Prime Minister’s Challenge Fund:

Improving Access to General Practice

Wave Two Application Form

Gateway reference: 02356
Section A. About you

Information about the area, providers and commissioners involved.

1. Pilot project title:

   Better Futures For All

2. Are you a member of the existing Challenge Fund Associate Network?
   ❑ Please tick

3. Lead contact details:

<table>
<thead>
<tr>
<th>Proposal on behalf of:</th>
<th>Bracknell and Ascot CCG General Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Lead:</td>
<td>Dr Jackie McGlynn</td>
</tr>
<tr>
<td>Patient Lead:</td>
<td>Morag Langhourne</td>
</tr>
<tr>
<td>Job title:</td>
<td>CCG Clinical Director</td>
</tr>
<tr>
<td>GP Practice/Organisation:</td>
<td>Bracknell and Ascot CCG and practices listed in section 4</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:Alex.tilley@nhs.net">Alex.tilley@nhs.net</a></td>
</tr>
<tr>
<td>Telephone:</td>
<td>01753 636037</td>
</tr>
</tbody>
</table>

4. Practices involved:

   Please indicate which GP practices are covered, where they are located and approximate population size for each (see Appendix A for a map of the geographic area covered by BACCG practices).
<table>
<thead>
<tr>
<th>Practice name</th>
<th>Practice code</th>
<th>Post code</th>
<th>List size (Jan 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Waterfield Practice</td>
<td>K81001</td>
<td>RG12 9LH &amp; RG42 3JP</td>
<td>11731</td>
</tr>
<tr>
<td>The Sandhurst Group Practice</td>
<td>K81006</td>
<td>GU47 0UB &amp; GU47 9BT</td>
<td>19779</td>
</tr>
<tr>
<td>Kings Corner Surgery</td>
<td>K81010</td>
<td>SL5 0AE</td>
<td>7222</td>
</tr>
<tr>
<td>Heath Hill Surgery</td>
<td>K81023</td>
<td>RG45 7BN</td>
<td>7182</td>
</tr>
<tr>
<td>Magnolia House</td>
<td>K81028</td>
<td>SL5 0QJ</td>
<td>9270</td>
</tr>
<tr>
<td>The Ringmead Practice</td>
<td>K81030</td>
<td>RG12 7WW &amp; RG12 8WY</td>
<td>15498</td>
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<tr>
<td>The Boundary House Surgery</td>
<td>K81032</td>
<td>RG12 9PG</td>
<td>8485</td>
</tr>
<tr>
<td>The Gainsborough Practice</td>
<td>K81059</td>
<td>RG42 3JP</td>
<td>10020</td>
</tr>
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<td>The Binfield Surgery</td>
<td>K81060</td>
<td>RG42 5JG</td>
<td>9773</td>
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<td>Green Meadows Partnership</td>
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<td>Easthampstead Surgery</td>
<td>K81087</td>
<td>RG12 7BB</td>
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<td>The Great Hollands Practice</td>
<td>K81094</td>
<td>RG12 8WY</td>
<td>3683</td>
</tr>
<tr>
<td>Forest Health Group</td>
<td>K81610</td>
<td>RG12 7PG &amp; RG12 1LH</td>
<td>11536</td>
</tr>
<tr>
<td>The Crown Wood Practice</td>
<td>K81656</td>
<td>RG12 0TH</td>
<td>4685</td>
</tr>
<tr>
<td>The Evergreen Practice</td>
<td>K81657</td>
<td>RG12 1LH</td>
<td>3686</td>
</tr>
<tr>
<td>Total population covered</td>
<td></td>
<td></td>
<td>137,857</td>
</tr>
</tbody>
</table>

5. Other providers involved:

Please give details of any other providers with whom you will be collaborating (e.g. community services, pharmacies, 111, etc.).

a) Patient Stakeholder Groups including Patient Reference Groups, Healthwatch, supported with wider engagement through facilitation and insight from Experience Led Commissioning (ELC). We have already undertaken engagement with ELC to support this application and to test existing primary care feedback data through triangulation of evidence with our stakeholders. There is an opportunity to continue this work to ensure co-design within this application.

b) Bracknell Primary Care Urgent Care Centre and East Berkshire Primary Care Out of Hours (OHH) services at RBH Bracknell Healthspace (One Medicare). One Medicare are a new primary care provider that opened in April 2014, who have quickly established good relationships with local practices and provide our patients with urgent access to minor injuries and illness treatment within the community. East Berkshire Primary Care Out of Hours services provide a valued and respected service for our patient through our local GPs. OOHs co-locate with the Primary Urgent Care Centre in Bracknell and work with our members to support our patients to remain in the community and their homes.
c) Berkshire Healthcare NHS Foundation Trust, Community and Mental Health Services are the existing community provider and are members of the CCG membership forum. They have been engaged in the programme to support and innovate the nursing workforce and integrated community and mental health services within primary care.

d) Unitary Authorities (Bracknell Forest Council and Royal Borough of Windsor and Maidenhead) work closely with the CCG to integrate services and most recently developed the model of Integrated Care Teams and intermediate care to support our patients to remain in their homes and their local communities.

e) Community Pharmacies via our Local Pharmaceutical Committee are integral to the sustainability of the changes proposed around sustaining patients accessing out of hospital health services.

6. CCGs covered:

Please indicate which CCGs are involved in this application.

Bracknell and Ascot CCG, King Edward VII Hospital, Windsor, Berkshire, SL4 3DP

7. NHS England Area Team:

Please indicate your NHS England Area Team.

Thames Valley Area Team

8. Patient satisfaction:

Latest position on patient experience of access\(^1\) across your proposed pilot area.

The CCG has drawn on insights to inform this application co designed with local people from a number of additional sources, including:

1. National GP Patient Survey 2014, with patient and CCG reflections across a variety of areas including access and a focus on patient with long term conditions (see Appendix B).
3. Analysis of the public’s feedback and proposals from three sessions with the patients and other stakeholders to inform our emerging vision for primary care in February, June and September 2014.

In addition to the respondents to the GP satisfaction survey, we have had in-depth conversations with over 1,000 people who use primary care regularly and over 160 people who deliver primary care.

\(^1\) See breakdown of access related questions from the latest GP Patient Survey results (by practice) in the supporting documents section on the PMCF web page.
Local understanding of patient feedback from these sources used to formulate this application:

- People who work also need access to routine healthcare, with 38% of people who are working living more than 30 minutes away from their surgery, and 31% of those reporting they cannot have time off work for routine healthcare. Therefore, the current GP core hours do not support access for this population in relation to primary care.
- The GP Survey shows that 78% of patients would like to access appointments after 18:30, and 42% would like access to appointments on Saturdays, with a lower percentage wishing for appointments on Sundays.
- Bracknell Forest Self-Care survey results show that many people have knowledge of health issues and their condition, however people have further shared that they are lacking motivation to put the knowledge they have into effect.
- Carers in Bracknell and Ascot do not give themselves this label, and one observation was that carers rarely attend consultations with the person they care for.
- The GP survey tells us that 15% of patients could not book ahead; more routine appointments through extended hours would support the ability to book ahead for routine care planning and well-being. Bracknell and Ascot currently show a lower uptake for face-to-face alternatives such as telephone appointments, skype and group consultations.
- Currently only 3% book their appointments online, however 45% would like to do this. This illustrates an untapped will for patients to use online services to book, which highlights a wider opportunity to provide more services and resources online.
- The GP survey tells us that 56% of people say they have a preferred GP and 60% see their preferred GP most of the time – continuity of GP care is rated particularly highly with our patients.
- The interviews with patients with LTC and their carers, showed that neither patients nor their carers felt prepared or supported to prevent crises in care.

In January 2015, Bracknell and Ascot CCG invited its community to come together to describe a positive possible future. This event focused on improving primary care support of people and families with long-term health issues in Bracknell and Ascot in January 2017 and beyond. Together, participants in the event explored:

‘What needs to happen so that people with long term conditions receive high quality routine primary care and are motivated to self-manage their condition?’

The following graphic is a plan on a page of what the community would like to see happen to achieve better health outcomes from routine care in people with LTCs. It describes the current and desired experience of care of this specific community:
People’s ambition has three key elements:

**People are involved in decisions about their care. Care goals are joint decisions in partnerships between people and clinicians support:**

- People always feel respected and that they have a choice. We have reached ‘no decision about me, without me’ in reality; not just political spin. The doctor and the person make all decisions together. Everyone feels fully involved in their care.

- People with LTCs have good access to routine care and a real sense of choice; especially around sharing goals.

- People are supported by health professionals who act as much as motivational coaches, setting meaningful targets and goals that are owned by the person for their future health. People feel deeply listened to as a result. People and health professionals feel that ‘we are in this together’.

- People understand their long-term conditions and all information they receive about their conditions, treatment, tests and results. They are confident about managing their condition and this has translated into self-management.

**People know their numbers**

- People recognise they have a responsibility to look after their own health. “They know their
numbers”.

- People understand the system and how to work around it and with it; and where they need to go.

- People understand and respect the cost of care and as a result, they recognise the value of the services they use. This has changed their attitude towards using services and they take more personal responsibility for service use.

**A shift in culture towards community support and partnerships**

- There has been a shift in culture so that the community is now supporting each other. This connection matters and is available both in the physical and online in the virtual world.

- People no longer feel isolated. They do not feel they have to do things and cope on their own any more.

- Young people and their parents know how to prevent LTCs and how to use services because education starts early and their awareness builds as they grow up. As a result, children educate their parents and grandparents on how to keep well.

- Proactive screening within the community means that we catch LTCs early, giving people a greater chance to take control of their long-term condition earlier – or even preventing the onset of a long-term condition altogether.

- The services in Bracknell and Ascot have become one united team. There is joint partnership between health, social care and the voluntary sector. Technology and a change in attitude has driven this change, rather than a change in building or physical location.

- There is distinction between ‘paid-for’ and ‘unpaid’ care; both need to be valued.

- The primary care workforce is happier. They feel they have come off the treadmill and onto the pitch and are now more available to everyone; Bracknell and Ascot United.

These insights and vision, co-designed with our local community, has informed the shape of this bid. We will be continuing to develop wider engagement to shape and design the implementation of the initiatives in this bid.
Section B. What you propose to deliver

Information about the proposed service innovations.

9. Project overview - Please give an overview of the proposed project. Please focus on what changes will be made to services. Max 1000 words:
The 15 practices in Bracknell and Ascot know the challenges that we face within our population, with this in mind the practices wanted to focus on two areas; patients with long term conditions and supporting them in primary care, and the bulk of our population who are working age with lifestyle issues preventing long term conditions.

We are committed to making Better Futures For All, and in the words of our patients and partners we see the challenge to:

“Know your numbers...” – We want to enable patients to become experts in their own health conditions, who will feel empowered to be aware of their own medical ‘numbers’ (e.g., HbA1c for diabetes). Patients will know the cost to our population of their health needs, and value the health and social care services available. Patients will feel empowered to take ownership for their healthcare, and be responsible for their own health in partnership with health and social care services. They will ensure they know where to go for the most appropriate help and feel motivated by the impact of their actions on their health.

Patients tell us that they have lots of information and knowledge about their health conditions, and also know where to find more should they need it. Communication around services that are available to them outside of health and social care, such as voluntary and community providers, would support them in their role of taking responsibility of their health and also valuing all the support services available to them. Bracknell and Ascot patients have indicated in the interviews that they are not currently using these services. However, under PMCF, we would implement a scheme based on the Olympic Games Makers from the Olympics, called HeathMakers. The HeathMakers will be supported to become leaders, and trained in LTCs prevalent in our population; diabetes, mental health and COPD. Every practice will have 2-3 HeathMakers from health care professionals, practice staff or patients. They will support patients to have a voice and apply their hands on skills, attitude and knowledge to support confident self-management of chronic conditions. It will:

- Contribute to reducing patients escalating to unplanned hospital care
- Reduce enquiries to practices around long-term conditions
- Build confidence and awareness of information and how to source it
- Cement solid relationships between patients and healthcare professionals

People are involved in decisions about their care. Care plans and improvement goals in partnerships between people and clinicians support - “My plan is mine! I own it! I Update it!” patients will feel in control through having access to their own patient records, have the confidence and knowledge to achieve their goals.

68% of patients with LTCs in the GP survey who had a care plan felt that they wrote their care plan with their GP. 61% of that group said they use their care plan to manage their health day to day. From the annual Self-Care Survey, most patients reported that they want more control of their health issues.
An ambition from the co-design exercise was for patients to develop their care plan in partnership with their health care professionals; to feel respected, listened to and to give them confidence and motivation to take control. People describe the care plan as the ‘game plan’ for their health team to support them to deliver their goals.

The practices would like to provide the patients with more control around their care, motivate them to improve their health through joint goal setting, and be an equal partner in their health team. Under PMCF, the practices in Bracknell and Ascot will promote and support patients in accessing and owning their patient records through online access. Patients with LTC will be given a digital application (app) which gives them control, motivates them to achieve goals and have access 24/7 to test results and care plans. Technically this will enable patients to input their own monitoring and health improvements into their primary care record providing up to date information for their health team to show improvements in health, and equally identify when patients are at risk of escalating in their condition.

The practice HeahtMakers and patient leaders will be developed as champions to support patients and a central support team will be available in core hours to support patients in their ability to use online services. A recent Bracknell Forest Survey confirmed that 94% of the population had access to the internet, however it is recognised that the skills and confidence of individuals particularly of the older generation may not be at the appropriate level and additional support will be identified.

**A shift in culture towards community support and partnerships** - “No arguments, No silos, Just good service”. This statement identifies integration as a priority in recognizing the benefit to patients and their carers. This focuses on supporting and co-ordinating ways of meeting all the health and social care needs of our patients. Additionally, we want to ensure patients’ views are heard, so that patients can feel in control when decisions are being taken about their health and well-being.

Through the Positive Futures event there was a specific focus around the Bracknell and Ascot team. The values of the team were translated in to how health and social care, plus the voluntary sector, councils, schools, pharmacies and HeathMakers can all add more value together.

Primary care will deliver support to schools, particularly around the upper infant years, where learning and sharing is so exciting; ‘they act like sponges’ through professionals going into schools and teaching about health services (signposting) and wider family health improvement messages, using pester power. Local employers will be engaged to improve the health of their employees, we believe that the bulge in population of ages 40 – 55 (see Appendix C) still have the opportunity to improve their health. In order to reach these populations, as we have learnt through Self Care week, in-reach to communities has a better impact. Some practices have been piloting the use of a Healthhub and we believe that a Healthhub/street doctor service would promote improved health by performing health checks and basic MOTs supported through the education centre currently permanently based in the Primary Care Urgent Care Centre.
10. **Project outputs** - Please describe the expected benefits for patients as a result of the project. Include expected service benefits and how this will support practices in delivery of core primary care. 
Max 1000 words

By April 2016, our patients will benefit from the following projects supporting access to core primary care.

<table>
<thead>
<tr>
<th>Access</th>
<th>Benefits to patients</th>
<th>How will this help support practices deliver core primary care access</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evening &amp; weekend clinics in general practice</strong></td>
<td>Improve access for patients who find it difficult to attend general practices during core hours, or patients with key carers unable to support during core hours.</td>
<td>Enable more patients to access core services in evenings which will provide improved patient outcomes around early detection of LTCs, particularly those that find it difficult to attend during core hours. Provide improved opportunities to prevent ill health through better access to screening and tests for patients who may not normally be able to attend. The additional extended appointments could free up practice time in core hours for the planned management of patients.</td>
</tr>
</tbody>
</table>

"My plan is mine! I own it! I Update it!"

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2 We would expect successful applications to also make reference to how the proposed scheme will achieve the wider range of benefits given in Section 6 of the wave two invitation.
| **Online Services** | Promote the full extent of Patient online services to enable patients to book their appointments online. 

Supporting people in accessing their records effectively and with confidence. 

Providing a personal app to motivate and record a healthier lifestyle with connectivity with their primary care record. 

Engage in community learning courses to encourage patients to use online services. | Patients will be aware of the online services, particularly booking appointments which is common practice for a significant proportion of patients. 

Evidence suggests that through having access to their medical records patients access reassurance about their consultation/condition and need fewer GP contacts. 

Patients will be able to keep a record of the self-management activities and use this information in their care. 

Additional time will be freed up for the practice to proactively support patients in the planned management of patients with LTCs. |

“Know your numbers...”
| **Signposting:** Valuing services | extend access to education and information within practices and community places. Patients will feel they have the best information, consistent with other health services and are able to take responsibility for their health. | Patients will know how best to use their local health services through experience and signposting. Professionals and patients co-design motivational interviewing skills. This would free up practice time in core hours for the planned management of patients with LTC. |
| **Patient Responsibility** | Deliver events for patients to take greater responsibility for keeping well and motivate them to manage their conditions more appropriately and preventing escalation into crisis. Targeted personal invitations to participate in health education events. | Patients will be able to have direct advice and support from multiple local professionals around their condition with their peers. This time enables professionals to deliver clear messages to larger numbers of patients on how they can improve their health and also instill the confidence to manage their conditions more effectively themselves. |
| **Healthhub** | Supporting patients’ self-management with the use of | Patient leaders promoting and enabling patients to self-manage their conditions |
digital technology through the introduction of Healthhub linking to patient records.

Enabling patients to input their own measurements into their primary care records and providing early indications for patients and professionals for significant changes to health.

Create a remote Healthhub with street doctor to visit communities to in-reach to groups, such as schools, workplaces, and community events.

and monitor them via appropriately.

The promotion of a healthier lifestyle should result in less demand on health services, leaving capacity to manage the more complex patients.

Identify patients as risk of becoming ill and targeting advice to them, capturing the population that may not access planned general practice services for screening and monitoring.

### A shift in culture towards community support and partnerships

| **Group consultation** | The patient feels they have had contact with their GP, and the GP has had the dedicated time to motive and share learning around the management of conditions  
They will get direct contact and support from peers who live with the same condition.  
Learning about their monitoring ‘numbers’ and what is normal ranges for them, what to do if abnormal and how others have learned to manage escalations in conditions. | Efficient use of GP and nurse time; systemised follow-up and review of people who use GP services regularly; fewer multiple appointments per patient (‘one stop shop’ for all tests).  
More rewarding experience for clinicians.  
A chance to innovate and develop practice and hone consultations skills that clinicians can also apply and will also impact on one-to-one consultations (especially around behaviour change). |
|---|---|---|
| **Simple Words** | Simple Words aims to improve conversations that either GPs or people or both currently struggle to have well together. | Chance for professionals to get better at supporting patients to take control of their health issues.  
Chance to reduce inappropriate service use in primary care and across other health services. |

We also expect to learn how the GP Out Of Hours service will need to look in future to deliver the new model of primary care, and this will be reflected in a new specification for the service when the current contract expires in 2016.
11. Describe how patients will receive some form of extended access outside of core opening hours above what is already provided. Please specify how many extra hours by practice the pilot will offer on weekdays and weekends (and number of consultations if available). Demonstrate that patients will be able to access general practice services from 8-8 on weekdays (or equivalent) and improved access at weekends. *This will be a minimum condition for receipt of funding.*

Max 1000 words:

Our patients have told us that they need to have access in evening and weekends to their practices, want to use online services for booking appointments, and value maintaining continuity of care for those with LTCs.

- People who work need access to routine healthcare, with 38% of people who work living more than 30 minutes away from their surgery, and 31% of those reporting they cannot have time off work for routine healthcare.
- The GP Survey shows that 78% of patients would like to access appointments after 18:30, and 42% would like access to appointments on Saturdays, with a lower percentage wishing for appointments on Sundays. Currently only 3% book their appointments online, however 45% would like to do this. This illustrates an untapped will for patients to use online services to book, which highlights a wider opportunity to provide more services and resources online.
- The GP survey tells us that 56% of people say they have a preferred GP and 60% see their preferred GP most of the time – the value of continuity of GP care is rated particularly highly with our patients.

**Extended hours model:** based on hours of peak attendance at other weekend services (UCC).

The practices currently work for integrated care in three clusters; this provides an existing platform for the provision of extended hours in an efficient way. The population of the clusters varies as do the sizes of the practices and their resources, so by utilizing the cluster model we have the ability to implement extended primary care quickly.

Across the three clusters this will create the opportunity for a maximum of approximately 40,000 15 minute additional appointments for our patients per annum. We will look to 20% flexibility in outcome measures to enable professionals to provide a comprehensive care review for our more complex patients. This will enable the health partnership to get the best outcomes for themselves preventing admissions and crisis. The submission will indicate an additional number of patients to be 30,000 for a 12 month fully functioning model.

Preferred model:

Practices will come together in three clusters to deliver 8-8 core primary care Monday-Friday, building on the North Bracknell, South Bracknell and Ascot cluster configuration which already
serves the multi-disciplinary integrated care teams across the CCG. This will give sufficient critical mass and skill mix for sustainable access. EMIS Web and interface with Vision will enable all practices to use real time clinical systems and remote booking into extended sessions. This will not preclude larger practices from further extending their hours, and various pilot arrangements are being planned.

<table>
<thead>
<tr>
<th>North Cluster</th>
<th>South Cluster</th>
<th>Ascot Cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binfield</td>
<td>Sandhurst</td>
<td>Green Meadows</td>
</tr>
<tr>
<td>Boundary House</td>
<td>Ringmead</td>
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</tr>
<tr>
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</tr>
<tr>
<td>Forest End</td>
<td>Great Hollands</td>
<td></td>
</tr>
<tr>
<td>Gainsborough</td>
<td>Easthampstead</td>
<td></td>
</tr>
<tr>
<td>Waterfield</td>
<td>Crown Wood</td>
<td></td>
</tr>
<tr>
<td>55,231 patients</td>
<td>56,050 patients</td>
<td>26,576 patients</td>
</tr>
</tbody>
</table>

Practices delivering primary care over the weekend will enable the integration of primary care with community and social care on a 7 day a week basis. This will enable the final models of working to consider the demand for the following deliverables from the cluster arrangements:

- Provide routine 15 minute appointments in extended hours, particularly for complex patients and care plan reviews with carers and professionals present, to avoid unplanned hospital admissions.
- Support integrated care from primary care to ensure that patients ready for discharge have a more successful transfer to the community, with primary care support as needed.
- GPs and nurses working closely providing advice and support for care homes with intermediate care to avoid patients going unnecessarily into hospital.
- Application of group consultations that can increase efficiency, systematise follow-up, activate self-care and improve peer connect.
- Increased use of simple words so that people understand what GP are saying about their condition, treatment and medicines and what they need to do for themselves – and so build improved confidence to self-care. GPs find it easier to uncover hidden agendas and can make diagnoses quicker and more accurately; GPs improve their ability to influence health related behaviour; GPs are able to address inappropriate use of services in an unthreatening way and change service use behaviour.

12. **Sustainability** - Describe how your project will lead to sustainable improvements once the non-recurrent funding is no longer available (including whether your CCG will support the scheme with supporting funding).

Max 1000 words:
| **Evening clinics in general practice** | Additional capacity in general practices will enable a wider spread of demand. Reduction in OOHs activity up to 20:00 and reduction in crisis to A&E. BCF funding if KPIs are met. |
| **Weekend clinics in general practice** | Booked appointments by cluster practices direct to the hub with demand management criteria agreed with patients. The model will be finalized following the pilot period to ensure utilisation and sustainability underpinned by high quality services. BCF funding if KPIs are met. |
| **Online Services** | Initial implementation expected, following a maximum 12 month implementation this will be supporting in existing resources from the expected efficiencies. |
| **Signposting: Valuing services** | Communications plan; built into business as usual following co-design with patients. |
| **Patient responsibility** | Minimum costs beyond implementation phase, annual intake funded through BCF if successful. |
| **Healthhub** | Non-recurring cost initially; target groups through needs analysis in joint venture with public health. |
| **Group consultation** | Funded in PMCF, if KPIs are met will funded by self-funding. |
| **Simple Words** | Funded in PMCF, if KPIs are met will funded by self-funding. |

The main consideration of the practices was the concern around attracting the best skill mix to deliver high quality extended hours, with this challenge in mind the practices are working to implement the following:

**Primary Care Nurse role:**

Through an integrated role between practice nursing and district nursing we will deliver a seamless service supporting the management of long term conditions in primary care and in patient homes. This will be accomplished by extending the skills of community nurses to deliver LTC management in the community.

This scheme will provide high quality and consistent care, meeting the complex needs of housebound patients, the frail and elderly, and also support patients with safe hospital discharge pathways. In the co-design exercise, our local population highlighted their concern for individuals becoming more isolated. The provision of this service in people’s homes to motivate them will improve their own mobility and will result in improved health outcomes.

Our pathway will ensure sustainability of primary care nursing through workforce development; offering continual professional development opportunities and attractive career pathways.

**Retain registrar GPs and trainee Practice Nurses:**

The practices and CCG are working with Health Education England on a programme for first year
qualified GPs and practices nurses. We value the strength in training practices locally and want to retain the skill mix for our local population.

Testing sustainability:

The projects being implemented will have the following questions included in the evaluation criteria:

- Has the intervention increased efficiency or reduced the workload on practice staff e.g. access to on-line booking as well as improved patient experience?
- What learning is there for longer-term workforce development e.g. greater use of community pharmacies, role for generic worker?
- What learning is there about capacity planning over the whole of primary care?
- What measurable improvements are there in the ability of local people to take responsibility for their own health and manage their own long-term conditions?
- What change has there been in the local perception and attitude to primary care and associated use of services?

13. How does the project link to the local strategy for the health and care system including its contribution to improving care for older people, promoting continuity of care, improving overall quality and productivity of local NHS services, and reducing health inequalities?

Max 500 words:

This bid responds to and is in line with the Bracknell and Ascot CCG 5 year strategy for BACCG plan which sets out our vision for primary care:

- Patients are able to secure support from primary care to manage their own condition, including signposting to support groups and charities, to be better prepared when ill.
- Primary care has access to health records to support their patients and provide confidence including giving holistic advice.
- Longer appointments to enable people to discuss their health with a professional, particularly where they have complex conditions.

People, and in particular our older residents, have told us that they only want to tell their story once and they value continuity of care. GPs are committed to keeping people well and out of hospital, and we have integrated with wider health and social care teams to support this.

Improving care for older people – a significant number of patients with multiple LTCs are elderly, therefore the support outlined in this bid will improve the support and care for these patients. The capacity by extending primary care will enable primary care consultations to flex giving longer appointment times for the complex patients, enabling carers/relatives to attend at more convenient times and establishing care plans that are owned and supported by the patient and
Promoting continuity of care – the model of care to three clusters will enable local clinicians to deliver the extended hours ensuring that local GPs can see their patients during extended hours. Implementing primary care records system that interfaces across all practices and hubs will ensure that the patient can be seen with full records available to the profession to avoid repeating basic information numerous times. Patients will be able to access their own records in a supported way, together with the knowledge and understanding through self-management support will mean the patient can lead their care, and be their own consistent expert in it.

Improving overall quality and productivity – the additional capacity will enable professionals and patients to listen and engage more during consultation which would lead to a more informed shared agreement on outcomes. Quality of contacts is essential to give the patients confidence to take control of their care. We work without CCG and partners to continue in partnership to realise productivity benefits such as, multidisciplinary teams for integrated care and intermediate care bed service with GP input.

Reducing health inequalities – practice population analysis shows a profile of high users of health services across a neighbourhood of practices, this population is weighed towards the younger family and working parents. By focusing extended hours on the 40-55 year old age group to increase self-management and attendance at routine appointments for checks and screening, we can reduce the health inequalities shown in their particular population.

14. How do you think your pilot might influence current patient pathways out of hours, linking to 111, GP out of hours and diverting people from A&E?

Max 500 words:

We know from the Self-Care survey that current services deliver low levels of reassurance and a lack of reassurance leads to increased use of unplanned care. We also know that people in BACCG use A&E once a year on average, which is something we would like to reduce for our patients. By putting in place more responsive, proactive routine care for these groups we expect to reduce unplanned care.

The practices believe that many of the conditions for which patients seek help from secondary care for unplanned care, can be better managed by primary care. This belief stems from systematic analysis of ACG risk stratification data supported by local audit of discharge summaries and admissions data. However patients need to share that confidence and have experiences, which build the belief that their own practice is their best first point of contact. That will only be achieved when people experience the support and care they need from their local practice networks and develop confidence, and belief in that support being there every time they need it.
It will not be enough to simply make that promise, we will need to have a communications and engagement plan which shares the evidence, and supports the spread of the messages about the new primary care people can expect for themselves and their loved ones. The PMCF will enable us to run a comprehensive communications and engagement programme which will leave a legacy of changed opinion and knowledge about local services, and raise confidence in them, whilst at the same time, equipping people to take ownership for their own wellbeing, whatever their circumstances. An example of this is to extend the calendar of engagement events by Patient Reference Groups, and use increased types of media including face to face, social media, local newspapers and radio, with targeted messages to meet people’s needs and preferences.

When this is successful we will expect to see a reduction in attendances at A&E and in avoidable admissions. We will also expect to learn how the GP Out Of Hours service will need to look in future to deliver the new model of primary care, and this will be reflected in a new specification for the service when the current contract expires in 2016.
**Section C. How will it happen**

Information about your strategy for leading this programme.

15. **Engagement** - Describe how local people and practices have been involved so far in designing this programme. Outline the methods by which organisations and professionals involved will continue to be engaged.

Max 300 words

The journey began with a stakeholder event in February 2014 and has continued through the year, both with special events, such as the AGM and planning event in Sept 2014 and by regular reviews and updates at our member forum, GP Council (which includes our partners). We have funded our local Healthwatch to support the development of our Patient Assembly so that there are strong local voices to inform our progress, and we met with these patient leads to present evidence and discuss local views around access to primary care.

We have also taken many opportunities to talk formally and informally with public and patients and gather their views. This work, corroborated with other evidence, such as the work we have done on themed joint commissioning strategies with our partners (for example the Bracknell Forest Dementia Strategy) has led us to understand the themes that people most commonly raise. Based on these findings we have commissioned *Experience Led Commissioning* to explore these in more detail and give us more evidence to identify the changes we need to make and the criteria for success (see Appendix D for ELC’s report).

In developing this bid, and in addition to the 2170 respondents to the latest GP satisfaction survey⁵, we have engaged and collected insights from in-depth conversations with over 1,000 people living with long term health issues who use primary care regularly in Bracknell and Ascot CCG - and over 160 people who deliver primary care, including: GPs, practice nurses, practice managers and receptionists. The team has been able to draw conclusions about the differences in experience for those who work (including volunteer and those studying) and those who live with LTCs and those who do not work (generally an older, retired population) and family carers.

We have co-designed a future vision of care with 38 people who attended a futures planning session on 14 January. This created our visual plan on a page (see section 8).

16. Demonstrate that you have the **capacity and capability for rapid implementation** and technical deliverability, with tangible benefits for patients being demonstrated during 2015/16.

Max 300 words:

The existing CCG primary care transformation board has brought together project management
skills, and technical expertise under committed clinical leadership to focus on the priorities for improvement. In addition to this, productive partnerships have been built with partners to add synergy to the programme. This ranges from building relationships at senior level to harness common goals, to having joint posts focusing on specific projects such as self-care.

We welcome the news in the ‘Forward View’ of the ‘short model grant agreement’ which will enable us to mobilise support from the voluntary sector with a minimum of bureaucracy, this will speed the implementation.

Health and social care partners across the area are already working closely on an IT interoperability project to allow safe sharing and access to clinical records. Since December practices and Out of Hours have been able to share clinical records, so one of the key enablers for this bid is already well advanced.

Our bid includes realistic project resource designed to ensure the capacity and capability to deliver a complex set of projects within the timescales. This will be integrated with the existing CCG management resource, which includes excellent programme management and primary care management expertise. Where required we have made provision for external expertise e.g. trainers, professional specialists.

17. **Leadership** - Can you demonstrate both clear leadership for the proposed work programme and strong commitment from all the practices involved (e.g. signatures of support).

Max 300 words:

The primary care transformation board was formed following the February 2014 workshop, chaired by Clinical Director Dr Jackie McGlynn and Patient Representative, Morag Langhouse. This established the initial commitment of members to further develop towards meeting the challenge of 7 day primary care and recognising the need to do something different to meet the escalating demands in general practice. We have also benefitted from leadership from our partners to respond to the challenge in general practice from their own perspective; this has enabled our leaders to gain valuable experience in broader fields such as intermediate care and organizational development. A project manager has been recruited, and early benefits are already being realised.

Our membership forum, GP Council, has monthly reports from the Primary Care Transformation steering group to ensure wider engagement that the immediate membership, and this PMCF application has been submitted with unanimous support. Member practices support the work of the primary care transformation board and a statement of support is attached (see Appendix E).

We have a statement of support from the chair of the Bracknell Forest Health and Wellbeing Board, who participated in the Positive Futures event in January 2014 (see Appendix F).

Membership developed a clear intention specifically around their models for extended primary
care: delivering a high quality, sustainable, supported service offering accessible outcome based care to meet the targeted needs of our population through working with our partners.

Our co-design approach will also ensure that we engage with the local voluntary sector, patient representatives and Healthwatch supporting them to build leadership capability, shared values and equip them with a shared co-design approach so that we can lead service change together.

18. How will you develop your GP community to ensure sustainable leadership after pilot funding ceases?

Max 300 words:

The Primary Care Transformation Steering Group is supported by CCG management and has thriving workstreams developing plans for federated working of practices, and 7 day access, each led by a GP and supported by practice managers, nurses and other members. The CCG has made available leadership skills training to support the practices in identifying and development of potential high performing leaders.

The energy generated by the primary care transformation programme has seen new leaders emerging from the practices, including GPs, practice managers and nurses. The pilot funding will enable us to underpin this enthusiasm with personal and organizational development for long term sustainability.

Investment through the PMCF in existing leaders and identifying future leaders will provide a legacy to the programme, the CCG develops many opportunities for clinical and non-clinical leaders to gain commissioning and technical experience, this will not stop following the PMCF. One example is the clinical lead for urgent care, who came to commissioning less than two years ago to ‘help out from a GPs perspective’ is now leading on the implementation and monitoring of the new Primary Care Urgent Care Centre in Bracknell, and also half way through a formal leadership course.

Developing patients as leaders will be a key outcome of the project, and our ground breaking HealthMakers programme will be a cornerstone of this (see Appendix G).

19. Improvement methodology - Outline the means by which you will redesign services and undertake testing and refinement of innovation ideas.

Max 500 words

The NHS Change Model is the basis for our transformation work. Since its foundation the CCG has adopted this methodology for inviting, appraising, implementing and evaluating ideas for innovations from member practices and other partners. An Innovations Fund has been set aside for this to seed local projects to continually test new ways of working and push for improvement. During the PMCF programme the learning through PDSA methodology will enable the learning to be continually supported through the programme board, Primary Care Transformation Steering
The programme governance will ensure rigor in its application; with full governance structure to the membership and Governing Body, with transparency with our partners and stakeholders on the expenditure and monitoring of outcomes.

We have used a new approach which includes a focus on listening deeply to people and understanding what matters to them to create a sustainable primary model. We will use this engagement approach in co-designing future services with our patients and emerging patient leaders. We recognise that without public engagement the outcomes will not be fully realised.

20. **Measurement** - The nine national metrics for wave one are:

A. Patient contact, as a direct result of the change in access

- The change in hours offered for patient contact;
- The change in modes of contacts;
- The utilisation of additional hours offered; and
- Impact on the ‘out of hours’ service.

B. Patient experience/satisfaction, including patient choice

- Satisfaction with access arrangements; and
- Satisfaction with modes of contact available.

C. Staff experience/satisfaction
• Satisfaction with new arrangements.

D. Wider system change

• Impact on the wider system attendances; and
• Impact on emergency admissions.

**List any additional metrics you would like to see included as part of the evaluation**

The evaluation will measure our success in delivering the local vision for primary care:

• Patients are able to get the support from primary care to manage their own condition, including signposting to support groups and charities to be better prepared when they become ill.
• Primary care has access to health records to support their patient and provides confidence by giving holistic advice.
• Longer appointments enable patients to discuss their health with a professional particularly their complex condition.

Required additional matrix:

• Changes in usage of the Bracknell Urgent Care Centre
• A&E attendances by target group e.g. under 5s, frail elderly people with care plans
• Reduction in readmissions over extended hours
• Online services uptake and evaluation of impact
• Self-Care Survey – improved outcomes and confidence

21. **Commitment from CCG(s)** - Please attach a statement from your CCG setting out their views on the proposals. Success and sustainability of new approaches to primary care are partly dependent on the commitment of the CCG.

See Appendix H for a supporting letter from the CCG.
Section D. Programme planning

22. Estimate of funding needed - Please include an estimate of the funding that you would need to support your proposal, including:

- how the investment will be funded (clearly indicating what funding is coming from PMCF and what from other sources – including matched / supplementary funds from partner organisations, recognising that PMCF has been identified as a revenue budget and funding is only available for the 15/16 financial year)
- a breakdown of all capital and revenue costs of the proposed investment.

Please note: Final decisions on funding will depend on the number of pilots selected and following dialogue between NHS England and applicants to help gauge the level of financial support they require.

Max 500 words:

This bid is for a total of £2,820,535. This amounts to an investment of £20.88 per patient over the life of the project on the basis of a population of 137,000. Our practices are clear that funding is only available for the 2015/16 financial year and is committed to supporting ongoing delivery of the pilot in successive years.

In line with the national commitment that Clinical Commissioning Groups (CCG) are no further than 5% from target allocations in 2016/17. Continuation of this project will be prioritised by the CCG from this additional funding.

A summary table is attached in Appendix I

23. Please indicate the organisation to which you would wish funding to be awarded (e.g. lead practice or registered CIC).

Bracknell and Ascot CCG to be transferred under enhanced service to member practices to provide services.

24. Timetable - Please provide a high level programme plan, indicating key lines of work, dependencies and milestones. Where possible, include this in both tabular and graphical (Gantt) form. Please assume that funds will be available from 1 April 2015.

Please see Appendix J for the High level month by month Implementation Chart.

25. Attachments:

Appendix

A. Map of geographic area covered by Bracknell & Ascot member practices
B. Bracknell & Ascot GP Patient Survey Results
C. Registered population pyramid compared with National profile
D. Experience Led Commissioning (ELC) Report and outcomes of event
E. Signatories of support from Bracknell & Ascot GP surgeries
F. Statement of endorsement from Bracknell Health and Wellbeing Board
G. HeathMakers
H. Letter of support from CCG
I. Project and costs summary table
J. High level month by month Implementation Chart

Further information:

If you have any queries about the application process, please contact the relevant NHS England area team.

Application submission:

Please send your completed application to the following mailbox by 5pm on 16 January 2015 to: England.challengefund@nhs.net and copy in your area team
Appendix A: Geographic area covered by BACCG
### Appendix B: Bracknell & Ascot GP Patient Survey Results

#### GP Patient Survey Results for Practices in England (July 2014 publication)

*Note: Results are weighted.*

**Data Source:**  
GP Patient Survey  
https://gp.patient.co.uk/surveys-and-reports

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* Indicates less than 0.5%  
* Indicates data suppressed due to small numbers  
* Respondents who indicated that they used another service (eg went to A&E) may also have seen or spoken to someone at their GP surgery
Appendix C: Registered population pyramid compared with National profile

Figure 1: Registered population pyramid for Bracknell & Ascot CCG compared with England and Wales at 30-Jun-14

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Total 68,925 60,514 128,309

Source: Health and Social Care Information Centre (July 2014)
Background
In January 2015, Bracknell and Ascot CCG invited its community to come together to describe a positive possible future for primary care support of people and families with long-term health issues in Bracknell and Ascot in January 2017 and beyond. Together, participants in the event explored:

‘What needs to happen so that people with long term conditions receive high quality routine primary care and are motivated to self manage their condition?’

38 people attended the Positive Futures Planning Event held on 14 January 2015 at Easthampstead Baptist Church.

This paper provides a narrative of the conversation. It will be used as part of the Bracknell and Ascot CCG bid to The Prime Minister’s Challenge Fund to secure funds for taking these initiative forward.

A Positive Future for Primary Care in Bracknell and Ascot 2017 and Beyond
The group worked with a facilitated visual planning process called PATH (Planning Alternative Tomorrows with Hope) to describe a positive possible future for primary care support of people and families with long-term health issues.

The planning process asked participants to consider for primary care in Bracknell and Ascot:
- What is our ambition for primary care?
- What is a positive possible future we want to achieve by 2017?
- What is happening now?
- What are the bold steps that will accelerate our progress?
- What are our personal commitments and next steps?

Our shared ambition
People’s ambition has three key elements:

People know their numbers
- People recognise they have a responsibility to look after their own health. They know their numbers
- People understand the system and how to work around it and with it; and where they need to go
- People have understand and respect the cost of care. As a result, they recognise the value of the services they use. This has changed their attitude towards using services and they take more personal responsibility for service use

People are involved in decisions about their care. Care goals joint decisions that partnerships between people and clinicians support
- People always feel respected and that they have a choice. We have reached ‘no decision about me, without me’ in reality; not just a political spin. The doctor and the person make all decisions together. Everyone feels fully involved in their care
- People with LTCs have good access to routine care and a real sense of choice; especially around sharing goals
- People are supported by health professionals who act as much as motivational coaches as clinicians, setting meaningful targets and goals that are owned by the person for their future health. People feel deeply listened to as a result. People and health professionals feel that ‘we are in this together’
- People deeply understand their long-term conditions and all information they receive about their conditions, treatment, tests and results. They are confident about managing their condition and this has translated into self-care and self management.

A shift in culture towards community support and partnerships
- There has been a shift in culture so that the community is now supporting each other. This connection matters and is available both in the physical and online in the virtual world
- People no longer feel isolated. They do not feel they have to do things and cope on their own any more
- Young people know how to prevent LTCs and how to use services because education starts early and their awareness builds as they grow up. As a result, children educate their parents and grandparents on how to keep well
- Proactive screening within the community means that we catch LTCs early, giving people a greater chance to of taking control of their long term condition earlier – or even preventing the onset of a long term condition altogether
• The services in Bracknell and Ascot have become one united team. There is joint partnership between health, social care and the voluntary sector. Technology and a change in attitude has driven this change, rather than a change in building or physical location
• There is distinction between ‘paid-for’ and ‘unpaid’ care
• The primary care workforce is happier. They feel they have come off the treadmill and onto the pitch and are now more available to everyone.

A positive possible future by January 2017
The group looked back from January 2017 and described what had happened over the past two years to move towards this shared ambition. The group agreed four principles that would be well established by January 2017 to drive forward change and improvement in primary care in Bracknell and Ascot. They are:

People own their care plan and develop it with others
• In 2017, every individual with a LTC owns their own care plan. The person can update and input what they are doing to look after their health and manage their condition. It belongs to them and travels with them
• This care plan is the lynchpin of their care. It is negotiated together with the person, their carer and the all of the relevant professionals - both within the NHS and in the community - such as the community pharmacy, nurses and the voluntary sector. This negotiation is not necessarily mediated by the NHS – or even the GP. But it is always a two-way discussion, supported by an expert advisor
• Although it is owned by the individual, the team work together to support the person’s goals.
• Each individual has access to a named person who supports them to manage their care plan. This named person is not always a GP. The person has choice about whom the named person is
• Groups of people with similar health issues have become self-managing. They can bring together services from across the community to support them. These groups are able to set their own goals and organise its own care
• People are now given less medication and more alternatives, such as other therapies and support. Keeping well has become about ‘more than medicines’.
• Because of these changes, a new ‘entity’ has emerged. It’s mantra is: no argument, no silos, just a good service that delivers seamless care focused on the individual’s needs.

People are educated where they are
• In 2017, people understand how to use services; work their way around the system and keep well. People have been engaged and educated where they are, including schools and work place support and education. Training now takes place regularly throughout the community
• We have done work with school children We have used social media to deliver key messages and help people to understand how to use services appropriately, building on the active Facebook community in Bracknell
• Education has helped to improve communication between people and GPs as people have a better understanding of their health issues and how to use the health system well.
Peer support is available from the point of diagnosis

- In 2017, people with LTCs gain motivation, support and information from their peers and the voluntary sector. People are actively engaged with community groups and benefit from their expertise and knowledge.
- The voluntary sector plays a key role and integrated support around education, peer support and self-care for long term conditions.
- In 2015, people were reluctant to engage with peer support and groups in their community. This has now changed for two reasons:
  - People are linked in with these groups as soon as they are diagnosed. Peer support is endorsed by GPs and other healthcare professionals and encouraged through things like group consultations - and usually a key part of peoples’ care plan.
  - The voluntary sector has been supported by Bracknell and Ascot CCG to learn from each other what works and motivates people to engage and overcome the feeling ‘it is not for me’. This potentially includes the use of incentives.
- After a new diagnosis of a long term condition, people get proactive contact from the appropriate community groups following diagnosis. Healthmakers visit people at home, which helps engage people get involved and make the most of the support these groups offer.
- The internet has also become a place where people meet and learn about their condition. Some peer groups meet virtually.
- As a result, people with long term health issues are now better connected and feel better supported within their community and feel they need to spend less time with their GP and health care professionals because their support comes more from peers.

People are triaged to the most appropriate service

- In 2017, there is nurse-led triage at every GP practice reception. This means that only those who really need to see the doctor are given appointments. Those who do not are directed to a more appropriate solution for their needs.
- Online booking for more routine appointments is available for those with LTCs, and as a result of the triaging system at GP reception, there are now many more appointments available, which can be booked in advance.
- The use of these new approaches have been thoroughly evaluated to check that they actually deliver efficiency and quality improvements – and that there are no unintended consequences e.g. those who cannot use the Internet are losing out as all the appointments are going to people who are more savvy.

Where are we now?
Participants described the things that we need to recognise about what is happening right now; the ones that matter most in relation to the changed that people want to see in 2017.
People described both positives and negatives:

Negatives (top line)

- Lack of time
- Not enough GPs and an expanding population
- More demand, more people
• We are not talking to each other
• Patient is not a part of ‘the team’

Positives
• Lots of people are here today with different background
• Physiotherapy waiting times are down from 14 weeks to 3 weeks
• New Primary Care Urgent Care Centre
• Good training for professionals on conditions like autism and dementia
• Patients like text message reminders e.g. for routine checks, but NHS is stopping text messaging service?
• Actively involved (GP) workforce
• Good relationships
• Town centre regeneration (demotion) happening – symbol of rebirth?

People also talked on their table-tops about:

Quality of care planning
• We have lots of young carers locally
• Care plans have commenced for over 75s
• Care plans are disconnected; a silo approach to care planning
• Care planning is few and far between - only for 20% of over 75s; some people with LTCs; care planning for LTCs = 2% of people discussed fortnightly in clusters = 4 patients per surgery on average
• Too many unplanned admissions
• Staff and patients don’t know their options (beyond medicine)
• Carers’ health deteriorates without being noticed until it is too late

Primary care capacity
• We do not know exactly what appointment management systems are being used
• Consistency of care is down to luck
• Not enough GPs for future plans
• General practice is massively overstretched; at capacity; under massive pressure
• Recruitment crisis; recruitment and retention difficulties (GPs and nurses)
• Poor access to GPs; appointments too short
• We are hearing named GP is not working in majority of surgeries for people over 75

Current beliefs and behaviours

COMMISSIONERS AND PROVIDERS
• We do not applaud good care to keep up motivation
• Money does not flow with patient
• Recent examples care failure e.g. autism – concerns about diversity in delivery (feedback from a social media exercise led by Bracknell and Wokingham College)
• We do not recognise the value of investing in transport

FRONTLINE
• Poor communication x2 It is hard to get hold of (fellow) professionals
- Joint working isn’t working. Professional protect their boundaries; silos and little cross professional working within statutory sector
- Third sector is often not recognised nor used. There is disconnect NHS and voluntary sector – not integrated with GP care; needs careful management. The voluntary sector is only as good as its leaders

PEOPLE
- Most people do not take ownership of their health. Some activated patients, but in general feel unengaged because NHS culture = feel patronised – not equal partner. There is apathy; lack of motivation and lack of confidence to self care
- Patients do not feel the voluntary sector/ support groups are their kind of thing
- People do not hold a record or ‘passport’ with their records in x2
- Older people do not want to take control. They still want anything the GP says as gospel. They feel they cannot question it
- Services are abused. Patients don’t respond to GPs calls

Education and information
- 94% of people in Bracknell and Ascot have daily access to the Internet
- Bracknell has a thriving Facebook community (over 5,000 people)
- Inequality is based on patients’ level of education and community support
- Practices do not have enough information on websites
- Not enough education and not early enough (school, home, college etc); not enough time
- Personal health is not on the school curriculum
- Isolated education campaigns; no consistent approach
- Patients do not know how many ways they can book a GP appointment (think can only phone)
- Mental health issues are often not recognised

**Bold Steps we want to take in Bracknell and Ascot CCG**
Bold steps are the game changers; the BOLD things that we can do to accelerate progress towards our positive possible future. The group agreed three bold steps to be put in place by JANUARY 2016. The group consensus on these three bold steps was:

- **FOCUS PM CHALLENGE WORK ON GPS ON DIAGNOSING LONELINESS AND INCREASING SUPPORT FOR PEOPLE AT DIAGNOSIS:** link this in with and make it an early focus of Healthmakers programme. Use READ CODES to evaluate increase in diagnosis. Put in place co designed support pathways to reach out to these groups proactively and connect them with voluntary/community organisations (within the bounds of confidentiality/with the person’s permission)

- **DEVELOP AND TEST A HEALTH PASSPORT THAT LINKS WITH A NEW CARE PLAN DEVELOPMENT APPROACH:** Co design patient led electronic care plans that can be updated as people progress. Support people around new care planning approaches, including group
and peer led models of support and consultation in primary care (not just GPs – nurses, pharmacists etc). Drive this using the plan to provide patient record access online

• CREATE A ‘STREET PRIMARY CARE TEAM’: Deliver primary care on the streets – outside GP practice to increase diagnosis of LTCs. Have ‘pop-up’ clinics around the community, including in workplaces. Include self care prescriptions and social media education on prescription.

Next steps
People then committed to person next steps. The commitments people made included:

• To inform people at the surgery how good this event was
• I will organise an event on access
• Expand HealthMakers project plan to incorporate the ideas for peer support to enhance other projects
• Promote prevention and self care
• Await the report
• Submit PMCF application
• Take comments back to surgery
• Investigate best practice across in voluntary care sector
• Work on a Primary Care nursing project
• I will feedback to GPs at the partner meeting

For further information, contact:
Georgina Craig
Mobile: 07879 480005
Email: georgina@gcraigassociates.co.uk
Appendix E: Signatories of support from Bracknell & Ascot practices

Wave Two Application for Prime Ministers Challenge Fund

Signatories Bracknell and Ascot Practices

15\textsuperscript{th} January 2015

The following practices together support the application to NHS England for the Prime Ministers Challenge Fund Wave two.

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Appendix F: Statement of endorsement from Bracknell Health and Wellbeing Board

Bracknell Forest Council – statement of endorsement

Bracknell Forest Council fully endorses this bid.

As a council and community we stand shoulder to shoulder with our CCG in seeking to deliver strong partnership working, in order to deliver resident centered health and care services.

We are committed to ensuring effective health education around staying healthy, and in the case of Long Term Conditions around self-care, mobility and access to good quality services.

We are committed to delivering seamless health.

Cllr Dale Birch
Chairman of Bracknell Health and Wellbeing Board
Appendix G: HealthMakers

HealthMakers

Join a community of patients
making a real difference

A new pilot scheme is being introduced by Bracknell and Ascot CCG to recruit ‘Healthmakers’ from the local community (we have been inspired by the Olympic Games makers!). The role of a ‘HealthMaker’ is to create strong communities and through their own experience helping patients with the Self-Management of their long term conditions, initially in groups. They do not replace doctors or nurses, but complement them. Initial conditions for the pilot are Diabetes, Chronic Bronchitis (COPD) and Arthritis.

Additionally, some HealthMakers are trained in patient leadership to act as “Advocates” alongside Health Care Professionals for one of three long term conditions – Diabetes, Chronic Bronchitis (COPD) and Arthritis. Advocates have a more strategic role in also developing future training modules, setting up groups, attending meetings and assisting health professionals in the development of new local services. We are clearly hoping that the pilot will prove successful and have aspirations for recruiting much larger numbers next year and beyond.

The Training Programme

1) **Self-Management** - This will explore how patients can understand their condition, thinking about the ‘whole person’, not just the disease; develop confidence in caring for themselves and in knowing when to seek help. In the first wave we aim to train trainers / group leaders, who want to continue using this skill to motivate others.

2) **Patient Leadership** - This programme will explore how individual patients can support each other, what it means to be an advocate, how to use personal experience to effectively influence decisions about local health services.

**Long Term Aims**

NHS England has already shown an interest in what we are doing and we have agreed to provide them with a case study. The long term intention is that for each of the clusters (Ascot, North Bracknell and South Bracknell) the CCG has HealthMakers, who can deliver training, peer support or contribute to commissioning in:

- Mental Health
- End of Life
- 5 priorities from the JSNA’s
- Children and Young People

Due to improved confidence in patients managing their conditions we expect improved health outcomes and therefore fewer hospital admissions, A&E attendances and primary care attendances in their long-term conditions.
Appendix H: Letter of support from CCG

NHS England

England.challengefund@nhs.net

16 January 2015

Dear Prime Minister

On behalf of NHS Bracknell and Ascot CCG, I am delighted to convey the support to our constituent practices who have come together with their patients to produce this Expression of Interest for the Prime Ministers Challenge Fund. The amount of commitment, discussion and co-design work that has gone into this bid is testament to the ability of Bracknell and Ascot to strive forward, with its population, and rise to the challenge of achieving new models of more flexible access to General Practice.

You will note that our practices have engaged with their patients and wider stakeholders to co-design the ‘Better Futures For All’ vision for Bracknell and Ascot. We have also received wider support in the form of a statement from the Chair of the Bracknell Forest Health and Wellbeing Board, which shows the joint working to deliver this application.

You will also find attached a list of signatories from every practice and the statement of support from the Health and Wellbeing Board for this bid.

I wish them every success and hope that you will consider their submission.

Yours sincerely

Dr William Tong

Clinical Chair of BACCG
Appendix I: Project and estimated costs summary table

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Notes:

- This application is requesting for the period of 12 months in line with Prime Ministers Challenge Fund
- Investment per patient = £20.88

GP IT – CCG allocation for GP IT
CCG NR – BACCG non recurring funds – innovation/£5 BCF
BCF – BACCG/BFC Better Care Fund
### Appendix J: High level month by month Implementation Chart

#### Estimated Implementations Gantt

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