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We are really proud of our history in Bradford of investing in and developing our primary medical care services. Over the last 20 years we have been at the forefront of innovation and development, bringing services out of hospital settings to be delivered close to patients’ homes in GP surgeries.

The last few years have seen unprecedented pressures in general practice and we have not been able to resource the growth and expectations to the same level as we had previously.

To ensure Bradford remains at the forefront of primary care development, we need a strategy that responds to the current climate of workforce shortages, funding changes, increasing demand and changing demographics. We need to future proof our services for generations now and in the future.

To do this, we will commission with conviction around new models of care as part of wide scale transformational change with the move to an accountable care system by 2021. We know that this will not succeed unless primary medical care is a key partner. Evidence from international studies has shown the importance of this, especially in relation to primary medical care’s leadership and management of long term conditions.

To make primary medical care sustainable over the next five years, we will commission services at scale, starting with extended access and complex care. This will allow for primary medical care service providers to work together, sharing resources and infrastructure and will promote equity of services for Bradford people.

Over the next five years, we want to commission so that all patients in Bradford to have access to the same services, no matter where they live. This may not always be at their own practice but, with primary medical care providers working together, all patients will benefit.

The primary care development history of Bradford has hinged to a large extent on the quality of GP leadership and by seizing opportunities to develop the primary care estate and infrastructure. Our strategy is to continue to invest in leadership, management, organisational development, technology and estate. We want to improve the quality of services delivered to our patients, and investment in these areas will ensure our system is resilient and fit for the future.

We also want people to invest in themselves and their own health and wellbeing. There are a number of self-care and prevention initiatives outlined in this strategy. To deliver many of these we will work with our voluntary and community sector partners who understand our populations and have strong links with them.

We have a huge asset base in Bradford of community and voluntary groups and individuals who are more than willing to work with us. But we need to invest in them, value their services to the same extent as statutory services and establish a proper basis for doing business with them that provides sustainability for this sector.

We will ensure people who need services and those who provide them are listened to and that any changes we make are informed by what we hear. Although challenging, the next five years are also going to be exciting as we ensure primary medical care is fit for the future and the system in which it provides one of the main foundations, is sustainable.
Executive summary

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

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

To attain our end state we will focus on the following six key areas and deliver our aspirations:

- improve access
- high quality
- workforce
- self care and prevention
- collaboration
- estates, finance and contracting

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

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

In October 2014 Simon Stevens, Chief Executive of NHS England, published the Five Year Forward View (FYFV) for the future of the NHS. He put patient experience, care closer to home and moving care out of hospital settings at the heart of plans for transforming the NHS. In the Bradford District and Craven health and care economy we have interpreted this challenge in our own Five Year Forward View and more recently our Sustainability and Transformation Plan (STP), to enable the transformation required to deliver our shared vision:

“to create a sustainable health and care economy that supports people to be well, healthy and independent”.

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

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

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

This approach will be outcome based. We are not interested in merely counting activity and inputs, rather, we want to know that the care received by our population is high quality, safe and of best value and that we commission interventions that improve the population’s overall health outcome. We believe, for this to succeed, primary medical care services must be the bedrock of our system. It
is clear that without total primary medical care involvement, a fully functioning ACS would not be possible. Therefore this strategy clearly sets out our ambition to ensure primary medical care services play a full part in the development and move towards an ACS.

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

The scope of this strategy covers the entire service element of primary medical care. This includes all services deliverable under core General Medical Services and Personal Medical Services. It also includes Enhanced Services, the Quality and Outcomes Framework, vaccinations and immunisations and locally commissioned services. The scope includes services delivered at both individual practice level and delivery at scale. The scope does not include services delivered by community providers e.g. district nursing. This does not mean that there will be no interaction or influence over the commissioning of community services and this interaction will be managed by the Out of Hospital Programme Board. The delivery of the strategy relies on all elements of the primary medical care workforce, not just GPs. This includes, but is not limited to, advanced nurse practitioners; practice nurses; practice managers; receptionists; health care assistants, practice-based pharmacists and practice volunteers.

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

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

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

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

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

- stabilising core funding;
- greater influence over the NHS budget for CCGs;
- increased numbers of GPs;
- increased funding for infrastructure development;
- initiatives to tackle health inequalities; and awareness of roles and resources to support self-care.

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

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

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

The General Practice Forward View\(^3\) (GPFV) focuses on five main areas:

1. investment
2. workforce
3. workload
4. practice infrastructure
5. care redesign

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

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

The BMA’s discussion paper “General practice and Integration”\(^7\) states that initiatives to reduce service fragmentation and align organisational interests for the benefits of patients through the development of collaborative working should be welcomed. The current arrangements of competing providers and at times, rigid separation between primary medical care, community providers and social care are having a
detrimental effect on patients, with disjointed service delivery, duplication, increased transaction costs and flows of funding which create incentives that do not reflect patient needs. Our CCGs agree with this, and the work we are doing on ensuring primary medical care is the bedrock to the accountable care system is our main approach in eliminating these issues in the future.

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

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

- adhere to the 'Brown principles'\(^9\)
- ensure any changes to services will include local engagement with patients, public, carers and wider stakeholders and ensure that this includes involvement of protected characteristic groups and that equality monitoring is undertaken for all engagement activity.
- all service reviews undertaken as part of this strategy, will undertake an equality analysis.
- service contracts and service specifications will reflect the need for equality monitoring and ensure that providers demonstrate and report on how they are meeting their public sector equality duty.
- any decision making resulting from this strategy will give consideration to any identified 'impact' on protected characteristic groups and where appropriate identify and implement mitigating actions.

adhere to the accessible information standard by ensuring that patients and service users, and their carers, can access and understand the information they are given. This includes making sure that people get information in different formats if they need it, for example in large print, braille, easy read or via email. We will also ensure that people get any support with communication that they need, for example support from a British Sign Language (BSL) interpreter, deafblind manual interpreter or an advocate.
1.2 Sustainability and transformation plan

The national FYFV sets out the aim of closing three gaps in health care:

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

The NHS planning guidance for 2016/17 outlined the importance of closing these gaps, and locally this would be enacted via each area producing and delivering a Sustainability and Transformation Plan (STP). The planning guidance made it clear that a STP is not just about writing a document, nor is it a job to be outsourced or delegated. Instead it involves five things:

1. local leaders coming together as a team;
2. developing a shared vision with the local community, which also involves local government as appropriate;
3. programming a coherent set of activities to make it happen;
4. execution against plan; and
5. learning and adapting.

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

The Healthy Futures group has identified that there is still a substantial financial and efficiency gap that must be closed if health and care services are to be sustainable in the future. The financial efficiencies that have to be achieved are extremely challenging and need to be met at both a local (CCG) and sub-regional (West Yorkshire) level. Five areas are being targeted across the whole of the West Yorkshire footprint. These are:

- mental health
- urgent and emergency care
- cancer
- stroke
- specialised services

This work will take into consideration the impact on protected groups regarding access, experience and outcomes.

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

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

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

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

- Urgent and emergency care
- Out of hospital care
- Self-care and prevention
- Planned care
- Mental health & learning disabilities
- Children and young people
- Strategic estates plan
- System wide workforce
- Bradford Breathing Better

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

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

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City population:

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>123,451</td>
</tr>
<tr>
<td>2021</td>
<td>125,056</td>
</tr>
</tbody>
</table>

Districts population:

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>339,800</td>
</tr>
<tr>
<td>2021</td>
<td>352,641</td>
</tr>
</tbody>
</table>

City: 75% South Asian, 25% Other
Districts: 19% South Asian, 81% Other

0-39 years – average (England)
40+ years – lower than average (England)

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

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

How long people can expect to live:

City:

- Men: 72.6 years (5.2 years 2006/10, 6.2 years 2008/12)
- Women: 78.8 years

Districts:

- Men: 77.1 years (4.2 years 2006/10, 4.0 years 2008/12)
- Women: 81.1 years

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

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

City
- Obesity: 13.02%
- Diabetes: 9.74%
- Depression: 7.29%
- Asthma: 6.34%
- Chronic kidney disease: 2.55%

Districts
- High blood pressure*: 13.2%
- Obesity: 11.21%
- Depression: 8.02%
- Diabetes: 7.75%
- Asthma: 6.57%

*Hypertension

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

People with mental health problems

City
- 7.29% of the adult population suffer from depression

Districts
- 8.02% of the adult population suffer from depression

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

How deprivation affects health

Multiple Deprivation Index score

City
- Deprived of our practices are within the four most deprived deciles of deprivation

Districts
- Deprived of our 40 practices are within the four most deprived deciles of deprivation; none are within the least deprived decile

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

The two CCGs in Bradford have differing provider landscapes. In Bradford City CCG there are 27 separate primary medical contract holders providing care for 124,000 patients, of whom 75% are of South East Asian origin with an average list size of 4,571. The majority of the population live in the 20% most deprived areas of England.

While in Bradford Districts CCG, 43 separate primary medical contract holders provide care for 328,000 patients, of whom 19% are of South East Asian origin. 41% of the population live in the 20% most deprived areas of England with an average list size of 8,288.

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

Contract types and values

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

The majority of these contracts outlined above are held by individual practices. However, we have a number of practices who hold multiple contracts across the district (e.g. one partnership holds 5 contracts) and often in these situations patients are able to access services at any of those sites. The list size across our practices also varies, in Bradford City CCG they range from 1,573 to 9,360, while in Bradford Districts CCG the numbers are 2,933 to 25,110.

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

Practices that are likely to suffer hardship as a result in the changes can make a request for further transitional support funding. The decision to grant further transitional funding will be one for each Governing Body to make and will be done
in an open and transparent way, with YORLMC Ltd oversight to ensure fairness and equity. Practices will have to demonstrate why the change in policy has resulted in hardship. All practices with a high premium should have been planning to manage a reduction so it will be necessary to demonstrate why the shortening of the premium recovery period cannot be managed without threatening the viability of the practice. Each Governing Body was clear that it did not want to see any practice’s viability threatened as a result of the change of pace arrangements. To support this, the CCGs have provided financial support to practices to allow them to manage the changes.

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

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

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

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

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

- **Individual GP practice**
  - the main source of healthcare in the NHS is general practice, for many patients it provides the first point of contact in the health system.
  - the CCG will work with practices to support new ways of working to meet the needs of their patients and improve processes.

- **Networks**
  - there are many different sizes of GP practices within Bradford and the CCG recognises that not all will be sustainable in the future under the current level of demand.
  - the CCG will support GP practices to work together to provide services on a locality footing or share specific functions.

- **Federations**
  - this can either be through informal arrangements or by a group of practices undertaking a formal agreement to support a different way of working.
  - the CCG is supporting the practices to move towards this way of working by providing organisational development funding to allow the time and resources to do so. The establishment of the Bradford Care Alliance has been a large achievement for the practices in Bradford towards this new way of working.

- **Accountable Care**
  - See section 1.3.4.

The Bradford Care Alliance (BCA), a community interest company, was established in June 2016. This represents the provider voice of the vast majority of member practices across Bradford. This will facilitate engagement in service redesign and service delivery, as the individual voices of primary medical care are channelled through the BCA. This is a definitive step for primary medical care services in Bradford. The CCGs recognise this and therefore will work with the BCA to deliver this strategy as well as with YORLMC Ltd, the statutory body that represents general practice providers.
1.3.4 Accountable Care System (ACS)

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

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

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

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

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

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

Given the vital role that primary medical services play in out of hospital care, it is logical for the implementation of this strategy to be a key part of the Out of Hospital Programme – recognising the interdependencies with other transformational and enabling programmes (e.g. urgent and emergency care, self-care and prevention).
The case for change covers both the need to change the way care is delivered and factors which impact on the future sustainability of the system.

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

**Planning – homes and workplaces**
Bradford Metropolitan District Council is preparing a new local plan for the District (2015-2030). The plan will shape the decisions such as where new homes, jobs and infrastructure are located and which areas such as green spaces are protected. The strategy of the new local plan is contained within the core strategy while the details of which sites will be identified to deliver that strategy will be contained in several separate plans – area actions plans for the city centre and Canal Road corridor areas and the Allocations Development Plan Document (DPD) for the rest of the district.

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

- **Regional city – 27,750 new homes**
- **Airedale (includes Bingley and Baildon) – 8,450 new homes**
- **Pennine towns – 3,400 new homes (includes Queensbury, Thornton, Denholme and Wilsden).**

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

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

**Workforce challenges**
At the same time, there is an emerging workforce crisis with shortages of GPs, many practices unable to recruit doctors, and evidence that some experienced GPs are considering leaving primary medical care altogether. Bradford is not always seen as a positive place to work – not all GP training places are filled and people choose to work elsewhere. There are different levels of GP shortages across Bradford, with the most significant problems in the City area. The CCGs are aware of a significant number of practice staff approaching retirement age which will put
further pressure on the system over the next few years. However, not all GP practices submit workforce returns, this can put into question the accuracy of the data, which is designed for future succession planning. Through the district wide workforce programme, as well as a local CCG approach, we need to undertake staff development and succession planning, taking a joined up approach with local partners to reduce the number of staff moving around the wider system. This must be supported by NHS England and Health Education England. We need to show that Bradford is an exciting place to work, with lots of opportunities for work satisfaction and professional and personal development.

**Finances**

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

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

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

**Patient experience**

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

- overall experience of their GP practice and
- satisfaction about opening hours.

Each CCG is benchmarked against comparator CCGs, i.e. other CCGs that have similar populations so comparisons can be drawn. As seen in the graphs on page 23, both CCGs in Bradford can do better. We recognise that improving patient experience is a key challenge for us.

This focus on patient experience is key, as this is what will allow our system to change and adapt. Until patients experience a positive change in the way they use and experience services they will not make any changes to the way they access and utilise services. We need to ensure that their experiences of the changes we are embedding are positive, so they continue to use them as they were commissioned, this experiential behaviour will be what facilitates a lot of the transformational change within the system.
Bradford City CCG:

**Overall Experience of GP Surgery**

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Bradford Districts CCG:

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3. End state

All of the information outlined in previous sections highlights the need to change our current system. If we do not, there is a very real risk that primary medical care will not exist in 2021 – that it will have collapsed. This possible future state is due to increasing levels of demand, reducing numbers of professionals wishing to work in Bradford, unsuitable estate, financial pressures and an increasing number of complex patients all putting stress on a system based on a model designed on the state of the population over 50 years ago.

Although this has not yet been seen across the full spectrum of primary medical care, there have been pockets of failure within the NHS where quality of service has severely deteriorated and systems fall down.

To ensure future sustainability of primary medical care, we need to develop a model that will better meet the needs of our population whilst being efficient and able to deliver high quality care. Shared learning and use of best practice evidence, using both comparator sites nationally and local experience can help us achieve this. As shown in fig 1, there is a fine balance to be found between sustainability and failure and how healthcare is both delivered and received.

Fig. 1

Sustainable primary medical care = greatest desire

System integration
Co-ordination

Achieve balance

Local empowerment
Local knowledge
Close to home

Everything at scale

Excessive control
Distant from home
Loss of identity

Nothing at scale

Silo working
Lack of co-ordination

Collapse of primary medical care = greatest fear

Ref: Barry Johnson - Polarity Management
The CCGS want to establish an efficient collaborative system that provides holistic care, which ‘wrap around’ a person and empowers our population. There is more work to be done in exploring the future model of primary medical care, in partnership with Bradford Care Alliance and YORLMC Ltd as the representative organisations of our local providers. As commissioners, the CCGs wish to see by 2021 a delivery model of primary medical care that will:

- build on the strengths of current services and deliver primary medical care at scale from individual and/or networks of practices so all people have equity of service. Care delivery will continue to be based around the practice list but services delivered across aggregated list sizes of a minimum of 7,500 will enable depth and sustainability to the workforce delivering the care. Networks will vary depending upon the service delivered, with some working across footprints of 30,000 – 50,000 while other, more specialised services being delivered across wider population numbers. For example, individual practices will continue to deliver long term condition management, while seven day services and complex care services may be delivered across networks of 50,000.
- be the bedrock of the ACS as we increase the breadth of primary medical care. Learning from best practice models which stress that primary care is the lynchpin, with a focus on prevention and ability to manage long term conditions effectively.
- include workforce roles that are not currently in place via local and national initiatives, including physician associates and medical assistant roles. This will be enabled through the establishment of a Bradford Primary Medical Care Academy (or similar). It will be supported by strong retention and skill development of all staff roles including increasing the number of professionals choosing to work in Bradford by providing a positive working environment.
- deliver care from fit for purpose estate that facilitates hub-working and supports primary medical care services delivering together and with other providers (e.g. community services) to provide seamless and holistic care.
- services will be commissioned so health care professionals, other than the GP, can refer patients and, where appropriate, patients will be able to refer themselves.
- deliver care and embed technology as part of our core offer. This will be widespread across the system and will not just be operated in silos. All patients will be able to communicate with a member of the primary medical care team either face to face, over the phone, via video conferencing or via text messaging. This will offer patients the choice of how they wish to interact with primary medical care and create a flexible and adaptive service. The use of technology for self-care will also be the norm, as tools and telemedicine will be widely available.
- commission for outcomes, not activity.
- be sustainable local and (where appropriate) using national investment which will shift in resources to primary care.

Our end state must include an improved experience for patients. Using direct patient feedback from a variety of sources e.g. patient networks, complaints, People’s Board, concerns, we will move to our future position (see figures 2 and 3).

We aim to capture the varied and diverse nature of our population but recognise that we will always need to check our engagement processes reflects our diverse, shifting population.
### Fig. 2. - Patient perspectives – current state

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<tr>
<th>Concern</th>
<th>Current Experience</th>
<th>Future Improvement</th>
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<tr>
<td>I need to call at 8am to make an appointment on the day</td>
<td>When you have family, caring responsibilities or young children, trying to make a morning call for an appointment is impossible</td>
<td>I don’t feel I can plan ahead and get good advice so I wait till I am really ill</td>
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<td>I’m not sure what the role of other practitioners are so I prefer to see the GP</td>
<td>I see a different person each time so I don’t build a relationship or trust – this means I always opt to see a GP or even go straight to A&amp;E</td>
<td>I will see a different doctor or nurse each time and have to explain my long term condition again or go through different treatment options because they don’t understand my condition, my history and my circumstances and what support I really need.</td>
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<tr>
<td>I feel like I call NHS 111 and then still need to go to my doctor for reassurance</td>
<td>The pharmacist is usually my last port of call</td>
<td>My GP practice does not feel welcoming</td>
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<td>I second guess advice given by health professionals</td>
<td>If I can’t see a GP, my only option feels like it is to go to A&amp;E and wait</td>
<td>I don’t think the professionals have time to communicate</td>
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<td>I don’t feel like the GP practice treats me with respect</td>
<td>I don’t really understand why I receive the medication I receive</td>
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### Fig. 3. - Patient perspectives – future state

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<th>Current Experience</th>
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<td>I can have the information and resources to understand my own health needs</td>
<td>I can manage my own appointments</td>
<td>I can see a practitioner who is familiar with my long term condition treatment and care plan</td>
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<td>My family and carers are recognised as being key to my good health</td>
<td>I understand my treatment, condition and care options</td>
<td>I feel confident and assured in the advice and care offered by my GP practice</td>
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<td>I know in advance where I am going, what support and treatment I will be provided with and who will be my main point of contact</td>
<td>There will be friendly and welcoming people within the practice who can guide me to the best place to receive information and care</td>
<td>There will be more peer support options available</td>
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<td>I will feel confident about the treatment and care given to me</td>
<td>My local pharmacist can offer more care and treatment options</td>
<td>The help, care and treatment I receive is given to me in a timely way</td>
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<tr>
<td>The service I receive is consistent and of high quality</td>
<td>There are wider choices to access help when I need it</td>
<td>My GP practice is linked to other health and social care services that I interact with – e.g. hospital care, school nurse and care homes</td>
</tr>
<tr>
<td>There are opportunities for me to share my experiences and help other people at my practice through volunteering and getting involved</td>
<td>I can have access to the best person to help treat a minor or acute illness</td>
<td>When I move between practitioners for my care, the service can respond in a joined up way</td>
</tr>
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</tr>
<tr>
<td>I can access activities and services that support my well being and good health</td>
<td></td>
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</table>
4. Vision, outcomes and key themes

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

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

The intended outcome of the strategy is:

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

The vision will be realised through the following key themes:

- **Improve access**
  - accessible and appropriate primary medical care services for all patients both in and out of hours
- **High quality**
  - consistent, high quality and safe care delivered to all patients
- **Workforce**
  - sustainable, motivated, integrated and with the right skills
- **Self-care and prevention**
  - empower and support people to take responsibility and control of their health and wellbeing
- **Collaboration**
  - collaboration, across practices, with patients and with partners
- **Estates, finance and contracting**
  - effective estates, finance and contracting models to enable integration and positive health outcomes

The challenge for primary medical care in future will be to work collaboratively, including with other sectors to lay a strong foundation for total service transformation and the move to accountable care. We also need to break down existing boundaries and service models to deliver patient centred care regardless of the provider.

We will need to explore new and innovative ways of delivering services whilst having a relentless focus on improving the quality of care for patients by reviewing, supporting, implementing performance management and shared learning, which will allow for continuous improvement.
5. Priority themes and key elements

In this section we outline a number of priority themes which are key to the transformation of the primary medical care elements of the out of hospital care system. Each theme outlines a number of key elements which will need to be addressed in order to deliver on the vision of this strategy. We aim to deliver these against a range of challenges, which include unwarranted variation in quality, an ageing population, increase in co-morbidities, funding constraints, workforce changes, declining patient satisfaction and variation in the utilisation of secondary care. It is apparent that there are areas of overlap between the priority themes, so we need to implement the totality of the strategy to achieve our goals.

1. improve access to primary medical services
2. high quality primary medical care
3. develop the general practice workforce
4. promote self-care and prevention
5. collaborative working
6. estates, finance and contracting
5.1 **Priority theme one: improve access to primary medical services**

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

**Core Access**
Accessible same day and pre-booked appointments within core hours
Monday - Friday at all GP practices

**Out of Hours Access**
Accessible access to urgent advice / treatment seven days a week outside of core hours

**Digital Access**
Utilise and increase the uptake of digital access to services via email, video consulting and text messaging

**Extended Hours Access**
Accessible same day and pre-booked appointments seven days a week from an efficient delivery model

**Use of Technology**
Access to services will be enhanced via the use of telehealth, telemedicine, Wi-Fi (promote agile working) and development of integrated systems

People should be able to easily access appointments both in and outside of core hours. (core hours are Monday to Friday, 8am to 6.30pm). There should be no difference in quality or access to care depending upon the time or day, there should also be equity of access. In the future it will not matter where our population live or are registered within Bradford, people will have access to all of the same services. We will support this by working differently with our partners, especially the voluntary and community sector (who can provide relevant and needed services to patients outside of the medical model) to improving access to primary medical care services. This has become clearer in Bradford following the work undertaken on the Community Assets approach and published report. Work is ongoing to allow us to better realise the benefits and outcomes from this way of working. Improving access is seen as a key enabler to deliver other parts of service transformation such as the Keogh recommendations around urgent care\(^{13}\). To support this we will look at the additional elements of funding beyond core GMS/PMS to see whether this can be used differently to support access.

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

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

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

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

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

**What we will do:**

- develop an effective and efficient approach to extended access through collaborative hub working
- increase the number of GP practices offering patient online services
- support the roll out of email and video consultations by exploring and commissioning the concept of 'virtual primary medical care'
work with NHS 111 and Local Care Direct to improve access to GP out of hours in the short term, exploring direct booking into GP practices in hours and extended access appointments

- establish the future of the out-of-hours service model post March 2019
- ensure all patients have access to the same services, even if their own practice does not offer it
- ensure that the primary medical care estate in Bradford has access to Wi-Fi to enable agile working from partner agencies
- utilise technology to support people to manage their own conditions and maintain independence
- ensure our providers maintain the Directory of Services to enable patients to be signposted to the right service at the right time
- review the extended hours directed enhanced service and use of other funds (e.g. primary medical care element of system resilience funding) to support access to practices
- commit to reduce transactional bureaucracy to increase time available for patient care
- access national funding which will facilitate the adoption and spread of technologies.
5.2 Priority theme two: high quality primary medical care

Consistent, high quality and safe care delivered to all patients.

**LONG TERM CONDITIONS (LTCs)**
Improve the quality of LTC management via care planning, case management, earlier diagnosis and self-care advice

**HIGH QUALITY CARE**
Above threshold performance in key quality areas, improved performance in patient reported outcomes

**CONTINUITY OF CARE**
Improve the continuity of care by sharing of information, joint care planning and transition planning

**PARITY OF ESTEEM**
Ensure mental health needs are seen to be as important as physical health needs and are treated as so

**CONSISTENT AND SAFE CARE**
Eliminate or reduce variation in the quality of services across all practices that safeguards and promotes a safety culture through active reporting of patient safety incidents and sharing of learning

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

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

High quality primary medical care requires medicines optimisation. This is a robust plan to integrate safe, cost effective medicines use into the commissioning of all services from development to monitoring of outcomes in order to secure best possible benefits for patients from finite NHS resources. Medicines optimisation is defined as ‘a person centred approach to safe and effective medicines use, enabling people to obtain the best possible outcomes from their medicines.”

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

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

From research it is clear that:

- only 16% of patients who are prescribed a new medicine take it as prescribed, experience no problems and receive as much information as they need
- 30-50% of medicines are not taken as intended and ten days after starting a new medicine 30% of patients will be non-adherent
- sub-optimal use of medicines leads to extensive waste in the system and lost opportunities in improving health and morbidity
- medication errors occur in up to 11% of prescriptions, mainly due to errors in dosage
- around 6.5% of all hospital admissions have been attributed to, or associated with, adverse drug reactions, with up to two thirds of these being preventable
- adverse reactions are particularly common among vulnerable groups, such as, frail older patients in nursing homes
- in hospitals, the General Medical Council’s EQUIP study demonstrated a prescribing error rate of almost 9%.

- over half a million medication incidents were reported to the NPSA between 2005 and 2010. 16% of them involved actual patient harm.

High quality care for all means that we must close the health gap between people with mental health problems and those with physical health needs. Addressing mental health and psychological needs will improve the quality of life for individuals, and may also reduce the impact and costs related to ‘physical’ long term conditions, e.g. chest pain, chronic obstructive pulmonary disease and diabetes. The cost of managing a patient with diabetes and co-morbid depression is four times higher than the cost of managing a patient with diabetes alone. People must be assessed and treated for their health problems, rather than through separate services for physical and mental disorders. Psychological therapies are crucial to this. Contemporary western medicine is based on a tradition of treating mental health separately from physical health – a tendency to assume that diseases occur independently of social context. When mental health is treated as separate from physical health, the healthcare experience is often stigmatized and the care process is fragmented. Depression, the most common mental health condition seen in general practice, often occurs with, and compromises, care of other chronic illnesses; yet stigma and secrecy often cause depression to go undetected, undiagnosed, or under treated. We will ensure that the outcomes defined as part of an ACS take account of individuals physical, psychological and care needs and mental health is equally as important as physical health. Through the delivery of the GPFV we will take advantage of the extra 3,000 mental health therapists which the document outlines will be in place by 2020. The aim of these is to support localities to expand the Improving Access to Psychological Therapies programme.
Throughout our work to deliver the primary medical care strategy we will maintain close links with the mental wellbeing strategy for the District, as many of the actions taking place under its remit impacts on primary care. For example, the mental wellbeing strategy includes a drive to improve the knowledge and awareness of mental health within the primary care workforce to enable a more holistic approach to patient management. It also outlines plans to develop a model of integrated physical and mental health services whereby people can have their care needs met at the same location as part of an agreed pathway of care, which will involve primary medical care services.

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

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

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

What we will do:

- provide opportunities for peer review and learning from other services
- provide medicines optimisation opportunities within primary care, focussing on LTCs
- ensure all patients with an identified need for a care plan have one
- commission pathways which support system approaches to the management of and early diagnosis of conditions and self-care management strategies
- support the delivery of parity of esteem by commissioning services which ensure people are treated holistically for their health problems, linking closely with the delivery of the mental wellbeing strategy
- commission services which are outcomes based on evidence-based clinical guidelines/best practice
- through the GP Joint Quality Group, develop a work plan to deliver against areas which need greatest improvement and/or have the highest unwarranted variation
- use the contract assurance process to support reductions in variation and quality improvements, ensuring equality monitoring data informs this work
- use the contract assurance process to support reductions in variation and quality improvements within prescribing
- promote and establish a patient safety culture to ensure all practices report patient safety incidents and learning from incidents is transparently shared, including those of medicines safety
- commission evidence-based support tools to use in primary medical care (e.g. Map of Medicine) to drive and support consistent, high quality care to deliver the best outcome for patients using the service
- maintain strong links with the mental wellbeing strategy and embed the actions relevant to primary medical care services.
5.3 Priority theme three: develop the primary medical care workforce

Sustainable, motivated, integrated and with the right skills.

**SUSTAINABLE WORKFORCE**
Appropriately resourced with a manageable workload both today and in the future

**INTEGRATED WORKFORCE**
Integrated multi-disciplinary teams in an accountable care system with general practice at the core

**EVOLVING WORKFORCE**
Use of other clinical and non-clinical professionals outside of traditional roles

**SKILLED WORKFORCE**
Staff have and retain the right skills to do their job and have plans for personal and professional development

**MOTIVATED WORKFORCE**
Staff who feel valued and empowered and who promote working in Bradford

Workforce planning in the NHS states\(^6\) that there are large data gaps on key areas of the workforce, particularly in primary and community care. This is in part due to the reluctance of many GPs to share workforce data with commissioners and workforce planners but, through our GP Joint Quality Group, we will encourage more practices to complete workforce data to allow for more accurate succession planning in the future.

The Centre for Workforce Intelligence\(^1\) has said that there is likely to be a significant undersupply of GPs by 2020 unless immediate actions are taken to redress the imbalance between supply and demand, as well as increasing training numbers for longer-term sustainability. Over the long term, the rate of increase in the number of GPs has also been dramatically outstripped by increases in the medical workforce in secondary care. An indicator of this locally has been heavy reliance on locum GPs because substantive vacancies have not been filled (which is especially the case with Bradford City CCG). Bradford Districts CCG has above the national average (England) of GPs per 100,000 population (53.21 compared to 51.20). However, Bradford City CCG is much lower with 43.81 GPs per 100,000 population. We have to make sure that our processes and pathways recognise the all member practices to submit a full suite of workforce indicators so that we can plan effectively for the future.

The total number of GPs in England has increased by 2.3 per cent, from 31,356 in 2010 to 32,075 full time employment in 2013, but modelling by NHS England and the Royal College of General Practitioners (RCGP) has demonstrated that this rate of increase will not even come close to meeting future demand (Health Education England 2015). To ensure a comprehensive picture is developed and to plan effectively for the longer term, the anticipated impact of retirements from service also needs to be taken into account. As part of our contract management, we will encourage...
high use of locum GPs within Bradford. Often implementation of new pathways can be negatively impacted upon as we do not communicate these changes appropriately to locum GPs. We need to work with our primary medical care providers to understand how we mitigate the risks around this. We need to understand how we improve our communication links from both the CCG and also internal mechanisms within primary medical care providers to ensure all staff groups are aware of our pathways and processes.

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

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

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

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

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

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

**What we will do:**

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

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

**PREVENTION**
System wide leadership and collaboration to drive healthy lifestyles, with a particular focus on children and young people

**SKILL DEVELOPMENT**
Ensure our workforce have the skills to educate and inform patients about self-care

**PEOPLE POWER**
Our population have the tools, techniques and confidence to aspire to live well

**NEW MODELS**
We commission new ways of providing and promoting prevention and self-care services to our communities

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

- give people the right tools and resources to self care and live a healthy life
- support health and social care staff to develop the skills to empower people they work with
- make self-care and prevention a priority across organisations and programmes.

General practice is overstretched and demand is growing with high numbers of patients seeking advice on social and emotional issues rather than medical or mental health problems. The Citizens Advice Bureau survey of 1,000 GPs in February 2016 estimated that the financial cost to the NHS from non-health demand on GPs is at least £395m. This represents more than 5% of the NHS England budget for general practice and is equivalent to the salaries of 3,750 full-time GPs and 19% of GP consultation time. The report also shows that three-quarters of GPs say that the proportion of time they spend dealing with non-health issues as part of consultations has increased over the past year and this affects their workload and quality of life. Self care and prevention work can support general practice to deal with some of this demand, for example by using social prescribing.

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

- social prescribing – a means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker. The link worker will provide with a face to face conversation during which they can learn about the services available and design their own personalised solutions, i.e. ‘co-produce’ their ‘social prescription’. This will empower people with social, emotional or practical needs to find solutions which will improve their health and wellbeing, often using services provided by the voluntary and community sector (VCS). We plan to commission a new service in general practice to support people with their social and emotional needs.
workforce – to deliver a range of learning opportunities to support staff to empower patients to self-care. For example, motivational interviewing training and new training for reception staff and health care assistants on self-care and active signposting.

self care hubs – we plan to co-design and transform underutilised health and community centres to offer a wider range of holistic health and wellbeing activities and services. The hubs will work with the voluntary and community sector, local people and self-care initiatives such as social prescribing to connect health and care services together.

self care digital solution – develop a new tool to provide the public, patients and the health and care workforce with a simple and accessible online digital platform to promote self-care and support people to manage their own health and wellbeing.

practice health champions – creating 'community centred practice' through volunteering and patient involvement. We have commissioned a further ten practices to implement the practice health champion model. 21 practices are now delivering the model and Bradford is now the largest city in the UK to deliver this approach.

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

What we will do:

work with the self-care and prevention programme to ensure that we align to wider work happening across health and social care and to provide consistent messages about self-care to local people.

provide our workforce with the tools needed to promote self-care and accelerate positive behaviour change towards prevention and self-care in the population. this will include e-learning, self-care and active signposting and intensive motivational interviewing and behaviour change techniques.

ensure that self-care is embedded within care pathways which are delivered in primary medical care.

support the self-care and prevention elements that are driven from our strategic priorities and programmes.

support the development of primary medical care staff being advocates for wellbeing by providing key healthy lifestyle choices, including smoking cessation, weight management and reduction in alcohol consumption.

promote screening programmes – cancer and general health checks, to encourage earlier presentation and earlier diagnosis.

commission preventative services.

review the delivery of immunisation programmes, looking for gaps in provision and promoting centres of excellence.

promote self-care principles and techniques as the first choice of action for many health care concerns.
5.5 Priority theme five: collaborative working

Collaboration, across practices, with patients and with partners.

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

This strategy is not promoting one single model for delivering primary medical care at scale, but is promoting a move away from the current establishment of small independent businesses working out of multiple sites. We will work with our practices to support the evolution of a new primary medical care model. This does not mean that there will one model for primary medical care in Bradford in the future, but that we ensure the sustainability of primary medical care. We will retain the list based model but we will commission services from single or aggregated lists of 7,500 and above, to allow for depth and sustainability of practice. Practices will also work within networks and federations. Federations and other collaborative networks are an important way of enabling primary medical care organisations such as GP practices to provide a wider range of services, while at the same time offering the benefits of a smaller organisation, such as convenient location and continuity of care. For example, we will commission locality services across networks of 30,000 – 50,000 patients and more specialised services will be commissioned over wider footprints of 100,000 and above. Services such as extended access and GPs with specialist interest services will be commissioned at scale.

The above principle will be considered in relation to the CCGs’ use of APMS contracts. In the past, when a provider has ceased working (for a variety of reasons) the CCGs have often re-contracted the service via APMS, but in the future the strategic aim of primary medical care at scale will be considered when the CCGs are considering the procurement of an APMS contract. This may include different contracting arrangements.
To ensure a model that is better placed to meet the needs of our local populations, both now and into the future, we will explore options for delivering primary medical care services in the most effective and efficient way that best addresses the current and predicted workforce and demographic challenges we face. This needs to take into consideration the role of primary medical care in the development of an ACS in Bradford. We need to ensure that primary medical care is the bedrock to the ACS otherwise the system will not work. Primary medical care has to be able to collaborate to fulfil this. An ACS would not work if practices were disengaged or were represented as sixty plus separate voices through many separate voices. Therefore through the ACS, the CCGs will award single contracts through alliance agreements. Work is already underway in Bradford in regards to working differently with each other within primary medical care. Federations of practices are already providing services to their populations of patients, and the development of Bradford Care Alliance allows our federations to come together as ‘one voice’ when appropriate. This is happening as primary medical care providers are aware of the need to make services sustainable in the long term and the CCGs need to support this as part of the move to an ACS.

Another step will involve delegating resources to primary medical care providers operating at scale. Therefore, we will continue to work with our primary medical care providers in the development of the ‘at scale’ model. The CCGs believe the development of Bradford Care Alliance will support this and want to ensure that this is sustainable in the future. To support this, primary medical care funding flows will change. For example, some of the national funding outlined in 5.6 could be delegated to either Bradford Care Alliance or federations rather than individual practices. This will change relationships with how providers of NHS services work together.

It will reduce the need for competition and will allow an increasing focus on prevention and self-care, providing patients with the choice of how they manage and receive their care. This should also impact on workforce and demand, as the GPFV\(^3\) states that 27% of appointments would not be needed if there was more co-ordinated working between primary medical care and hospitals.

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

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

Primary medical care practitioners do not only need to collaborate with each other, they also need to collaborate with patients and patient representatives. We want to establish a true culture of co-production with patients and patient participation groups. We do not want to blame
patients for living in high levels of deprivation, or having lower levels of educational attainment, but work on strong, cohesive and resilient population to develop health services. Getting true patient buy-in building the relationship between the practice and patients is key to helping develop a strong, resilient primary medical care system at scale.

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

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

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

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

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

What we will do:

- through our commissioning processes we will increase the level of patient engagement in service design and primary medical care decision making which is inclusive and reflects our local population
- establish processes (including funding) to actively support the delivery of primary medical care at scale
● develop commissioning strategies that positively encourage networks of practices and stakeholders as providers
● embed this strategy in the future of primary medical care contracts
● ensure primary medical care services are the foundation of the accountable care system
● support the development of the voluntary and community sector to engage as one voice across the system to support improvement
● develop a thorough understanding of relevant regulatory and legal frameworks and provide solutions relating to indemnity in respect of working outside of core hours and providing care for patients registered elsewhere
● 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 in Bradford.
5.6 Priority theme six: estates, finance and contracting

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

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

As outlined in 5.1, the use of technology will alter the way our populations access services and the way staff across the health and social care system deliver care. For example, installation of Wi-Fi in GP practices will enable patients to access their own records and staff to work flexibly across sites. These changes will benefit both our population and staff, improving the experience of both the delivery and receipt of primary medical care.

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

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To undertake real transformational change we will look to different ways of contracting and commissioning. We will maximise the opportunities placed before us via delegated commissioning, with primary medical care leading the way and shaping the new models of care that we plan to deliver. This will be key in the ACS, where a new contracting model can provide the opportunity to work collaboratively around workforce, service delivery and the holistic care of patients. Through delegated commissioning we can use primary medical care resources differently, focussing on the delivery of our strategic priorities and to build in sustainability. We will use our delegated responsibilities to ensure that GP practices are treated fairly in regards to contracting discussions. We will follow agreed policies regarding list closures, list reassignments and boundary changes. We will make sure no patient or patient group is disadvantaged, ensuring patients always have a choice of where they register to receive primary medical care services.

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

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

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

We will implement the outcomes of the equitable funding review without destabilising primary medical care, whilst improving the service offer. We will ensure that the resources we have are fairly distributed to reduce unwarranted variation and health inequalities. To further support practice sustainability, the GPFV3 assumes additional investment from CCG allocations into primary care over the period to 2020/21. Taken together with increases in allocation for primary care and central investment in general practice, it is expected that the overall share of the NHS budget going to primary care will increase over the period to over 10%.

As outlined in the GPFV3 we are planning to spend approximately £3 per head (totalling £1.4m non recurrently locally) across 2017/18 and 2018/19 for practice transformational support, set out in the GPFV3. The investment will be used to support the roll out of extended access across both of the Bradford CCGs. As part of the West Yorkshire Urgent and Emergency Care Acceleration Zone the roll out will be accelerated and the £1.50 in 2017/18 will be used to commission services (likely via hubs) across the patch. Initial delivery will be from April 2017 and this will be expanded in 2018/19 with the use of the £3.34 from national funding, plus the £1.50 from the CCGs. Both CCGs have already provided financial resources to support the development and maturing of the federated approach being taken forward by practices in Bradford.

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

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

- **vulnerable practice scheme**: we are in discussions with NHS England in regards to five practices which we feel would benefit from access to the vulnerable practice funding currently. We recognise that this funding allocation has now been committed so there will be no further opportunities to access this.

- **online general practice consultation software systems**: Bradford Districts CCG expects to receive £88,661 in 2017/18 and £118,104 in 2018/19 to support the role out of this work. Bradford City CCG expects to receive £32,025 in 2017/18 and £42,618 in 2018/19. The CCGs will be clearer on the detail of the work to be done on publication of the national specification and monitoring arrangements but expect this to be non-recurrent.

- **training care navigators and medical assistants**: Bradford Districts CCG expects to receive £59,107 in 2017/18 and £59,052 in 2018/19 to support the role out of this work. Bradford City CCG expects to receive £21,350 in 2017/18 and £21,309 in 2018/19. The CCGs will be clearer on the detail of the work to be done on publication of the national specification and monitoring arrangements but expect this to be non-recurrent.

- **general practice resilience programme**: we recognise that this funding will be delegated to local teams. A number of our practices have self referred against this funding pot and we will work with NHS England to identify those who will receive support as we believe there is a great need for this investment within Bradford. We would like to see West Yorkshire wide work being taken forward around workforce, including baseline information collection. On a local footprint we would be keen to utilise this funding to support the development of local sustainability initiatives, such as a local locum bank which all practices could utilise.

- **estates and technology transformation fund (ETTF)**: Bradford Districts CCG submitted eight schemes against the ETTF, seven of these are being taken forward into the next stage. All seven of these relate to improving GP premises to allow for better patient experience and improving patient access. The technology bid aims to provide the public, patients and the health and care workforce with a simple and accessible online digital platform to promote self-care, support people to remain independent and to manage their own health and wellbeing. Bradford City CCG submitted six schemes, three of which have been taken through to the next stage. These are a mix of estate and technology proposals, and go beyond improvements to GP estate. These include the establishment of self-care hubs and the roll out of Wi-Fi in GP practices to support both patients and flexible working for community staff. We will work with the national team to undertake the work needed to further all of these proposals.

- **reception and clerical staff training and online consultation systems**: The CCGs have received the first allocation of this funding and we have plans are in place to roll out training from January 2017. The plans for the existing and future allocation have been developed in conjunction with general practice and in the first instance are looking at ‘signposting with confidence’ training for receptionists.

- **international recruitments**: Bradford City CCG looks forward to receiving further information this year regarding international recruitment as the CCG would benefit from the recruitment of new doctors. The national average (England) of GPs per 100,000 population is 51.20, while this is much lower
6. Expected benefits and local metrics

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

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

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

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

The delivery of this strategy will also support the achievement of our sustainability and transformation plan and the local delivery of the GPFV. The different areas of focus outlined in this strategy all align with elements of the GPFV and support the closure of the health and wellbeing gap, care and quality gap and the finance and efficiency gap.
7. Enablers

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

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

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

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

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

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

This engagement with member practices will continue through the implementation of the programmes of work that are defined within this strategy predominantly through the out of hospital programme, but also via other programmes, including self care and prevention, planned care and urgent and emergency care.

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

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

- using existing patient networks and groups, using feedback from previous events
- Healthwatch Report – invisible at the desk
- patient participation groups
- grassroots process
- social media / online survey monkey
As with member practices, engagement with patients and public will continue through the future implementation phases and structured collaboration. Where there are potential service changes patients will be engaged in the process and be involved in co-production of key work priorities. Consideration will be given to the impact on patients and our populations in regards to any changes made, especially relating to protected groups.
9. Summary

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

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

## Appendix 1 – Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACS</td>
<td>Accountable Care System</td>
<td>Care system to improve health of a whole population across community and hospital care, physical and mental health. Focus is on outcomes and joined up health &amp; social care services that simple, accessible and responsive to needs. Care is personalised using community assets and agreed payment schemes to support joint commissioning.</td>
</tr>
<tr>
<td>ADPD</td>
<td>Allocations Development Plan Document</td>
<td>The ADPD supports the delivery of the Core Strategy. It allocates specific sites to meet needs for housing, employment, education, shopping and open spaces in Bradford District.</td>
</tr>
<tr>
<td>ANP</td>
<td>Advanced Nurse Practitioners</td>
<td>An ANP makes autonomous decisions for which they are accountable and receive patients with undifferentiated and undiagnosed problems, make an assessment of health care needs and prescribes accordingly.</td>
</tr>
<tr>
<td>APMS</td>
<td>Alternative Provider Medical Services</td>
<td>A contracting route available to enable CCGs to commission or provide primary medical services within their area to the extent that they consider it necessary to meet all reasonable requirements.</td>
</tr>
<tr>
<td>AQP</td>
<td>Any Qualified Provider</td>
<td>CCGs determine the services to be commissioned as AQP; the intention is to increase patient choice. All providers must meet the qualification criteria set for a particular service and once qualified their service will appear on choose and book for patients to select.</td>
</tr>
<tr>
<td>BCA</td>
<td>Bradford Care Alliance</td>
<td>A Community Interest Company (CIC) established in June 2016. Represents the provider voice of the vast majority of member practices across Bradford.</td>
</tr>
<tr>
<td>BBB</td>
<td>Bradford Breathing Better</td>
<td>A CCG programme to raise awareness about respiratory issues such as asthma, COPD etc.</td>
</tr>
<tr>
<td>BDCft</td>
<td>Bradford District Care NHS Foundation Trust</td>
<td>Provider of mental health, learning disabilities and community health services across Bradford, Airedale and Craven.</td>
</tr>
<tr>
<td>BHWB</td>
<td>Bradford Health and Wellbeing Board</td>
<td>The Health and Social Care Act 2012 established Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. As a result, patients and the public should experience more joined-up services from the NHS and local councils.</td>
</tr>
<tr>
<td>BMDC</td>
<td>Bradford Metropolitan District Council</td>
<td>Provider of social care, reablement and rehabilitation services, public health services across Bradford and Airedale.</td>
</tr>
<tr>
<td>BPMCA</td>
<td>Bradford Primary Medical Care Academy</td>
<td>BPMCA or something similar to be developed to help workforce roles that are not currently in place via local and national initiatives, including physician associates and medical assistant roles.</td>
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<tr>
<td>Abbreviation</td>
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<tr>
<td>BSL</td>
<td>British Sign Language</td>
<td>BSL is a visual means of communicating using gestures, facial expression, and body language. Sign Language is used mainly by people who are Deaf or have hearing impairments.</td>
</tr>
<tr>
<td>BTHFT</td>
<td>Bradford Teaching Hospitals NHS Foundation Trust</td>
<td>Hospital trust made up of Bradford Royal Infirmary (BRI) and St Luke’s Hospital. Key provider of hospital services locally.</td>
</tr>
<tr>
<td>CAB</td>
<td>Citizens Advice Bureau</td>
<td>Provider of free independent advice and advocacy services.</td>
</tr>
<tr>
<td>CB</td>
<td>Clinical Board</td>
<td>Responsible for leading and setting the vision and strategy, developing commissioning plans and overseeing the commissioning process across the CCG.</td>
</tr>
<tr>
<td>CCF</td>
<td>Clinical Commissioning Forums</td>
<td>GPs and Practice Managers attend these meetings and get involved in the work of the CCG.</td>
</tr>
</tbody>
</table>
| CCG          | Clinical Commissioning Group | Established in 2013 with clinicians at the heart of decision making. CCGs responsible for commissioning health services: 
- Bradford City CCG made up of 27 member practices and 124,000 registered patients 
- Bradford Districts CCG made up of 40 member practices and 339,000 registered patients |
<p>| CIC          | Community Interest Company | A CIC is a type of company introduced in 2005 under the Companies Act 2004 and is designed for social enterprises that want to use their profits and assets for the public good. |
| CoM          | Council of Members (Bradford City CCG) | Main GP forum within the CCG and is responsible for agreeing the vision, values and overall strategy of Bradford City CCG. |
| CoR          | Council of Representatives (Bradford Districts CCG) | Main GP forum within the CCG and is responsible for agreeing the vision, values and overall strategy of Bradford Districts CCG. |
| CQC          | Care Quality Commission | Independent regulator of health and adult social care in England. The CQC makes sure health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve. |
| DES          | Directed Enhanced Service | Directed Enhanced Services (ES) require an enhanced level of provision above what is required under core GMS contracts. Commissioners taking part in the ES ensure they have read and understood the requirements in the Directions and NHS England service specifications, as well as the guidance provided. |
| EFR          | Equitable Funding Review | In January 2014, NHS England agreed that the current funding arrangements for General Medical Services (GMS) and Personal Medical Services (PMS) practices would be reviewed with a view to addressing the wide variation in core funding per patient and to ensure that funding. |</p>
<table>
<thead>
<tr>
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<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>GB</td>
<td>Governing Body</td>
<td>Responsible for ensuring that the Clinical Commissioning Group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically.</td>
</tr>
<tr>
<td>GMC</td>
<td>General Medical Council</td>
<td>Regulator of the medical profession. Its purpose is to protect, promote and maintain the health and safety of the community by ensuring proper standards in the practice of medicine.</td>
</tr>
<tr>
<td>GMS</td>
<td>General Medical Services</td>
<td>The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. NHS Employers leads negotiations with the General Practitioners Committee (GPC), which is part of the British Medical Association (BMA) on changes to the GMS contract.</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioners</td>
<td>A doctor who works from a local surgery or health centre. Most are independent contractors providing services to patients through a contract with the NHS.</td>
</tr>
<tr>
<td>GPFV</td>
<td>General Practice Forward View</td>
<td>NHS England document which represents a step change in the level of investment and support for general practice. It includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to accelerate transformation of services.</td>
</tr>
<tr>
<td>GPPQIG</td>
<td>General Practice Performance and Quality Improvement Group (Districts)</td>
<td>The GPPQIG is a sub-committee of the Primary Care Commissioning Committee and contributes to ensuring the achievement of the CCG strategy and fulfilling the duty of the CCG in relation to the quality of primary medical services. (Also see Primary Care Commissioning Committees - City and Districts)</td>
</tr>
<tr>
<td>GPwSI</td>
<td>GP with Special Interest</td>
<td>A GPwSI supplements their role as a GP by providing an additional service while still working in the community as a GP.</td>
</tr>
<tr>
<td>HCA</td>
<td>Health Care Assistants</td>
<td>HCAs are a vital part of any practice, hospital or care setting nursing team.</td>
</tr>
<tr>
<td>HEE</td>
<td>Health Education England</td>
<td>HEE was established to support the delivery of healthcare and health improvement to the patients and public of England by ensuring that the workforce has the right numbers, skills, values and behaviours, at the right time and in the right place.</td>
</tr>
<tr>
<td>HF</td>
<td>Healthy Futures</td>
<td>The CCGs of West Yorkshire and Harrogate and Rural District have agreed to work collaboratively under the Healthy Futures banner. Initially work is focussed on cancer, urgent and emergency care and mental health.</td>
</tr>
<tr>
<td>ICB</td>
<td>Integration and Change Board</td>
<td>Partnership between health, social care and the VCS to promote integration. The ICB oversees a portfolio of programmes.</td>
</tr>
<tr>
<td>JCB</td>
<td>Joint Clinical Board</td>
<td>Combination of the Clinical Boards for Bradford City &amp; Bradford Districts CCGs.</td>
</tr>
<tr>
<td>LCD</td>
<td>Local Care Direct</td>
<td>A community owned healthcare provider delivering a wide range of NHS services 24 hours a day, 365 days a year. Current provider of out-of-hours services across West Yorkshire.</td>
</tr>
<tr>
<td>LES</td>
<td>Local Enhanced Service</td>
<td>Schemes agreed by CCGs in response to local needs and priorities, sometimes adopting national service specifications.</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>LMC</td>
<td>Local Medical Committee (also see YORLMC)</td>
<td>A LMC is a statutory body in the UK. LMCs are recognised by successive NHS Acts as the professional organisation representing individual GPs and GP practices. The NHS Act 1999 extended the LMC role to include representation of all GPs whatever their contractual status.</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Condition</td>
<td>Long Term Condition is defined as a condition that cannot, at present be cured but can be controlled by medication and other therapies. Examples of Long Term Conditions are diabetes, heart disease and chronic obstructive pulmonary disease. There are 15.4 million people living with a long-term condition in England.</td>
</tr>
<tr>
<td>NHSE</td>
<td>NHS England</td>
<td>NHSE leads the National Health Service (NHS) in England and sets the priorities and direction of the NHS. It also encourages and informs the national debate to improve health and care.</td>
</tr>
<tr>
<td>NPSA</td>
<td>National Patient Safety Agency</td>
<td>The NPSA leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector. It is an Arm’s Length Body of the Department of Health and through its divisions covers the UK health service.</td>
</tr>
<tr>
<td>OHP</td>
<td>Out of Hospital Programme</td>
<td>New programme that has embarked on a structured collaborative approach for services outside of hospital (community services). It’s vision is “I can plan my care with people who work together to understand me and my carer, allow me control, and bring together services to achieve the outcomes that are important to me”.</td>
</tr>
<tr>
<td>PCCC</td>
<td>Primary Care Commissioning Committees (City and Districts)</td>
<td>On 1 April 2015, the CCGs accepted full delegated responsibility from NHS England to commission GP primary care services. The PCCC make decisions on the review, planning and procurement of primary care services.</td>
</tr>
</tbody>
</table>
| PG    | Protected Groups       | Nine groups covered by the Equality Act 2010  
- age  
- disability  
- gender reassignment  
- marriage and civil partnership  
- pregnancy and maternity  
- race  
- religion or belief  
- sex  
- sexual orientation |
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMS</td>
<td>Personal Medical Services</td>
<td>Locally agreed alternative to General Medical Services (GMS) for providers of general practice, which offers greater flexibility for the GP. PMS agreements aim to improve access to and the quality of services within primary care, recruit and retain GPs in areas of greatest need, develop new ways of delivering services, and help integrate services.</td>
</tr>
<tr>
<td>PQIP</td>
<td>Practice Quality Improvement Group (City)</td>
<td>PQIG was established in September 2013. The role of this group is to support our member practices in improving the quality of primary medical services that they deliver through leadership and skills development. (Also see Primary Care Commissioning Committees - City and Districts)</td>
</tr>
<tr>
<td>PSED</td>
<td>Public Sector Equality Duty (Equality Act 2010)</td>
<td>The Public Sector Equality Duty requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality and Outcomes Framework</td>
<td>The QOF is part of the General Medical Services (GMS) contract for general practices and was introduced on 1 April 2004. The QOF rewards practices for the provision of ‘quality care’ and helps to fund further improvements in the delivery of clinical care.</td>
</tr>
<tr>
<td>RCGP</td>
<td>Royal College of General Practitioners</td>
<td>The RCGP is the professional membership body for GPs in the UK and overseas. The RCGP is committed to improving patient care, clinical standards and GP training.</td>
</tr>
<tr>
<td>StC</td>
<td>Structured Collaboration</td>
<td>Commissioners, providers, patients, service users, carers and the public working in partnership to define outcomes and agree the scope prior to awarding and mobilising services.</td>
</tr>
<tr>
<td>SCP</td>
<td>Self-care and prevention</td>
<td>Self-care is a way for people to look after themselves (with support as required) in a healthy way.</td>
</tr>
<tr>
<td>STP</td>
<td>Sustainability and Transformation Plan</td>
<td>Introduced in December 2015 as part of the NHS Shared Planning Guidance 2016/17 – 2020/21. Every health and care system in England will produce a multi-year Sustainability and Transformation Plan (STP) showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.</td>
</tr>
<tr>
<td>U&amp;EC</td>
<td>Urgent and emergency care</td>
<td>Urgent &amp; Emergency Care services provide life-saving care so patients get safe and effective care whenever they need it.</td>
</tr>
<tr>
<td>VCS</td>
<td>Voluntary and community sector</td>
<td>Not for profit organisations</td>
</tr>
<tr>
<td>YAS</td>
<td>Yorkshire Ambulance Service</td>
<td>Provider of Ambulance services across Yorkshire</td>
</tr>
<tr>
<td>YORLMC</td>
<td>YOR Local Medical Committee (also see Local Medical Committee)</td>
<td>Local Medical Committee for Bradford GPs.</td>
</tr>
</tbody>
</table>
### Appendix 2 – Measures that matter

<table>
<thead>
<tr>
<th>Metric</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned hospitalisation for chronic ambulatory care sensitive conditions</td>
<td>Maintenance or reduction in number of patients admitted</td>
</tr>
</tbody>
</table>
| Patient experience of primary care - GP services                       | Increase in number of patients reporting ‘good’ or ‘very good’  
Experience of making an appointment                                       |
| Patient safety incidents reported                                       | Increase in number of patient safety incidents reported (short term)  
Longer term reduction as learning is embedded                              |
| Primary medical care: Management of LTCs                               | People with a LTC who feel supported to manage their condition  
Reduced / no increase in admissions to hospital for people with a LTC  
Reduced / no increase in admissions to hospital for conditions which should not require a hospital admission |
| Primary medical care: Primary care workforce                           | Increased number of professionals working within primary care                                                                       |
| Cancer screening coverage                                               | Increase in percentage of patients screened  
Early diagnosis  
One year survival rates                                                |
| Population vaccination coverage                                         | Increase in percentage of patients vaccinated                                                                                  |
| Health-related quality of life for people with a long term mental health condition | Increase in quality of life reported                                                                                               |
| Anti-microbial resistance: Appropriate prescribing of antibiotics in primary care | Reduction in number of antibiotics prescribed                                                                                      |
## Appendix 3 – Alignment with STP and GPFV

<table>
<thead>
<tr>
<th>Key areas outlined in Primary Medical Care Commissioning Strategy</th>
<th>General Practice Forward View</th>
<th>Sustainability &amp; Transformation Plan Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Investment</td>
<td>Workforce</td>
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<tr>
<td></td>
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<tr>
<td>Core access</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Out of hours access</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Digital access</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Extended hours access</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Use of technology</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Long term conditions</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>High quality care</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Continuity of care</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Parity of esteem</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Consistent and safe care</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Sustainable workforce</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Integrated workforce</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Evolving workforce</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Skilled workforce</td>
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<td>√</td>
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<tr>
<td>Motivated workforce</td>
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<td>√</td>
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<tr>
<td>Prevention</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Self-care skill development</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>People power</td>
<td>√</td>
<td>√</td>
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<tr>
<td>New models of self-care</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Primary medical care at scale</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Using our assets</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Co-production</td>
<td>√</td>
<td>√</td>
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<tr>
<td>New models of primary medical care</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Estates</td>
<td>√</td>
<td></td>
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<tr>
<td>Outcome based and integrated contracting</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Fair contracting</td>
<td>√</td>
<td>√</td>
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<tr>
<td>New ways of contracting</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>
Appendix 4: Policy Documents and References

1. NHSE Five Year Forward View -
2. 5 Year Forward View (2014-19) Bradford District and Craven Health and Care Economy
3. General Practice Forward View April 2016
5. The RCGP (2013) – the 2022 GP – A vision for GP in the future NHS
6. NHS Alliance – Think big act now
7. The BMA discussion paper on General Practice and Integration
8. Equality Act 2010
9. The Brown Principles
11. NHS England Call to Action
    https://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/
12. Accountable Care Organisations explained www.khn.org
13. The Keogh Urgent and Emergency Care Review
14. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes NICE guideline
15. NHS Outcomes Framework
    https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/
16. Kings fund – workforce planning in the NHS
    http://www.kingsfund.org.uk/publications/workforce-planning-nhs
17. Centre for Workforce Intelligence
    file:///Z:/Documents/Downloads/CfWI%20GP%20in-depth%20review%20summary_July%202014.pdf
18. A Very General Practice Report
19. Invisible at the desk
    http://www.healthwatchbradford.co.uk/news/invisible-desk-healthwatch-publishes-report-gp-services-0