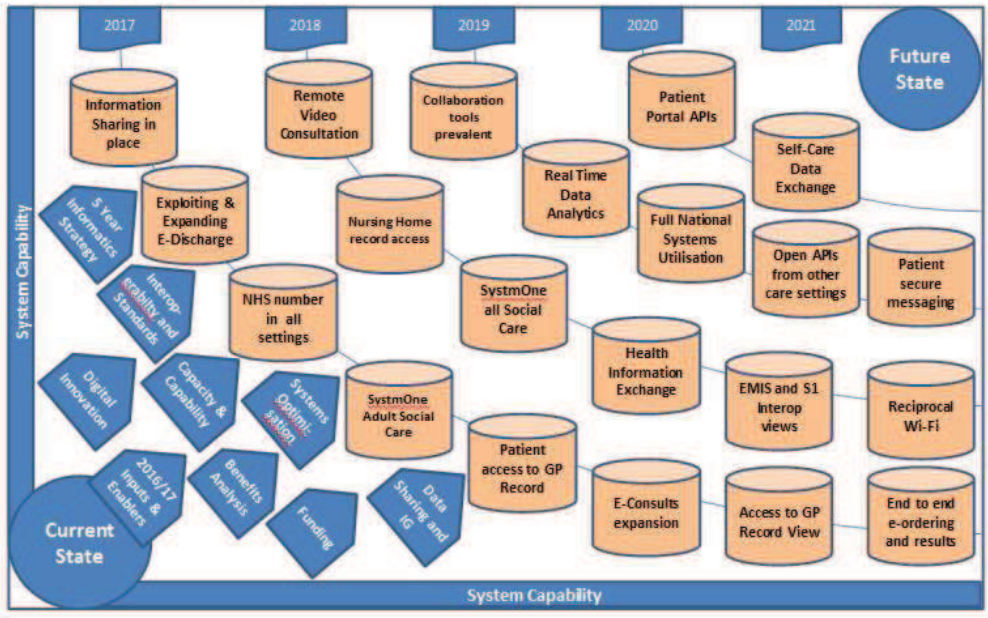
Building the basic digital skills of the NHS workforce to ensure that everyone has the digital skills needed to support people's health needs.

An ambitious target that at least 10% of registered patients in each GP practice should be using a digital service such as online appointment booking, repeat prescriptions and access to records by 2017.

Looking further ahead as our Sustainability and Transformation Plans mature they will detail an ambitious journey, alongside our primary care estates and infrastructure strategy, supporting all organisations that are key in delivering our transformation activities including the delivery of integrated out of hospital care.

Specifically in terms of IT, our Local Digital Roadmap describes our journey to an improved digital future and a paper free record by 2020/21 for all. This roadmap also reflects the requirements of the GPIT Operating Model 16-18 and highlights a plan for achieving a number of exciting transformational capabilities:

Informatics System Capability Schematic 2016-2021



We will continue to work with our GPIT Delivery Partners, eMBED Consortium, to ensure we maintain and deliver all of the core requirements set out in the GP IT Operating Model 2016/18. We have already made significant progress in a number of areas and some of these are highlighted below:

GPIT Requirement	Comment / Progress	Status / Delivered by
SMS Text Messaging	Programme already completed. Period of optimisation to follow to reduce spend via message length rationalisation.	Complete. To schedule. To complete by end 31-03-17.
Wi-Fi in GP Practices	Project request initiated with a 4 Phase approach:	

	Phase 1 – Physical installation of Wi-Fi kit in agreed strategic areas Phase 2 – Enablement of Staff and Guest (Guests will typically be from other Care Provider organisations) Phase 3 – Reciprocal Wi-Fi with ANHST, BHTFT, BDCFT and CBMDC as a minimum (others to be defined) Phase 4 – Enhanced Guest Wi-Fi services to enable Patient access including landing pages, registration, and access to health apps including Patient Online.	To complete by 31st January 2017 To complete By 28th February 2017 To complete by end 2nd quarter 2017 To complete by end 3rd quarter 2017
Patient Online	Support from NHSE continues to optimise utilisation across the district	>10% registered patients using Patient Online by 2017 Desires to achieve 25% in 17/18 and 50% in 18/19
Electronic Prescription Service (2)	Ongoing Programme of enablement supported by our IT Delivery Partner	>60% utilisation already achieved across the district. Desires to achieve at least 90% in 17/18 and 95% in 18/19
GP2GP	Ongoing Programme of enablement supported by our IT Delivery Partner	>60% utilisation by the end of 16/17. Desires to achieve 90% in 17/18 and 95% in 18/19
Electronic Referrals (ERS)	Programme of optimisation yet to be initiated with our IT Delivery Partner	>60% utilisation by the end of 16/17. Desires to achieve 80% in 17/18 and 90% in 18/19

Alongside our West Yorkshire colleagues, in support of the West Yorkshire Urgent Care (Record) Vanguard, we are undertaking an assessment of the Enhanced Summary Care Record with a view to commencing enablement in Q4 16/17 and into 17/18.

The CCGs submitted one bid against the Estates and Technology Transformation Fund (ETTF) as this is the key priority to enable delivery of Keighley Medical Group and hub working in Keighley. The bid was to undertake options appraisal, develop a business case leading to a bid for capital funding. We understand that that the CCG may now be required to fund options appraisal and business case.

The Bradford Craven and District Interim Estate Strategy in its first iteration focuses purely on primary and

community care estate as we recognise the importance of getting these core services right to enable them to be a platform for service transformation. The proposals that we put forward as part of our ETTF submission highlight this, as there is a key focus on primary care estate.

Through all of our New Models of Care programmes and participation in the National Accelerate and Pioneer work we recognise the need for core primary care to deliver safe, high quality services for our programmes to be successful. In the absence of this transformation change through an accountable care system which includes general practice will not be realised. Without strong primary care we will not be able to transform services, nor give patients the confidence and ability to self-care. To allow primary care and an accountable system to do this it must have estates that are fit for purpose and allows for different ways of working within the community. Therefore the main focus of our ETTF proposals is the strengthening of this primary care base.

We will:

1. Work with strategic partners CHP & NHS Property services to explore the possibilities and plan an alternative approach to ETTF to secure capital funding to deliver a premise solution and hub for Keighley (general practice plus at scale) and reconfiguration of existing estate to deliver locality hubs in Craven and Wharfedale

2. Work with NHS England on short to medium term plan for the provision of service to patients registered at North Street Surgery should this be required. The future for these patients will be know at the time of submitting the final plan (Now resolved)

3. Engage in delivery of the Digital Road Map through the Digital 2020 Programme (which has taken account of primary care requirements)

Better manage workload and redesign how care is provided	A plan to improve the capacity in general practice through redesign (e.g. LEAN / Releasing Time to Care) and collaboration (such as shared clinical services and back-office functions)

Practices in Airedale, Wharfedale and Craven have a track record of participating in improvement initiatives having been involved in Health Improvement Foundation programmes (formally National Primary Care Development Team) and other such initiatives. The national and international learning and experiences shared through involvement in the Pioneer programme enabled new approaches of care to be designed, developed and delivered with the aim of pro-active care reducing demand and releasing capacity. This includes through involvement of new types of workers and roles within the practices such as care navigators and physiotherapists. We have some powerful case studies which endorse this approach. This required review and redesign of ways of working, promoting services, signposting and care delivery. Initiatives such as the care home quality improvement schemes have had a significant impact on requests for GP home visits from participating care homes. AWC practices are always looking for areas to change and improve and share learning and experience through their networks, this includes our local commissioning forums. We feel we can clearly demonstrate a quality improvement culture within AWC.

The action plan to support delivery of the vision for general practice included a commitment for practices through the federation to explore opportunities for shared back office functions and use of primary care estate, for instance co-locating staff from different practices to fulfil these functions more efficiently. There is already evidence of joint working with recent practice mergers/sharing of staff roles (for example Kilmeny Surgery and Oakworth Medical Centre.

Practices have attended workshops held in Leeds which introduced the LEAN/Time to Care Initiatives. They are currently exploring the high impact change areas and those which they feel will have most impact locally and those they feel they have already undertaken. They have considered and reviewed an offer from www.gpip.co.uk to participate in a programme this year and have indicated their desire to participate in this or similar in 2017/18.

We will:

1. Support our practices to access the new national development programme (as outlined in the GPFV) to allow them to make changes which should impact on releasing capacity within the system. Opportunities will be put in place to allow practices to benefit from the Ten High Impact Actions.

2. We propose that we utilise 2017/18 PMS premium funding to support practices to participate

3. Support practices through the Yordales Federation to identify where they can access strategic workforce planning support as they have asked for this

Organisational form	A description of the current organisational form of general practice within the CCG The ambition for primary care at scale underpinned by a delivery plan A description of how the "future state" is linked to the wider strategy for integrated out of hospital care

In Airedale, Wharfedale and Craven there are 17 practices and 16 contracts, this is likely to reduce as talks are underway regarding mergers and development of large practice bases.

Practices are naturally located within three distinct localities:

Airedale:
The majority of services provided by 5 practices in Keighley which are exploring possibilities of developing a super practice - Keighley Medical Group. The remaining Airedale practices being located on the periphery of Keighley serving villages on the outskirts.

Craven:
This covers a large rural district served by 4 practices which are well suited to a hub (2 Skipton practices) and spoke arrangements (spoke being Settle, Grassington and Crosshills).

Wharfedale:
There is an appetite from some to consider the possibility of developing one super practice, less so from others.

The vision for general practice is based around hub and spoke arrangements however the degree of ambition with regard involvement in an accountable care system will determine configuration of services and organisational form. Through the accountable care system development and the Accelerate programme the appetite for the degree of integration will be determined through discussions in 2016/17. As mentioned in previous sections there is the possibility of:

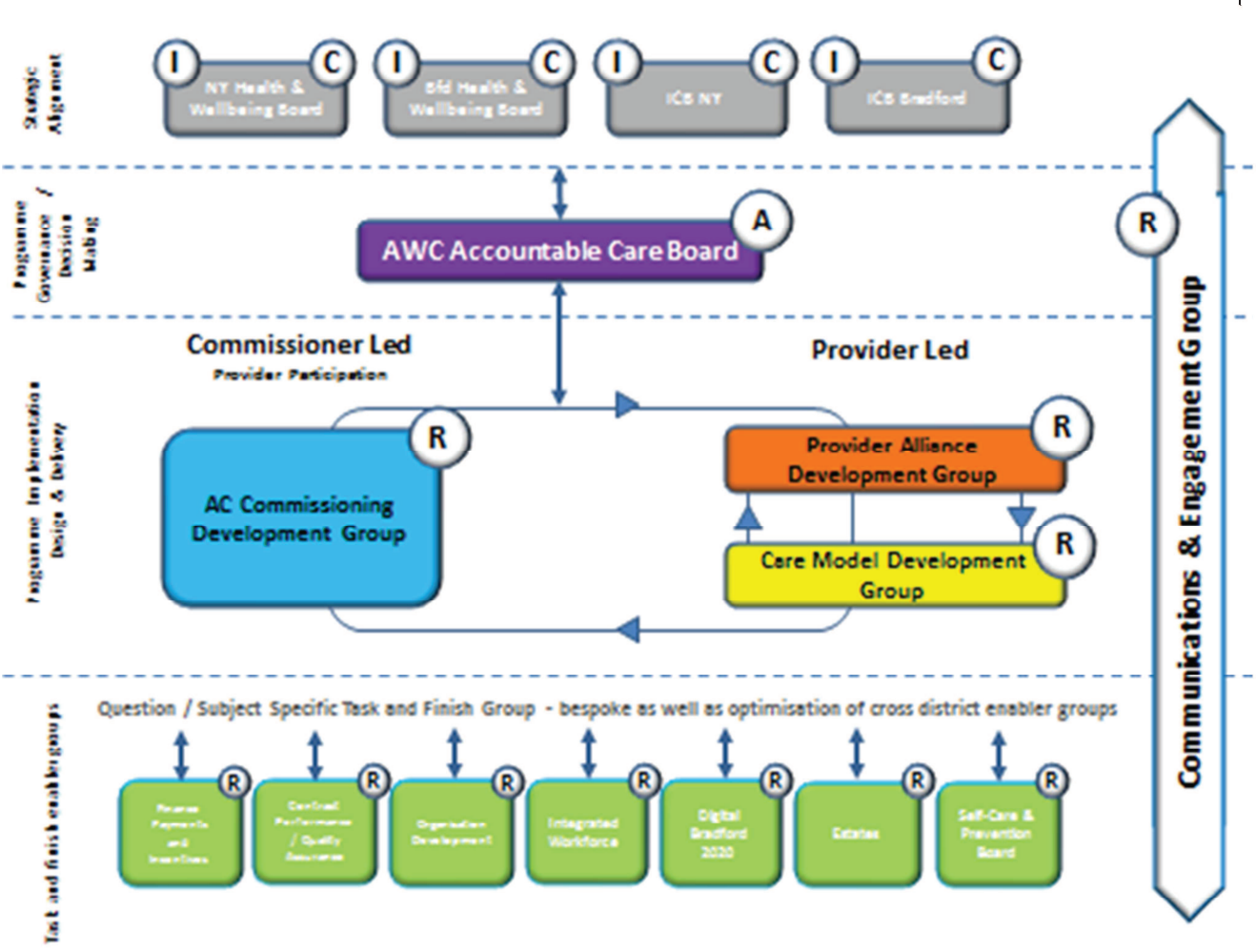
- Virtual Integration - where general practice integrates as part of the accountable care system

through retaining their GMS/PMS contracts and agreeing to an overarching integration agreement;

- A Mixed Economy/Partial Integration - where some practices suspend their GMS/PMS agreement and become an integral part of the accountable care organisation (with right of return to GMS/PMS); and
- Full Integration - where all practices suspend contracts and become part of the ACO

Through the National Accelerate programme we are exploring these options with general practice and the local system leaders and discussions will take place at the Accountable Care Board which includes the federation and YORLMC representing general practice, the provider alliance and care model design group. Exploration is in early stages and requires changes to regulations in order to progress. No clear intent has been agreed however there is involvement of key parties in exploring possibilities.

Accountable Care Governance Framework



Potential Organisational Forms for General Practice as Part of an ACS
An example for illustration purposes only follows

DRAFT FOR DISCUSSION ONLY

NHS England

Broad options for GPs participating in the MCP

1	Virtual MCP	Existing contracts remain in place, but with a new alliance agreement overlaid, binding the parties into a shared vision and integrated service / organisational model
2	Partially integrated MCP	MCP is procured to include full range of integrated services under a single contract, except core primary medical care; GMS/PMS contracts remain in operation; separate Integration Agreement between MCP and GPs
3	Fully integrated MCP	MCP is procured to provide full range of integrated services, including core primary medical care under a single contract; GMS/PMS contracts are given up or suspended

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An accountable care system will not succeed without general practice at its heart. A strong sustainable accountable care system needs strong sustainable primary medical care.

What we will do:

1. Conduct an options appraisal to identify the most appropriate model and subsequent form for primary medical services
2. Increase the level of general practice involvement in Accountable Care Airedale (ACA) discussions
3. Ensure robust involvement through Federation & LMC as general practice representatives
4. Increase the level of patient engagement in service design
5. Put in place processes to actively support the delivery of primary medical care at scale
6. Ensure general practice is key in C&E activities as part of ACA programme
7. Where procurement rules allow, have commissioning strategies that positively encourage networks of practices and stakeholders as providers
8. Ensure primary medical care services are the foundation of an accountable care system
9. Support the development of the Voluntary and Community sector to engage as one voice across the system to support improvement
10. 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

Engagement	A description of the CCG is engaging local primary care professionals (GPs, dentists, pharmacists, optometrists) and the local population and patients in the development and delivery of the Transformation Plan.

There has been continuous engagement with our stakeholders throughout the development of the Accountable Care System Programme

This includes:

- Enhanced Care Reference Group
- Integrated Service Development Group
- Practice Nurse network
- Healthwatch/Patient Networks/Practice Participation Groups
- YORLMC Ltd
- Provider Alliance
- Health and Social Care Overview and Scrutiny Committee
- Integration and Change Board
- Health and Wellbeing Board
- CCG Clinical Boards
- CCG Governing Bodies
- Specific GP engagement events
- Public Governing Body meetings

However we recognise that as discussions and the approach to the accountable care system progresses we need to establish and implement a robust and comprehensive communications and engagement plan which takes account of a broad range of stakeholders not least the public and other local primary care professionals. This will be undertaken with partners through the Communication &Engagement work stream of the Accountable Care Programme and will include representative committees for DOPs

Risks and mitigation	A GPFV project risk register will be developed with risks escalated to the corporate risk register and / or Governing Body Assurance Framework as appropriate. A description of the key risks and mitigation follows

Key risk	**Mitigation**
Finance: There is a risk that the planned transformational change does not realise expected benefits (both financial and outcomes) due to failure in planning and / or evidence base resulting in increased financial pressure and system instability	Robust planning informed by available evidence and national and international learning, modelling applied to inform realistic contract values, regular monitoring and adjustment of schemes if evidence not delivering
Access: There is a risk that GPs will not 'buy in' to rationale for 7 day services/extended hours due to existing general practice pressures, current culture, custom and practice, burn out and impact on work life balance resulting in an inability to commission	Work with Yordales Federation & YOR LMC to ascertain interest and undertake market engagement. Include LCD in discussions and model for 24/7 care. Plan for external procurement if necessary

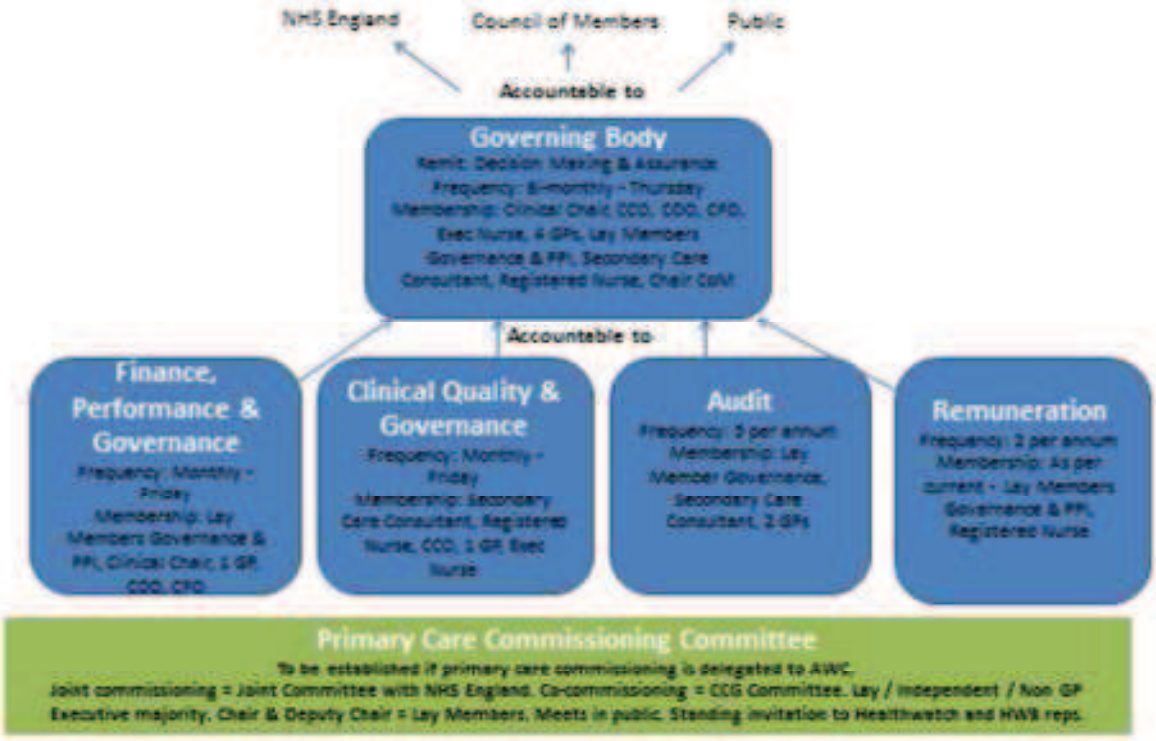
extended access locally	
Baseline information: There is a risk that the baseline information being requested as part of this plan will not be available and / or sufficiently robust due to no established system in place locally to collect or analyse such data. This may result in non-compliance with GPFV requirements and plans being designed from a flawed evidence base	Source tools and advice from NHSE or develop local approach, recognising that local approaches will not be suitable for benchmarking due to inconsistencies. This will require incentives for practices to record, collect and provide data and CCG resource to receive analyse and interpret
Access to national resources: There is a risk that national resources to support delivery of the FYFV will be insufficient due to unrecognised patient need / demand / expectations resulting in gaps and pressures for CCGs	Maintain links with NHSE Regional Team to ensure communication and information channels in place to access resources and highlight need
Workforce: There is a risk that the capacity of the future workforce will be insufficient to deliver the FYFV aspirations due to national workforce pressures and a competitive staffing environment resulting in non-delivery of services or sub optimal services within AWC	Full engagement in district and local workforce planning and establishment and delivery of robust action plan locally (including recruitment and retention). Approach NHSE & HEEE for support with strategic planning and access to expertise. AWC is a relatively attractive area in which to live and work
Delivery timeline of ACS: There is a risk that the planned timeline for ACS in 18/19 is not realistic due to optimistic planning and governance/regulatory barriers resulting in additional system pressures and an increasingly competitive provider environment	ACS programme management and commitment from senior leaders, access to expertise and support through national Pioneer and Accelerate Programme
OOH: There is a risk that GP OOH services standalone out with the planned ACS due to the contract end date of March 19 and time-line for re-procurement resulting in system and care pathway fragmentation	Task and finish group established locally and CCGs to engage in WY wide conversations
CCG resources to deliver: There is a risk that AWC CCG has insufficient staff and financial resource to deliver the FYFV aspirations and associated plan due to budgetary constraints and running costs restrictions resulting in non-compliance with GPFV requirements and weakened delivery of services	Review management structure in partnership with Bradford and identify opportunities for joint working, factor into financial plans. Utilise system resource through ACS programme and utilise PMS premium to support GP engagement
Limited evidence base: There is a risk that the plan and the ACS will not be realised or deliver the required efficiencies and improvements due to insufficient evidence base outputs resulting in non-compliance with GPFV requirements and system pressures	Utilise Pioneer and Accelerate resource and share learning adjusting approach where necessary. Utilise system resource through ACS programme and utilise PMS premium to support GP engagement
LMC challenge: There is a risk that the representative committee does not support the action plan due to	Engage via Liaison meeting, include LMC in strategy discussions, Accountable Care

perceived increase in unremunerated work for general practice and / or workload pressures resulting in non-compliance with GOFV requirements	Programme Board and Local groups such as the care model development group and enhanced care reference group
Public and Patients: There is a risk that the public do not accept new ways of working, self-care, self-management and alternatives to seeing their GP due to perceived 'drop' in standards/access to expert advice and / or unwillingness to change resulting in adverse publicity and repeated churn as people try to get access to what they perceive they need – GP appointments	Consistent messages and communications and engagement plan, consultation. Self-Care and Prevention programme and ACS programme

Governance	A description of the governance arrangements to provide the CCG with assurance that the plan is being delivered fully and on time.

Governance will be through the CCG Governance Structure with assurance and decision making at Governing Body level (please see diagram below for current arrangements)

Governance structures are currently being reviewed in light of the development of a shared senior management team and increased partnership working between NHS AWC CCG, NHS Bradford Districts CCG & NHS Bradford City CCG. This work and any revised governance structures will take account of the requirements of the GPFV.



CORPORATE GOVERNANCE OF AWC CCG

MANAGEMENT OF AWC CCG

Airedale, Wharfedale and Craven (AWC) Vision:

General Practice will operate as equal partners in an Accountable System of Care, using a resilient workforce to deliver innovative and proactive healthcare improving the wellbeing for all our population

What we will do

- Develop a sustainable and highly motivated collaborative workforce
- Promote and increase uptake of self- care and self-management
- Ensure General Practice is an equal partner in an Accountable Care System (ACS) delivering placed based population healthcare for AWC
- Tailor high quality care to the needs and lifestyle factors of our patients and communities
- Continue to implement, refine and expand our New Models of Care (NMoC)

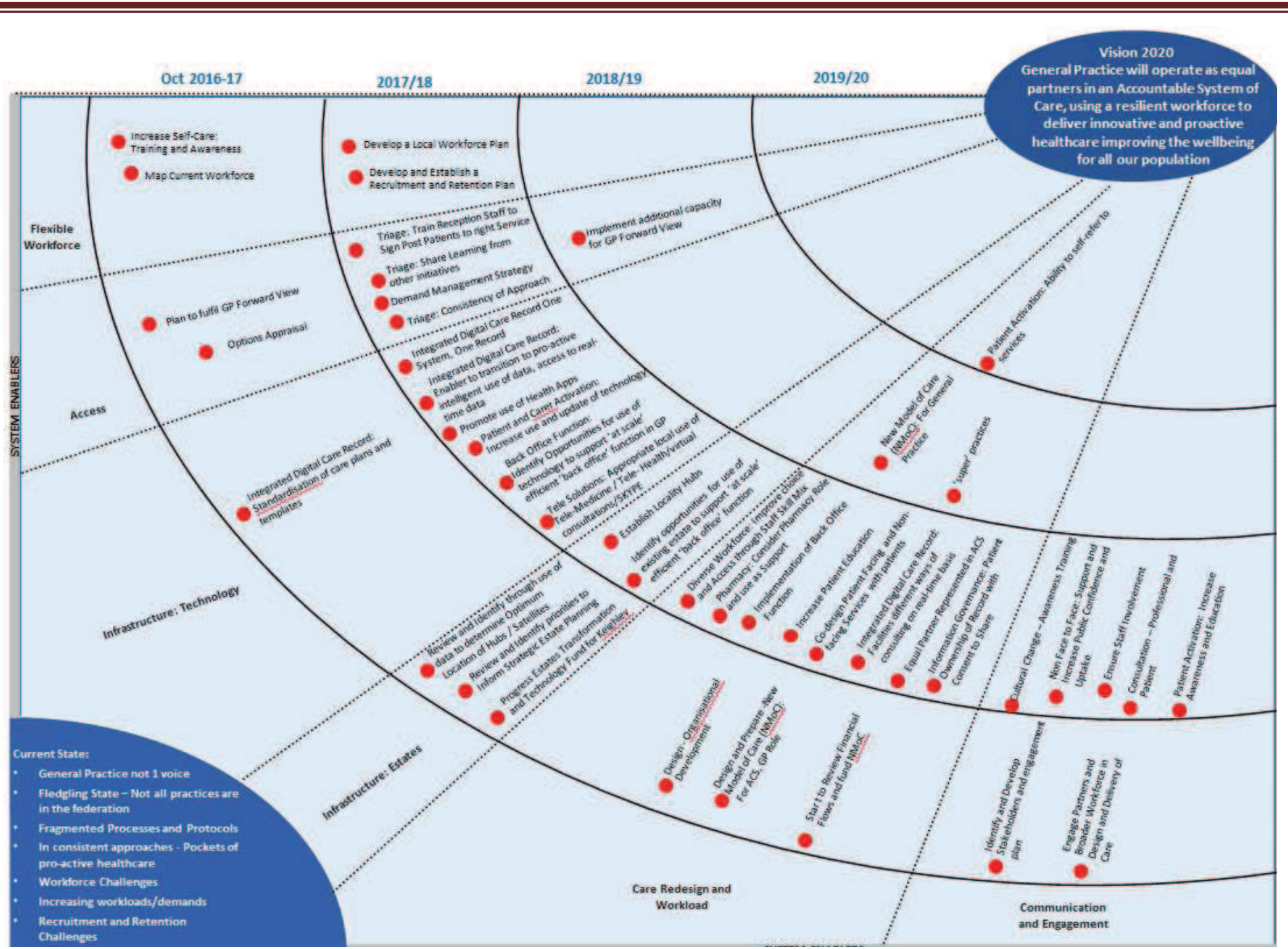
How will we do it?

The following key work streams have been identified:

- **Workforce** – Review skill mix, expand existing roles and develop new ones, pool resources, increase training and support for new workforce and fully implement recruitment and retention policies
- **Technology –** Use digital technology to support new ways of working, enable collaborative working for health care professionals, to improve access to care and ensure patients have a choice of how they access care including virtual consultations and non-face to face access. Establish a single integrated care record and sharing of care plans across providers
- **Estates –** establish hub and spoke model to deliver extended access and develop 'super' practices to pool resources, work more efficiently and promote resilience
- **Improve Access –** Support practices to work collaboratively to deliver equitable services for all, increase public awareness and confidence about range of roles and support available from primary and community services, increase choice of appointment times and types
- **Care Redesign –** Continue to develop and refine our enhanced and complex new models of care, share best practice and learning across the system, promote consistency and collaboration, co-design with service users and general practice workforce to develop new ways of working with focus on role redesign, development of 'super' practices and to promote prevention, self-care and self-management and support implementation of 10 high impact changes
- **Culture & Engagement –** Support general practice to fully engage and be an equal partner in the single place based system of care for AWC. Support workforce with change management and promote awareness and engagement with public to support progression at pace towards an accountable system of care and implementation of new models of care

What we will achieve

- Patients receive the right care in the right place from the right person the first time
- Improved outcomes for patients, people are supported to stay healthy, well and independent and have access to care and support when they need it
- An efficient and integrated place based system of care for AWC


Oct 2016-17
2017/18
2018/19
2019/20
Vision 2020
General Practice will operate as equal partners in an Accountable System of Care, using a resilient workforce to deliver innovative and proactive healthcare improving the wellbeing for all our population
SYSTEM ENABLERS
Flexible Workforce
Access
Infrastructure: Technology
Infrastructure: Estates
Care Redesign and Workload
Communication and Engagement
Increase Self-Care: Training and Awareness
Map Current Workforce
Develop a Local Workforce Plan
Develop and Establish a Recruitment and Retention Plan
Implement additional capacity for GP Forward View
Triage: Train Reception Staff to Sign Post Patients to right Service
Triage: Share Learning from other initiatives
Demand Management Strategy
Triage: Consistency of Approach
Plan to fulfil GP Forward View
Options Appraisal
Integrated Digital Care Record: System, One Record
Integrated Digital Care Record: Enabler to transition to pro-active
Integrated Digital Care Record One
Integrated Digital Care Record: Standardisation of care plans and templates
Promote use of Health Apps
Patient and Carer Activation: Increase use and update of technology
Back Office Function: Identify Opportunities for use of technology to support 'at scale' efficient 'back office' function in GP
Tele Solutions: Appropriate local use of Tele-Medicine / Tele- Health/virtual consultations/SKYPE
Establish Locality Hubs
Identify opportunities for use of existing estate to support 'at scale' efficient 'back office' function
Diverse Workforce: Improve choice and Access through Staff Skill Mix
Pharmacy: Consider Pharmacy Role and use as Support
Implementation of Back Office Function
Increase Patient Education
Co-design Patient Facing and Non-facing Services with patients
Integrated Digital Care Record: Facilities different ways of consulting on real-time basis
Equal Partner Represented in ACS
Information Governance: Patient Ownership of Record with Consent to Share
New Model of Care (NMoC) For General Practice
'super' practices
Patient Activation: Ability to self-refer to services
Review and Identify through use of data to determine Optimum Location of Hubs / Satellites
Review and Identify priorities to Inform Strategic Estate Planning
Progress Estates Transformation and Technology Fund for Keighley
Design - Organisational Development
Design and Prepare 'New Model of Care (NMoC)' For ACS, GP Role
Start to Review Financial Flows and fund NMoC
Cultural Change – Awareness Training
Non Face to Face: Support and Increase Public Confidence and Uptake
Ensure Staff Involvement
Consultation – Professional and Patient
Patient Activation: Increase Awareness and Education
Identify and Develop Stakeholders and engagement plan
Engage Partners and Broader Workforce in Design and Delivery of Care
Current State:
General Practice not 1 voice
Fledgling State – Not all practices are in the federation
Fragmented Processes and Protocols
In consistent approaches - Pockets of pro-active healthcare
Workforce Challenges
Increasing workloads/demands
Recruitment and Retention Challenges

High Level Action Plan:

In addition to the Roadmap on the previous page a summary of actions set out in this Assurance Plan follow:

Action	Forum to progress	Do once with Bradford	Timescale
Investment Plan			
1. Agree with member practices and NHSE an approach to justify investment and redistribution of PMS premium by way of securing meaningful engagement and clinical leadership to support co-design and delivery of extended access, the GPFV and Accountable Care Airedale	Council of Members & NHS England Establish new general practice engagement network		Q 4 2016/17
2. Agree a plan with practice managers and support them to commission training to the value of the £14k allocation for signposting and document management	New general practice engagement network		Q 4 2016/17
3. Review and implement national specifications and additional requirements relating to investment made available; such as training care navigators and medical assistants	New general practice engagement network		When made available. Expected Q 4 2016/17
4. Consider taking into account health inequalities when designing funding formulas	Primary Care Commissioning Committee (when established) SMT & Governing Body Accountable Care Programme 'Engine Room'		2017/18
Workforce			
5. Support General Practice so that is has an equal voice and is recognised as an equal partner in the developing accountable care system,	Accountable Care Programme and CCG support to Yordale Federation		Ongoing 2016 to 2019

6. 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.	Integrated Workforce Programme	Yes	Ongoing 2016 to 2019
7. Continue to develop new roles as explain previously, and take account of the care navigator and medical assistant specification and implement	Accountable Care Programme, Care Model Development Group – inform Integrated Workforce Programme		Ongoing 2016 to 2019
8. 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 and Craven District through schemes such as work experience, training placements and apprenticeships	Integrated Workforce Programme	Yes	Ongoing 2016 to 2019
9. 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	Bradford and Craven Digital 2020 programme	Yes	Ongoing 2016 to 2019
10. 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	Integrated Workforce Programme	Yes	Ongoing 2016 to 2019
11. Where resources, both financial and people, 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	Integrated Workforce Programme	Yes	Ongoing 2016 to 2019
12. Progress at pace our self-care and prevention programme and continue to build into specifications provider requirements to promote and implement 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	Self-care and Prevention Programme Care Model Development Group	Yes	Ongoing 2016 to 2019

health care professional			
13. Review and promote the new GP Retainer Scheme	Integrated Workforce Programme	Yes	Ongoing
14. Tap into GP trainers as potential advocates and future leaders within the ACS, support collaborative approach to training delivery	New general practice engagement network Clinical Leadership Programme		Ongoing
15. Commit to developing and delivering different roles and approaches to skill mix of primary care teams.	New general practice engagement network Integrated Workforce Programme	Yes	2017/18
16. Build on work to date and support practices to work together and expand and develop a range of different roles to become part of practice MDT's. These will include use of care navigators, health promotion, Physicians Associates, physio therapists and ANP's as well as GP's and GPwSI's	New general practice engagement network Care Model Development Group Integrated Workforce Programme	 Yes	 2017/18
17. Review the range of roles being tested in the CCG through New Models of Care and build on learning, delivering the requirements of the care navigator and medical assistant specifications when made available	New general practice engagement network		Q4 2016/17 into 2017/18
18. Support practices to enable additional commitment to training and development programmes, this will include development of new roles, and expansion of existing roles and will consider the role of pharmacist and physio therapist working in different ways – embedded and becoming part of general practice teams	Integrated Workforce Programme	Yes	Q4 2016/17 into 2017/18
19. Address difficulties in recruiting GP partners and heavy reliance on locums through a pro-active recruitment campaign, shared approaches to recruitment, development and promotion of local website advertising opportunities, reducing reliance on recruitment companies and associated costs of recruitment.	New general practice engagement network Consider application to GP resilience Fund		Q4 2016/17 into 2017/18

20. Through the Bradford & Craven workforce programme we will support practices, the federation and LMC to work in partnership to develop robust recruitment and retention policies which extend beyond individual practices. Advertise and plan recruitment as a system	Integrated Workforce Programme	Yes	Q4 2016/17 into 2017/18
21. Encourage practices to complete the Health Education England Workforce toolkit to provide reliable workforce data	New general practice engagement network		Q4 2016/17
22. Explore wider issues and reduction in number of medical students choosing general practice as a career.	Integrated Workforce Programme	Yes	2017/18
23. Utilise 17/18 PMS premium funding to secure clinical leadership and engagement in consulting, and designing care models and access improvements through hub approach	New general practice engagement network		2017/18
24. Build consensus around direction of travel for development of super practices	New general practice engagement network		2017/18
25. Support further development of a super practice approach and establishment of Keighley Medical Group.	New general practice engagement network		Q4 2016/17 & 2017/18
26. Support the federation in developing more shared back office functions and efficient use of primary care estate	New general practice engagement network		Q4 2016/17
27. Evaluate and utilise learning from the Primary Care wellbeing service	New general practice engagement network		
28. Extend the Complex Care	Completed		
29. A funding request has been submitted to the National Pioneer team to secure addition Personal Support Navigator roles to expand the workforce associated with the enhanced primary care	New general practice engagement network		

and primary care wellbeing service. Testing the added value of this role will inform future workforce requirements			
30. We work closely with our local authority colleagues through a range of forums such as health and wellbeing boards and Accountable Care Programme Board to ensure joint strategic need assessment and to ensure plans are aligned	Accountable Care Programme Board		Ongoing
Improve Access			
31. Engage with our population through the New Models of Care communication and engagement programme and ascertain views and desires regarding extended general medical practice provision including extended hours over 7 days	Accountable Care Programme Board New practice engagement network & PPRGs		Q4 2016/17 and ongoing
32. Utilise 17/18 PMS premium funding to secure clinical leadership and engagement in consulting, and designing care models and access improvements through hub approach	New general practice engagement network Care Model Development Group		Q4 2016/17 and ongoing
33. Build on the pro-active outcomes focussed enhanced primary care and complex care models to support reduction in demand for GP appointments	New general practice engagement network Care Model Development Group		Q4 2016/17 and ongoing
34. Engage in the West Yorkshire Acceleration Zone and deliver an extended access hub using this to inform trajectories for 100% coverage	New general practice engagement network Care Model Development Group		2016/17
35. Work with NHS 111 and Local Care Direct to improve integrated working with the GPs co-located within A&E and primary care streaming from A&E	Care Model Development Group		2016/17
36. Market test and prepare for procurement of extended GP services			

should this be necessary	CCG SMT		Q4 2016/17
37. Establish the future of the out of hours service model post March 2019	Accountable Care Programme Board		2018/19
38. Ensure that the necessary estate in AWC has access to Wi-Fi to enable agile working from partner agencies	Digital 2020 Programme	Yes	2017/18
39. Promote use of technology to support people to manage their own conditions and maintain independence	Digital 2020 Programme supported by: Accountable Care Programme Board Self -Care and Prevention programme	Yes	2017/18
40. Increase complex care and enhanced primary care caseloads and accelerate delivery of outcomes through robust contract management	Operational Development and Delivery Group		2017/18
41. Ensure our providers maintain the Directory of Services to enable patients to be signposted to the right service at the right time	Contract Management Boards	Yes	Ongoing
42. Commit to continue to reduce transactional bureaucracy to increase time available for patient care; examples of this are our outcomes focussed approach to our local enhanced service bundle	New general practice engagement network		Ongoing
43. Access national funding which will facilitate the adoption and spread of technologies	Digital 2020 Programme	Yes	Ongoing
Technology & Infrastructure			
44. Work with strategic partners CHP & NHS Property services to explore the possibilities and plan an alternative approach to ETTF to secure capital funding to deliver a premise solution and hub for Keighley (general practice plus at scale) and reconfiguration of existing estate to deliver locality hubs in Craven and Wharfedale	Strategic Estates Group		Ongoing

45. Work with NHS England on short to medium term plan for the provision of service to patients registered at North Street Surgery should this be required. The future for these patients will be know at the time of submitting the final plan	Resolved/Completed		Complete
46. Engage in delivery of the Digital Road Map through the Digital 2020 Programme (which has taken account of primary care requirements)	Digital 2020 Programme	Yes	Ongoing
Workload and Redesign			
47. Support our practices to access the new national development programme (as outlined in the GPFV) to allow them to make changes which should impact on releasing capacity within the system. Opportunities will be put in place to allow practices to benefit from the Ten High Impact Actions.	New general practice engagement network		2017/18
48. Support practices through the Yordales Federation to identify where they can access strategic workforce planning support as they have asked for this	New general practice engagement network		2017/18
49. See also Workforce section			
Organisational Form			
50. Conduct an options appraisal to identify the most appropriate model and subsequent form for primary medical services	New general practice engagement network National Pioneer Programme		2017/18
51. Increase the level of general practice involvement in Accountable Care Airedale (ACA) discussions	New general practice engagement network and, Accountable Care Programme - Ditto –		Ongoing
52. Ensure robust involvement through Federation & LMC as general practice representatives			
53. Increase the level of patient engagement in service design	Care Model Design Group		Ongoing

54. Put in place processes to actively support the delivery of primary medical care at scale	New general practice engagement network		Ongoing
55. Ensure general practice is key in C&E activities as part of ACA programme	New general practice engagement network and, Accountable Care Programme		Ongoing
56. Where procurement rules allow, have commissioning strategies that positively encourage networks of practices and stakeholders as providers	CCG SMT		Ongoing
57. Ensure primary medical care services are the foundation of an accountable care system	New general practice engagement network and, Accountable Care Programme		Ongoing
58. Support the development of the Voluntary and Community sector to engage as one voice across the system to support improvement	Accountable Care Programme		Ongoing
59. 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	Accountable Care Programme	Yes	