NHS

Birmingham CrossCity
Clinical Commissioning Group

Primary Care Strategy 2016/20

Our commitment

We will commission an enhanced and high-quality primary care service; one that delivers an increased range of services to all local patients, regardless of where they live in Birmingham.

Patients will be able to access primary care services easily; for both urgent and planned care. As far as possible, we will strive to ensure that patients complete their episode of care, with all appropriate tests and investigations, undertaken at their first point of contact with the NHS. It is also crucial, that a clear and ongoing plan is developed in partnership with them.

Patients will receive joined-up care across the range of general practice, community care, intermediate care, mental health services and social care. We will reduce unnecessary duplication across administrative and clinical services, by making services more efficient and reducing the need for patients to repeat their story.

Primary care will be responsible for improving health and wellbeing and preventing illness. This will help to reduce health inequalities across our city.

We will support the development of new and emerging provider organisations, as well as working with existing organisations, to develop fully accountable partners. We will work together to improve the health of local people and ensure the delivery of a sustainable primary care system.

We fundamentally believe that general practice should continue to treat all patients, with a wide range of medical conditions. This is achieved by using their expert communication skills and ability to assess and manage patients, in a timely way, whilst recognising when patients would benefit from more specialist input. We need to build on this generalist expertise; not change it into an overly specialist service.

The story so far

NHS Birmingham CrossCity Clinical Commissioning Group has the fourth largest population of all clinical commissioning groups (CCGs) in England. We have 100 member practices and commission healthcare service for around 715,000 people.

As a GP led membership organisation, we have always recognised the importance of strong primary care and a thriving GP service.

In April 2013, we launched our Aspiring to Clinical Excellence (ACE) scheme for practices; ACE started with a foundation level, which focused on improving the quality of general practice across the city. Through this scheme we have improved both adult and children's safeguarding, now screened over half our population over the age of 65 for atrial fibrillation, identified and supported thousands more carers and improved the quality and safety of our prescribing.

From this initial building block, we developed ACE Excellence, which delivers a universal and enhanced service for all patients in general practice, close to where patients live. ACE Excellence has acted as a major catalyst; motivating practices to work together in larger groups to deliver a universally enhanced level of patient care. We have 100 practices working together in 15 ACE provider groups. All of our patients now have local access to quality assured diagnostics; ECGs, spirometry, 24 hour blood pressure monitoring and injectable treatments for diabetes.

Through ACE Excellence we have also focussed on improving management for a range of long-term conditions, with a holistic patient-centered approach at the core of these services. ACE provider groups have started to work much closer with community services and mental health services to deliver this more integrated care.

The Five Year Forward View, published in October 2014, and the vision of primary care at-scale, with the plan for multispecialty community providers and ultimately fully accountable care organisations, has confirmed our local aspirations.

This national direction of travel has given further impetus for practices to look to work even more closely together and consider the structures that might best support them to do so. The CCG supported this further development and out of facilitated workshops and discussions; a GP provider group, a new corporate partnership and federations have since emerged. These different models reflect the CCG's approach to support all our practices to develop in the way that they choose, but always with a focus on high-quality care.

Listening to local people and our members

In December 2015, an independently commissioned primary care survey of 1000 residents across Birmingham told us that the majority of patients would like to be able to access primary care on a Saturday and most would like to have a drop-in session service at their practice, in order to guarantee obtaining an appointment.

In addition, people told us that they feel it is more important to see the same GP and go to the same building, as opposed to having access to a range of services that may be located in different settings, with the possibility of getting an earlier appointment. Telephone consultations would help patients to more effectively communicate with their GP and patients are happy to see other clinical or medical professionals, instead of a GP.

In January 2016, we asked local people for their views on the accessibility of urgent care. Patients told us that they want to be able to access urgent medical advice and treatment in Birmingham more easily; 24 hours a day, seven days a week, in easily accessible locations, with good transport links.

Dedicated membership events in January 2016, have acted as the main catalyst for facilitating discussions for shaping and agreeing the priorities for primary care in Birmingham and the overall development of this strategy.

The challenge

The biggest challenge, and opportunity, for Birmingham CrossCity CCG is to ensure we are offering consistently high-quality care to our diverse local population.

Birmingham has an ethnically diverse population; with over one million residents in total. People living here are also younger than the national average, and we have a very large student population. Birmingham is ranked the ninth most deprived local authority in the UK.

Over three quarters of the city is in the most deprived 40% areas nationally. Nearly half of our under 18's live in the most deprived 10% areas in the country. Life expectancy is lower than the national average, the variation in life expectancy across the city ranges from 85 to 76 years.

We understand and appreciate that this diversity and variation requires us to work differently, to ensure that local people are receiving consistently high-quality care that is responsive to their needs. We would like to address the health inequalities across the city and reduce the gap in life expectancy.

The variability in GP services across our city, especially in terms of good and consistent access and the overall level of provision, is another challenge. There are also workforce challenges, with large numbers of GP leaving the profession for a variety of reasons. The primary care estate is variable too, with state of the art facilities in some areas, whilst other areas require improvement and development.

Our strategy

This focussed strategy has been developed in consultation with local patients, clinicians and organisations; it will be delivered through a detailed operational plan to be developed in the coming months, and implemented over the next four years.

This strategy outlines the vision for the next four years and sets out some clear steps that will need to be taken on the way, both by us as commissioners, and also by providers of primary care.

The strategy also sets out the rationale about our key areas of focus, why these are important, what we expect services to look like and the model of care that we will deliver. It then goes on to outline the steps that will need to happen to get there, as well as how we will know that we have delivered what we know to be important to people in terms of improved outcomes. These are reducing health inequalities and developing a high-quality primary care service that people can access quickly, in time of need, and with confidence that their needs will be met.

The key areas of focus are:

1. **Access:** accessible primary care, which is responsive to people's needs.

2. **Whole person:** person centred care, delivered seamlessly.

3. **Support:** empowering patients to have more control and respond to the current challenge in primary care provision.

4. **Treat:** providing the right care, quickly, close to home.

1

Access

Accessible primary care, which is responsive to people's needs.

Why is this important?

It is really important to patients to have good access to local primary care services.

Good access is the foundation to a high performing and functioning local NHS health economy.

Small changes in primary care have big impacts. For example, for every person that attends an accident and emergency department, 17 people are seen in general practice.

General practice and wider primary care services are currently under pressure and the current inequity of access for people in different parts of the city needs to be addressed.

What will this mean for you?

When someone needs medical advice and treatment, they need care they are able to access at the right time, in the right place.

There will be faster access for children who are acutely unwell.

Medical advice will be available in different ways, such as phone and online, as well as face-to-face to meet patients' different needs.

There will be 24 hours a day, seven days a week access to high-quality, urgent primary care services.

A service that continues to deliver continuity of care, to the patients who need it.

Improved access and preventative treatments for vulnerable people, such as the homeless, patients with learning disabilities or severe mental health problems, and other people who currently struggle to access primary care.

High-quality care, which meets your individual needs.

What we need to do

Ensure that we set high standards of access to services and make local people aware of the services that are available to them.

Ensure that information provided to patients is in an accessible format, which meets their individual needs.

Develop direct access pathways into defined services, to enable patients to self-refer where appropriate e.g. physiotherapy and podiatry services.

Ensure that staff are working to the limits of their competency and ensure that competencies are defined and understood by whole team.

Build teams with a wider range of health and care professionals.

Encourage smarter working across across the whole general practice team.

Adopt appropriate technology, to help signpost patients to most appropriate services.

Explore new contracting models that enable practices to work together.

Define and agree outcomes for patients that link together the responsibility for delivering these across pharmacy, community services and community mental health.

Lead the way in securely sharing patient information, to provide a more efficient service, as well as better and safer care.

Develop services that reach people who have the poorest health outcomes, who may not currently access full primary care services.

Commission a fully integrated primary care and urgent care service.

Ensure that as far as possible, health problems are dealt with by the first medical professional seen by the patient.

Develop and implement a wide ranging estates strategy, with a view to reducing the total number of buildings and maximising the use of remaining assets.

How will we measure success?

We will:

Set standards for access, which can be measured. For example, accessible information about the next available GP appointment and the ability to receive telephone advice.

Achieve reductions in health inequalities, by committing to specific aspirations for particular patient groups and medical conditions.

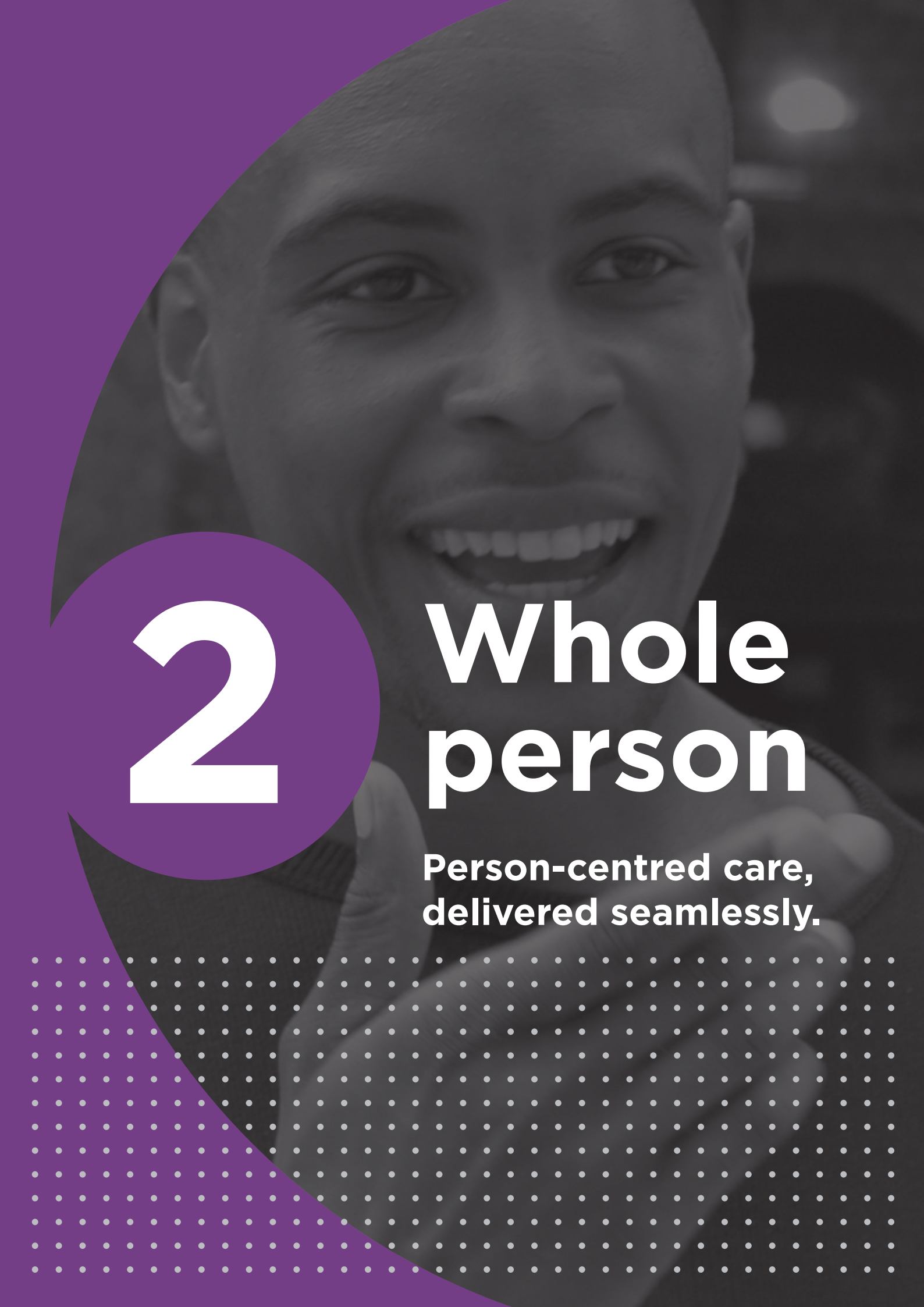
See improved patient satisfaction regarding access to primary care. We will make a commitment to a specific aspiration and will measure ourselves against this.

Have improved feedback from the Friends and Family Test and the national GP patient survey; both of which are independent and statistically reliable sources of information.

See reductions in non-elective admissions and people attending accident and emergency departments.

See higher levels of satisfaction, through a nationally mandated and locally implicated GP workforce survey.

Have higher levels of workplace satisfaction and a reduction in sickness absence across whole team, through an improved primary care staff survey.



2 Whole person

Person-centred care, delivered seamlessly.

Why is this important?

People rightly want and expect seamless care delivered around them, as an individual, and not around an organisation or outdated way of providing care.

Holistic care delivers improved outcomes in terms of quality, but also patient reported measures, such as quality of life scores.

Looking at the whole person reduces the potential for crises and the non-elective admissions that can occur as a consequence. This is a benefit for both the patient and the NHS.

It reduces duplication and the frustration of a patient telling their story multiple times, to different healthcare professionals.

Mental health and physical health problems frequently co-exist. They need to be managed together, in order to improve the overall health and wellbeing of an individual.

Social care and other factors that affect wellbeing, such as isolation and environment, need to be integrated with health. This will help to ensure all a person's needs are being met.

We need to ensure that at-risk and vulnerable patients do not fall in-between services and opportunities to intervene are missed.

We recognise that people want to remain independent and in their own homes, for as long as possible.

What will this mean for you?

Continuity of care, by having a named health professional and a local GP practice.

A single patient record, and plan, for your medical and social care needs.

Having your broader health needs addressed, such as social isolation or lifestyle.

Patients who have complex needs will receive the specialist input quickly, when it's needed.

Improved access to a wide range of mental health services, which will be available in primary care.

Faster access to a wider range of diagnostic assessments.

Every at risk, or vulnerable person, will have a named professional who will be accountable to them for the delivery of individualised care that meets their needs.

Services in place that support people to live independently.

The ongoing development of services for people with dementia, their families and carers; as set out in the multi-agency Birmingham and Solihull dementia strategy.

End-of-life care that addresses all the needs of the person, their family and carers, in-line with the CCG's strategy.

What we need to do

Develop integrated teams, including social care, with single line management structures in a progressive and managed way.

Create primary care organisations that are of sufficient scale to deliver an integrated team approach to care.

Develop alternative funding models for patients with complex needs.

Explore a new contracting model with third sector organisations, to help us deliver outcomes such as reduced social isolation.

Work more closely with Birmingham Public Health to improve people's lifestyles, promote the benefits of physical exercise and reduce smoking, especially amongst pregnant women.

Improve access to specialist opinion and advice, working with colleagues in secondary care, to redefine the role of a consultant.

Lead the way in securely sharing patient information, to provide a more efficient service, as well as better and safer care.

Have a single budget for out of hospital health and social care.

Design a primary care mental health service, which is fully integrated with other NHS services, to provide seamless care for our patients.

Further develop our relationships with key strategic partners, whose areas of speciality have an impact on health and wellbeing. Such as; housing associations, the Department of Work and Pensions, relevant third sector and community organisations.

Fully implement the CCG's end-of-life strategy, working in close partnership with hospices and other care relevant providers.

How will we measure success?

We will see:

Improved patient satisfaction across all services.

A reduction in childhood and adult obesity.

A reduction in the number of people who smoke.

A reduction in non-elective admissions.

Fewer people entering long-term residential care and more people living independently.

More end-of-life patients dying in their place of choice.

3

Support

Empowering patients to have more control and respond to the current challenge in primary care provision.

Why is this important?

Patients want to be empowered to have more control over how their care is provided, and be able to confidently self-care.

Many families may need additional support during pregnancy and in the early years of a child's life. This support helps improves the current health of a child, as well as when a child grows up.

There is a current workforce crisis in primary care, with increasing numbers of professionals either leaving general practice, or choosing to work overseas. Morale is low and this needs urgently addressing, this is compounded by a lack of doctors and nurses entering primary care.

Due to the current workforce crisis, larger groups of GP practices need to be supported to be able to develop into organisations that can deliver new models of care, and also become accountable for improving the health and health outcomes of all of their patients.

The full potential of the voluntary and third sectors need to be developed to be able to offer services to people wherever they live in Birmingham, with the same improved outcomes. This may mean working in a very different way.

Support needs to be provided to existing community and mental health services, so they can move towards delivering a fully accountable care model.

What will this mean for you?

You will be able to make more confident and informed choices about your own health and social care.

Parents will be equipped with the skills and confidence to raise healthy children.

The primary care workforce will adapt to new ways of working and delivering care. They will be supported to develop new skills and continuously maintain their full professional competency.

New providers of primary care will be developed, with a view to becoming multispecialty community providers. They will then become organisations who are accountable for delivery of improving the health and the health outcomes of all of their patients.

Third sector and other organisations will work within the new providers, in an integrated and unified way, all focussed on delivering the same outcomes for patients.

What we need to do

Lead the way in securely sharing patient information, to provide a more efficient service, as well as better and safer care.

Support accessible technology and information that enables patients to self-care.

Work with Birmingham City Council's service for children, young people and families department, alongside other agencies, to identify and work with families most at risk.

Expand personal health budgets and make them available to more patients, with appropriate advice and support.

Provide support to help patients make a decision, before any medical intervention.

Work with new and existing providers to develop new models of care and support their response to the primary care strategy.

Increase capacity in primary care, by streamlining processes and working smarter.

Support practices to become more efficient, through improved working practices and the use of technology.

Provide regular education and personal development opportunities to the primary care workforce.

Define the limits of clinical competency and support all people to work to this level.

Work with practices and Health Education England, to describe the future of the primary care workforce.

How will we measure success?

We will see:

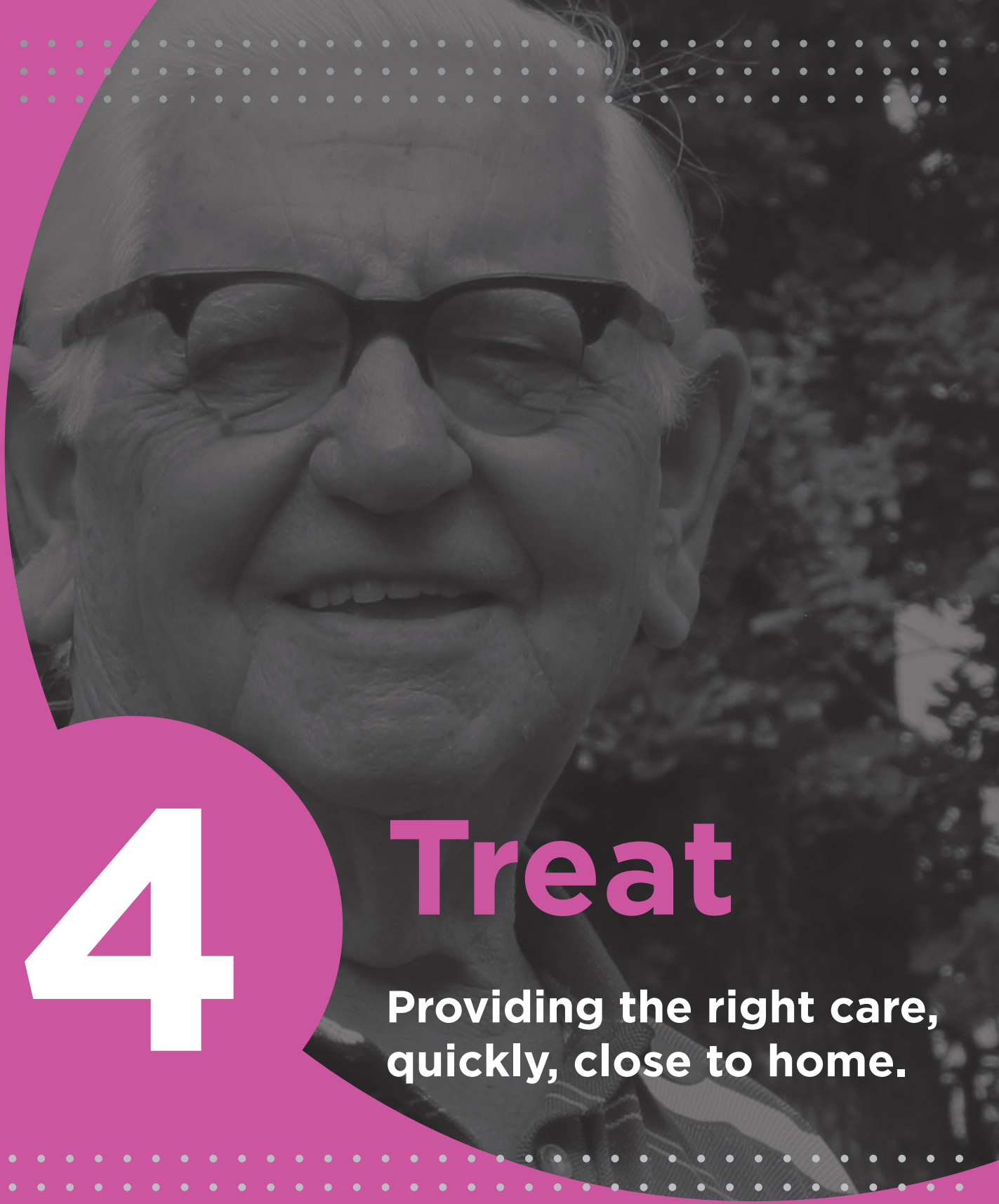
More patients who feel more supported and are able to make decisions about care.

More patients who are in receipt of personal health budgets.

Positive feedback from GP workforce survey, with an increase in job satisfaction.

Increased retention of current staff and more people applying to work in primary care.

New organisations flourishing, as a result of appropriate support.



4 Treat

Providing the right care, quickly, close to home.

Why is this important?

People who are at particular risk of illness need to be identified, in both primary and secondary care settings. By treating people early, this reduces morbidity and improves the health of the whole population.

Every patient should receive the same high-quality and local of care, regardless where they live in Birmingham.

Treating all patients according to the best available evidence, will both improve clinical outcomes and reduce non-elective admissions and accident and emergency attendances.

Patients, when unwell, want and need rapid investigation. By receiving treatment quickly, this reduces uncertainty and the associated anxiety.

Patients want to be treated as close to home as possible, in an appropriate and clean setting, with the right equipment.

Patients want to be treated by a professional who has access to the correct and up-to-date information about them.

Care that is appropriately delivered and resourced in primary care frees up specialist capacity for patients, when they need it.

What will this mean for you?

Targeted focus on the conditions that are responsible for the health inequality gap. Specifically; diabetes, respiratory and cardiovascular disease.

A universal offer of an extended, locally based, primary care service.

You will receive evidence based treatment and specialist opinion rapidly, when required.

Consultants working within an enhanced primary care team, to support the high-quality delivery of care. This will result in improved outcomes to a whole population of patients, in areas such as; diabetes, heart failure, rheumatology and elderly care.

Clinicians, who work in both primary and secondary care, will have increased knowledge of services available in primary care. This will result in better patient experience.

Modern buildings and infrastructure, providing an appropriate setting for delivering high-quality care, that is fit for purpose.

Quality assured enhanced primary care provision.

What we need to do

Continue to develop the ACE programme, in order to deliver local investigations in primary care. This must be available to all patients in their local area, but larger than local practice scale.

Identify the most effective treatment interventions in the ACE programme and ensure that they are available to all patients.

Undertake a review of diagnostic capacity across primary and secondary care.

Build capacity in primary care to treat more people in their own homes when unwell, and if admission to hospital is required, support patients to recover in their own home.

Ensure that standardised approaches based on best evidence to common conditions, are embedded across primary care, to reduce clinical variation.

Work with local hospital trusts, to establish new ways of consultants working across primary and secondary care.

To obtain the clinical opinion of a consultant, we need to have access to real-time advice, guidance and referral support. Consultants need to be mapped to local areas on rotation, to establish good working relationships and access support and advice.

Develop a financial and contracting model for primary care, which aligns patient outcomes, supports prevention and early treatment.

Invest in high-quality clinical support and decision aids, to ensure patients are treated effectively.

Develop and implement a wide ranging estates strategy, with a view to reducing the number buildings and maximising the use of remaining assets.

Fully implement and support the Your Care Connected programme, to facilitate safe and effective sharing of patient information.

Work with Care Quality Commission (CQC), to define the standards of quality assured primary care.

How will we measure success?

We will see:

A reduction in non-elective admissions.

Reduced lengths of stay for both non-elective and elective admissions.

An overall reduction in readmissions.

A shorter time for referral to treatment.

Improved clinical outcomes, such as reduction in diabetic complications and strokes.

Validated quality questionnaires, which are condition specific.

A reduction in people who are absent from work, due to ill health.

All premises being fully CQC compliant.

Next steps

The delivery of this four year strategy will be supported by the development of a detailed operational plan.

The operational plan will be a dynamic document, which will evolve over the course of time. We will ensure appropriate governance arrangements are in place to oversee this.

This strategy will also inform our urgent care strategy, as there are significant interdependencies between both documents.

We are developing a sustainability and transformation plan in Birmingham; primary care provision will be a major component of this plan, which will be developed in conjunction with all of our providers.

We will implement the strategy in collaboration with our providers, working with local people throughout, to ensure that as services are developed and refined they deliver the higher quality services we are aspiring to.

In terms of measuring our success; aspirations, baseline information and key metrics will be included in the operational plan, to ensure that we are successfully achieving what we set out to.

We are ultimately accountable to the people of Birmingham and are committed to reducing health inequalities and ensuring high-quality and local care for our patients in the city. We believe that when fully implemented, this strategy will deliver what our population needs from a high-quality primary care service. It will also be fundamental in supporting the long-term sustainability of our health and social care system in Birmingham. We are committed to putting our patients at the heart of this.

Excellence in Commissioning
Through Excellent Primary Care

NHS Birmingham CrossCity Clinical Commissioning Group
Bartholomew House
142 Hagley Road
Edgbaston
Birmingham
B16 9PA

Telephone: **0121 255 0700**
Fax: **0121 682 0090**
Email: **bhamcrosscity@nhs.net**