NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Primary Care Operating Framework: October 2014

Listening. Responding. **Delivering.**

Contents

1. Introduction – The Future

Patient voices:

I'm 87 with four chronic health problems and apparently I'm in a special "stream" of patients which means **I have all my care co-ordinated by a very experienced GP**. Usually I see the specialist heart or diabetic nurses at the Integrated Care Centre where my surgery is but there's a social care co-ordinator in the team too who is very helpful at sorting things out for me at home.

I often feel the invisible hand of my GP conducting my orchestra of care - the nurse or team pharmacist will tell me my GP has asked them to do something for me because she's seen my latest blood results and wants something changed.

Last year I was diagnosed with diabetes. I've been to the DAPHNE classes at my local health centre so I understand better what's happening and how important it is for me to stay healthy. My local pharmacist and the diabetes nurse specialist keep an eye on me too.

Between them **they've given me the ability to monitor and manage my condition** now I can check levels of glucose in my blood and ketones in my urine.

Usually I just email my practice when I'm worried about the children because it's easier and they reply with good advice really quickly. Sometimes they ask me to bring my asthmatic child in and then we usually see the nurse. **I don't really mind who we see as long as we get the right help quickly**, I just need to know that something isn't serious and what to do. My dad is with the same practice and he always sees the same doctor. When I asked why, he told me his GP is a special one who deals with complex care whereas the doctors I see are trained to look after people who are mostly fit and well and have occasional health problems.

I had my other hip replaced a few months ago and my GP made sure I had my usual physiotherapist from the local integrated care team to help me get back on my feet. She saw me in the hospital and the community and even visited me at home. **My therapist knows all about me** - what I can and can't do - so I know I won't be able to get away with not following the exercises she gives me…

Since my GP moved into the Integrated Care Centre **I don't have to go to the hospital for my respiratory clinics anymore**. I've even seen the consultant and my GP at the same time when they started off my treatment in the Centre.

And I really like the Breathe Easy classes they run there now.

GP voices:

I joined the practice just after completing my training and I was amazed at how structured the GP career path is here with so much **more choice for GPs to follow their interests and better ability to manage their workload with less stress**. Newly qualified GPs work in a team with practice nurses looking after the less complex stream of patients. We look after all the children and young families, all the sexual and reproductive health and helping patients return to baseline health after episodes of ill health or trauma.

We have a stream of patients, generally older, who are at risk of becoming complex and frail. I spend half my week working as a GP in the team looking after these "intermediate needs" patients.

I've also been **specialising in gynaecology** for ten years now so I, and another GP colleague, work very closely with the local hospital gynaecology consultants.

We run joint sessions in the Integrated Care Centre which is a "hub" in our locality and the more we learn the more we provide locally. We also encourage and help the consultants to manage patients differently, for example we have hysteroscopy and colposcopy clinics at the Centre, all meeting national standards but with shorter waiting times and a better environment for patients.

I've worked in this practice for five years now and am **developing an interest in diabetic care**. During my first years I got a good grounding in all aspects of general practice because young people sometimes have chronic conditions and through clinical team meetings and development days.

I'm **studying for a Masters in Public Health and being trained to lead change as well as working as a GP** in the team in our locality. I'm leading a project to help reduce obesity and diabetes in school children locally. Most of the leg work is done by school nurses, health visitors, teachers, pupils and parents but I provide the leadership. I've agreed targets and an evidenced based plan with our practice group leadership team and the local public health team. I'm monitoring that plan and making sure the project gets the support and resources it needs and I'm evaluating the approaches to see what works best locally. We're doing a lot to improve diet and activity levels across the communities.

We're particularly aiming for marginalised groups where obesity and diabetes prevalence is higher.

Our practice moved into the local community hospital last year when space was freed up as part of the plan to support more patients in their own homes. I work as part of the team looking after patients with "high need". **We are extremely proactive and work as a closely integrated team** in a "hub" of practices with specialist nurses, social care workers and the voluntary sector. We closely monitor all our patients and intervene swiftly to prevent deterioration. Hospital admission and readmission rates have very significantly reduced.

2. Foreword

A challenged health economy

The health economy across Leicester, Leicestershire and Rutland faces serious financial and service challenges. Funding available cannot support the existing configuration of health services with a projected £398m deficit by 2019 if nothing were to change. This is detailed in the Better Care Together Five Year Strategic Plan published in June 2014.

General medical practice is facing a national crisis with escalating pressures from an ageing population living with multiple long term conditions and a national shortage of GPs and practice nurses. This is repeatedly described in national publications.

Major structural change is urgently needed

East Leicestershire and Rutland Clinical Commissioning Group believe only major transformational structural changes will deliver the Better Care Together strategic plan and financial and service stability for all areas of health services, including primary care.

The Better Care Fund will help transform social and community health services and the draft Integrated Community Services Strategic Framework underpins this transformation.

The CCG offers this primary care operating framework as the means support to general practices through the major structural change needed and to respond to the strategic plans.

This will not be easy

GPs know national experts advise them to work together “at scale” and to be leaders and coordinators of care. They know the system needs them to act proactively to assess and manage risk, to lead the process of integration and influence development of other services. GPs know they are central to the system, have a unique overview and yet a deep understanding of the needs of their patients and communities which need to be harnessed to promote public health and reduce inequalities.

The CCG has invested time in listening to our member practices. We have held engagement events, carried out surveys and telephone interviews. We have analysed the data, identified the common themes and noted the issues and ideas. The views we have heard from our member practices shape this primary care operating framework.

We know our member practices are struggling to meet current demands. To leave the comfort zones of their practices, to move from being in control of a practice to being an influencer within a group presents risks and requires much time and effort. The CCG and its membership must present a convincing case for change, provide extensive support for practices to come together and offer sufficient certainty and resource to give GPs the time and motive to reshape their world. If the health system fails to deliver this support then general practice will fail to deliver their part of the Better Care Together programme.

Without support general practices will find other ways to protect themselves from the pressures: closing their lists to new patients; limiting appointment slots; referring and admitting patients to hospital at an earlier stage; and reducing the element of their consultations directed to emotional wellbeing, health promotion and disease prevention.

Can we afford to invest in primary care?

Evidence shows that investing in primary care generates cost effective returns. Investing in more GPs directly reduces mortality in the local population. Integrated teams built around general practices that offer enduring relationships; continuity of care; a person-centred approach; a regular entry point and comprehensive cover are proven to deliver:

- Better health outcomes and lower all-cause mortality
- Fewer patients admitted for preventable complications of chronic conditions
- Lower hospitalisation rate
- Less use of specialists and emergency services
- More efficient use of resources
- Improved treatment intensity and quality of life
- And many other benefits to patients, health staff and the wider health system

Failure to support and enable general practice through this transformation will lead to failure to realise these benefits. To the question “Can we afford to invest in primary care?” the answer is:

Can we afford not to?

3. Executive Summary

This primary care framework provides a compelling case for changing primary care in East Leicestershire and Rutland. It sets out clear objectives for new models of care supported by different ways of working to achieve real benefits for patients, general practices and the wider system and sets out the path to deliver them.

The Case for Change

The local health economy faces serious financial challenges and strategic work has identified the need to shift care into more cost effective settings in the community. Rapidly rising pressure on general practice services is set to continue and escalate as the ageing population lives longer with more complex needs.

The current model of general practice is no longer sustainable. National evidence and research on alternative models recommends practices coming together to work “at scale” to realise the benefits of economies of scale, improve opportunities for career structures and professional support and deliver a wider range of services.

The CCG has listened to member practices and appraised the options available and concludes that based on the evidence available the route most likely to achieve maximum benefit to patients is to support general practices to come together to expand their services through a new contract over and above their core contracts.

Interventions and Timelines

The strategic objectives are to expand and develop primary care to 1) deliver the Better Care Together strategy through 2) people centred primary care with 3) continual quality improvement offering 4) integrated, consistent, wrap-around care, whilst 5) actively shifting care closer to home with 6) primary care professionals equipped to meet the challenges.

This framework proposes an offer from between the CCG and its member practices. This offer will help them to work together at greater "scale" and deliver an expanded range of integrated services able to keep patients, particularly those with complex needs, at home for longer.

The offer is help to implement models of care that are fully aligned to those being developed through the Integrated Community Services Strategic Framework, the Better Care Fund, the Better Care Together five year plan and advised by NHS England.

All these strategies ask GPs working in conjunction with their MDTs to lead and coordinate care for patients with more complex needs through an integrated approach with other local services including specialists. Time may be released to do this if they develop a team approach to less complex patients, using nurses, pharmacists and therapists to provide more of the walk in and planned care for this group. This new approach represents transformational change for general practice.

The offer includes extensive support to reach a state of readiness to agree a contract with the CCG to provide Community Based Services to a population of 25,000 – 45,000. Practices are invited to carry out their own option appraisal (a draft template is provided) as a first step to help them plan their future.

The offer is for a flexible approach to implementation with individual practices setting the pace of change. The rest of the health system will also need to adapt to support and facilitate the success of these new models of care. It is estimated that achievement of transformed primary care models sits within a 4-5 year time frame if the system provides the necessary support to practices.

Benefits and Outcomes

One of the major aims of this framework is to secure the future of general practice. The priority is to build a robust and sustainable foundation of primary care from which integrated care can be provided to an increasingly complex mix of patients. Only then will a greater proportion of clinical activity be able to take place in community settings and the objectives of the Better Care Together programme to shift care closer to home be realised.

Significant benefits to patients, GPs and the wider health economy are described with possible measures suggested to monitor improvement.

Benefits range from: improved health outcomes and reduced inequalities in health for patients; through to reduced workload and opportunities for professional development for GPs; to lower hospitalisation rates and reduced pressure on emergency services.

Enabling Strategies

A wide range of work programmes will be required to ensure delivery. There are links to other local strategies such as the draft Integrated Community Services Framework and the Better Care Fund that should create greater momentum for change. Communications with all stakeholders and particularly member practices, patients and the public will be vital. A high level risk assessment is included.

The investment required is estimated to be £6.3m of transitional funding over the next 3-5 years to deliver this transformation plus up to £10m recurring commitment to fund primary care expansion and £20-50m capital costs for premises development.

4. The Case for Change

Position Statement

Evidence demonstrates primary care is very cost effective at improving and maintaining the health of individuals and communities.

Primary care provision locally is very good. Excellent professionals work extremely hard and provide high standards of care, but they are operating under high and rising pressure. Local practices are unable to fill approximately fourteen GP vacancies and with a national shortage of GPs this recruitment and retention problem is set to escalate.

GPs are working in a model of general practice that has not fundamentally changed since 1948. This model, of every practice offering every service (rather like a District General Hospital) is struggling to respond to rising patient need. The income of many practices has started to drop as contract changes require more work for less payment.

The CCG undertook an extensive listening and engagement exercise with local member general practices and used their views to shape this document. With resources and support many practices are open to working together and integrating services as promoted by the Better Care Together Five Year Plan, the Integrated Community Services Strategic Framework, the Better Care Fund and the Local Area Team Primary Care Framework.

This primary care operating framework aims to show how the CCG, with support, will support and help drive general practice and give it the capacity to keep people at home for longer.

National Picture

Nationally demands on general practices have increased rapidly including a 40% rise in consultation rates and an increase in the average length of a GP consultation by 50%. Further detail is available in the Appendices here.

General practice is experiencing a GP workforce crisis and cannot keep up with rising patient needs. The model of general practice needs to urgently change and develop to meet these present and future challenges, as NHS England has made clear:

> "The situation is not sustainable because currently services are not integrated, no new money is available, and the General Practice workforce is already overloaded. Further, our premises are of variable quality and are not used to their full capacity, quality of interventions is variable and we are sometimes failing the most vulnerable. All this is set against a background of a rising population with increased long term conditions."
>
> *"**Transforming Primary Care in Leicestershire and Lincolnshire**", Leicestershire and Lincolnshire Area Team, NHS England 2014*

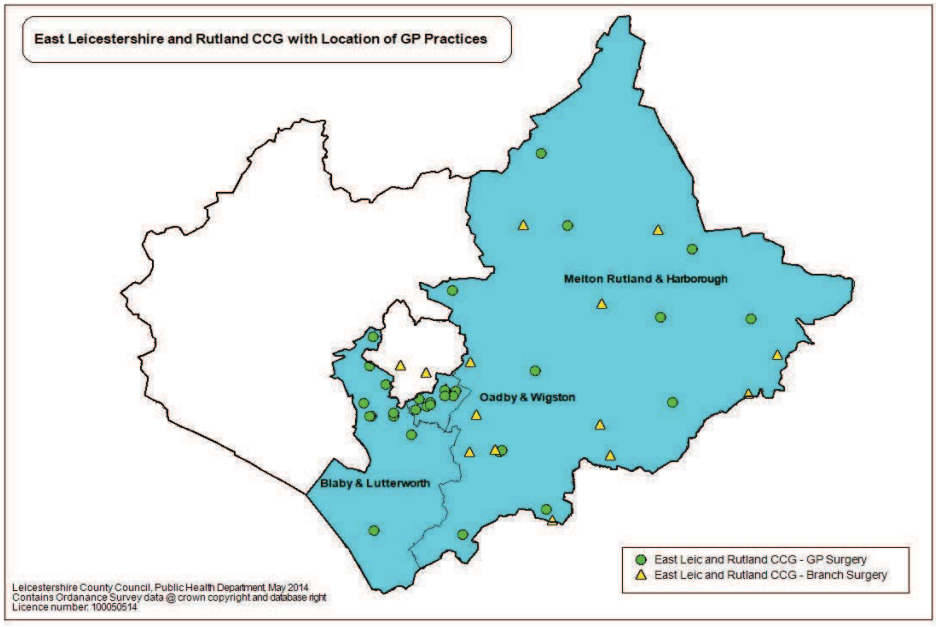
The increasingly out dated model of general practice is reinforced by the current complexity of contractual requirements and funding streams to general practice which do not support

new ways of working together at a greater “scale” to provide a greater range of services and better outcomes for patients.

Where we are now locally

East Leicestershire and Rutland CCG is a membership organisation, which comprises 34 medical (GP) practices in three localities:

(i) Melton Mowbray, Rutland and Market Harborough
(ii) Oadby and Wigston
(iii) Blaby District, Lutterworth and surrounding areas



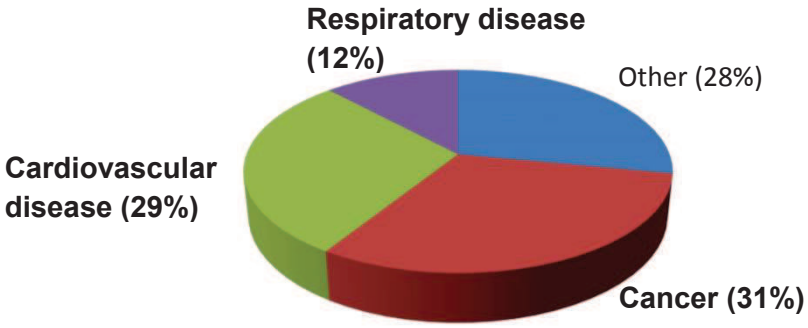
The CCG has a registered population of approximately 320,000 patients.

Health issues:

The health of our local population is generally better than the overall population of England. However, there are a significant number of people affected by ill health, including GP diagnosed:

- Coronary heart disease (10,837 people)
- Hypertension (46,917 people)
- Diabetes (16,145 people)

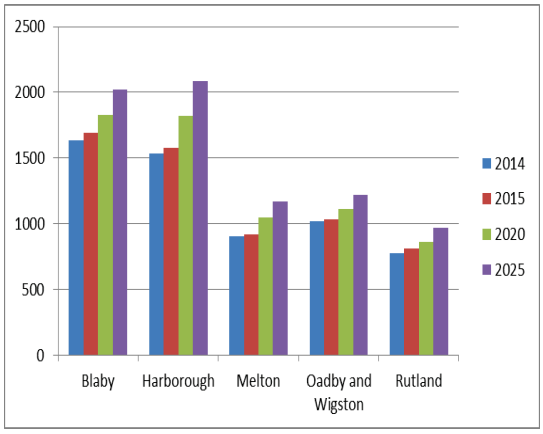
73% of all deaths in East Leicestershire and Rutland are from three major diseases:



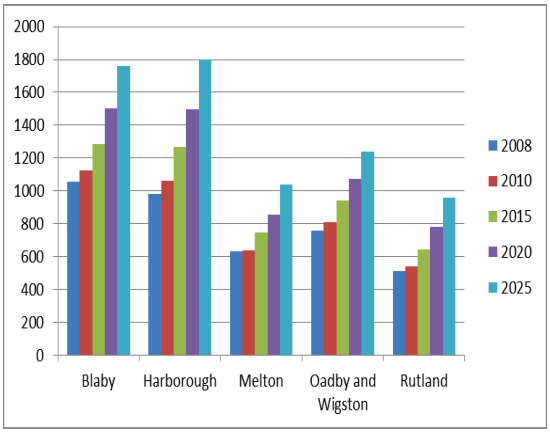
Prevalence of long term disease in East Leicestershire and Rutland is increasing rapidly, particularly amongst the older age groups.

The graphs below show the predictive prevalence of just three long term conditions in over 65 years olds across the CCG. The trend is similar for other conditions such as stroke, obesity, chronic obstructive pulmonary disease and myocardial infarction. Further information is available in the Appendices here.

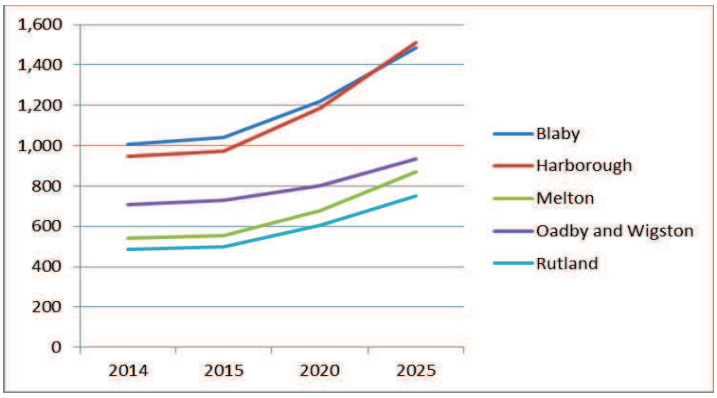
Depression



Dementia



Diabetes (over 75s)



These trends present a significant challenge to the effective identification, treatment and ongoing management of patients with long term conditions, many of whom have multiple co-morbidities.

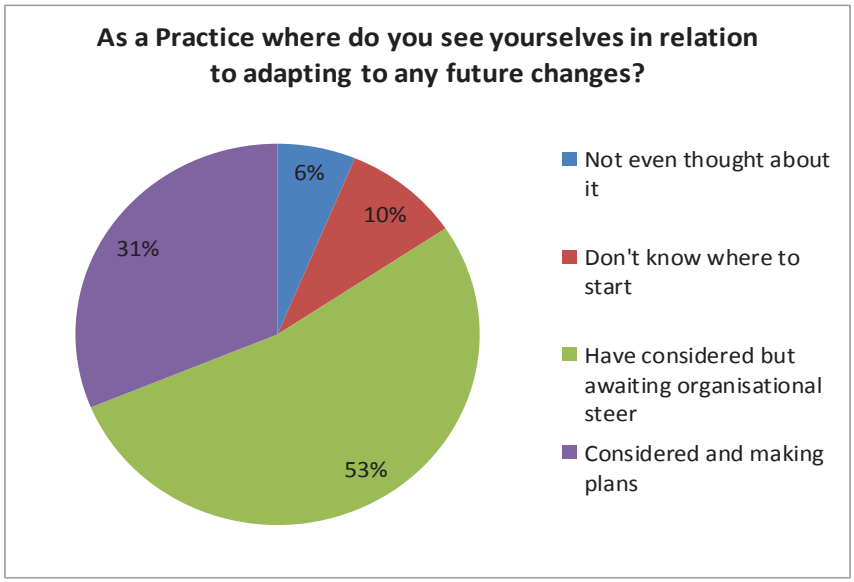
Other demographic pressure:

The population of East Leicestershire and Rutland is estimated to increase to 350,000 by 2025 with:

- An increase of 66.6% in the 85+ age group
- An increase of 28.6% in the 65-84 age group

The impact on local general practices:

The CCG has surveyed its member practices, held engagement events and used telephone interviews to the views of practices over recent weeks to find out more about how they are experiencing the rising pressures, what they are doing about them and their views on the future of general practice. The high level feedback shows that many practices are looking to the CCG to provide a steer on what to do next.



Problems with recruitment and retention and premises constraints were highlighted by some practices but funding was the top priority concern across the board. Practices express concern that resource is dropping but costs and workload are rising.

Practices were very supportive of developing urgent care hubs allied to community and primary care services and the full integration of health and social care support and they gave significant support to adapting clinical models, CCG co-commissioning of primary care and the development of federated alliances of practices.

GP age profiles across ELR CCG as reported by the practices shows over half are in the last decade or so of their working life in general practice.

An overview of the results is included in the Appendices here.

Changes needed across the wider health system locally:

Analysis of current trends shows that the local health economy of Leicester, Leicestershire and Rutland is facing a financial gap of £398million by 2019 if the system does not change.

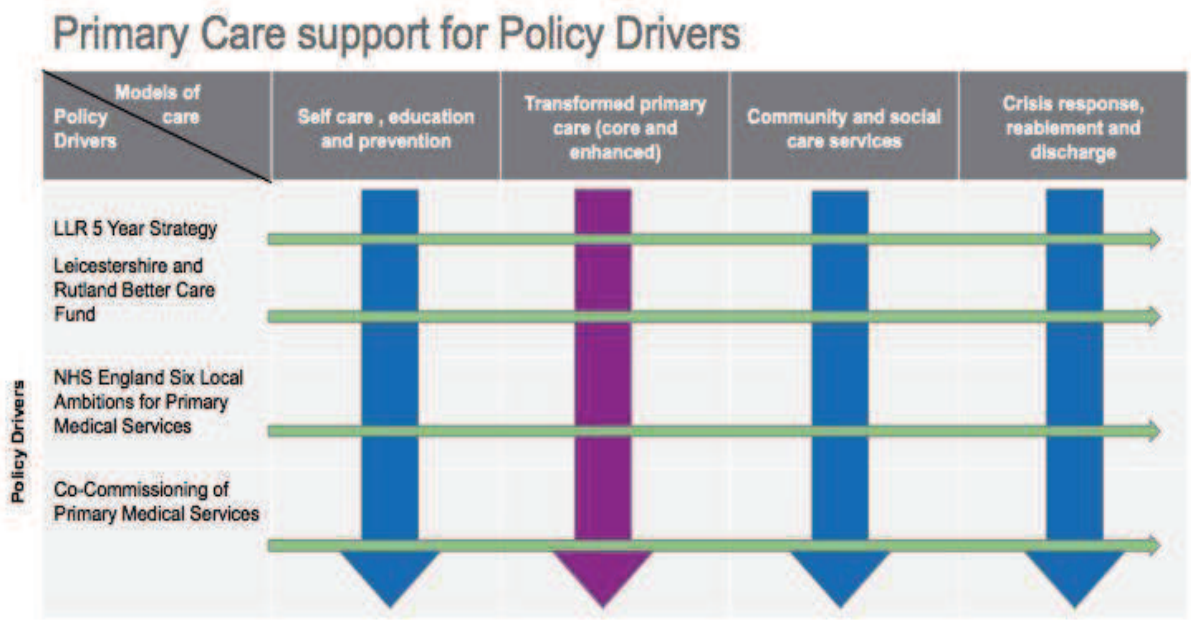
The "Better Care Together" strategic plan has been developed to understand this financial gap and to set out at a high level what needs to be done to close the gap whilst retaining the quality of care for patients and continuing to address their health needs.

The strategy highlights:

> "We need to strengthen primary, community and voluntary sector care, optimising the use of physical assets such as estates, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste."
>
> "***Better Care Together: The Five Year Strategic Plan***", A partnership of Leicester, Leicestershire and Rutland Health and Social Care, June 2014

The strategy sets out plans for each setting of care and describes "transformed primary care" across the area, embracing the national direction of **"**wider primary care services provided at scale". More detailed information showing the aims of each Better Care Together of particular relevance to primary care is included in the Appendices here.

The importance of primary care in all the strategic policies is summarised in the diagram below:



This is supported by clear evidence that the capacity and capability of primary care directly impacts on other services, for example:

> "A recent paper reviewing the relationship between GP access and A&E attendance concludes that moving practices from the lowest quartile access score to the highest quartile access scores could reduce A&E attendances by 111,739 in England."
>
> "***Securing the Future GP Workforce – Delivering the Mandate on GP Expansion***", GP Taskforce Final Report, March 2014. (The GP Taskforce was established by Medical Education England and Department of Health).

The whole system of primary care

Our member practices have told us in recent feedback they are affected by the provision of wider primary care services such as pharmacy, optometry, dental and community nursing services. Developing an integrated approach across this network is vital to deliver the best patient outcomes most efficiently. This primary care operating framework links to the CCG's Integrated Community Services Strategic Framework with plans for integrated teams working at "hub" level to wrap care around patients with complex needs, initiatives developed through the Better Care Fund to provide faster and more responsive care to patients with complex needs and NHS England's vision for general practices working at greater "scale" and integrating with the wider primary care team .

GPs may bring community pharmacists into their integrated teams to help support medicines reconciliation after patients are discharged from hospital and support GPs with polypharmacy work and chronic disease management. NHS England has established a local professional network for community pharmacists which is developing suggestions on how they can reduce the workload burden on GPs and improve patient care.

Optometrists may also become integrated into the team to help streamline eye care pathways. They may be able to forge links with specialist ophthalmology departments and provide space for routine assessment and treatment in local settings.

Co-commissioning opportunity

The CCG has applied for full delegated authority to co-commissioning general medical services. Further guidance and clarification on this initiative are awaited, but assuming the CCG is in a position to progress, there may be an opportunity to be more flexible about the contracting mechanisms offered to practices to help implement this framework more quickly.

Summary of the Case for Change

An ageing population with increasingly complex needs is generating high pressure on all health services. General practice is experiencing a workforce crisis which is compounding the pressure. The local health and social care system is facing huge financial challenge alongside the increased need and demand.

National and local plans, backed up by national research and evidence, encourage general practices to come together to provide services at greater scale and integrate more fully with other local community, primary and social care services. GPs are encouraged to offer services differently to patients depending on the complexity of their needs.

Local member practices recognise change needs to happen and are looking to the CCG for guidance and support. Practices are concerned about falling income, recruitment difficulties and premises constraints and are open to working differently.

Radical and urgent action is needed to save the most effective features of general practice and build resilience and capacity to meet patients' needs and keep people at home for longer.

The full Case for Change is available from the CCG and here:

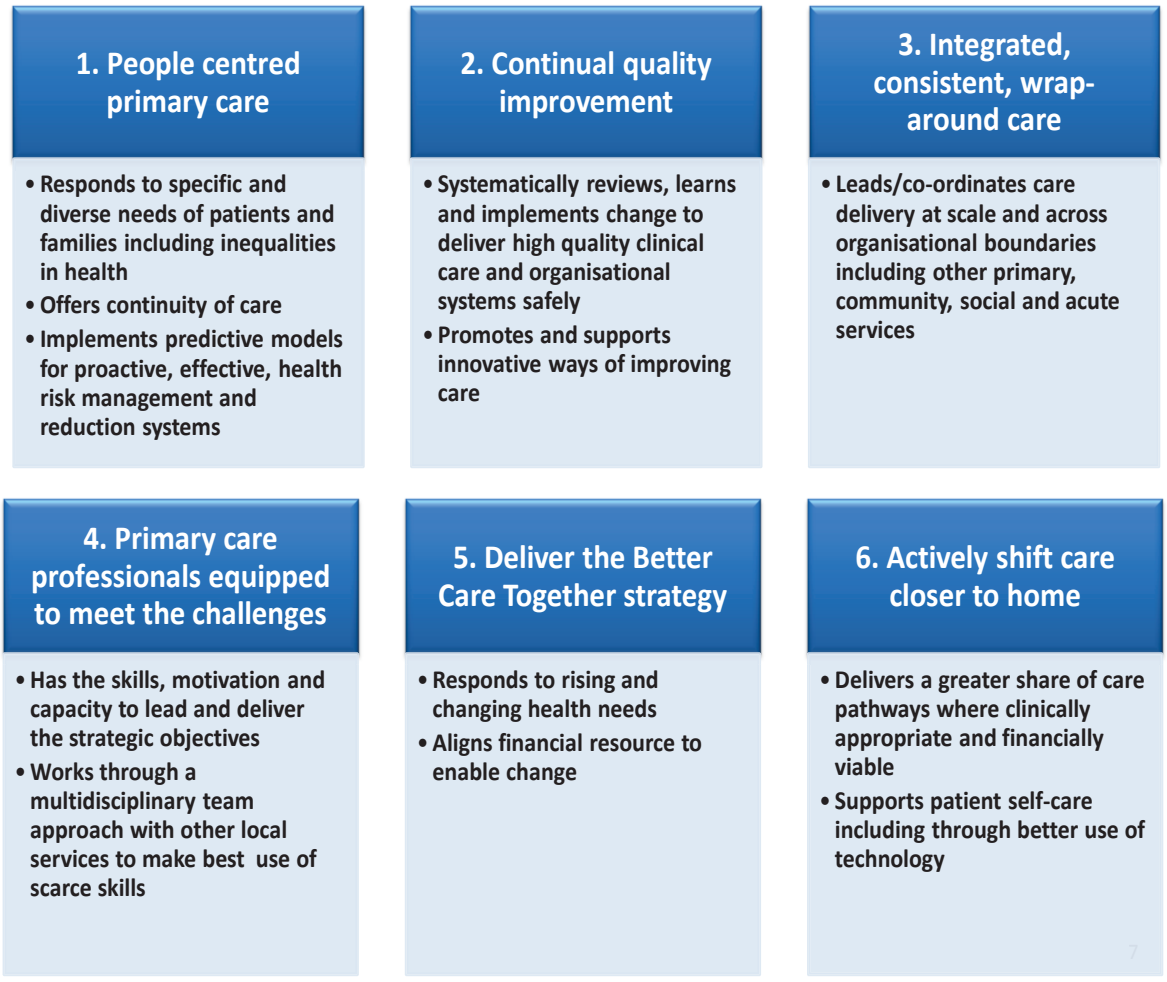
ELR CCG Primary Care Case for Chang

5. Interventions and Timelines

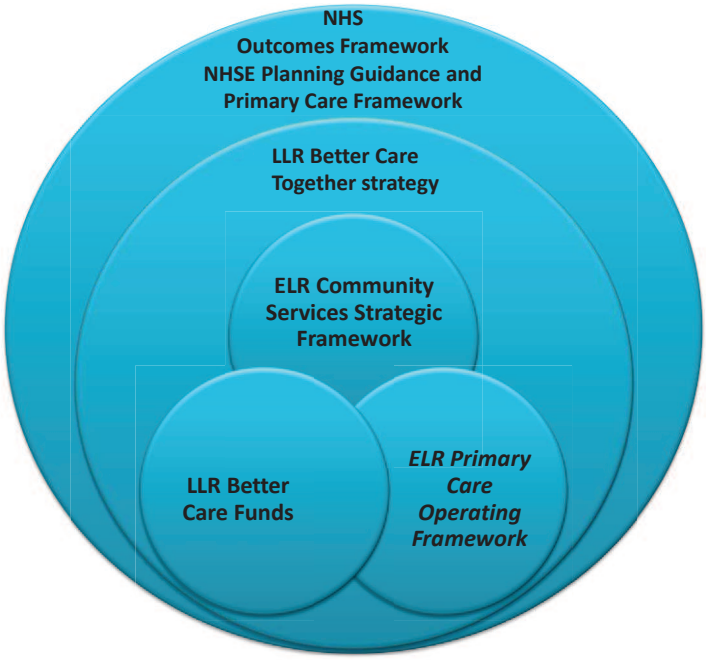
Aims and Objectives

The Case for Change in primary care – six key objectives:

The Case for Change (available from the CCG) reflects global research evidence, expert guidance, national and local strategies (more detail on the national guidance is available in the Appendices here). It sets out the following six objectives underpinned by strengthened abilities of primary care:



These objectives and therefore this framework are aligned to other key frameworks, guidance and strategies nationally, at NHS England Area Team level and locally:



ELR CCG's Draft Integrated Community Services Strategic Framework

The objectives for primary care are aligned to the vision for community services, with examples shown in the table below:

Integrated Community Services Strategic Framework vision	Primary Care Operating Framework objectives
"a fully integrated, coordinated model of service provision for health and social care" **"Services will be delivered to the citizens of Leicestershire in a coordinated way that recognises that people often need support from more than one service"**	"integrated, consistent, wraparound care" Primary care which "Leads/co-ordinates care delivery at scale and across organisational boundaries including other primary, community, social and acute services"
"puts people at the centre of delivery of health and social care services"	"people-centred primary care" which "Implements predictive models for proactive, effective, health risk management and reduction systems"
"The aim is to meet the needs of an increasingly elderly population, particularly the frail elderly and those with long term conditions" **"increased emphasis on early intervention"**	Primary care which "Responds to specific and diverse needs of patients and families including inequalities in health Offers continuity of care Implements predictive models for proactive, effective, health risk management and reduction systems" "Responds to rising and changing health needs"

Integrated Community Services Strategic Framework vision	Primary Care Operating Framework objectives
	"Delivers a greater share of care pathways where clinically appropriate and financially viable"

The framework also describes a "platform" for delivery of services across ELR CCG: an Integrated, Coordinated Health Care (ICHC) service representing the first stage of development towards a fully integrated, coordinated model of service provision for health and social care across ELR, delivering seven day services.

The service will recognise that people often need support from more than one service, particularly the frail elderly and those with long term conditions, mental ill health or disability. The service brings together community nursing and therapy services and will be aligned with the GP practices grouping to form a "hub" – which this primary care operating framework will help to deliver by providing GPs with a route to establish these "hub" entities to integrate and co-ordinate care in the manner described above.

The document also references a six week engagement exercise which took place in spring of 2012. Most respondents ranked local GP practice as the most preferred location for diagnostic, day case and out-patient services, something this framework seeks to enable through working at "scale".

Better Care Fund and Social Care Development

The Better Care Fund is investing in initiatives which directly align with the models and approach set out in this Primary Care Operating Framework, for example:

Clinical Nurse Leads (CNLs) will be appointed to provide clinical leadership across each of the primary care 'hubs'. These are experienced senior nurses who co-ordinate care, promote optimum health, self-management and effective liaison between agencies, manage complex, high risk patients with long term conditions and exercise independent clinical judgement. They will provide direct patient care when necessary and support multi-disciplinary team arrangements with primary care to deliver safe, effective care co-ordination and supporting people to live at home. By preventing deterioration they will avoid the need for acute services.

The Integrated Crisis Response initiatives being developed by both Leicestershire County and Rutland County Councils will provide effective short term support at a point of crisis, helping to maintain people in their own homes including coordinating wider support such as assistive technology, meals and intermediate health care.

The Health and Social Care Frail Elderly Service proposed by Leicestershire County Council is a multiagency initiative including geriatricians and "up-skilled" GPs or Advanced Nurse Practitioners to provide a rapid assessment and treatment service for frail/complex older people in the community.

The Intensive Community Support service which was established in December 2013, accessed via the Leicestershire Partnership Trust Single Point of Access, acts as a comparable alternative to a community hospital bed admission.

GPs working together at greater scale will provide an expanded range of services that will integrate with the initiatives being developed by the Better Care Fund. This is set out in more detail later in this document.

Invariably the services being established will experience difficulties and pressures as they develop, GPs working at scale will be better placed to influence their operational model and their priorities and will be better able to respond to their pressures.

NHS England Planning Guidance 2014 - 2019

NHS England states that any high quality, sustainable health and care system in England will have a number of characteristics in five years' time. Those of particular relevance to the development of primary care are:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care

The guidance highlights the need for "Wider scope primary care at scale" and "Integrated care" with "People in control" as three top priority objectives.

This Primary Care Operating Framework is completely aligned to these ambitions and the models being offered in this document, along with the anticipated benefits to patients, general practices and the wider system fully reflects those characteristics.

Options

The scale of change required in primary care is such that the CCG needed to carry out an option appraisal as part of its Case for Change (available from the CCG).

The options considered were:

1. ***"No change"*** – continue to commission services at general practice level

2. ***"Commission a new model at scale by service specification"*** - Commission a new primary care landscape by specifying a model for services at scale (covering a population of approximately 25-45,000) and inviting providers to apply for a **new contract* (see note below)** to provide services on this basis

3. ***"Commission by strategic objectives at scale with minimal support"*** - Commission a new primary care landscape by offering a **new contract*** at scale on the basis of the agreed strategic objectives and offer minimal market development support during development and implementation of proposals

4. ***"Commission by strategic objectives at scale with extensive support"*** - Commission a new primary care landscape by offering a **new contract*** at scale on the basis of the agreed strategic objectives and offer extensive market development support during development and implementation of proposals

***Note:** The new contract does not include core GMS/PMS/APMS contracts which will remain unchanged within each GP practice unless practices themselves propose changes to their core contracts. Any new contract offered would be a standard NHS Contract for community based services (non-core GMS/PMS/APMS) or an Alternative Provider Medical Services contract, whichever is assessed as most appropriate.

The outcome of the option appraisal was that the option judged to be most effective at achieving the strategic objectives of the CCG is Option 4. This option supports the development of primary care at scale by providing extensive support to enable general practices to come together to deliver the agreed strategic objectives.

A summary of the conclusions of the Case for Change is included in the Appendices here.

The Approach

The CCG proposes a supportive approach aligned to that of NHS England:

> **"The GP workforce must be supported through the period of transformation, as increasing pressures and rising expectations have left many without appetite for further change."**
>
> *"**Transforming Primary Care in Leicestershire and Lincolnshire**", Leicestershire and Lincolnshire Area Team, NHS England 2014*

The options appraisal included in the Case for Change reinforces this point.

Building on general practice as the foundation stone of primary care:

Primary care spans many professions, including pharmacy, optometry, dentistry and nursing with general medical practice sitting at the centre.

General practice provides a level and type of service unparalleled elsewhere in the NHS. Three key features stand out:

1. A registered list of patients entitled to receive general medical services from the provider
2. A contractual requirement to provide care to all temporary patients who request it
3. In most cases, a permanent contract to provide services

These features mean that general practices provide care to all patients in the CCG area and have a stake in the ongoing health and wellbeing of those patients. This makes general practice a foundation stone embedded in the communities and as such the CCG's approach builds on this bedrock.

The CCG has used research and evidence to identify the benefits to patients of offering new contracts to our existing general practice providers to extend their services rather than running a competitive process such as procuring new services through the open market.

The World Health Organisation which has researched the subject thoroughly summarises:

> "**It is at the entry point of the system, where people first present their problems, that the need for a comprehensive and integrated offer of care is most critical.** Comprehensiveness makes managerial and operational sense and adds value….it maximizes opportunities for preventive care and health promotion while reducing unnecessary reliance on specialized or hospital care"
>
> "***Primary Health Care – Now More Than Ever. The World Health Report 2008***", The World Health Organisation.

The benefits to patients of offering new contracts to existing general practice providers rather than running a competitive process:

The CCG has been guided by the extensive research of the World Health Organisation and the credible evidence it presents of the benefits to patients of using existing general practice as the foundation stone to develop integrated care locally. The unique features of general practice mean that integrated care will be much more effective at generating the benefits and strategic objectives.

The evidence of these benefits to patients is summarised in the table below:

Features of general practice	Evidence cited by the World Health Organisation of the benefits to patients of these features
Comprehensive cover	Better health outcomes Increased uptake of disease-focused preventive care Fewer patients admitted for preventable complications of chronic conditions
Regular entry point	Increased satisfaction with services Better compliance and lower hospitalisation rate Less use of specialists and emergency services Fewer consultations with specialists More efficient use of resources Better understanding of the psychological aspects of a patient's problem Better uptake of preventive care by adolescents Protection against over-treatment
Continuity of care and enduring relationships	Lower all-cause mortality Better access to care Less re-hospitalisation Fewer consultations with specialists Less use of emergency services Better detection of adverse effects of medical interventions

Person-centredness	Improved treatment intensity and quality of life Better understanding of the psychological aspects of a patient's problem Improved satisfaction with communication Improved patient confidence regarding sensitive problems Increased trust and treatment compliance Better integration of preventive and promotive care

(From "***Primary Health Care – Now More Than Ever. The World Health Report 2008***".)

The advantages to patients offered by building on the current model of general practice services as set out above would be lost by bringing new providers into the area on contracts of perhaps 3-5 years:

> "**A direct and enduring relationship between the provider and the people in the community served is essential** to be able to take into account the personal and social context of patients and their families, ensuring continuity of care over time as well as across services."
>
> "**Building enduring relationships requires time.** Studies indicate that it takes two to five years before its full potential is achieved but…it drastically changes the way care is being provided."
>
> "**Comprehensiveness, continuity and person-centredness are critical to better health outcomes**. They all depend on a stable, long-term, personal relationship (a feature also called 'longitudinality') between the population and the professionals who are their entry point to the health system..."
>
> "***Primary Health Care – Now More Than Ever. The World Health Report 2008***".

The CCG sees no benefit in running a competitive exercise for the expansion of primary care services where introducing new providers would lead to greater fragmentation rather than comprehensiveness, less continuity, higher risk of duplication, lack of and undermining of existing enduring relationships as well as increased entry points when a single entry point is demonstrably a critical success factor.

Instead, the CCG supports the approach recommended by the World Health Organisation as further detailed in the Appendices here.

The Offer

The Goal: A new Community Based Services Contract offered to all local general practices

The Case for Change justifies offering a new contract to local general practices to deliver the key strategic objectives. It will be for providers to generate solutions most appropriate for the local communities.

The scope of the new contract will focus on the six strategic objectives in the table on page 14 and the performance measures will reflect the aims of Better Care Together in the table in the Appendices. The new contract will be aligned with other relevant plans. It will maximise opportunities for services to be delivered in a way that: patients experience as integrated

and empowering of self-care; helps equip practices to better meet rising needs; and facilitates continual development and improvement.

The new contract will be offered “at scale” so only practices able to demonstrate that they are ready to work together at scale will be eligible to deliver the new contract. It is expected to be a standard NHS Community Based Services contract but if a better contract route is identified then this will be used. If the CCG needs to work with NHS England to develop one or more contracts to achieve the desired outcomes (for example through a mix of Local Enhanced Services contracts and NHS standard contracts) then this will be done.

Some practices may wish to merge, with a single GMS or PMS contract and a new partnership agreement. Others may choose to come together as a federation or an alliance with distinct and autonomous practice identities working with clear responsibilities and accountabilities to achieve shared goals. More information on these options is included in the Appendix on Models of Care Structure here.

Working at scale enables key specialist nursing and medical staff to be brought to this level to work with the GPs. It enables a more integrated way of working with the community services hubs already structured in this way. It enables the development of broad career opportunities which will make ELR much more attractive to GPs and others, increasing our ability to recruit and retain a high quality primary care workforce.

Pioneering general practices already working at scale (see case studies highlighted in the References Appendix here or in the Case for Change available from the CCG) have demonstrated economies of scale, improved efficiency and quality of care. These practices offer a more varied career structure to GPs and a wider range of services to their patients.

The new contract will link into the plans for Integrated Community and Social Care Services (including Better Care Fund initiatives) and will support their delivery. It will help practices develop new models of care, address workforce issues and build capacity and resilience to keep more patients at home.

Encouraging general practices to take this opportunity:

This initiative starts with individual practices looking differently at how they provide care. Each practice will be in different starting position and some will have already started progressing down this route.

It is suggested each practice considers all the options and makes a decision as to which one to pursue. A draft template which could be modified and used by practices is included in the Appendices here.

The CCG will not be prescriptive to practices about the structures they would develop but the recurring theme throughout all the national and local guidance and strategies is the increasing need for practices to work together to provide services “at scale”. The CCG has defined “at scale” as at a population level of approximately 25,000 – 45,000.

Developing the form of whatever organisational structures are chosen is not the first step. In “A Toolkit to support the development of primary care federations” The Kings Fund, Hempsons and the Nuffield Trust quote:

> "Don't start with structures, instead look at what the organisation is trying to do, who should be involved and how it would look from someone else's perspective – particularly GP colleagues and patients" *Dr Wilson of the pioneering BADGER organisation in Birmingham*

This voice of experience echoes the widely used management mantra of "form follows function". Another GP quoted in the document states:

> "What really matters is developing a culture of collaboration"
> *Dr Liston, Washington GP Practices, Tyne and Wear*

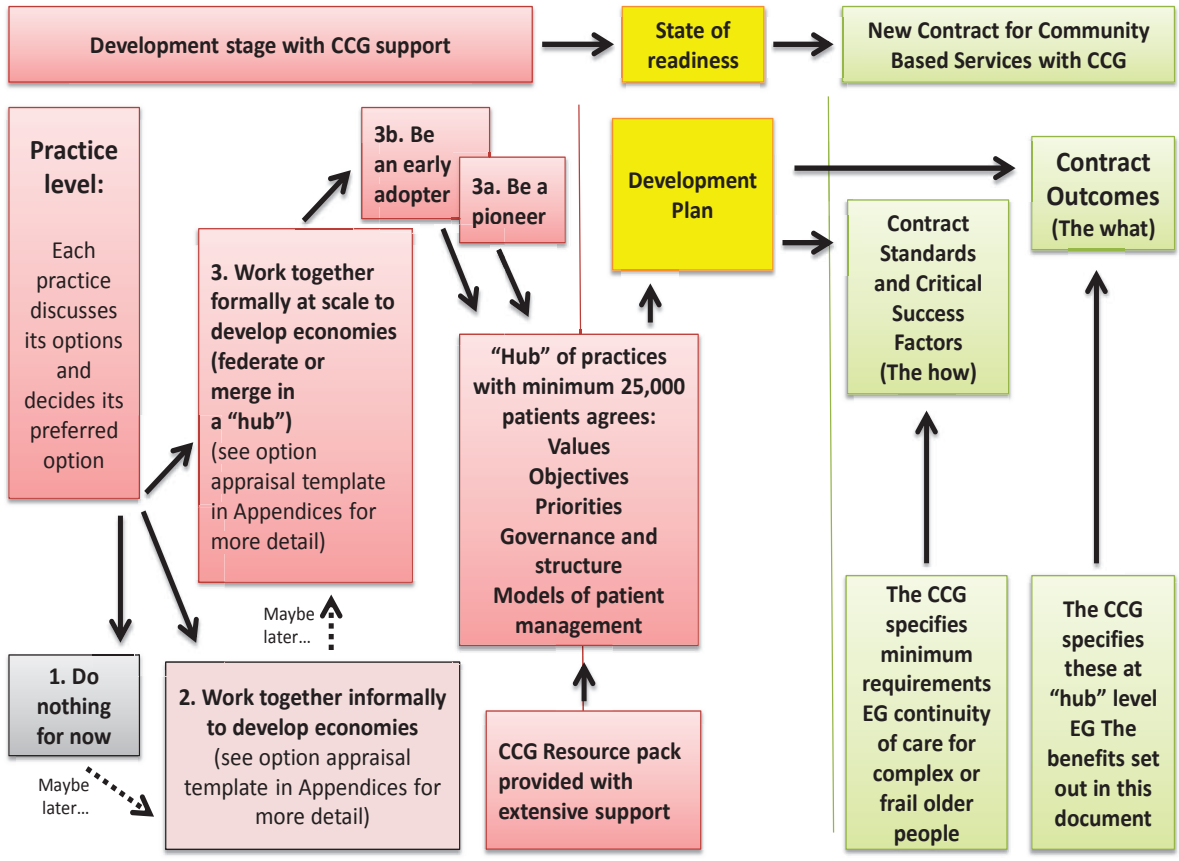
Dr Liston also stresses the importance of developing a shared vision and mission as a fundamental first step.

The CCG has developed a path which reflects these lessons.

The practice journey:

An overview of the path practices will be able to take is set out below:

Key milestones for practices on the path to delivering the new services "at scale"



These considerations need time and space. See the Appendices here for further guidance from research on the more detailed steps to follow.

Extensive support provided by the CCG:

This new contract will represent a considerable challenge to most general practices in the area – the scope will be very stretching. Practices will need significant development work before they are ready to sign up to and deliver such a contract.

One size does not fit all and the options appraisal highlighted the importance of enabling local general practices to find the best solutions for their circumstances, this includes timing.

When practices have considered their options and are ready to progress the CCG will provide extensive support to enable them to move forward. This support will include change management support, access to legal advice, transitional funding and opportunities to access other funding, for example for premises developments and information management and technology. Support to model activity levels and flows will also be provided. Additional funding streams are expected to become available as part of the Better Care Together strategic programme to transform the local health and social care economy.

The CCG will act as a co-ordinator of support to the general practices as they develop along the path and will provide specific aspects of support at each milestone. See the Appendices here for more detail on CCG support on the route to expanding general practice.

Some practices will be more than ready to start this journey whereas others will wish to see the frontrunners demonstrating benefits before they invest their time and effort in entering a process of change.

Mutual commitment with those practices keen to develop early:

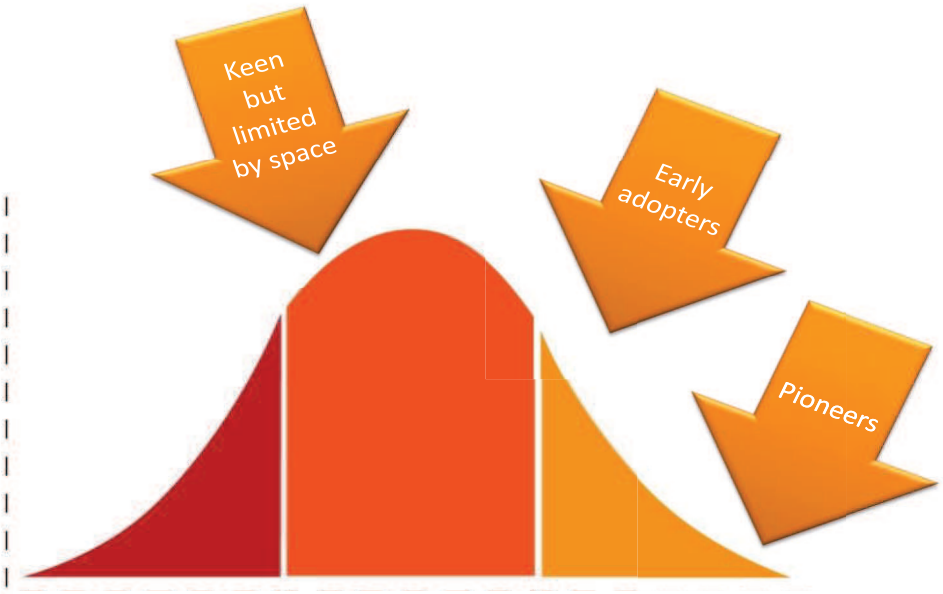
Good change management practice recognises the value of frontrunners, or “pioneers” and acknowledges that they take risks and invest more time and effort in “inventing the wheel”. More intensive support will be offered to practices coming forward as pioneers to help match this extra commitment practices will either have already given or are about to give.

The CCG also recognises the value of “early adopters”, those practices that quickly learn the lessons generated by the pioneers and put them into practice. These practices help mainstream new approaches and create the “tipping point” needed to ensure widespread success. Additional support will be offered to “early adopters”.

Following feedback from practices it is clear some practices are keen to expand their responsibilities and services but are constrained by their premises. This group of practices will also be offered extra support to overcome this significant barrier to change.

The diagram below uses the curve of “normal distribution” to demonstrate where these practices are on the process of change. This graph is sometimes used to show the range of the pace of change in a population of individuals or group.

Recognising the value, input and commitment of general practices that are pioneers and early adopters in the change process



The "Normal Curve"

Practices not in these three groups will also be supported, but the level of support is unlikely to be as high or intense because the pioneers and early adopters will have built governance structures and adopted policies and plans that will be available to the other practices to tailor to their own circumstances.

The CCG encourages all practices to define themselves as pioneers or early adopters and the speed of progress will be determined by the practices, not the CCG because they will be responsible for implementing the changes.

Geographical coherence:

The ideal end point is for local general practices to come together to form an entity with which the CCG can contract for extended primary care services through an NHS Community Based Services contract. Ideally this will include all the patients registered with the practices within that geographical area so there will be comprehensive cover of a locality, without gaps.

The journey to reach this end point may begin with a number of practices in the area keen to progress whilst some other practices in their area are more reticent.

Enthusiastic practices should not be held back by a requirement for comprehensive cover of a locality from the start, but there needs to be enough geographical coherence (the practices working together are all in one area, not scattered) and a critical mass of patient numbers (25 - 45,000) to merit the resource input contributed by the CCG.

Where there is geographical coherence but not comprehensiveness, it is expected that the practices working together agree to "keep the door open" to the reticent practices and enable them to join when they are ready. The enthusiastic practices may agree entry criteria such as agreement to participate in peer review and require the more reticent practices to meet

the entry criteria when they seek to join, as long as the existing members of the group have already met those entry criteria and that the criteria are reasonable (ie most GPs would agree them to be so).

Role of the Development Plan:

The proposed Development Plan introduced in the diagram on page 22 is a tool to help the CCG and practices assess the readiness of the general practice groups to take responsibility for the new Community Based Services Contract.

The Development Plan will need to show that certain organisational development milestones have been reached by the practices, *such as*:

EXAMPLE: Areas which could be included in phase one of the development plan
(pending consultation with local practices and other stakeholders)

*In line with the agreed plans for community and social care locally

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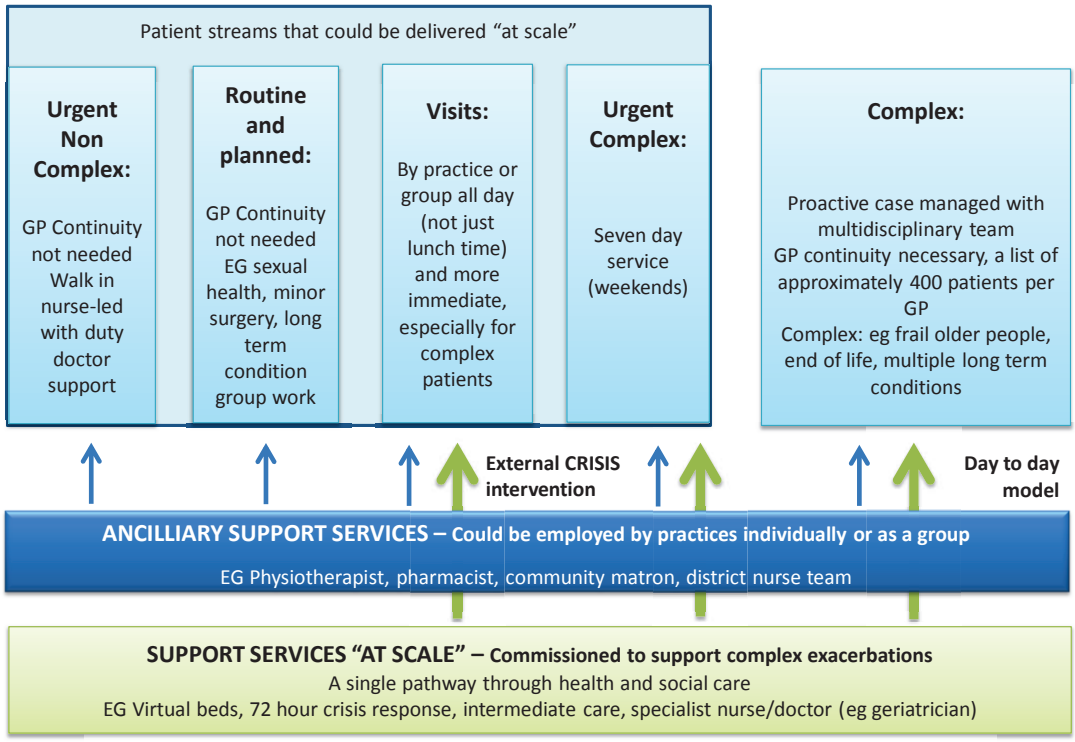
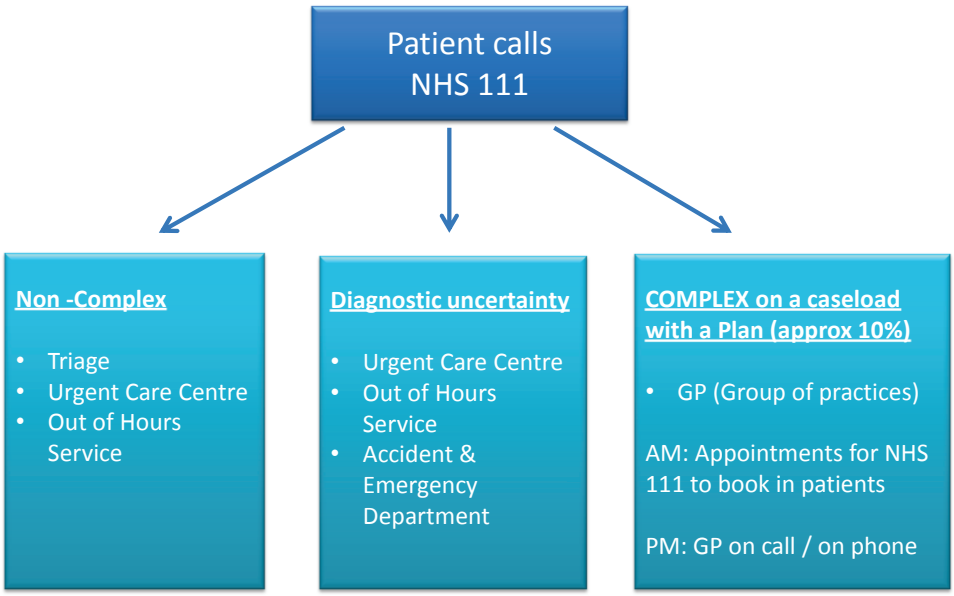
As part of the Development Plan practices will need to consider new models of providing primary care such as the examples set out below:

Possible model for streaming of practice patients with support services

Stream patients according to need and level of proactivity required



Possible service model for providing seven day (Saturday and Sunday) primary care services to patients with complex needs



System wide support for general practices:

Action by general practices alone will not enable system wide change. All the local organisations will need to work more closely and more responsively to one another to change care pathways as required to deliver Better Care Together and to meet the challenges of the future.

This scale of change for established institutions is not easy and there will inevitably be times when GPs, working on the frontline of complex risk and care management, experience difficulties. When a GP cannot get hold of, *for example*, a social care worker to organise an adaptation in a patient's home to prevent a Friday evening hospital admission, it reduces their confidence in the ability of the system to support them to manage more patients at home. Recent feedback from local practices strongly reinforces this point.

Experienced GPs working "at scale" will need to articulate in their plans how community and social care services need to also develop to keep patients well and independent at home for longer and they need influence to ensure these changes are made and services respond.

The CCG and other local organisations will have to make changes to the way they work:

EXAMPLE: Areas which the CCG and other local organisations may need to develop as part of phase one of the development plan (pending consultation with local practices and other stakeholders)

The Better Care Together five year strategic plan requires primary care to keep more patients at home and prevent the need for admission to hospital. General practice will only be able to achieve this if local organisations can achieve the changes set out in the above diagram.

Timelines

An outline implementation plan is set out below for discussion and development. This plan estimates some milestones in practice readiness to develop into working "at scale" and realising the benefits of doing so.

Action	Timeline
Primary care operating framework is developed, consulted upon, reviewed and agreed. Implications identified and worked through including the development of a CCG Resource Pack including case studies, design principles and templates.	September – December 2014
Public and patient engagement plan and due regard work to ensure the framework meets all requirements	September – December 2014
The Better Care Together programme seeks and secures agreement to the Strategic Outline Case and Project Initiation Document. High level modelling work undertaken.	October – November 2014
Extensive support offer proposed by CCG	November - December 2014
Pioneering practices start to take up the offer	January – March 2015
Governance arrangements including patient and public involvement developing in pioneers	January – April 2015
Specialist expertise such as legal advice being utilised	January – April 2015
CCG develops the new Community based services contract in discussion with stakeholders	January – September 2015
Early adopter practices start to take up the offer	April 2015
Possible start date for co-commissioning	April 2015
Governance arrangements including patient and public involvement developing in early adopters	April – September 2015
Practice mergers, federations or other models start to take shape and agree plans	May – November 2015
Practice Groups start to become ready to deliver the Community based services contract – possible pilot phase	September 2015 – March 2016
Later waves of practices start to take up the offer of CCG support	February - September 2016
First wave of practice groups sign up to delivering the new contract	March 2016

Action	Timeline
Alternative possible start date for co-commissioning	April 2016
Benefits start to be realised for perhaps 10% of the area	September 2016 – March 2017
Further waves of practice groups sign up to delivering the new contract	October 2016
Benefits start to be realised for perhaps a further 25% of the area	March – September 2017
Benefit realisation of a "tipping point" of critical mass of perhaps 65% of the area	From April 2018

Immediate next steps:

A local debate about this primary care operating framework will further shape: this document; the offer of support from the CCG; and the ideas around the contract to be offered to enable delivery of the new models of care.

The Better Care Together programme will use this document, along with the equivalent documents from West Leicestershire and Leicester City CCGs to shape the Strategic Outline Case and the subsequent modelling work. Common themes will be identified across the CCGs to enable support at strategic level to overcome barriers to change.

An assessment will be made of which services may be decommissioned or commissioned differently to enable the new model to become established. There may be a temporary "double running" period whilst old service models are gradually phased out and new models become established. This will require careful planning and full consultation with the local communities with due regard to the impact on all patient groups to reduce inequalities.

There will also be work to better understand the current financial flows and any scope to use these differently, for example using the Directed Enhanced Services or other funding currently with NHS England. Also exploring opportunities to pool budgets with local authorities to secure maximum return on investment and facilitate integration.

All these work programmes will need to be supported by risk management plans to address concerns (including those expressed by patient representatives) and minimise risk.

There will need to be agreement at strategic level before resources can be released. At that point the CCG will be in a position to start implementation.

6. Benefits and Outcomes

The purpose of this Operating Framework is to enable benefits to be delivered for patients, for general practices and for the wider health and social care system. ***One of the most important benefits is to enable the survival of general practice during the next ten years.***

The key priority is to build a solid and sustainable foundation of primary care from which integrated care can be provided to an increasingly complex mix of patients. Only then will a greater proportion of clinical activity be able to take place in community settings and the objectives of the Better Care Together programme to sustainably shift care closer to home be realised.

The performance measures in the new contract being offered to general practices will need to focus on the delivery of that solid and sustainable foundation, this is the area GPs are best able to deliver and control. The CCG will encourage practices to develop a well-staffed and integrated model to "stream" patients and therefore deliver patient outcomes which result in less need for people to be admitted to hospital.

There can be no significant transfer of routine patients into the community unless and until this solid and sustainable foundation is in place.

Some examples of areas in which possible performance measures could be developed are included in the tables below. These would need extensive discussion with local GPs and other key stakeholders and considerable further development before being offered in a contractual form.

Benefits to patients	Possible Outcome Measures
Based on a model of care which streams patients and ensures those with complex needs have continuity of care by a named GP, are proactively supported to self-care, proactively risk managed and provided with wrap around integrated care including specialist doctors/nurses	
Patients continue to feel "owned" and receive continuity of care where this is important to them	Proportion of patients with complex needs (including frail older people) who are under the care of a named GP Practice systems in place to demonstrate patient "streaming" is implemented from first contact through to follow up and ongoing management
Patients' care is coordinated as necessary	Named GPs for complex patients are demonstrably those best qualified/experienced/accredited for the work. GPs coordinating care report that other local organisations are responding by organising services in a way which patients experience as integrated
More proactive care for patients with complex	Risk stratification and management system in place and used with emerging evidence of benefits

Benefits to patients	Possible Outcome Measures
needs	
Appointment slots are tailored to their particular needs	Practice systems demonstrate longer appointments for certain patient "streams"
More care provided locally, without needing a visit to an acute hospital	Increasing numbers of patients seeing a specialist doctor and/or nurse in a community setting for consultation, assessment and where appropriate, treatment
Increased patient confidence in self care	A summary description of the initiatives by practices to empower patients and numbers of patients participating in the initiatives
Patients find it easier to access appropriate and convenient care from a local general practice	Patient survey results Practice systems with patient "streaming" and sharing functions across practices and arrangements for seven day working
Able to influence the expansion of primary care services in their local area	A Patient Advisory Group established to meet at least four times a year to be consulted on plans and to comment on the quality of services in the local area

Benefits to General Practices	Possible Outcome Measures
Based on a way of working at greater scale as determined by the practices, with a structure which enables economies of scale and a wider variation of ways of working including a more integrated approach with other primary, community and social care services	
Workload	A defined GP career structure in place with clarity about how priorities will be changed including "streaming" patients, team working with appropriately qualified and experienced nurses, therapists and pharmacists to share the work Feedback from younger GPs that stress levels have reduced which should translate into better recruitment and retention of GPs
Appropriate resource allocation	Resources in place to enable greater proportion of work to take place in an out of hospital setting
Sharing the challenge of seven day working	Initiatives developed by practices
Career development opportunities and improved job satisfaction	Defined GP and MDT / Nurse career structure builds in opportunities for portfolio working, developing and delivering a specialist interest whilst retaining and improving generalist

Benefits to General Practices	Possible Outcome Measures
	skills in a sufficiently supportive environment Defined career progression structure for other clinicians, management and administrative staff working in practices
Wider primary, community and social care services more accessible and aligned locally	Feedback from GPs that services are integrating around patients and enabling them to conduct the “orchestra of care” Emerging evidence that a greater proportion of complex patients are being managed in the community
Peer support and skill sharing	Initiatives in practice to enable peer review and support and skill sharing
Improvement in practice efficiency such as merged practice functions/ closer working	GPs and/or practice managers leading on aspects of change and system improvement across a number of practices rather than every practice “reinventing the wheel”
Leadership and change management skill development	GPs and Nurses playing a greater leadership role and managing more change across a wider system including public health measures

Performance measures for benefits to the wider health and social care system are particularly difficult to develop and monitor and the areas in the table below are included to stimulate broader discussion and debate.

Only a few of these would be appropriate to include in a contract offered to GPs but all could be considered in monitoring the success of the new contract over the longer term.

Benefits to the wider health and social care system	Possible areas for the development of Outcome Measures (need to be specific and directly linked to action)
Based on a model of working in which general practices form the bedrock and work together at greater scale, offering continuity of care where it counts, comprehensive integrated and person centred provision with a regular entry point.	
Improved health outcomes for patients	Long term morbidity and mortality Hospitalisation rate (lower)
Improved recruitment and retention of staff	GP, Nurse and Practice Manager vacancies Brief feedback from practices on recruitment issues

Benefits to the wider health and social care system	Possible areas for the development of Outcome Measures (need to be specific and directly linked to action)
Faster achievement of the relevant Better Care Together aims (see page 46)	Measures linked to those aims Strategic objectives achieved
Mobilisation of community resources to improve health and wellbeing	Initiatives led by GPs working with public health and other local organisations to target health improvement such as reducing prevalence of obesity and diabetes in school children
Reduced inequalities in health (eg in marginalised groups)	Long term morbidity and mortality across the different communities
Improved system efficiency	Proportion of care delivered in cost effective settings
Reduced pressure on Accident and Emergency services	A&E attendances Proportion of "inappropriate" A&E attendances

Risks

The following high level risks and barriers have been identified with proposed mitigation:

Risk identified	Level of risk	Mitigation
Contractual and organisational restrictions	High	High level and explicit commitment needed from all local organisations to the Primary Care Operating Framework Commitment of all organisations to support primary care development through the Primary Care Operating Framework to be formalised through agreements specifying their contribution to enable delivery Systems to be agreed to enable GPs to be assured that they will be supported on the ground when taking on additional responsibilities Regular monitoring by the CCG during implementation with rapid escalation of problem areas to a senior team to enable speedy resolution
Lack of sufficient resources to provide the support needed to deliver the strategy	High	High level and explicit commitment needed from all local organisations to the Primary Care Operating Framework Clarity on the implications or risks of not delivering this

Risk identified	Level of risk	Mitigation
		framework and the subsequent costs to ensure continued support
Reluctance of practices to embrace change	High	The Operating Framework must make it easy for practices to start the developmental journey Practices to have extensive and practical support during the developmental journey, particularly those breaking new ground or overcoming particularly difficult obstacles
Patient demands and patients perception of not being 'owned'	High	Engagement of patient and public groups from the beginning A clear and consistent message of how patients will benefit including how continuity of care will be maintained where it matters to patients Support for GPs to take time out from the pressures of meeting patient demand to redesign their working environment
Defining Out Of Hours Services, who is responsible and the effect of seven day services	High	Definition and clarity to be sought. Modelling work on the implication of seven day services Close monitoring of the impact of seven day services on general practices Support through the Primary Care Operating Framework for practices to work together to provide cover for seven day services
Workforce	High	Inadequate numbers of clinical and managerial staff to support the change in care setting or manage increased demand
Media response to general practice as change develops		Clear and consistent communications, including the benefits to patients and evidence from elsewhere Strong patient and public involvement
Challenge by providers outside the local primary care provision who see large scale change and resource shift for which they have no ability to bid	Medium	Evidence based rationale for offering current general practice providers the new contract rather than carrying out a competitive process Discussion and decision by the CCG Board with a written record of the increased expected benefits to patients of choosing this route, as required by Monitor
Leadership instability or indecision/inability to follow through	Low	Commitment of all organisations to support primary care development through the Primary Care Operating Framework to be formalised through agreements

Risk identified	Level of risk	Mitigation
leads to a lack of momentum or credibility		specifying their contribution to enabling delivery
Failure of commissioners to follow due process, for example by providing equally accessible support to providers through a clear, justifiable and transparent framework	Low	Transparent and rational support framework equally accessible to all practices.

Further discussion and development of the risks, including scoring them and developing a risk management plan, will follow.

7. Next Steps and Investment

This Primary Care Operating Framework is not only a response to the Better Care Together strategic plan, but a plan to support our members through a process to support them and patients to a new and improved primary care service

The CCG and partner organisations need to work together to put in place a number of enabling strategies to deliver this Framework. Some of these, such as the Better Care Fund initiatives and the Community Services Strategic Framework, are already developing.

Once this Framework has been discussed and agreed further work will take place to develop the following:

Enabling strategy	Examples for inclusion:
Models of care: Integration with other local services including community, specialist and social care ELR CCG's Draft Integrated Community Services Strategic Framework	Development of a 'Complex Integrated Care Team' where this patient group would be dealt with separately within practice delivery considering skill/expertise Enable proactive care planning eg six monthly reviews and plan patient care through an extended consultation not react to immediate need A wider multidisciplinary team to include pharmacist, discharge co-ordinator, social worker and community nursing as part of practices working at scale Patient education – self management needs expanding to follow the diabetes model

Enabling strategy	Examples for inclusion:
Better Care Fund NHS England Primary Care Framework	Opportunity for closer working on seven day services Federation or mergers of practices to form an entity with which the CCG can contract for extended primary care services through an NHS Community Based Services contract
Premises	Potential for premises conversions and section 106 monies Development of integrated care centres to co-locate members of the multidisciplinary team and enable patients to experience care which is better integrated
Multi-agency sign up	Commitment from all relevant local organisations to the Primary Care Operating Framework with specific plans from each as to how they will support its delivery and how they will monitor how effective their support is
IM&T	Appropriate sharing of patient information across the multidisciplinary team Enabling patients to use technology to access clinical advice and support more quickly where appropriate Wider use of telehealth and telecare to support self-care
Workforce	The role of the GP could be one of 'Supervising, monitoring and co-ordinating care' – being a good generalist Inform undergraduate GP Training programme to dispel myths of primary care Develop and support formal training and development of nursing and other clinical staff to improve recruitment and retention Communicate the flexibility of primary care as a career choice Make ELR a more attractive location by developing the career structure of GPs, nurses and others locally to enable portfolio working, supporting the development of special interests and leading public health initiatives with an aim of reducing inequalities in health Develop roles and clarify the potential for the wider primary care team, eg pharmacists, to help reduce the workload on GPs
Communications plan	Consistent and clear messages to patients and the public Clarity on the benefits to patients Engaging patients and the public in developing and implementing plans. For example, mobilising sixth formers to do project work to support consultation on proposed changes or on public health

Investment

Primary care needs transitional funding to align and expand as described in this document. The following areas of expenditure have been identified with sums estimated:

Investment type	Needed	Purpose	Estimated amount needed
Transitional (already in place)	2014 (part year) 2015 2016	Transitional funding for general practices as part of the "journey" to being ready to sign up to and deliver a new contract for Community Based Services. This includes the £1.50 per registered patient currently paid for "Joint Working and Collaboration" in the "Support and Investment Plan for General Practice".	£480,000 £960,000 £960,000
Transitional (new)	2014 (part year) 2015 2016	Additional expertise, including change management, legal and communications support to enable practices to complete the "journey" to readiness to deliver the new contract. More intensive and costly support to practices that are pioneers and early adopters so "front loaded"	£300,000 £300,000 £300,000
Transitional (new)	2014 2015 2016	Funding for planning, application and legal costs of capital development (including IM&T and premises) to enable integration	£1m £1m £1m
Revenue	2015 onwards	A new Community Based Service with practices operating at scale (population 25-45,000). Matched by £10m community services current funding Other existing income to be added in where possible (eg LES, QOF)	£10m
Capital costs	2015 onwards	New and expanded premises: Development of Integrated Care Centres – estimated to need 3-4 new large centres plus development of some existing estate	£50m

Resource Shifts

In some areas of the above table it will be more appropriate to shift resources from another area of expenditure than look for additional funding. This will be worked through with expertise from the financial team.

8. Appendices

Rising Need and Demand

Nationally:

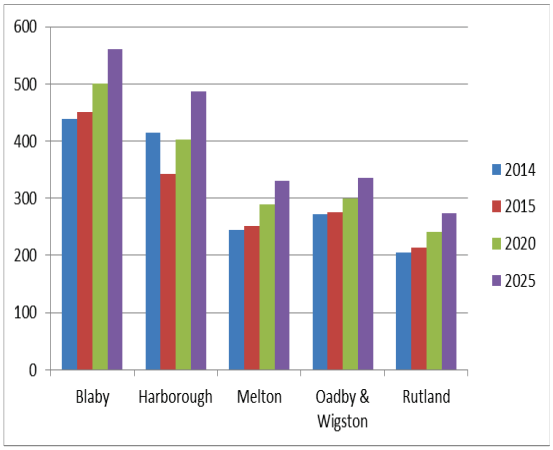
The national picture
1993 – 2013 saw the average GP consultation lengthen by 50% (from 8 to 12 minutes)
2005-2008 saw a 40% increase in GP consultation rates
The average patient now sees their GP six times a year (100% up on 10 years ago)
Average annual consultations among the over 75s have increased by over 50% from 7.9 in 2000 to 12.4 in 2008
In 2010 people with LTCs (29% of the population) accounted for over 50% of all GP appointments

RETURN to this section in the main document

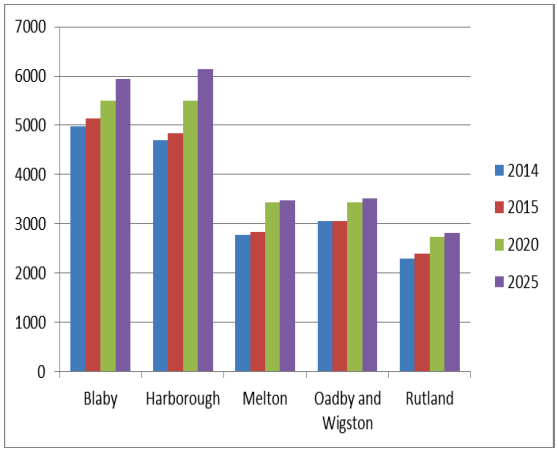
Locally:

Predictive prevalence in over 65 years olds across the CCG:

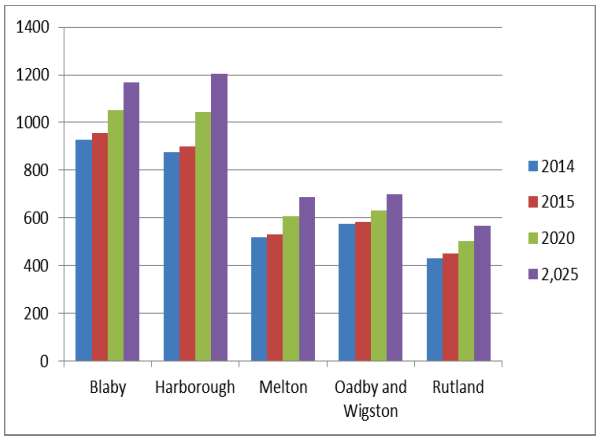
Stroke



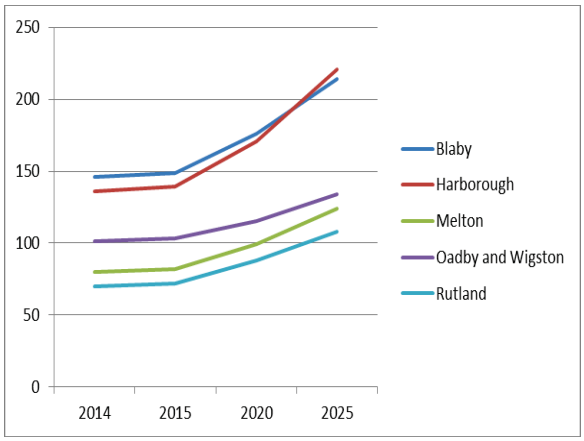
Obesity



Myocardial infarction (over 65s)



Chronic Obstructive Pulmonary Disease (over 75s)



The latest population projections (from the 2011 Census) also clearly show that East Leicestershire and Rutland has an ageing population and, with the focus nationally on proactive care of the elderly, our strategy and investment needs to help manage this.

Demographic led housing plans indicate housing stock will increase in all areas of ELR:

Borough/District	Household projection increases over next 12-22 years
Blaby	336
Harborough	396
Melton	194
Oadby and Wigston	75
Oakham	1035
Uppingham	240

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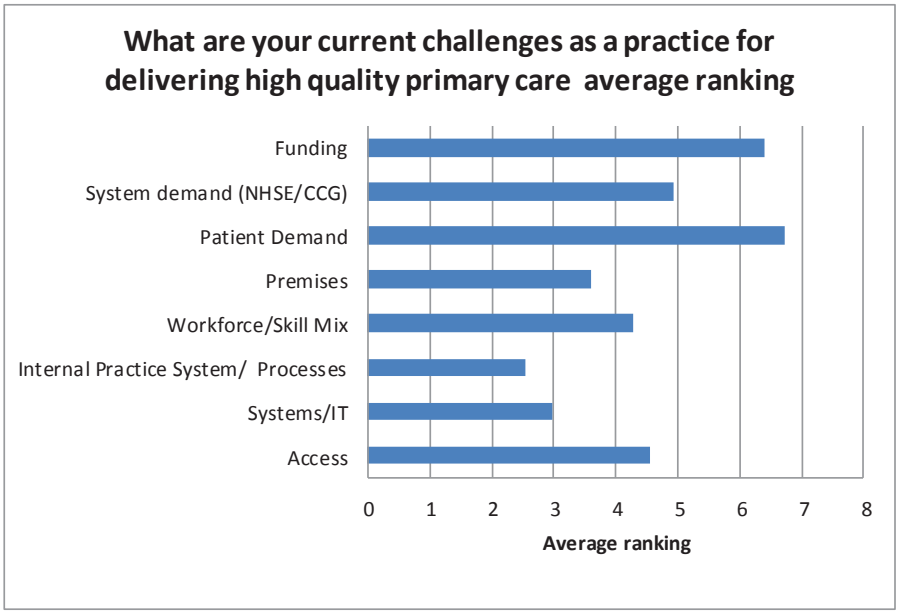
Views and information provided by local general practices

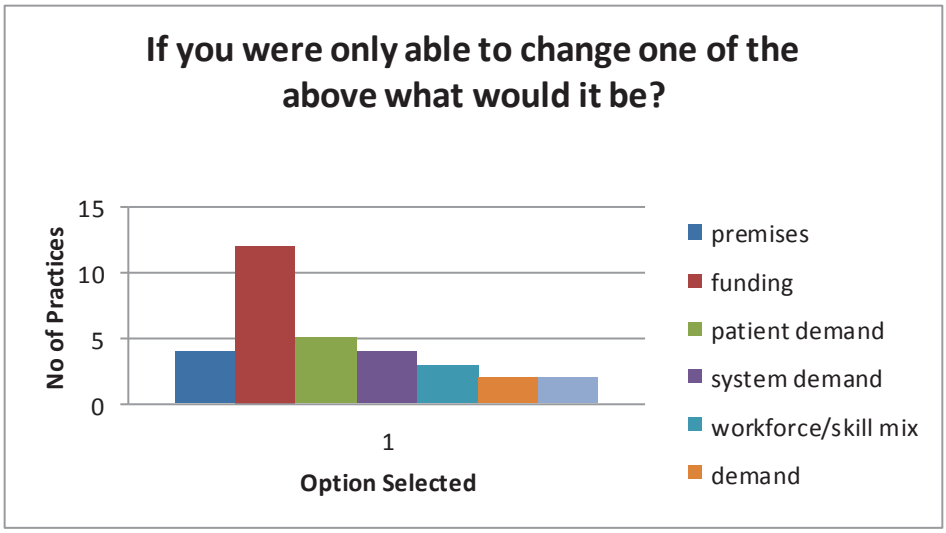
All practices were invited to complete a survey, thirty two responded and the results are summarised in the charts below:



The biggest reported challenges for practices at present are the demands of patients and the level of funding to provide services.

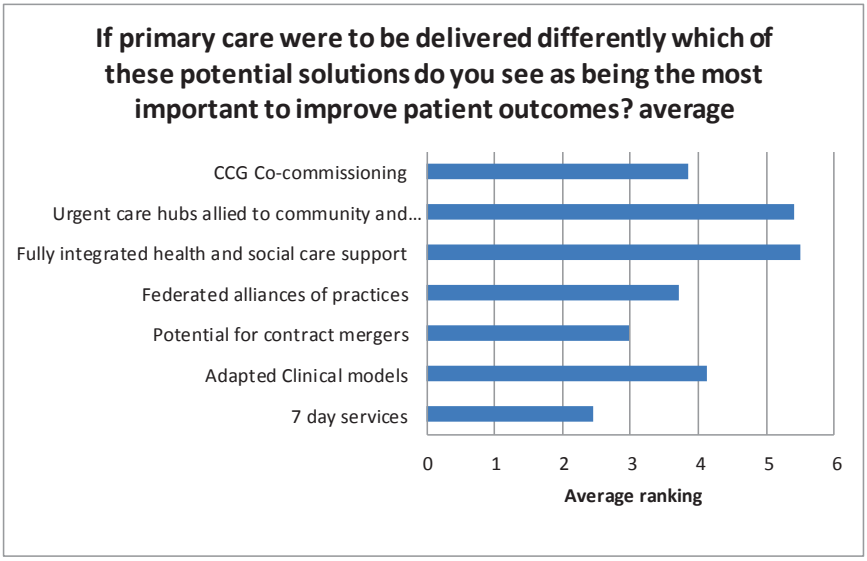
Patient access and the demands of the system are also ranked highly. Analysis of individual practice results shows that some practices ranked premises and workforce/skill mix as their top priority but as these were not issues for quite large numbers of practices they did not feature highly overall.

The top priorities for change reflect fairly closely the answers describing the biggest challenges.



Funding has again been identified as the biggest issue, with patient and system demands on practices also selected by many practices.

When asked about the most popular solutions to improve patient outcomes:



Generally practices ranked developing urgent care hubs allied to community and primary care and the full integration of health and social care support most highly and gave significant support to adapting clinical models, CCG co-commissioning of primary care and the development of federated alliances of practices.

All practices were also contacted for a telephone interview with an agreed practice representative to go through a series of set questions. Common themes are shown in the table below:

Workforce	Premises	Revenue
Generally workforce is stable	Saturated room usage	Overall reduction in income
A number reaching retirement (GPs)	Not fit for purpose	Affecting practices differently
A number of practices would like to expand clinical workforce	About 10 years out of date	Reduced partner drawings
Recruitment for GP/Nursing vacancies difficult		Weighted list issues based on formula

Practices made a number of helpful suggestions such as:

More specialist nursing services including diabetes and respiratory

The County Practice

More alignment of community services and nurses to each GP practice to facilitate the best use of resources…flexibility between teams to allow scope to develop skills and enhance motivation

Oakham Medical Practice and Market Overton & Somerby Surgeries

Large hubs with GPs and other services would be efficient, benefit from economy of scale

South Wigston Health Centre

Increase the numbers of generic district nurses, intermediate care teams, step down beds, Macmillan nurses….

Increase the number of health care assistants trained in more straightforward district nurse tasks

The Uppingham Surgery

A secondary care point of contact ie Helpline to sort out what isn't done that patient can access and who will sort out very quickly and easily their problems with secondary care. Currently these come to practices to resolve and take a huge amount of time….this would be a quick win.

The Wycliffe Medical Practice

Staff recruitment: New GPs and medical students are in the decline and University Hospitals Leicester is not attractive. This needs to be addressed and Leicester made more enticing.

Glenfield Medical Practice

Share ideas for new initiatives/good practice quickly. Not reinventing the wheel. Better communication between practices.

Oakham Medical Practice and Market Overton & Somerby Surgeries

Who manages/owns the integrated team is important: would be interested in the community matron role integrated within the GP team

Long Clawson Medical Practice

Combined chronic disease management clinics (to reduce unnecessary contacts)

Jubilee Medical Centre

Could consider doing some services across practices eg family planning, minor surgery and chronic disease management.

Empingham Surgery

Look at federation model to help long term recruitment

Kingsway Surgery

More generalist physicians to provide care in the community

The County Practice

Integrated health records where other organisations can see GP inputs and vice versa.

The Masharani Practice

Falls services more localised and at home service (people with falls problems don't travel well).

The Masharani Practice

Need to rearrange how surgery works and stream patients' appointments better. Ten minute appointment doesn't work for complex patients

Hazelmere Medical Centre

We need to find a way to regenerate everyone's enthusiasm.

Kingsway Surgery

Commission advice from secondary care – virtual clinics

Oakham Medical Practice and Market Overton & Somerby Surgeries

Pharmacy links need to improve eg pharmacy minor ailments service. Also pharmacy could act as a "second check" for drug interactions for patients on multiple medications

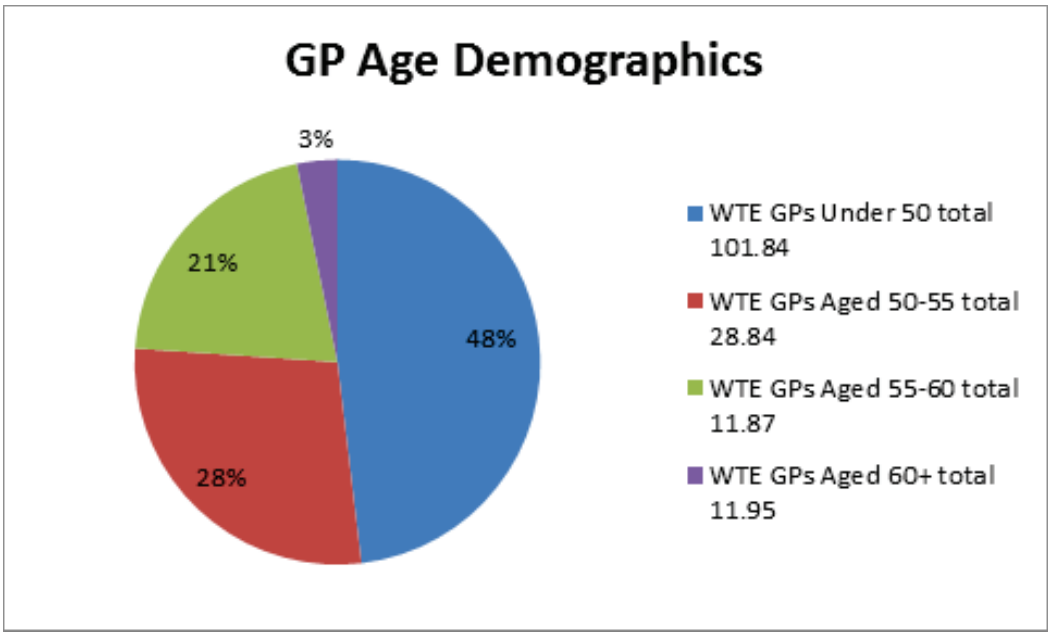
The County Practice

Use GPs to triage more actively rather than patients going to A&E. Use GPs at Walk in Centres to triage out minor conditions

The Practice, Oadby

Local practices also provided detailed information about their current workforce.

Information on GP ages across ELR CCG shows over half are in the last decade or so of their working life in general practice:



This local picture of increasing pressure on general practice is echoed by national research:

> "Our analysis of the available evidence on the demand for GP services points to a workforce under considerable strain. The existing GP workforce has insufficient capacity to meet current and expected patient needs."

Centre for Workforce Intelligence, 2013

> "Evidence is also emerging from the NHS Information Centre that the GP workforce is now shrinking rather than growing… 54% of GPs over the age of 50 are intending to quit direct patient care within five years…65% of GPs currently in training are women – and 40% of women who leave practice each year are under the age of 40"
> "***Securing the Future GP Workforce – Delivering the Mandate on GP Expansion***", GP Taskforce Final Report, March 2014. (The GP Taskforce was established by Medical Education England and the Department of Health).

The information provided by practices highlighted apparent wide inequalities from one practice to another in terms of the numbers of doctors and nurses available to patients. That variation does not appear to have any relationship to the level of core funding available to practices.

There appears to be a very wide variation in core funding between practices just as there are very significant differences in income drawn by, or paid to, GPs. There is no clear relationship between them. It is difficult to draw any conclusions from the information, partly because definitions of, for example Whole Time Equivalent, vary from practice to practice with full time GPs in some practices working different numbers of sessions.

The CCG also looked at some of the results from the last patient survey and cross referenced at a high level to look for a relationship with core funding or clinical staffing levels. There was no clear relationship apparent between these factors. It is clear this is a complex area with many factors involved.

General practice contractual issues:

Feedback from practices expressed frustration at the number of different income streams and contractual complexity they are managing on a daily basis which diverts so much of their time from delivering patient care.

The increasingly out dated model of general practice is reinforced by the contractual mechanisms used to try to maximise the efficiency and outputs of providers. The contract mechanism is essentially a core contract supplemented by various other elements and contracts. These include the Quality and Outcomes Framework (QOF) which has provided a significant investment in general practice since it was introduced in 2004 but which requires a high level of organisation, effort and monitoring on the part of practices to maximise their income.

Other sources of income include Directed and Local Enhanced Services contracts, the Prime Minister's growth fund and the CCG's own GP Support and Investment Plan. Practices consistently report that the bureaucracy and monitoring is seriously eroding patient contact

time. The myriad of funding streams and reporting, all of which is at the level of the practice, neither supports new ways of working at scale or provides the best outcomes for patients.

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Better Care Together Aims: Primary Care

Work programmes within the strategy include the following aims which are very relevant to local primary care services:

	Better Care Together Aims (particularly relevant to primary care)
Urgent care	Targeting support to those who need it through case management
	Develop more services to support people at home or in the community
	Support A&E to be as consistent as possible
	Help people to choose right and look after themselves where appropriate
Frail and older people	Develop programmes to support people to participate in society – healthy and active for longer
	Develop care plans together to improve health outcomes to be the best they can be
	Support people to leave hospital as soon they are medically fit
	Intervene appropriately and in a timely manner when older people are unwell
Long term conditions	Intervene in line with care plans in a timely manner in the setting people have chosen when they are unwell
	Build systems to predict those most at risk of urgent care so they can be supported beforehand
	Develop telehealth, coaching and telecare services
	Increase self-care and screening for long term conditions
	Work with primary care and patients to increase education
	Be clear when people move into the palliative phase of their disease and care plan for that circumstance
Planned care	Improve patient and clinicians' knowledge to support timely referrals
Maternity and neonates	Increase take-up in the first 12 weeks of antenatal services by hard to reach groups
Children, younger	Develop options to facilitate greater integrated working between all sectors (to improve the health of children, young people and families)
	Develop a strategy around optimising children's life chances through public

	Better Care Together Aims (particularly relevant to primary care)
people and families	health interventions
Mental health	Develop case management capability in all sectors to maintain relationships for people at times of (mental health) crisis
	Develop locality based (mental health) teams to manage care closer to home
Learning disabilities	Better support for universal and primary care services (for people with learning disabilities)
	Develop more integrated pathways and short breaks provision (for people with learning disabilities)

This highlights the range of areas in which primary care is seen as a key part of the solution in meeting the challenges faced by the local health system.

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National guidance and research:

National guidance and research describes how general practice could develop.

"Patients with long term and complex needs should be jointly managed through an integrated team in line with a single care plan led by the most appropriate named clinician. This would require a much greater alignment of incentives and funding streams between general practices and hospital and community service providers." **"*Developing General Practice today*" the BMA**

"Practices within federations will offer more community services to the population registered within their respective practices – for example, dietetic services, podiatry, and outreach services dependent on GP skills (eg minor surgery and complex contraceptive services). Some practices will form large federations, incorporating hospital, third-sector, private and community providers". **"*The 2022 GP*" the RCGP**

"Proactive case management with GPs leading the coordination of care, within a multidisciplinary and multiagency approach. Whilst GPs should lead this process, day-to-day coordination and delivery of care would often be by other members of the extended practice-based team." **"*Developing General Practice today*" the BMA**

"The GP of the future will need to be skilled in using a suite of new and flexible tools for communicating with patients…the 2022 patient will expect to access their GP or primary care nurse remotely, attend virtual clinics involving primary and specialist practitioners, and communicate with their healthcare team via text message or social media-type tools" **"*The 2022 GP*" the RCGP**

"The models of care share a desire to improve and extend primary care services, develop management and leadership capacity, and assume a more significant role in the health system." **"*Securing the future of general practice*" the Kings Fund**

"Small multidisciplinary units including GP, nurse, healthcare assistant, social care worker and patient advocate, attached to practices and providing continuity to an identified group of patients. Micro-teams could also include practitioners from other specialties, such as mental health, paediatrics and medicine. These 'micro-teams' will provide extended clinical reviews and support, enabling greater shared decision-making with patients and carers, as well as improved continuity of care." **"*The 2022 GP*" the RCGP**

Kings Fund – "*Community Services: How they can transform care*" (February 2014)

The Kings Fund recognised that the Transforming Community Services policy of 2008 had, out of necessity, focused mainly on the structural changes required at the time. They therefore convened a working group of community services providers to consider the next stage – what is required to develop community services in a way that will deliver the transformation element of the policy. The main steps identified are:

- Reduce complexity of services
- Wrap services around primary care
- Build multi-disciplinary teams for people with complex needs, including social care, mental health and other services
- Support these teams with specialist medical input and redesigned approaches to consultant services – particularly for older people and those with chronic conditions
- Create services that offer an alternative to hospital stay
- Build an infrastructure to support the model based on these components including much better ways to measure and pay for services
- Develop the capability to harness the power of the wider community

The report goes on to say that this approach requires locality-based teams that are grouped around primary care and natural geographies and with a multi-disciplinary team, offering 24/7 services as standard, and complemented by highly flexible and responsive community and social services. These teams need to work in new ways with specialist services (both community and hospital based) to offer patients a much more complete and less fragmented service. The new services need to be capable of a very rapid response and to work with hospitals to speed up discharge.

Case studies provide real life examples of emerging models:

Case studies describing groups of general practices coming together to provide services at scale and in the ways described in the national papers above are plentiful and available in the references here and in the Case for Change available from the CCG.

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Summary Conclusions of the Case for Change Option Appraisal

The option appraisal within the Case for Change came to the following conclusions:

1. **No change**

   This will result in a failure to meet the rising pressures with the developments at scale which have been assessed* as necessary. Practices will suffer escalating pressure and patients will experience deterioration in the quality of services and poorer health than they might have, had the opportunities been seized.

   The CCG's investment will generate increasingly poorer value for money as the system receives patients in a state of poorer health requiring more intensive interventions. A lack of integration with community, social and acute services will persist.

2. **Commissioning a new model at scale by a service specification**

   This would enable significant improvements by specifying how services should be delivered at scale including delivering the Better Care Together strategy and a level of integration with other services.

   But it would be less likely to generate the level of ownership by providers and the more locally appropriate response which other options would, both of which are considered important factors for success.

3. **Commissioning for strategic objectives at scale with minimum support**

   This would enable significant improvements to be realised through provider-led proposals to achieve the strategic objectives. This option would generate better ownership and a more locally tailored response from providers.

   However, with only minimal support by commissioners providers may struggle to develop and implement proposals which reflect the level of ambition required to deliver the strategic objectives, particularly in the more complex change areas such as integration with other services.

4. **Commissioning for strategic objectives at scale with extensive support**

   This would enable the CCG to demonstrate system leadership and a high level of ambition for strategic change whilst also providing the market development support necessary to enable the ambition to be realised including support for more technical and complex areas such as IM&T and premises development and driving forward integration with other services. This option recognises that the commissioner's market intelligence has informed its plans to provide more extensive support.

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Adopting the approach recommended by WHO

Three broad and evidence based overarching approaches recommended by the WHO:

Instead of carrying out a competitive process, the CCG plans to support and implement three broad and evidence based approaches which the World Health Organisation, based on extensive research and evidence, advocate and describes as:

"…critical for the transformation of conventional care – ambulatory and institutional-based, generalist and specialist – into local networks of primary-care centres"

These three approaches are (to directly quote from the WHO):

1. **Bringing care closer to people**
   …in close proximity and direct relationship with the community, relocating entry point to the health system from hospitals and specialists to close-to-client generalist primary-care centres
2. **Giving primary-care providers the responsibility for the health of a defined population in its entirety**
   …the sick and the healthy, those who choose to consult the services and those who choose not to do so
3. **Strengthening primary-care providers' role as coordinators of the inputs of other levels of care**
   …by giving them administrative authority and purchasing power

Some elements of these three approaches already feature in our general practices. For example, the combination of a registered patient list and the Quality and Outcomes Framework already encourage practices to take responsibility for the health of a defined population in its entirety.

GPs have also been coordinating the care of their patients since the inception of general practice but with the rapid increase of people living with multiple long term conditions this coordination role needs to form a greater part of the working life of a GP, particularly one with experience in complex care.

The CCG plans to build on this experience in our general practices and empower them, as recommended in the third approach above, to expand their responsibilities and their services as the best route to deliver the increased capacity and capability to meet the challenges of today and tomorrow.

This approach fits with the national direction of travel and the other local frameworks and strategies in many ways, including:

- Demonstrating an evidence base centred on benefits to patients
- Building on continuity of care as an important feature for patients with complex needs
- Enabling the integration of care, wrapped around the patient who is at the centre
- Supporting general practices to work together at a greater "scale"
- Facilitating seven day service provision and improved access to care

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Option appraisal template for general practices

When you are faced with difficult choices it often makes sense to do an option appraisal. It doesn't need to take long. This template offers three steps and a GP can do each step in about 10 minutes if they know their practice well and don't want to go into detail. But if you give it a bit more time it will be more robust. If you have a willing and able volunteer they can do much of the leg work for people to add to or amend. It will take longer the more people you involve.

A good reason to do the option appraisal and agree the outcome as a practice is that if you later hit problems or people start backtracking you can go back to the options appraisal to remind yourself why you chose that route – it provides justification for your decisions. You can always review and change it at any time if circumstances change or new information/knowledge from experience becomes available.

This template is offered to general practices to modify/use to consider their options. It can be used in the form of short questionnaires given to all those participating in the exercise.

Step One involves finding out whether you need to make changes. If so, it finds out what the problem areas are, how important they are relative to each other and what all the possible solutions are.

Step Two involves developing a shared understanding of the possible solutions.

Step Three involves working out which solution is the best one to achieve your objectives and why.

STEP ONE

Draft a questionnaire like the one offered below. Decide as a practice how you want to get the questionnaire completed to everyone's satisfaction. It depends on how much time you want to give to this collectively rather than individually. You can:

1. Find a willing and able volunteer to complete it and circulate it to everyone to add to and amend and then the volunteer pulls it together for complete/sign off at a practice meeting
2. Circulate to the practice team to complete individually with someone then pulling it together and/or share answers as a group to agree finished result
3. Discuss and complete it as a group

Although you can do Step One quickly, ideally people need to be given time to discuss and consider the answers to the questions in this step.

A PARTLY WORKED EXAMPLE *(you only need to complete the third column):*

Primary Question	**Questions to help answer this:**	**Your Answers:** *[Consider as fully as time allows/you are able and think about now and a couple of years ahead]*	**Next step/ Comment**
Question 1 **Do we need to make changes?**	Are there difficulties coping with our workload?	*Example: Yes, although we are just about coping now when Dr X retires in March we expect to struggle to recruit and the loss of an experienced partner is likely to make a big impact on our workload*	If your answers are all No then there is no need to progress further at this stage - Recommend repeating the exercise in a year or earlier if people consider circumstances have changed If you have any answers that are Yes it may be worth continuing with the option appraisal. The more Yes answers the more time you need to take and the more detailed you need to be.
	Are we unhappy with our income?		
	Do we have premises issues?		
	Are the needs of our patients are not being met as well as we want?		
	Could we organise things better?		
	Do we believe there are opportunities we may miss by not changing?	*Example: Yes, other practices in our locality are talking about working together and if we don't join them we may miss the chance to shape the way things are organised and have our say*	
	Do we see any looming threats for which we need to prepare?		
	Does anyone have serious concerns about the way we are working/planning our future?		
	Are we professionally dissatisfied are unsatisfied?		
	Any other reasons we may need to make changes?		
Question 2 **If we were to change something**	Workload issues – what are they?	*Example: Overcoming the problem of difficulty recruiting new GPs* **so** *we don't collapse under the workload*	Your answers should provide your **objectives**.

Primary Question	**Questions to help answer this:**	**<u>Your Answers</u>:** *[Consider as fully as time allows/you are able and think about now and a couple of years ahead]*	**Next step/ Comment**
what issue would we be trying to tackle and why?	Finance issues – what are they?	*Example: We want to develop a new income stream to offset reductions we expect in the future **<u>so</u>** our pay does not go down*	Try to also include the WHY: what you want to achieve. The word "**<u>so</u>**" can be helpful to prompt this. This makes sure you have identified what is really important to you.
	Premises issues – what are they?		
	Organisational issues – what are they?		
	Seizing which opportunities? What new things might we want to achieve?	*Example: Using the opportunity to work with others and have influence over the future set up **<u>so</u>** any new entity reflects our values and priorities*	
	Protecting against which threats?		
	Serious concerns – what are they?		
	What is preventing professional satisfaction?		
	Any other problems?		
Question 3 **What is important to preserve?**	What aspects of our practice or ways of working do we need to make sure we preserve?	*Example: Our values – **<u>so</u>** we are comfortable with decisions being made* *Example: We like having a certain degree of autonomy over our decisions – **<u>so</u>** we feel in control (because we trust our judgement)*	As per the box immediately above .
	Anything else important to note?		
Question 4 **What is most important for us to tackle?**	Which of the issues identified in our answers to questions 2 and 3 are most important and/or urgent?	*Example: Preserving income levels may be seen as three times as important as the others and the recruitment difficulty may be seen as*	Ideally you will have a list of your objectives with a **weighting** for

Primary Question	Questions to help answer this:	**Your Answers:** *[Consider as fully as time allows/you are able and think about now and a couple of years ahead]*	Next step/ Comment
		twice as important as the others: *Preserving income: x3* *Recruitment: x2* *Work with others: x1* *Preserve our values: x1* *Retain autonomy: x1*	each so you know their relative importance.
Question 5 **What solutions can best tackle these problems?** [Think of as many solutions as possible, be creative and describe as much as possible what they mean]	What ideas do we all have about how to tackle these problems?	*Example: perhaps we could start working together informally on a small scale so we can see if it works*	You should have a list of solutions (options) and people may have at least partly described these. Everyone now needs to understand better what these actually mean.
	What have others done (or are doing now) elsewhere to tackle these problems and how applicable to us are these solutions?	*Example: **merging to create bigger practices** so the GPs can have a more structured and varied career progression with development opportunities – this helps recruitment*	
	What do experts advise should be done to tackle these problems and how applicable to us are these solutions?	*Example: experts advise **practices to "federate"**, to work together to share staff to enable similar benefits to the box above*	

At the end of Step One you should have, for your practice, agreed objectives weighted to reflect their importance and a range of suggested solutions. Next you need to make sure everyone has a shared understanding of the suggested solutions.

Step Two

Put all the ideas for solutions (the options) into a table such as the one offered below. Use any descriptions people have already made when suggesting solutions and ask people to put their views forward on each one. They can add to the description and they can suggest benefits and costs/risks. Some people will be better able than others to give their views.

Give people space to make further comment at the end as they may have ideas about how to make something work well or have example case studies to provide. Again you can do this using a willing and able volunteer, individually, as a group, or both whichever works best for your practice.

If two or more people have put forward the same solution but described it quite differently these are probably best appraised as different solutions. You could label them A and B for the same solution name.

UNDERSTANDING THE SOLUTIONS - A PARTLY WORKED EXAMPLE *(you need to complete all the columns)**:***

Options	Description	Benefits	Costs/risks
Do nothing	As now	No need to invest any time or effort	Doesn't tackle our problems Other practices develop around us and we become less attractive as a practice to patients, GPs and staff leading to other problems May lose the ability to provide certain enhanced services as they may be offered only to practices delivering services "at scale"
Do minimal	Work informally to share: Training of VTS Skills of nurses Joint learning of systems and processes Care home cover (one practice one home) Templates Joint PLT/learning events…	Suits the cautious approach of some members of the practice Less work for stressed and busy practice manager and partners…	Unlikely to be sufficient to tackle our recruitment problem… Unlikely to preserve our income Other practices develop around us and we become less attractive as a practice to patients, GPs and staff leading to other problems May lose the ability to provide certain enhanced services as they may be offered only to practices delivering services "at scale"
Federate with other local practices	Discuss with practices X, Y and Z in our locality creating a new entity to enable us to: Share back office	Qualifies us to deliver new contract being offered by CCG – a new income stream Long term sustainability should be improved and	Short term we would need to put time and effort into making this work. Will need to move quickly to ensure we can

Options	Description	Benefits	Costs/risks
	functions Share some planned services (eg minor surgery, sexual health) Employ wider support team (eg pharmacist) Hold joint clinics and/or education sessions for patients with long term conditions Create joint visiting service Create joint walk-in clinics…	help tackle our problems Our patients will have access to a wider range of services Keeps our autonomy and control More interesting work for GPs Chance to be at the forefront of change – suits some members of the practice Secures transitional support and resources from CCG Can still merge later if decide to do so…	influence the federation with our values and priorities Some members of the practice are reluctant to see change and will resist [how do we overcome?]…
Merge with other local practices – separately located	As per box immediately above but rather than creating a new entity alongside our practices, merge practices to have a single GMS/PMS contract delivered through all our practice premises…	Qualifies us to deliver new contract being offered by CCG – a new income stream Long term sustainability should be improved and help tackle our problems Our patients will have access to a wider range of services Secures transitional support and resources from CCG Can keep a degree of autonomy and smaller, friendly team ethos in our individual buildings but share everything else…	Short term we would need to put time and effort into making this work Will need to move quickly to ensure we can influence the merged organisation with our values and priorities May be difficult to harmonise so much with different cultures – do we share the same values and objectives? Some members of the practice are reluctant to see change and will resist [how do we overcome?]…
Merge with other local practices and relocate together	As per box immediately above but also co-locate into one shared building…	Qualifies us to deliver new contract being offered by CCG – a new income stream	As per the box immediately above and we'll have to deal with the hassle of premises planning and relocation

Options	Description	Benefits	Costs/risks
		Long term sustainability should be improved and help tackle our problems Our patients will have access to a wider range of services Secures transitional support and resources from CCG Solves our premises problems More room to expand services…	Patients may not like the practice moving premises, we would need to assess the impact on them, engage them in the decisions and carry out consultation Risk of premises cost increase, needs further work to determine Some members of the practice are reluctant to see change and will resist [how do we overcome?]…

Step Three

Now everyone better understands the options and what they mean. The final step is to judge how well they may help you achieve your objectives.

Another table needs to be pulled together by someone, listing the options suggested and the agreed objectives. Then everyone needs to score the options: individually, as a group or both. Or the willing volunteer has a go and circulates. Ultimately you will need a group discussion to agree the final scoring as this is an important step to bring conclusion.

It is normal to look at the outcome of the first option appraisal and see whether it feels right. If it does not feel right then it is normal (and not cheating) to go back over your objectives and your weighting and scoring of them and adjust these until the outcome does feel right.

SCORING THE OPTIONS A PARTLY WORKED EXAMPLE:

Our *example* objectives are:

1. Preserve our income (weight x 3)
2. Enable recruitment of GPs (weight x 2)
3. Work with others (weight x 1)
4. Preserve our values (weight x 1)
5. Retain our autonomy (weight x 1)

Objectives ---------->	**1 Income**	**2 GP Recruitmt**	**3 Work with others**	**4 Values**	**5 Autonomy**	**SCORE** [out of 5]
Do nothing	1 x 3 = 3	1 x 2 = 2	1	5	5	16
Do minimal	1 x 3 = 3	3 x 2 = 6	2	5	4	20
Federate with other local practices	3 x 3 = 9	4 x 2 = 8	3	3	3	26
THIS IS JUST AN EXAMPLE AND DOES NOT REPRESENT ANYONE'S VIEWS The outcome depends on what your objectives are and how important they are to you (the weighting you give them)						
Merge with other local practices – separate premises	4 x 3 = 12	5 x 2 = 10	4	2	2	30
Merge with other local practices and co-locate	5 x 3 = 15	5 x 2 = 10	4	2	1	32

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Suggested steps for practices from research

The CCG's Draft Integrated Community Services Strategic Framework references "Lessons from Experience – Making Integrated Care happen at Scale and Pace" setting out the following key steps:

- Find common cause with partners and be prepared to share sovereignty
- Develop a shared narrative to explain why integrated care matters
- Develop a persuasive vision to describe what integrated care will achieve
- Establish shared leadership
- Create time and space to develop understanding and new ways of working
- Identify services and user groups where potential benefits from integrated care are greatest
- Build integrated care from the bottom up as well as top down
- Pool resources to enable commissioners and integrated teams to use resources flexibly
- Innovate in the use of commissioning, contracting and payment mechanism and use of the independent sector
- Recognise that there is no 'best way' of integrating care
- Support and empower users to take more control over their health and wellbeing

- Share information about users with the support of appropriate information governance
- Use the workforce effectively and be open to innovation in skill mix and staff

These steps offer a checklist to practices when considering how they wish to progress.

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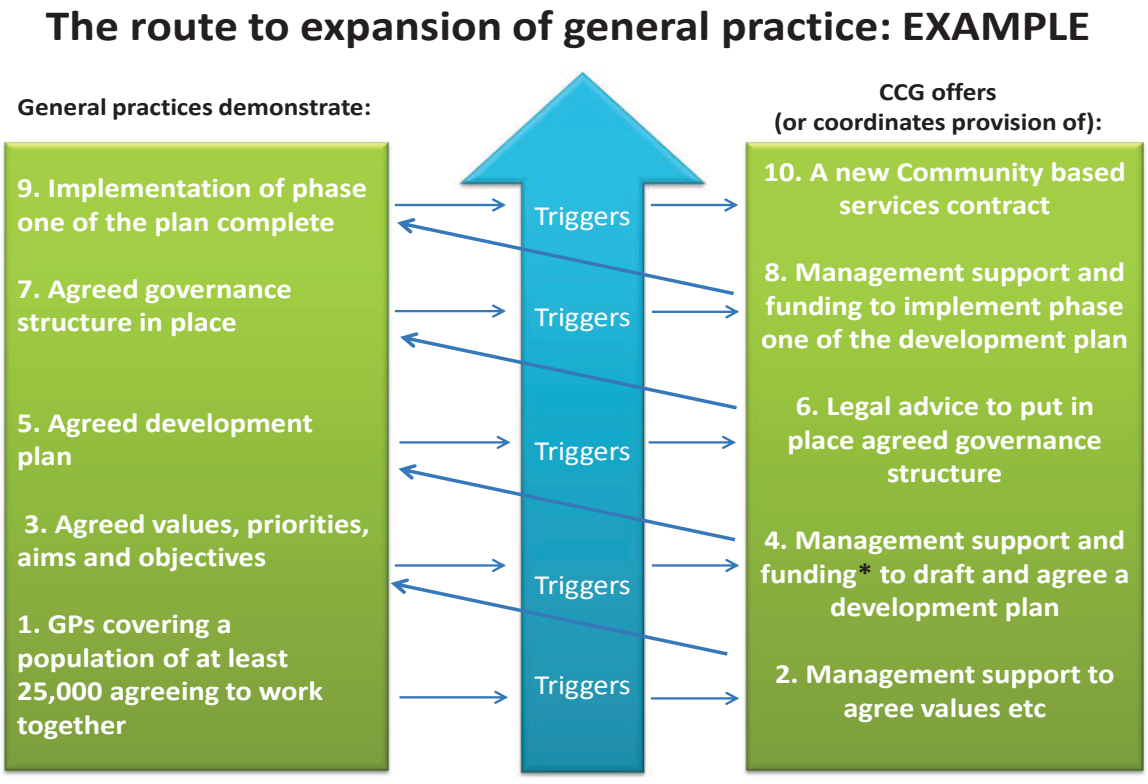
Support to reach milestones

The CCG has identified a number of trigger points for practices to reach on the development journey towards taking on the new contract and expanding their responsibilities. These trigger points reflect the advice from pioneers elsewhere in the country, to develop the culture of collaboration and to establish shared values and objectives ***before*** establishing the organisational structure best able to help people live the values and deliver the objectives.

The diagram below represents the mutual responsibilities involved in this path:



*Funding will be broadly similar to that currently available through the "Support and Investment plan for General Practice 2014/16" for "Joint Working and Collaboration".

This model demonstrates a phased approach which allows support from the CCG and others to be triggered when practices are ready to make best use of it.

Models of Care Structures

This section replicates the “models of care” described in the CCG’s application to NHS England to co-commission general medical practice:

Ensuring a sustainable model of health care across primary, community and social care services will require a change in the model of commissioning and provider set up to enable integration. The models that will be explored to enable this are:

- **Horizontal:** This can be defined as a strategy linking similar levels of care such as hospitals providing similar services, or a formal merger of two or more organisations producing similar goods to expand market share. The aim is to strengthen the financial position of an organisation, whilst expanding the delivery network.

- **Vertical:** Through vertical integration the CCG would integrate all or parts of the production process as a measure of rationalising its operation and increasing cost control over it. In managing new processes, this could mean that providers purchase or form consortia / alliances with other organisations to gain maximum referral base with the aim of improved coordination between trading partners (Burns & Pauly, 2002[2]) and a hierarchical form of governance created to formalise transactions. This means that a single hierarchy of authority and unity of purpose could be created with integrated delivery systems, which incorporates primary care, specialty panels and hospitals (Gaynor, 2005[3]; Robinson & Casalino, 1996[4]). It also provides opportunities to better align with broader services, e.g. community pharmacy.

- **Virtual:** This is an organic form of organisation, which is more flexible than hierarchical or bureaucratic models (Lindstrom, 2000[5]). There is a lesser degree of formalisation at the structural, functional and clinical levels resulting in integration between commissioners and deliverers of health care based on links which do not alter the integral structure of the participating organisations. This has been described as the network approach, where these networks seem to exist alongside and complement hierarchies to accomplish various corporate or institutional tasks. They have often achieved a greater advantage to patients than a series of separate services, which if taken to their conclusion can shift health care responsibility to that of integrated services. The resulting virtual healthcare organisations encompass a multiplicity of relationships between commissioners and providers, supporting cooperation and improving network performance. This is achieved with the flexibility of contracting rather than employing or owning and a transfer of risk away from the organisation to the provider, therefore reducing duplication.

Key to this system is the right estate, which provides outpatient clinics, diagnostic facilities and primary care teams. There are key positives to integrating the NHS system, but there are large risks to introducing integration and creating large geographical and functionally diverse health care provider networks. This is a very difficult mindset for both the public and providers to overcome. It is imperative that these networks are not forced by compulsion, control and centralised design also known as “Controlled Collegiality” (Hargreaves, 1994[6]), but are spontaneous, discretionary and involve voluntary engagement, which allows creativity. Based on this principle, healthcare in England could be reframed as a system that puts emphasis on the relationships over the component parts. This could be achieved by decoupling services, teams and individual professionals from buildings and institutions and ensure that services are available in the most appropriate setting.

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