Fit for the Future
Working together to keep people well

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Cambridgeshire and Peterborough's General Practice Forward View Strategy

2017 - 2020

DRAFT February 2017

Table of Contents

i Foreword

1. Introduction 5
2. Model of Care 8
3. Improving Access 14
4. Workforce 17
5. Workload 22
6. Infrastructure 27
7. Investment 29
8. Governance and Programme Management 33
9. Appendices 36

122

i. *Foreword*

We are committed to addressing the current challenges facing primary care, and creating a sustainable future for General Practice in Cambridgeshire and Peterborough.

Cambridgeshire and Peterborough Clinical Commissioning Group (C&PCCG) has been tasked, under the National Operational Planning and Contracting Guidance[1] (2017-2019) with the development of a General Practice Forward View (GPFV) strategy. This comes at an opportune time. We currently have 105 practices in Cambridgeshire and Peterborough, with dedicated staff finding new and innovative ways of delivering high quality, responsive care for their patients. They are united in wanting the best for their patients: local GPs have told us "we all want to deliver the kind of care we would want for our families." Yet, an increasing number of practices are struggling. Demand continues to grow, and patient needs are changing and becoming more complex: this is reflected in practices struggling with operational, clinical and financial challenges. General Practice is at a cross-road, and it must evolve to meet the needs of both the patients and the workforce.

Over the past four months, we have engaged with patients, local GP leaders, GP Federations, the Local Medical Committee (LMC), our local Sustainability Transformation Programme (STP) clinical working groups, as well as external partners such as Social Care and HealthWatch, to distil their views of the future of general practice.

Our strategy is built around a vision of practices working together to engage a wide range of staff to deliver proactive, standardised and integrated care. We have outlined, in this document, key strategic actions to deliver this vision. Our ambitions are set out below, and then described in more detail in the rest of the document.

1. Our new care model will be enabled by practices working increasingly at scale, with redesigned incentives for better ways of working and full population coverage.

2. We will redesign how care is delivered, with a particular focus on patients in care homes, patients with multiple long-term conditions, and patients with urgent care needs. This care will need to be delivered by groups of practices, focusing on populations of at least 30,000-50,000 patients, working closely with community teams, voluntary and social care services.

[1] Planning guidance states: CCGs will need to submit one GPFV plan to NHS encompassing the specific areas outlined in this guidance. Plans will need to reflect local circumstances, but must – as a minimum – set out: • How access to general practice will be improved • How funds for practice transformational support (as set out in the GPFV) will be created and deployed to support general practice • How ring-fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, will be deployed.

3. We are required by NHS England to determine how we will improve access to routine primary care over evenings and weekends. We will ensure this access is used to support patients with the greatest need, aligned to the care model above.

4. Our workforce programme's ambition is to support our primary care staff in working safely, through improving supply and retention, leadership development and capacity creation. We will create new opportunities for employment within the new care model to ensure our primary care system can benefit from the additional clinical workforce being sourced through the national programmes of the General Practice Forward View.

5. We will begin by supporting the creation of capacity in primary care, finding strength and resilience through enabling practices to adopt proven methods of addressing workload challenges and through working together more effectively, the CCG has re-prioritised its staffing to provide significant additional support to general practice from early 2017;

6. Our strategy will be enabled by ambitious digital and estates strategies. We wish to maximise the benefits of modern information technology in supporting care and creating capacity, and to develop a clear approach to premises investment linked to the service and provider developments above.

7. If we take on delegated commissioning in 2017, we will focus on ensuring a smooth transition of responsibilities, work to improve contract administration and responsive contractual decision-making.

Our health and care system rests on the foundation of general practice. Our patients want, and need, general practice to be resilient and sustainable. We believe we have an ambitious plan which will allow us to achieve that goal over the coming four years, whilst providing a responsive, high quality service which will serve our patients well. This document sets out our strategy for delivering the commitments made in the GPFV. The aspirations and plans in this document are in line with both the GPFV and the Cambridgeshire and Peterborough Sustainability and Transformation Plan (STP) which details how we – as a whole system - propose to improve services and become clinically and financially sustainable.

Dr Gary Howsam
Clinical Chair & Chief Clinical Officer CCG

1. Introduction

1.1 Vision

Our vision for a sustainable future involves practices working together to engage a wide range of staff to deliver proactive, standardised and integrated care.

In our vision for care in Cambridgeshire & Peterborough, general practice will continue to provide excellent evidence-based care for our patients. It is a place where communities and patients play a fuller role in maintaining good health, and when physical or mental health is in need of support, a responsive, broader primary care team can signpost the *most relevant* health professional to help the patient and enable people to manage their own needs and return to their normal lives.

Our vision for the future involves practices increasingly operating at scale. In the next five years, we see practices triaging patients to the most appropriate destination for their care, with an appropriate suite of services available in the community to wrap around patients. Practices will have access to a diverse team, all operating at the top of their license, such as pharmacists, mental health support workers and physiotherapists. Specialised support, both from GPs with a special interest, and from secondary care, will link into these at-scale models to provide input directly to patient care as well as up-skilling GPs, nurses and other community professionals.

We will reshape how we commission care to reflect the increasing prevalence of multi-morbid patients. We will ask our providers (including general practice to proactively manage long-term conditions, and focus on the holistic needs of the patients). We will support them to help patients regain control of their health and gain confidence in dealing with their conditions. At the same time, we will lead the integration of care around these patients so their interactions with community teams, social care, voluntary sector and secondary care are joined up around their needs.

Similarly, primary care will continue to have a responsibility to support patients who are urgently ill, but we wish to support practices to manage on the day demand in new and innovative ways. This will give people access to their GPs when they most need it, but also make most effective use of the wider urgent care team - with paramedics, A&E, NHS 111 and other urgent response services in Cambridgeshire & Peterborough.

Patient safety and quality will underpin everything we do.

This will be a place where new GPs and other clinical professionals look to build careers in general practice taking on several roles as their careers progress. A system where people are fulfilled by their roles, and where all staff feel valued and work in teams they are proud to be part of.

1.2 Current STP and General Practice Landscape

Our health and care services face multiple challenges. Ours is one of the most, if not the most, challenged health systems in England, making it essential that we work together to develop robust plans for long-term change. The population of Cambridgeshire and Peterborough is growing rapidly (940,112 as at 1 October 2016). Our population is diverse, it is ageing, and it has significant inequalities. There are also more people with long term conditions, such as diabetes, and there are high levels of obesity.

In addition, we are facing practical challenges:

- healthcare is not as good in some places as in others, and does not always meet the standards that it should
- recruiting and retaining staff is a challenge for all health and care services
- our health, local authority, and other care services are not always joined up. They do not always meet people's individual needs, and they do not always balance physical health with mental health and wellbeing
- local needs are growing and changing. Our average age and levels of sickness are all growing, and faster than in other parts of the country
- overall, we spend too much of our time and resources treating illnesses which can be prevented or kept under control in better ways
- The current health system is financially unsustainable. The local system has a total annual budget of more than £1.7billion for NHS services, but we spend about £160million more than that each year. We need to deliver our current plans and radically change the way we provide services. If we don't do both of these things the deficit is projected to increase to £500million by 2020/21.The Sustainability and Transformation Plan (STP) proposes ways in which we can deliver the best possible care to keep our population fit for the future, and address our service and financial challenges[2].

General Practice is at a cross-road. It cannot continue in its current form and must evolve to meet the needs of both the patients and the workforce

General practice in Cambridgeshire & Peterborough increasingly does not have a sustainable operational model. Demand is steadily growing and primary care is struggling to manage. Increasingly complex care pathways are not consistent or readily adaptable, and primary care services are currently ill-equipped to manage complex elderly and multi-morbid patients. The impact is being seen with a

---

[2] Cambridgeshire & Peterborough's Fit for the Future STP. Sourced from world wide web: http://www.fitforfuture.org.uk/what-were-doing/publications/

number of practices being identified as requiring support to become more resilient. We need to change the way primary care operates, to better manage the demand and complexity coming through our doors.

General practice faces a workforce shortage. Our current workforce is ageing, and we are struggling to recruit and replace primary care staff in many areas. We need to enable general practice to be a more attractive place for people to work and to create the employment opportunities for new roles across the skill mix.

General practice does not have a sustainable financial model. Operational and workforce pressures are resulting in an increasing number of financially challenged practices, including some where the salaried physicians are earning more than the practice partners, or where practices are failing to find solutions to the impending workforce crisis.

Our patients' needs and expectations are changing. Our population is ageing and experiencing more long term conditions, including lifestyle related illnesses. Previously unaddressed needs such as mental health problems are being recognised, with a requirement to meet them. We need to improve the ways we address issues of prevention in primary care, working with our public health and social care colleagues. Patients with long term illnesses need and want integrated, proactive care to keep them healthy and well at home. They value continuity of care with their primary care team. At the same time, we are seeing increased 'health seeking behaviours' and demand for care, with patients looking to GPs to address health and wellbeing needs beyond those which are traditionally the scope of general practice. We need to better manage patient expectations and usage of primary care, and focus on providing the type of care which most improves patient health.

Patients want a seamless service experience across health and care organisations. Services are often co-located in the same buildings, but not integrated with each other. There are barriers to information sharing and a lack of resource in both Primary Care and Community Care. Professionals are currently unable to manage their workload to allow GPs and other primary care clinicians to focus on what they do best. We need to work better with our STP partners in community, social, voluntary and secondary care.

Cambridgeshire & Peterborough's GPFV strategy recognises the need to ensure the foundation of general practice is sustainable, but also to build a strong primary care platform that will enable us to deliver on future STP ambitions.

1.3 Priorities for Action

As this strategy forms part of our system's wider STP, the priorities for action have been aligned to its implementation. These actions also reflect the nine 'must do' priorities for 2017/18 and 2018/19, as set out in the NHS operational Planning and Contracting Guidance 2017-2019. A high level delivery plan and risk register is attached for your information (please refer Appendix One and Appendix Two respectively), which sets out the CCG's work programme for the next two years. This programme will evolve and be refreshed as this strategy is implemented and it is further aligned to the implementation plans and work programme of the STP.

2. Model of Care

Ambition 1: Our new care model will be enabled by practices working increasingly at scale, with redesigned incentives for better ways of working

The Cambridgeshire and Peterborough health and care system aims to work together to eliminate the perverse incentives which prevent proactive, integrated care from being delivered to patients. The Health and Care Executive[3] want to see the behaviours of an Accountable Care Organisation[4] mirrored in the system. For general practice, this requires reorganisation and a different model of care.

There are currently three General Practice Federations within Cambridgeshire and Peterborough. Collectively they cover 80 (76%) practices and a total population of 684,500 (73%). Over the past two years, the CCG has financially supported the development of each Federation and will continue to encourage practices to reap the benefits of working collectively, through shared back-office functions, collective purchasing, shared workforce, and implementation of standardised best practice processes. Shared administration teams can help manage correspondence and test results; pharmacist teams can help manage medication changes and reviews; shared business intelligence will support case finding and proactive care delivery.

Funds for transformational support have been identified by the CCG, over 2017/18 and 2018/19, based on £1.50 per head per year. It is intended that this will fund initiatives to maximise the benefits of at-scale provision including further phases of local *Time to Care* Testbeds, increased support for practice reconfiguration including specialist facilitation and professional advice; and support.

Aligned with the vision of the Five Year Forward View, the type of organisational model that is starting to emerge across Cambridgeshire and Peterborough is the Multispecialty Community Provider (MCP). One form of this is the Primary Care Home, “a model that aims to re-shape the way primary care services are delivered, based on population need" (National Association of Primary Care, 2017).

Although not one of the 15 vanguard sites to take this model forward, one of the practice reconfigurations in South Cambridgeshire, Granta Medical is currently developing its services, in partnership with other agencies, to deliver a stronger patient centred health and well-being model of care. It is developing this model in discussion with the National Association of Primary Care and other health and social care partners within Cambridgeshire.

---

[3] Comprising the Chief Executives of the CCG, Provider Trusts, and with representatives from Peterborough City Council and Cambridgeshire County Council and general practice.
[4] An Accountable Care Organisation is an organisation which adopts accountability for the full health needs of a population, coordinating care to improve the patient experience and population health. It provides elements across of care across the care continuum, including primary care, and is supported by capitated payment mechanisms, patient-linked IT datasets and a culture of continuous improvement.

In Peterborough, the GP Federation is currently exploring how it might transform into a multispecialty community provider. It is aspiring to become a future vanguard and is supported by both the CCG and local NHS England team in this endeavour. It will be specifically focussed over the next 12 to 18 months on:

- stabilizing the general practice landscape, which includes supporting *Time to Care* development and the introduction of pharmacists into the general practice team
- understanding and defining what a MCP entity would be and what would be different to the current GP Federation model
- developing the model with member practices that will provide a strong primary care platform to deliver the priorities of the STP, which aims to:
    - coordinate care better, so that it meets the needs of the individual
    - pay close attention to the health and care services necessary to keep people living at home successfully, because we know this is the best way to keep people healthy and to maintain their independence
    - take every opportunity to spot warning signs and focus local support to help people live with long term health conditions.
    - Support and encourage more joint working between local health and social care, with GPs playing a central role, supported by hospital clinical teams; as much care as possible must be led by primary care (GPs).
    - support GPs to share best practice, work together, access advice from hospital consultants and to provide the enhanced primary and community care that our local people need.

Across the county, there are multiple sites planned for redevelopment, which provides us with an opportunity to further develop general practice and new models of care integrated within communities.

The CCG is currently working with Cambridge University Hospital, South Cambridgeshire District Council and the Homes and Community Agency (HCA) to develop a healthy new community over the next 20 years at Northstowe, situated five miles north of Cambridge. Northstowe will accommodate 10,000 new homes, and aspires to include housing for an ageing population and treating more people locally in the community, and tackling obesity through providing mixed/inclusive/walkable neighbourhoods, with good cycling and walking connections and excellent access to facilities and open space.

Ambition 2: Working closely with clinicians and patients, we will redesign how care is delivered, with a particular focus on patients in care homes, patients with multiple long-term conditions, and patients with urgent care needs.

We will design this new model of care working closely with patients and their carers. Through Patient Participation Groups, we will aim to ensure that the new model of care meets the varying needs of our local patient population. The new models of care will incorporate STP service plans for urgent and emergency care and clinical/integrated care pathway development, as well as seeking to empower people to self-care.

I. Patients in Care Homes

a. We recognise that care home patients require integrated care from GPs working together in a coordinated way with specialists and Social Care. We will start by equipping the wider primary care team to provide specialist geriatric, end of life, and care planning in care homes using improved links between practices and community and secondary care teams.

b. We will build a business case to inform the delivery of this plan, including changes in staff skill-mix to encourage a multidisciplinary approach which will ensure rapid access to the right care for those most in need.

c. We will explore innovative methods of connecting general practice into care homes, including the use of technology. We will work jointly with the councils to protect the capacity and continuity of the care currently in place.

d. We will continue to work to help staff in care homes improve their skills and confidence in looking after their patients and to manage care according to their and their carers' needs and wishes.

e. This piece of work will be owned by the Primary & Integrated Neighbourhoods Team (PCIN) group within the STP. The group will be expected to produce a modification to the current commissioning arrangements for Enhanced Care Home Support in primary care.

II. Patients with multiple long term conditions

a. Across the system, the patients with the greatest need tend to be those with multi-morbidity and frailty. These patients need, and want, an enhanced set of services provided in the community to keep them safe, healthy and at home. An enhanced primary care service for these patients will include:

- Health coaching, to help them identify their personal goals and focus their care;
- Collaborative care and support planning, to organise and implement ways to address their needs and goals;

- Proactive management of their conditions, to prevent escalation (with specific pathways for conditions including respiratory, diabetes, dementia, mental health, chronic pain, CVD, COPD, and end of life) as well as a generalised care plan for those with multiple morbidities;
- Integration with community teams, the voluntary sector, social care services, paramedics and secondary care to support delivery of the patient's needs and wishes.

b. We will invest in a locally commissioned service for the enhanced care of patients with long term conditions from primary care, to be provided over several years, to help practices identify and proactively manage the needs of these patients in a standardised and integrated manner. This specification and required outcomes will be developed by the PCIN group within the STP, and tested extensively with federations, emerging at-scale providers and patients.

c. The service will be implemented in a phased way, working with groups of practices for delivery and to ensure the right staff[5] and range of skill mix is in place for delivery, then supporting and monitoring them once the service is up and running.

d. The CCG will continue to work with our mental health provider to embed their workers into practices, improving the provision of mental health advice and support to practices, promoting early assessment, treatment and/or onward referral. There will also be support for patients 'stepping down' into primary care from secondary mental health care. We are also working to improve access to psychological therapies (IAPT) for patients with lower level mental health problems (anxiety and depression) caused by other long term medical conditions such as Diabetes and COPD.

e. We are already developing a Healthy Ageing strategy, with particular support to the frail elderly in prevention of falls and UTIs, working closely with Social Care to support people in living independently at home.

f. Over the longer term, we may consider the case for an extensive care practice model. This would involve a team (including an Advanced Nurse Practitioner, a key carer and a GP 'extensivist' with an interest in geriatric medicine) working with identified multi-morbid patients who are deteriorating, to help stabilise them and gradually de-escalate their care needs.

[5] Planning guidance: Commissioners should also have established pathways of care that integrate with community pharmacy. For example, we would expect CCGs to have considered the value provided by a community pharmacy based minor ailments service and also the contribution to better medicines use by patients with long terms conditions – both of which are expected to have a positive impact on patient experience and practice workload.

III. **Patients who need urgent care**

a. We will look to commission a hub-based model of urgent care provided over 7 days, including support services such as in-house radiology, testing/diagnostic, and minor injuries. The aims for our development of local urgent care service hubs for Wisbech, South Fenland and Ely are to:

- integrate services which are currently fragmented into an easier to understand offer for patients
- converge opening times
- act as a focal point for the local urgent care network and link with A&Es, ambulatory care and other acute specialties
- support sustainable general practice
- provide a platform for improving primary care access
- make most efficient use of resources
- re-patriate patients from acute hospitals to local services
- develop local but cost effective solutions for the rural geography.

b. We will support general practice to work more closely with:

- Secondary Care to ensure that patients with primary care needs are redirected to a suitable service
- Paramedics, to assist in redirecting 999 calls and assessing home visit request
- Joint Emergency Team (JET) for patients experiencing an escalation of their planned care needs
- Enhanced primary and minor injury services, as an alternative to hospital.
- NHS111, within a newly developed clinical hub, to support GPs in clinical decision-making, and direction of patients to the appropriate location.

c. The CCG will work to improve links with secondary care consultants, to provide access to specialist input for improved patient care and referrals such as ambulatory care pathways that enable patients to be managed at home for as long as possible.

d. We will explore options for supporting patients with emergency carers in times of crisis, working with the councils in line with the carer strategy

These actions will have the benefits of managing emergency department flow and preventing unnecessary admission to hospital.

2.1 Key Deliverables for the First Two Years

Key Deliverables	Baseline position	Key Actions/Milestones (2017/18 – 2018/19)
Development of a MCP in Greater Peterborough	GP Federation (28 practices serving a population of 265,000) with an ambition to become a MCP vanguard which is supported by the CCG and local NHSE. GP Federation has been in operation since 2015	• Support time to care testbed programme beginning April 2017 • Bid for funding to employ pharmacists to support general practice workload – February 2017 • Development and agreement of the MCP model with member practices, potential partners, patients and CCG by March 2018 • Submit proposal for wave two MCP vanguard (Date TBC)
Development of a Primary Care Home in South Cambridgeshire	From April 2017, Granta Medical will consist of three merged practices servicing a population of 33,000. A fourth practice has also expressed an interest in joining. The practice has spoken to the National Association of Primary Care and is starting to develop a population based service model, that includes working with local agencies that will support patient's health and wellbeing	• Continue to develop model of service delivery for local population over the next twelve months • Understand funding within current environment and model what this might look like for the future STP model
Strengthened model of integrated care in Care Homes	As part of avoiding hospital admissions programme, Care Home Educator Support team employed by CCG during 2016 and referrals to JET Service introduced. However, still work to be done to ensure patients and staff in care homes are fully supported by a MDT that spans primary, community, social and secondary care	• Using the framework for enhanced health in care homes, we are working with the Urgent Care and PCIN STP Delivery Groups to develop a LES for care homes that strengthens integrated working for 2017/18 • Re-commission general practice LES to support new model of care beginning 1 April 2017
Enhanced Care for people with long term conditions	Community Neighbourhood Teams (NTs) supporting practices to deliver a model of MDT working that focuses on people with long term conditions. This model of care is linked to social care. Trailblazer pilots were run in the second part of 2016 with plans to roll out in 2017.	• Further develop MDT model of care based on evaluation from phase one and feedback from general practice. Trial new model of MDT being sited in general practices in March 2017 for Cambridge Pilot • Further develop STP business case for a local community service for general practice to deliver the 'House of Care' model by March 2017 • Continue to work on STP long term condition pathway development for COPD, Diabetes, and Atrial Fibrillation, supporting the business case for investment (March 2017) and subsequent delivery for 2017/18 • Work through commissioning implications/requirements for general practice via a locally commissioned service

Urgent Care Hub development in Wisbech, South Fenland and Ely	Three MIUs operating separately to general practice; Variable levels of investment and infrastructure. All three currently under-utilised whilst general practice struggles to meet demand and recruit to either partner and/or salaried positions.
	
	The LUCS hubs are intended to support local delivery of the GP Forward View, with potential to address many of the 10 high impact actions, and our local GPFV priorities, but in particular the following
	a) broaden the workforce by 'connecting the patient directly with the most appropriate professional' – making best use of the expertise and capacity of the nursing and medical manpower;
	b) productive workflows – 'introduce new ways of working which enable staff to work smarter' – focused on local re-design of on the day / urgent demand
	c) 'create collaborations with other practices and providers in the health and social care system' – the LUCS hub development work has already catalysed joint working on an 'at scale' basis;
	d) delivering national improved access requirements: the hubs could offer an efficient, easy to understand way for local practices to provide extended access
		• Support development and implementation of STP's proposed local urgent care hub pilots which includes integration of general practice with an anticipated go live in May 2017
		  • Phase 1: Spring 2017 - March 2018: Pilot three hubs (Ely, Doddington, Wisbech) / Evaluation / Engagement & Consultation
		  • Phase 2: April 2018: Commission new model of care incorporating learning from evaluation and STP service developments

Development of Primary Care provision in Northstowe Healthy New Town	A Project Manager was appointed late last year to develop the wider plan for Healthy New Town delivery. The CCG (working with local GPs in the area) and the local authority have been assigned the lead in the design of the planned community health service	• Continue to work with the key stakeholder delivery group in the design plans for Northstowe HNT • Develop a model that supports the ambitions of the STP and GPFV strategies by March 2018

3. Improving Access

Ambition 3: We are required[6] by NHS England to determine how we will improve access to primary care over evenings and weekends. We will ensure this access is used to support patients with the greatest need[7], aligned to the care model above.

[6] National planning guidance: Funding to improve access to GP services (£6/head in PMCH areas; £3.34 in other areas). For eligibility, will require: After 6:30pm appointments, pre-bookable and same-day (+1.5 hrs/day); Weekend appointments, pre-bookable and same day; Provide robust evidence for proposed service disposition throughout week based on utilisation rates; Provide a minimum additional 30 minutes consultation capacity/1000 population, Rising to 45 minutes/1000 population; ensure usage of a nationally commissioned new tool to be introduced during 2017/18 to automatically measure appointment activity; ensure services are advertised to patients

We are mandated, through the operational planning guidance, to provide access to pre-bookable and same day routine appointments over evenings and weekends. Given the existing capacity and workforce pressures on general practice, we recognise the need to do this in a collective and strategic manner. We will also work closely with patients through Patient Participation Groups to develop the service in accordance with our population needs. It should be noted that in a Healthwatch survey, the requirement for extended hours/increased access to GP surgeries was not a key issue and therefore.

3.1 Baseline for Current Extended GP Access

In April 2015, GP practices across Greater Peterborough were given £2.6 million funding as part of the Prime Minister's Challenge Fund bid. This funding was for local GPs to develop and trial different ways of working within primary care to improve access and patient care; looking at how primary care can support patients and other services at weekends; providing online access to primary care advice; and increasing capacity within primary care.

Practices have been working together under the umbrella of the Greater Peterborough Network GP Federation to provide seven day services to all patients, regardless of the surgery they are registered with. Patients can book appointments as late as 8:30pm Monday-Friday, as well as on Saturday and Sunday mornings. Patients may be asked to attend a practice other than their own; however, full access to their patient record is available to the health professional that they see.

In September 2016, the Federation were funded for an additional 12,000 appointments, to be delivered over a twelve month period and the service has developed strengthened and expanded hub delivery to support increased integration with local urgent care pathways, including ED streaming at weekends, and the introduction of a range of clinics utilising the wider skill mix. This reflects the direction that the service will continue to develop in as the specification for year three is finalised.

The general practice extended hours Directed Enhanced Service that is contracted via NHS England allows payment to a maximum of £1.90 per registered patient as at the 1st April 2016. The budget for this DES for 2016/17 was £1.77m.

In February 2017, the CCG received £517,061 non-recurrent funding to increase access to general practice to support winter system pressure. 75 practices have signed up to provide additional capacity (33,284 additional appointments in total), over February and March.

---

[7] NHS England's website states, on extended access: "This might include commissioning provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) and at weekends, meeting local population needs as appropriate. This should help reduce demand on both general practice in-hours, and urgent care services."

3.2 Moving Forward

Learning from and improving upon our experience in Peterborough, the CCG will commission extended hours from groups of practices or via GP Federations across the Cambridgeshire and Peterborough area. We will engage with local practices to consider whether we do this as local systems (for instance around the main hospitals and urgent care centres) or in more discrete geographical localities (hubs), recognising that solutions need to reflect local need and circumstances. As part of our STP programme, we are planning to pilot (subject to approval) three local urgent care hubs in Wisbech, South Fenland, and Ely. These three sites will include extended hours access.

Over the next two years, we will explore how we can integrate NHS 111, community service teams and secondary care providers into the extended access service model, thereby increasing the uptake by prioritising patients with the most significant needs into these appointments. This work will dovetail into the development of our new models of care. We will review the funding for this extended access to see how this service might reduce attendances at A&E for conditions more appropriately seen in primary or community care and enable redirection of this resource to supplement this service.

We will work with practices to implement the national data collection associated with expansion of access, using the new (awaited) nationally commissioned tool – mandated through operational planning guidance.

We will look to further trial new technologies associated with e-consultations, in order to diversify the type of support available to patients, and in line with NHS England's 2020 goal to support innovation in primary care. We will build on local experience of trialling online consultations and utilise national resources to support increased availability. The work through the *Time to Care* testbeds and the 10 high impact changes will help practices to reconfigure services in order to accommodate online consulting with patients. We will work with patients to identify and maximise the benefits of online access and explore how uptake is widened. By working with practices and our partners in health and care, patients will be made aware of the extended services through a range of communications channels. We will consider where we site these services to make them accessible to patients.

We recognise that achieving this will be a challenge within the current workload and workforce constraints affecting general practice. Implementation will be phased in line with national funding, with the overall aim of achieving full patient coverage by 2019/20. Investment will start to be available outside of Greater Peterborough in 2018/19, so preparatory work will be undertaken during the next financial year to ensure readiness. The CCG recognises the risk associated with this part of our strategy and will work with local GP federations and/or practice groups to assess and better understand what will be required in terms of meeting the potential demand and reducing inequalities.

3.3 Key Deliverables for the First Two Years

Key Deliverables	Baseline position	Key Actions/Milestones (2017/18 – 2018/19)
Securing extended hours provision for Greater Peterborough for 2017/18 and beyond	Practices working together under the umbrella of the Greater Peterborough Network GP Federation provide seven day services to all patients, regardless of the surgery they are registered with. Patients can book appointments as late as 8:30pm Monday-Friday, as well as on Saturday and Sunday mornings. Extended hours DES contracted with practices but increased demand for both general practice and A&E services. Increased access provided during February and March to support winter pressure on acute services.	• Secure continued provision from 1 April 2017 including further development (over the next twelve months) of central hub to support increased access/utilisation, and supporting local A&E with minors with current access provider, as well as increasing integration with other providers, such as NHS111/OOHs
Assessment of demand for extended access across remainder of CCG footprint and how this might be provided to meet NHSE requirements		• Undertake an assessment of demand for extended access outside the Greater Peterborough catchment by September 2017 • Develop with general practice and patients a sustainable model and implementation plan to extend and improve access in line with requirements for national funding, acknowledging the potential implications for Out of Hours provision November 2017 • Engage with key stakeholders on proposed model January 2018
Procurement of extended access for 2018/19 and 2019/20		• Agree implementation and procurement process to extend access for the total population with NHSE local team

4. Workforce

Ambition 4: Our workforce programme's ambition is to support our primary care staff in working safely, through recruitment and retention, leadership development and capacity creation.

The GPFV sets ambitious workforce aspirations to address the gaps and issues relating to both the aging workforce, and increased demand and complexity of workload. As well as aiming to recruit GPs, the GPFV also supports the development of new roles in General Practice to improve skill mix and to maximise the GP resource available. The development of a local strategy will combine the requirements of the national GPFV and the context of the local STP to set a sustainable direction for general practice in Cambridgeshire

and Peterborough. Solutions that see greater integration between practices and across health care providers will result in new roles and utilisation of the primary care workforce. The emphasis will be on creating efficient ways of working and directing clinical staff to clinical functions and away from administration and bureaucracy.

.

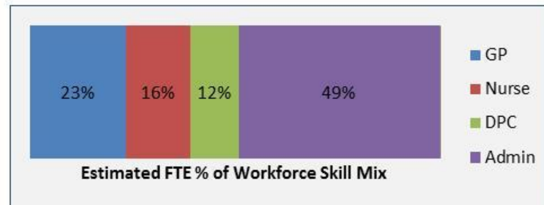
4.1 Workforce Profile

The General Practice workforce profile across Cambridge and Peterborough is varied. The following table (from the latest National Workforce Minimum Data Sets) sets out the estimated workforce profile as at March 2016.

Cambridge and Peterborough CCG

Workforce Estimates and Benchmarking
Submission Rate: 98%

1. Workforce Estimates	FTE
Total GPs excluding Retainers, Registrars and Locums	465
Total Nurses	309
of which Advanced, Specialist and Extended Nurse Roles	78
of which District Nurses	0
Total DPC	234
of which Therapists (DPC)	1
of which Pharmacists (DPC)	5
of which Physician Associates (DPC)	0
Total Admin and Management	975
Total Patients	918053



Estimated FTE % of Workforce Skill Mix

2. Workforce Indicators	CCG	National
Patients: % of Patients aged over 74	7%	8%
GP demographics: % of GPs aged under 35 (Headcount)	13%	18%
GP demographics: % of GPs aged over 54 (Headcount)	20%	21%
GP demographics: % of Partnered GPs (FTE)	75%	65%
GP demographics: % of Non UK Primary Medical Qualification	26%	29%
Nurse demographics: % of Nurses aged under 35 (Headcount)	8%	7%
Nurse demographics: % of Nurses aged over 54 (Headcount)	32%	31%
Nurse demographics: % of Trainee Nurses (Headcount)	0.2%	0.7%
DPC demographics: % of DPC aged under 35 (Headcount)	24%	18%
DPC demographics: % of DPC aged over 54 (Headcount)	27%	26%
Capacity to population: Patients per GP (FTE)	2031	2037
Capacity to population: Patients per Nurse (FTE)	2970	3756
Capacity to population: Patients per DPC (FTE)	3924	6109
Skill mix: Ratio of Nurses to GPs (FTE)	0.68	0.54
Skill mix: % of Advanced, Specialist and Extended Nurses (FTE)	26%	20%
Skill mix: % of HCA in Total DPC (FTE)	56%	63%
Skill mix: Ratio of DPC to Nurses (FTE)	0.76	0.61
Skill mix: % of Admin and Management Staff in Total Staff	49%	54%

Notes
Table 1. Workforce Estimates:
- Full Time Equivalent (FTE) estimates based on submitted data and expected data for non submitting practices.

Table 2. Workforce Indicators:
- Colours are not an indication of good or poor performance, but are merely a visual representation of a CCG indicator against an average national benchmark. Light blue (below national average)/dark blue (above national average).
- Indicators calculated using submitted data only.

Please use this information in conjunction with Primary Care Workforce Report. Appendices include lists of practices with abnormal indicator scores e.g. practices with a Patient per GP ratio above 2500.

Source:
NHS Digital, Workforce Minimum Data Set March 2016

Whilst 20% of the CCG's General Practitioners (GPs) are over the age of 54 years, Cambridgeshire has a relatively younger GP profile with only 18% of GPs over the age of 54 years; however, in Peterborough this rises to 25%, higher than the national England average (21%).

Across Cambridgeshire and Peterborough the age profile for GPs under the age of 35 years (13%) is well below the national average (18%), with the lowest in the county being in Peterborough at just 6%.

Approximately a third of general practice nurses in Cambridgeshire and Peterborough are aged over 54 years, again an outlier. General Practice Nurses in Peterborough represent 0.9 whole time equivalent (WTE) for every one WTE GP; higher than the national England average ratio of 0.5:1. There is also a high ratio of advanced, extended and specialist nurses in Peterborough. This suggests that nurses are working to their full potential and supporting GPs with more complex patients. This provides career opportunities for general practice nurses moving into the system, and goes some way to help with the current issue of GP vacancies. However, with 32% of general practice nurses aged over the age of 54 years, the area faces a serious gap in clinical expertise

The challenges facing general practice are widely reported. Practices across Cambridgeshire and Peterborough are not immune to these pressures. Perceived and actual pressures in general practice are a deterrent to recruitment. Local management to support new care models and implementation of the aspirations of the GPFV are key to addressing these service delivery and small business pressures.

4.2 PC Workforce Development 2015-2017

Working in collaboration with the wider system we implemented a primary care workforce development programme, commencing in 2015 to address some of the pressing workforce issues in general practice. To date the following outcomes have been achieved:

- 123 apprenticeship starts across primary care. The majority of which have been in general practice and clinically focused.
- 13 Health Care Assistants undertaking the foundation degree in nursing with the local university
- A local designed programme, delivered to three cohorts delivered, provided an opportunity to upskill health care assistants enhancing their clinical competence
- Increasing pre-registration nursing placements from 5% to 20% of our GP Practices
- Significant increase in the numbers of Practice Nurses accessing CPD funding
- 19 practice nurses have commenced an advanced nursing practice masters
- Development of a range of media materials to promote careers pathways for general practice nursing. This included a promotional GP Practice Nurse video, which was adopted nationally by HEE

- Recruitment of eight post CCT GP Fellows, supported two of our provider trusts offering opportunities for integrated working across primary and secondary care
- Three CEPN's have been established delivering arrange of KPI's, linked to the GPFV.

The programme received recognition by the Health Service Journal by being shortlisted for its work in the 2016 HSJ Value in Healthcare Awards.

4.3 General Practice Workforce Plan 2017-2020

Building on the success of the workforce development programme, a workforce plan to 2020, is currently being developed which links to the vision of the GPFV and our local STP. This will be finalised over the next three months. This plan includes the following key themes and actions.

Theme One: Improving supply and retention

- Developing portfolio careers which meet the expectation of our current and future clinical workforce.
- Promoting Cambridgeshire and Peterborough as an area - offers attractive job opportunities in General Practice to attract new talent. This will include working with other health partners, to provide content for the addition of a healthcare sector as part of a Peterborough Social Media network, encouraging people to choose the city as a place to live and work, our most challenged recruitment area.
- Retention of organisational knowledge by offering new role opportunities for retiring GP and Practices Nurses in education, mentoring and commission roles.
- Growing our own. We will continue to develop a range of apprenticeships career pathways which will enhance clinical competency, and support those who wish to step onto a registrant pathway. We will continue to support non-clinical apprenticeships.
- Increase the capacity of our mentors and educators.

Theme Two: New role development

- Development of a reception care navigator programme to up-skill general practice receptionists to navigate and signpost patients through the system.
- Medical Assistants Role - Working collaboratively with our local HEE to develop options for the design and implementation of this role, linked to the apprenticeship standards.

- Support practices to participate in the clinical pharmacists programme. In addition to this, we will continue to promote pharmacy roles in general practice to pre-registration students by expanding pre-registration placement capacity.
- Expand the number of physician associates working in primary care.

Theme Three: Scaling up new ways of working and up-skilling

- To continue to support Primary Care at scale, which will include:
    - Federations
        - CEPN's
    - Practice Mergers – consideration being given to centralisation of back office functions.
    - Test-bed programme, a quality improvement programme looking at :
        - Phase 1 – Understanding the current state
        - Phase 2 – Creating capacity for patient care
        - Phase 3 - Implementing an integrated, proactive model of care for patients with LTCs
        - Phase 4 - Implementing/improving community support for acute illness in children and adults
    - New contracting models i.e MCP and, Primary Care Home
- Linking to our STP programme, co-design new models of care, which encourage the expansion of multi-disciplinary teams. This will require reviewing our skill mix to ensure our workforce is working to their fullest potential, including Mental Health practitioners. We will be working closely with practice nurses to support enhancement of roles and development of a training strategy.

Theme Four: Leadership development

Working with our Federations and CEPN's, we will develop a collaborative leadership culture which fosters the right values and behaviours of our workforce, across four domains:

1. Individual effectiveness
2. Innovation and improvement
3. Relationships and connectivity
4. Learning and capacity building

Our CEPN's will be instrumental in leading the development of a workforce fit for the future.

4.4 Key Deliverables for the First Two Years

Key Deliverables	Baseline position	Key Actions/Milestones (2017/18 – 2018/19)
Improved supply and retention of primary care workforce	Variable workforce with differences between Peterborough and Cambridgeshire. Recruiting to Peterborough is particularly challenging and therefore high use of locum staff. Losing organisational/professional knowledge and experience as GPs and Practice Nurses are retiring. 123 apprenticeships started since 2015 13 HCA undertaking foundation degree in nursing	• Continue to develop a range of apprenticeships and support those who wish to step onto a registrant pathway • Undertake a recruitment campaign that utilises a range of media to encourage people to choose Peterborough as a place to live and work beginning June 2017 • Development of portfolio careers for workforce that meets future expectations and aligned to STP plans • Developing new role opportunities for retiring GP and practice nurses in education, mentoring and commissioning
New roles developed and/or expanded: Care Navigators Medical Assistants (MA) Pharmacist Physician Associates	Workforce challenges across all practices with increasing workload and limited capacity to support patients that have more complex health and social care issues. Social prescribing pilots still to be implemented. Only eight Pharmacists are employed within practices No physician associates but supported two placements in 2016 from Essex cohort	• Develop local reception care navigator programme by June 2017 • Work with local HHE to develop options for design and implementation of MA role , potentially linked to the apprenticeship standards • Support practices/GP Federations to participate in the clinical pharmacists programme and continue to promote pharmacy roles to pre-registration students • Facilitate further Physician Associates placements where required
Primary Care workforce is aligned to new models of care working to its full potential	Separation between general practice and community services' neighbourhood teams with MDT working. Limited integration with secondary care services A PRISM pilot has been running in six GP surgeries in Huntingdon since August 2016. The service will be rolled out to GP practices across the county in 2017	• Work with/commission Federations (CEPNs) to support the development of the workforce for new models of care that are starting to emerge in Peterborough and South Cambridgeshire • Link with wider STP workforce development plan • Review skill-mix to ensure all staff are working to their full scope of practice, including strategy for practice nurses • MH PRISM model implemented
Strong primary care leadership across Cambridgeshire and Peterborough	Current investment in formal leadership training includes • Lead. Manage. Thrive (Red Whale) - four negotiated places Nov 2016 • Chief Resident Clinical Leadership & Management Development Programme - six places 2015-16 and three places 2016-17	• Continue to support and increase places for formal leadership training • Work with GP Federations and CEPNs to support the development of a collaborative leadership model that supports system working and implementation of STP

5. Workload

Ambition 5: We will begin by supporting the creation of capacity in primary care, finding strength and resilience by enabling practices to adopt proven methods of addressing workload challenges, and through working together more effectively. The CCG will re-prioritise its staffing to provide significant additional support to general practice from early 2017.

As stated in the foreword to this strategy, general practice is at a cross-road. Demand is steadily growing and primary care services are currently ill-equipped to manage complex elderly and multi-morbid patients. The impact is being seen with a number of practices being identified as requiring support to become more resilient. We need to change the way general practice operates, to better manage the demand and complexity coming through our doors.

5.1 Reducing administrative burden created externally

We will work to address immediate pressures by enabling practices to implement the opportunities identified in the GPFV, including reducing administration and bureaucracy, and improving links with secondary care and community care (e.g. linking GPs and secondary care consultants; improving turnaround times for discharge letters; standardising pro-formas and integrating with GP computer systems).

143

This will be done through national contract requirements with hospital and community Trusts, and also by working with practices and GP Federations.

The CCG will support federations and groups of practices working together to create business cases to improve operational practice. This will include mechanisms for improved demand management, and better use of other staff groups, including mental health workers, pharmacists, physiotherapists, social workers, benefit advisors, carer support teams, and alcohol and drugs teams. A range of specialist secondary care consultants will see patients in primary care settings as part of the wider local team, without any formal referral pathways, enabling us to transform our planned care referrals so that only those who need to go to hospitals will be sent there. This will support GPs in continuing to work to the top of their license and increase the skills and mix of staff working in primary care, improving job satisfaction and morale.

There are a number of demand management initiatives that are currently being implemented within Cambridgeshire and Peterborough that will help reduce the administrative burden of managing referrals. Consultant virtual triage and assessment services within Acute Trusts will help streamline the referral process, by providing advice and guidance if applicable, referring directly for a scan if required, and/or booking the patient into the most appropriate clinic. Where this model of referral triage has been in place, it has been well received by GPs across the county and is therefore being rolled out to other specialities. In addition, the CCG is looking at a more direct advice and guidance model, such as *Consultant Connect* to support GPs with more ‘urgent’ patients.

The CCG is also working with practices to develop clinical support tools/processes that will support and simplify the referral management process for GP providers, by utilising current practice information systems and electronic documentation wherever possible and minimising the workload of general practice keeping relevant CCG information up to date, by centralising this functionality.

5.2 Supporting GP Resilience

Across the country, general practice is under pressure. This is no different for Cambridgeshire & Peterborough with a number of practices being identified as requiring support to become more resilient. The CCG will continue to work with NHS England to support vulnerable practices to develop a clinically sustainable model of care, and support practices to come together in innovative ways to alleviate the challenges they face. 10 local practices have recently been successful in their bids for resilience support for 2016/17. The total value of this support is £145,381.

5.3 Time to Care & GP Development

The CCG will be running a local programme to release capacity (*Time to Care* [8]testbeds), focusing on the implementation of the 10 high impact actions. This programme will be run through the STP, under the governance of the local Area Executive Partnerships (AEPs). Additionally, the CCG will work with NHS England on the national programme for releasing capacity in General Practice.

144

By working across groups of practices in local areas, providing time, facilitation and shared learning, the *Time to Care* testbeds will seek to strengthen primary care resilience and improve local relationships within primary care and across the interfaces with community and acute services. Each testbed will work through five phases, running for approximately 12 months in total, with the most intensive support provided in the first four to six months.

The programme includes five phases and is outlined as follows:

Phase 1 (approx. 6 weeks) - **Understanding the current state** - Develop a deep understanding of the current state, challenges, vision and local population in testbed areas

Phase 2 (approx. 4 months) - **Creating capacity for patient care** - Create capacity in general practice through changes in operational practices, using quality improvement methodologies, as well as improving integration and standardization of care across Cambridgeshire & Peterborough.

[8] Planning guidance: CCGs should have clear plans for how they will support the planning and delivery of a local Time for Care development programme, to implement member practices' choice of the 10 High Impact Actions.

Phase 3 (approx. 4 months) - **Implementing an integrated, proactive model of care for patients with Long Term Conditions (LTC)** – Build on current MDT model to actively support patients with LTC and create capacity for GPs by redirecting appropriate LTC visits into community and social care teams

Phase 4 (approx. 6 weeks) - **Implementing/improving community support for acute illness in children and adults** - Improve primary and community based capacity for minor acuity

Phase 5 (ongoing) - **Scaling effective interventions across the system in a localised, step-wise manner**

The first three *Time to Care* testbeds will commence in February 2017, with further testbeds commencing in phases throughout 2017/18. Funds identified by the CCG for Practice Transformational Support (refer below to *Section 7: Investment*) will be used to resource the testbeds and enable the practices, working in groups, to source quality improvement support, specialist facilitation and professional advice associated with reconfiguration and implementation of aspects of the new care model.

In addition, the CCG will make a bid for General Practice Forward View Development Fund resources to link the specialist teams sourced nationally to the groups of practices in testbeds in creating capacity, improving systems and reducing variation.

5.4 Key Deliverables for the Next Two Years

Key Deliverables	Baseline position	Key Actions/Milestones (2017/18 – 2018/19)
Implementation and monitoring of national contract requirements	All 2017 – 2019 Trust contracts negotiated as agreed as per national contract requirements (December 2016)	• Hospital interface requirements will be monitored monthly to ensure delivery and appropriate contract mechanisms used where necessary • Monitoring via practices to ensure compliance quarterly
CCG/STP demand management programme	Increasing demand for elective care with multiple drivers for why GPs refer, including multiple pathways, providers and clinical threshold policies. In addition, GPs need to manage patient expectation and increasing risk of litigation Referral management processes and pro-formas are not streamlined	• We will develop consultant virtual triage and assessment services within Acute Trusts. Significant work has happened in the STP around introduction of CASs where A&G is the default choice in providers. Two main phases for Go Live - February for April and July increases in specialties with CASs. The first phase focuses on CAS's for the 4 main specialties of the STP - Cardiology, MSK, ENT and Cardiology. The second phase is for acute providers and the CCG to look to clinical specialties or specialties where there are capacity pressures to launch new CASs to reduce demand for FAOP. This second phase is phased for Q2 2017 • We are currently implementing a project that will develop clinical support tools/processes to support and simplify the referral management process for GP providers, with an aim to have this in place by September 2017. This project involves actively working with practices to ensure that the tool/processes are effective in supporting their decisions and directing patients to the right place, at the right time
GP Resilience	Some practices already identified as requiring support to become more resilient as they struggle to meet increased demand and to deliver quality services to their registered population due to workforce challenges 10 practices successful in their bids to secure national resilience funding support in 2016/17	• Continue to work with NHS England to support vulnerable practices to develop a clinically sustainable model of care • Run *Time to Care* testbed programme supporting practices with implementing relevant high impact actions • Continue to support practices as required, especially those who are rated inadequate by CQC and/or are in special measures • Support Federations and practice groups(via the GPFV transformation fund) in their development of new models of care and workforce
Time to Care Testbed Programme	Expressions of Interest process completed with three groups selected as pilot sites	• Implement *Time to Care* programme with successful testbeds beginning April 2017 • Evaluate programme using a PDSA approach that will inform the success or otherwise of this programme (learn as we go) • Use evaluation to determine how the CCG can continue to support practices and enable them to free up time with an aim to deliver an enhanced service for people with LTC

6. Infrastructure

Ambition 6: Our strategy will be enabled by ambitious digital and estates strategies. We wish to maximise the benefits of modern information technology, and to develop a clear approach to premises investment linked to the service and provider developments above.

As stated, in guidance provided by the local NHS England team, successful delivery of the GPFV is reliant on having the right infrastructure in place to make the changes that will transform care and keep services sustainable. Our local digital roadmap and estates strategy will therefore enable Cambridgeshire and Peterborough to deliver on the seven ambitions outlined within this strategy for general practice.

6.1 Local Digital Roadmap

Our Local Digital Roadmap describes our digital strategy for Cambridgeshire & Peterborough. It is under-pinned by four key ambitions.

1. **Paper-free at the point of care (PF@POC)** - health and social care staff will be able to access patient and citizen data electronically wherever they or the patient or citizen are.
2. **Digitally enabled self-care** - patients and citizens will be able to interact electronically with health and social care providers about their own health and care. This can include patient apps.
3. **Real time analytics at the point of care** - the clinical system used by the clinical staff will have the ability to provide real time analysis of the data about the patient and citizens across the health and social care systems including patient/citizen provided data.
4. **Whole systems intelligence to support population health management and effective commissioning, clinical surveillance and research** – providing access to pseudonymised data for analysis across the whole footprint.

In relation to general practice, technology changes, information exchange and new digital services have already been deployed to support the delivery of primary care at scale. These developments will continue to be supported as we further develop new models of care.

Digital plans over the next four years for general practice will continue to focus on:

- improvement of patient access to PatientOnline, in order to book GP appointments, order repeat prescriptions, view results and view clinical letters

- implementation of practice wi-fi and replacement of N3 network
- online practice consultation software systems – we will participate in the national programme through the General Practice Forward View to maximise opportunities for providing consultations online. Many practices across the CCG are already incorporating e-consulting into their range of appointment options – we will seek to ensure that this is a consistent offer to patients and a viable alternative for general practice teams who wish to develop this further.

Provision and use of services digitally to patients within Primary Care tends to be higher than the national average. For example, approximately 20% active patients are using Patient Online services. Cambridgeshire & Peterborough CCG is actively working with NHSE Digital to meet the national requirements and timeframes for delivery.

6.2 Estates Management

In recent years, with the organisational changes that have occurred, it has become less clear where the responsibility lies to plan and develop primary care building infrastructure for the future. There is a perception that the current estate is not flexible enough to cope with either the new growth anticipated and/or new models of care, which will see increased provision of care in the community, greater integration and co-location of providers and an evolution of primary care based ‘hubs’.

148

Our emerging system estates strategy recognises the need to maximise usage within the existing portfolio and to seek solutions which integrate service provision. There is a need to balance the opportunity of ‘hubs’ with the on-going need for local delivery, close to patients. Development, for example, of the combined general practice/urgent care (MIU) hub model of care currently being considered as part of our STP may mean a reconfiguration of the current estate.

Where new growth projections mean that existing estate cannot meet the needs, development of premises will need to be designed with new models of primary and community care delivery in mind rather than based on traditional approaches to service provision. Links with local planners and developers ensure that maximum contributions from housing developers are achieved to invest into premises expansions.

6.3 Estates and Technology Transformation Fund

Investment secured through the Estates and Technology Transformation plan is being progressed to support the sustainability of general practice through investment to:

- support more flexible ways of working
- increase the physical capacity across a range of sites to accommodate population growth, support services integration and at-scale ways of working.

The investment detail is outlined below in Section 7.3.1. It should be noted, however, that the current level of investment was secured prior to the development of this strategy (and the wider STP strategy for estates) and therefore may potentially need to be re-aligned. In addition future revenue needs to be quantified and approved.

6.4 Key Deliverables for the First Two Years

Key Deliverables	Baseline position	Key Actions/Milestones (2017/18 – 2018/19)
Improvement of patient access to PatientOnline	Across Cambridgeshire and Peterborough, approximately 20% active patients are using Patient Online services The national target for 2017/18 is that there will be a minimum 20% of patients registered for online services at each GP Practice. As at December 2016, 54 practices had already achieved this target	• Continue to support and enable practices to meet the national requirement of 20% by March 2018 by sharing the learning and providing strategies for improving uptake
Implementation of wi-fi in all General Practices	It is anticipated that wi-fi will have been installed in 37 sites by March 2017. Funding to support this initiative was secured via the 2016/17 bid for ETTF. Future funding for further implementation is still to be confirmed, with a national completion target, however, of December 2017	• Continue to work with NHS England to confirm funding and specification requirements and resources to achieve the national target for implementation for all practices by December 2017
Increase on-line consultations	On-line consultations were included in Greater Peterborough's Extended Access bid to the Prime Minister's Challenge Fund, with 13 practices piloting a service model for delivery. There are lessons to be learned from this pilot that we need to take forward Further clarity is required to understand what we mean by this type of consultation (clarity of definition) and therefore how it could/should be delivered to meet and/or manage key stakeholder expectations	• Develop and agree proposal for commissioning on-line consultation software system, including roll-out plan. • Include this consideration within the *Time to Care* testbed programme for those practices participating in the first three pilot sites, using the learning from Greater Peterborough • Incorporate this within plans for extending access across all practices
ETTF-implementation of planned initiatives	ETTF funding for 2016/17 of £1.75m has enabled development of practice facilities/ IT initiatives, which are due for completion by March. Additional estates funding (£3.35m)has been identified with a planned trajectory over the next three years through to 2019/2020, however, funding for IT development has yet to be agreed going forward	• Deliver implementation of estates development cohorts two and three as planned 2017/18 and 2018/19 • Work with key stakeholders to continually assess programme in line with wider system plans as these develop under STP transformation programme
Support for the development of the STP Estates Strategy	Our emerging system estates strategy recognises the need to maximise usage within the existing portfolio and to seek solutions which integrate service provision. There is a need to balance the opportunity of 'hubs' with the on-going need for local delivery	• Review of all local estates by STP Area to help inform system wide strategy, which is planned for completion on 31 March 2018

7. Investment

The case for change and associated ambitions to deliver the transformation of general practice in Cambridgeshire and Peterborough requires significant investment. This investment includes current CCG baseline funding, GPFV transformation fund and funding provided via NHSE and HHE. Our assumption is that we are meeting minimum required levels of spend; however, further work will be required over the next year to fully understand the required investment as we implement this strategy and the STP programme moving forward.

7.1 Transformational Support

The Transformational Support Fund of £3 per head for 2017/18 and 2018/19 will be equally allocated over the next two years. This equates to approximately £1.4m each year. This investment, however, is indicative at this stage and will require CCG approval with key performance indicators/success measures, as set out in the Delivery Plan, monitored by the Primary Care team.

As we implement our plan for 2017/18, we will flex our budget, as required, to reflect the level of development achieved and/or need for a greater level of investment upfront to achieve success.

Area of Investment	Investment 2017/18 (£)	Investment 2018/19 (£)
Primary care at scale - Supporting the development of new models of care and preparing practices outside the Greater Peterborough for increasing access	933,762	756,412
Workforce – supporting CEPNs and delivering the workforce plan	115,000	115,000
Workload – *Time to Care* testbeds and supporting referral management	200,000	150,000
Contingency - To support other general practice management, pathway development and programme administration if required	149,238	376,588
Estimated Total Funding	**1,398,000**	**1,398,000**

Note that the investment allocated for 2018/19 reflects the following:

- continued investment for LUCHs and PCH/MCP acceleration, but also to support other emerging models of care as they develop for those practices not involved with current LUCHs, PCH or MCP initiatives
- reduced investment for extended access preparation, practice mergers
- on-going investment in testbeds and CEPNs to support development of models of care and integrated pathways
- on-going resource to support the workforce plan.

- increased centrally held resource to be allocated to supporting implementation of STP ambitions regarding LTCs and integrated workforce.

7.2 Ring-Fenced Devolved Funding

Funding has been devolved locally and ring-fenced over the next two years for:

i. on-line consultations
ii. training of care navigators and medical assistants
iii. extending access for all practices

The total level of funding will be £5,913,579. This is set out in the following table

Initiative	2017/18 Funding (£)	2018/19 Funding (£)	Plan for Delivery
On-line Consultations	242,474	323,921	Develop and agree proposal for commissioning on-line consultation software system, including roll-out plan. This plan will build on current practice development that has occurred in Greater Peterborough as part of the extended access programme and new model of care development within practices.
Training Care Navigators & Medical Assistants	161,649	161,960	Develop and commission a local rolling care navigator training programme delivered at scale and available to reception and administration staff within each C&PCCG member practice. We will work with local HHE and practices to develop options for design and implementation of the Medical Assistant role.
Extended Access	1,401,692	3,621,883	Funding for 2017/18 will be used to commission extended access in Greater Peterborough. From 1 April 2018/19 the CCG will commission extended access across the Cambridgeshire & Peterborough STP footprint. Over the next year, we will work with GP Federations and practice groups in preparation, beginning with local urgent care pilot sites in the Fenland area and successful *Time to Care* testbed practices.
Total Funding	**1,805,815**	**4,107,764**	

7.3 Other Investment

Other investment that is available to support the delivery of this GPFV strategy includes the following initiatives. Some of this funding covers multiple years, beginning this financial year 2016/17.

In submitting and supporting bids for the ETTF, the CCG undertook a due diligence process to ensure planned initiatives were achievable, however, it will be mitigating any residual revenue impact risk as part of the STP's digital roadmap and estates strategy.

Initiative	Total Funding (£)	Plan for Delivery
GP Resilience Programme	145,381 (2016/17)	10 practices recently successful in their bids for resilience support this year. The CCG will continue to support practices requesting resilience funding.
ETTF	5,188,276 (2016/17 – 2019/20)	Total funding over three cohorts to be delivered over four years, based on bids from practices and the CCG submitted in 2016. Excludes funding for IT initiatives that were in original submission for 2017/18 and 2018/19, which now have to be bid for separately
GP Trainees (HEE)	TBC	In addition to supporting Health Education England's GP trainee programme, workforce plans include aims to strengthen recruitment and retention.
Practice based MH therapists	TBC	PRISM is a new primary care service for mental health and run by Cambridgeshire & Peterborough Foundation Trust. The service puts specialist mental health staff in GP surgeries so that patients with moderate to high mental health conditions can be seen there and then. PRISM staff are also there to provide GP practice staff with specialist mental health advice on patient care.

7.4 Delegated Commissioning

Ambition 7: If we take on delegated commissioning in 2017, we will focus on ensuring a smooth transition of responsibilities, and work to improve contract administration and responsive contractual decision-making

Cambridgeshire and Peterborough CCG has applied to take on delegated commissioning responsibilities from NHS England beginning in April 2017.

Our first task in the period before this transition is to exert pressure on the organisations to ensure the appropriate systems are in place to make timely payments for contracted work already being undertaken (whether commissioned by the CCG or by NHS England). We will also address pressing local commissioning issues. We want to get the basics right, reduce irrelevant clinical and administrative activity in primary care to take pressure off practices by asking them to collect and report only those measures that improve outcomes for patients. We will continue to address quality and service variation, and are presently developing a practice-level outcomes dashboard to inform efforts to standardise patients' experience for the whole population.

In the event that the CCG does not take on delegated commissioning, we will work with NHS England to support a reduction in bureaucracy and improved administration. We will continue to work on understanding the reasons for variations in general practice (particularly on quality, referrals and prescribing), and work on reducing any unwarranted differences.

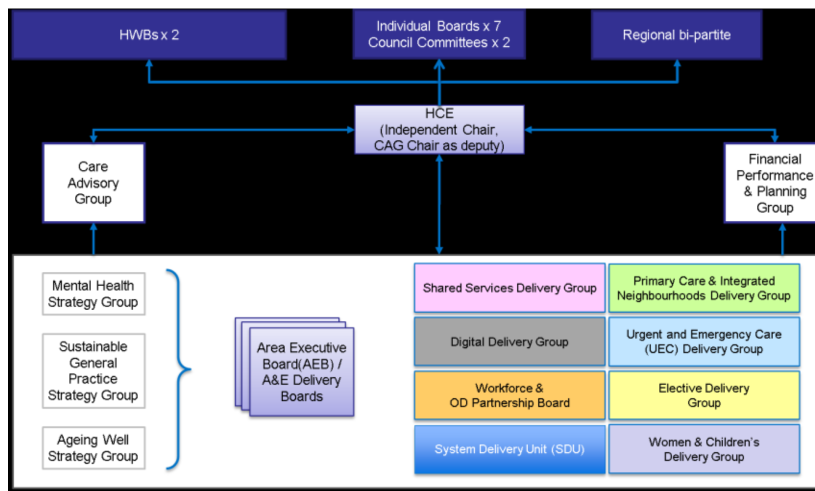
8. Governance and Programme Management

8.1 Governance

The governance structure required to support and enable the successful delivery of this strategy sits within the STP for Cambridgeshire & Peterborough. Three Area Executive Partnerships for Greater Peterborough, Huntingdon and the Fens, and Cambridge and Ely, are responsible for ensuring implementation of projects (including savings realisation) where a common design needs to be tailored locally. The projects supervised include a mix of proactive care (e.g. integrated neighbourhoods) and reactive care (e.g. in-hospital flow, attendance avoidance).

The STP has established eight delivery groups covering UEC, elective, primary care and integrated neighbourhoods, women and children, workforce and organisational development, digital, shared service, and system delivery. These groups are responsible for ensuring implementation, including benefits realisation, designing projects and delivering projects (where implementation needs to happen consistently across our footprint). Delivery groups are also tasked with horizon scanning to identify future opportunities that support system sustainability. In addition, there are three cross-cutting strategy groups for Sustainable General Practice, Mental Health, and Ageing Well. These groups are responsible for steering/quality assuring projects that span multiple delivery groups and, in particular, implementing the GP Forward View, mental health strategy, and aspects of BCF implementation. These groups may develop business plans for future savings and investments that pertain to more than one project group, across multiple delivery groups.

These groups are structured as follows:



153

8.2 Programme Management

The CCG has recently restructured and created a new Primary & Planned Care Directorate. The primary care team within this Directorate will be responsible for implementation/programme management of this strategy. Please refer to the Delivery Plan and Risk Register attached. A *Prince* light project management methodology has been adopted by the CCG, using a web-based tool (WAVE) to ensure robust programme management is in place.

8.2.1 Stakeholder Engagement

As this strategy evolves and we progress development of new models of care, we will continue to engage with key stakeholders, including C&PCCG general practice members, patients, GP Federations, the Local Medical Committee (LMC), our local Sustainability Transformation Programme (STP) clinical working groups, as well as external partners such as Social Care and HealthWatch.

Healthwatch Cambridgeshire has specifically made comments on this draft plan during its development and will continue to support further development and engagement, as Cambridgeshire and Peterborough's GPFV strategy evolves.

> "We welcome the strategic approach and the investment to build a strong platform for primary care across the whole area. It is good that elements of the support described in the plan are available to all practices, as well as the opportunities to move quickly with those that are leading change.
>
> These investments, although falling short of the overall population growth for the area, are vital to lay the basis for ambitions described in the *Cambridgeshire and Peterborough Health and Care System Sustainability and Transformation Plan* (October 2016). Healthwatch supports the STP vision to shape care around the patient and the community, and to support them in their home and neighbourhood where it's safe and effective to do so. We know that empowered individuals, families and carers, can be enabled to make even greater contributions to their care and well-being. This strategy and its delivery plan should show more powerfully that local people are indeed part of the solution to the ambitious transformation that is required for a hard-pressed workforce, with their partner organisations, to adapt and provide joined-up care for all in the coming years.
>
> It is Healthwatch Cambridgeshire's view that:
>
> - this strategy should be available to the public in formats they can understand and respond to about ideas and concerns
> - should support hard-pressed GPs to find space to respond and develop solutions that work for them and their communities. More detail on existing examples of practice and models of care that support the integration of care for patients should be shared and learnt from
> - the necessary cultural shift, training and funding to support shared decision-making with patients and self-care should be acknowledged more clearly

- a communications plan and public engagement strategy should support ongoing exploration of issues such as the public understanding of different roles in primary care, and the potential impacts on help-seeking behaviour
- the delivery plan and risk register should reflect and be regularly updated on issues arising from patient and public engagement.

Healthwatch Cambridgeshire will support communications to the public about developments for general practice and in primary care. We will spread our learning from working in detail with practices on how to develop their Practice Participation Groups to reach their full potential”.

The CCG believes in the patient voice and fully commits to engage further with both Cambridgeshire and Peterborough Healthwatch, but also directly with patients and actively involve them, as we further develop and implement this GPFV strategy.

This strategy will be included in the public STP engagement plan, and it should be noted that engagement for plans to pilot local urgent care hubs in Wisbech, South Fenland and Ely has already occurred and will continue as the model develops over the next 12 months.

9. Appendices

9.1 Appendix One: Delivery Plan

9.2 Appendix Two: Risk Register