

The Next Steps to the Strategic Commissioning Framework

**A vision for strengthening general
practice collaboration across London**



Our commitment to support general practice

- We will give practices the resources they need to help them develop and carry out plans for collaborating at scale.
- We will give practices the flexibility to develop models that best suit their local circumstances.
- We will work with partners to get regular evidence from across the country, and use it to support collaboration and share best practice – all while retaining our core values.

This document sets out the vision and framework for our support. It uses existing evidence and the experiences of our clinical leaders to define what 'good' larger-scale general practice looks like. But this is, and always will be, a shared venture. We will continue to work together, as leaders in London, to build a general practice that is not just fit for the future, but that leads the wider transformation of care in our city.

Transforming Primary Care Clinical Cabinet, 2018

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Foreword

General practice is at the heart of our NHS and is widely recognised as vital to sustaining the best possible health and care system in England in the years to come. In 2015 the Strategic Commissioning Framework¹ for Primary Care Transformation in London was published as the vision for commissioners to make primary care in London fit for the future.

Supported by resource from the *General Practice Forward View*², and driven by providers, commissioners and other system partners, we now have more GPs in training, a broader skill mix in our primary care workforce, greater use of digital technology, and extended access for Londoners.

But there are still considerable challenges to overcome. Demand on general practice services continues to increase and grow in complexity, which despite the on-going commitment of our practice teams, puts great pressure on people and resources. We must:

- **restore joy** – by supporting our teams and improving their working lives. This will also make it easier for us to recruit and keep the best people
- **offer more** – by broadening the skills and roles in our workforce
- **boost collaboration** – between isolated individuals and local health and care organisations
- **use technology and information more intelligently** – to better understand population need; inform care delivery, design and implement quality improvement; and provide a joined-up health and care system.

How do we get there?

This document describes how deeper and wider collaboration between practices is key to achieving these goals. By working together at greater scale, general practice can be both 'small' and 'big'. It can keep providing patients with personalised, whole-person care at practice and network levels – one of its greatest strengths. But it can also provide strategic support and leadership within larger-scale general practice organisations. With the right support and focus, this can lead to better population-based, person-centred, primary care, as well as more powerful participation in the wider care system.

What are we doing already?

Collaboration is not new to general practice in London, and we have already made considerable progress towards our vision. In recent years, practices across the capital have been developing stronger relationships with each other and with other care providers.

This takes effort and courage. The system still rewards institutions based on their individual performance, rather than on how they contribute to the system as a whole, or on how much they improve population health. This creates a culture of competition rather than collaboration.

But despite this, almost every practice is now part of a larger-scale general practice organisation. While terminology varies, these are mainly borough-based, federated organisations, with population sizes of around 150,000-300,000. They provide the foundations for new Integrated Care Systems (ICSs) across London, which will bridge the traditional boundary between provider and commissioner.

Integrated Care Systems will provide for the care needs of whole populations, and make sure that general practice acquires the critical mass it needs to play a central role in care delivery, system leadership and the transformation of our health and care system. If we are to achieve our ambition of whole-person, population-based care, we need a strong, collective, primary care voice. A voice that is not just at the table, but that is proactively participating in and leading this change.

What is in this document?

With the support of all five Sustainability and Transformation Partnerships (STPs), and our regional clinical cabinet for primary care, we are setting out a clear, achievable vision for how general practice organisations can work collaboratively at scale, and a commitment to provide practices with the resources they need to support this change at practice Primary Care Networks (PCNs), and Larger-scale General Practice Organisations (LGPOs) levels. This is not without risk, and we must continue to learn from best practice as we proceed, building on existing evidence and using emerging evidence on new models of care, and making sure that the value and values of general practice are not lost in the process.

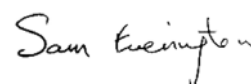
This document brings together learning from across London, the country, and the rest of the world. It forms the basis for a programme of support, which also includes ring-fenced financial resources and on-going sharing of leading practice. It will take forward at scale working in a way that is true to the values of general practice, as the NHS realises its vision of Integrated Care Systems nationally. In so doing, we are confident that we will protect and enhance this cornerstone of care provision in London.



Michelle Drage,
Chief Executive Officer,
Londonwide LMCs



Jonty Heaversedge,
Medical Director for Primary Care,
NHS England (London Region)



Sam Everington,
Chair, London Clinical
Commissioning Council

Describing larger-scale general practice

One of the strengths of general practice is its diversity; each individual and organisation is different. This difference also reflects the populations and people we serve, and practices must keep their individualism and their ability to adapt to their own circumstances and patients. Being 'big' and 'small' at the same time is challenging, but it is central to our ambition.

Our aim in this document is not to homogenise general practice, or to suggest that all organisations should be set up in a certain way. Instead, we want to help people to navigate the uncertainties of integrated working. To give them principles, tools and functions that will let them collaborate, and develop their organisations effectively.

We also believe that it is important for individuals and organisations to innovate. Without some risk-taking we will struggle to adapt and improve. Evaluation should be embedded into all change, to ensure that we learn from our successes and failures, and develop truly patient-centred, effective services. This should include an unwavering commitment to the values of general practice. Because of the need to innovate, it is difficult, and potentially unhelpful, for us to give a single definition of how larger-scale general practice organisations should be set up or run. But we have tried to develop consistent terminology so that we can create a shared language, and build on the progress that London practices have already made.

Throughout this document we talk about two main types of collaborative arrangement between general practices: Larger-scale general practice organisations and Primary Care Networks.

Larger-scale General Practice Organisations (LGPOs)

These organisations consist of multiple practices working via formal collaborative arrangements across a large, geographically coherent population. This enables them to develop and train a broad workforce, and to create shared operational systems and quality improvement approaches, including use of locally owned data. It also creates opportunities to support the delivery of collective back office functions that reduce waste and enhance efficiency, develop integrated unscheduled and elective care services for the whole population, and provide

professional leadership through which a strong voice for general practice can be heard across boundaries.

These organisations are not intended to replace practices, or diminish practice autonomy, but should support a number of vital functions that can best be achieved at this larger scale. In London, these are, for the majority, at the scale of a borough. Though most organisations in London are federations, there are multiple forms for such organisations.

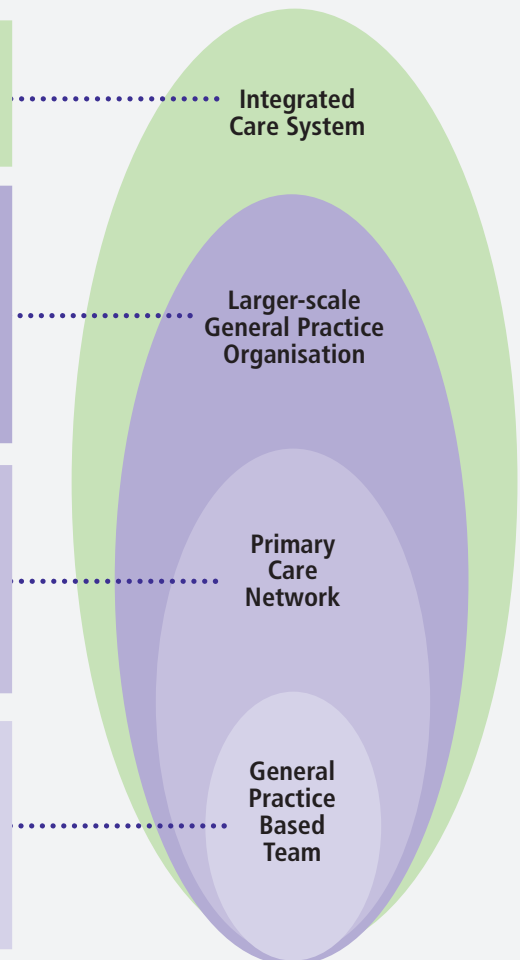
Illustrative model of care

General practice as the foundation of a wider Integrated Care System – working in partnership with other health and care providers to collaboratively manage and provide integrated services to a defined population within a shared budget

Usually at a borough level and often a single formal organisation e.g. federation or multi-site practice organisation – this is the platform to provide the scale to develop and train a broad workforce, create shared operational systems and quality improvement approaches including use of locally owned data, support the delivery of collective back office functions to reduce waste and enhance efficiency, develop integrated unscheduled and elective care services for the whole population, and provide professional leadership and the “voice” for general practice in the local health economy.

Serving populations of 30-50,000, bringing together groups of practices and other community providers around a natural geography. Support multi-disciplinary working to deliver joined up, local and holistic care for patients. Key scale to integrate community based services around patients’ needs to provide care for people with enduring, complex health and care needs, who require close collaboration between service providers and long-term care coordination.

Small enough for the benefits of continuity of care and personalised service. Big enough to safely cover rotas and ensure a balanced skill mix. Providing care to patients with on-going illnesses and flare-ups of established conditions, undifferentiated or medically unexplained symptoms or health anxieties, who may benefit from an episode of continuity pending diagnosis and effective treatment, or long-term continuity of care with single clinician or a clinical team for an enduring condition.



Collaborating to strengthen general practice

- A strong general practice voice in the provider landscape
- Strengthened practice resilience
- Effective system partnerships
- On-going quality improvement
- Economies of scale
- Workforce development
- New population based approaches to care
- Innovative approaches to care provision
- Adopting new technology

Large-scale General Practice Organisational Forms



Source: Large-scale general practice in England: What can we learn from the literature? Literature review, Luisa Pettigrew, Nicholas Mays, Stephanie Kumpunen, Rebecca Rosen and Rachel Posaner, September 2016.

Primary Care Networks (PCNs)

These networks are formed by practices coming together with other community providers, local people and the voluntary sector, to serve populations of approximately 30,000-50,000 people. Those that do exist currently in London are largely at an early stage of development. They are intended to bring together groups of practices, likely formed around local communities,

with other community based health and social care services. Through these arrangements, comprehensive, team-based, multi-disciplinary care can be provided for people with enduring, complex health and care needs, who require close collaboration between service providers, and long-term care coordination.



Section 1

Value of general practice

The strengths of general practice

General practice is at the heart of the NHS. It is still the first port of call for the vast majority of Londoners, providing accessible, expert, generalist, whole-person care. It works with a registered list, which means that GPs intimately know their patients' needs and circumstances. It helps prevent disease and empowers patients to look after their own health. Patients have a continuous, trusting relationship with their GP that is proven, time and again, to be strongly associated with high-quality care and patient satisfaction. Historically, general practice has proven to be resilient and versatile, adapting over time to diverse geographies, communities and socio-economic circumstances. We must ensure that the core values of general practice continue to be protected and preserved.

GPs serve individuals

There are over 7,000 GPs working in London and for many, they represent the personal face of the health service.

General practice has nurtured an environment in which patients feel safe to divulge their innermost concerns, meaning clinicians can provide personalised care because they understand their patients on a personal level.

The versatility of general practice allows clinicians to care for the whole person, while meeting their individual, specific needs.

They can target specific conditions while also addressing the social factors behind the growing epidemic of multi-morbidity, and prevent disease by empowering patients to look after their own health.

GPs serve populations

General practice is the glue that binds together disconnected services across community and hospital settings in local areas, coordinating the care of people with multiple conditions and complex needs. This involves GPs and practice teams struggling with administrative barriers on a daily basis.

The core values of general practice Londonwide LMCs

- 1 The **registered list** – individuals and practice population.
- 2 **Expert generalist** care of the whole patient.
- 3 The **consultation** as the irreducible essence of delivery.
- 4 Take into account **socio-economic and psychological determinants** of disease and the inverse care law.
- 5 The **therapeutic relationship**.
- 6 Deliver safe, effective long term and **preventative** care, balanced with timely **episodic** care by promoting access to relationship **continuity**.
- 7 **Advocacy and confidentiality**.

Thanks to practice-based, registered patient lists, general practice can offer tailored care to specific populations. GPs feel responsible for their populations, enabling them to develop prevention strategies and care pathways that are right for their patients and local communities. This leads to better health outcomes at a lower cost to the system, and helps reduce health inequalities between the richest and poorest in our society.

The system relies on general practice

There is consistent evidence that the foundation of an effective care system and good patient outcomes is strong general practice.³

This is no great surprise. General practice teams are particularly good at managing clinical risk, and investing their time, expertise, and knowledge of their patients to optimise their care. Whether someone needs support within the practice or local community, advice on self-care, or referral to a hospital specialist, practices can help make sure that this happens in the best possible way. This means that general practice can deliver high-quality care but also make the best use of public resources by avoiding over-medicalisation, and by coordinating the most effective use of specialist services.⁴

Practices are passionate about care quality

We know that it is the goodwill, expertise, professionalism, hard work, personal pride and commitment of our teams that keeps general practice going.

But with falling numbers of clinical staff and greater demand for the service, general practice teams have been working harder and harder, often sacrificing their work-life balance or even their personal health.

It is clear that general practice is facing a critical moment in its history and that the status quo is not sustainable. We must do more to support this integral part of the care system.



“There is arguably no more important job than that of the family doctor [...] if general practice fails, the whole NHS fails.”

Simon Stevens, Chief Executive, NHS England, 2016

The challenges we face as a system

Patients value general practice as much as ever and are anxious about change in the NHS. But if we are to sustain and improve general practice, while protecting its strengths and values, we need to recognise the considerable challenges that these organisations and their practice teams are facing.

Growing demand for our services

GP practices are experiencing ever-greater demand, due to some key factors.

Population growth

London's population grew by over 7% in the five years to 2016, and is expected to reach 9.8m in 2025.⁵

Older patients with more complex needs

The UK's ageing population means more patients with multiple medical conditions and complex health and care issues. The number of patients in London with long-term conditions has also grown markedly in the last four years with, for example, the incidence of dementia alone rising by 37%.⁶

Rising expectations placed on general practice

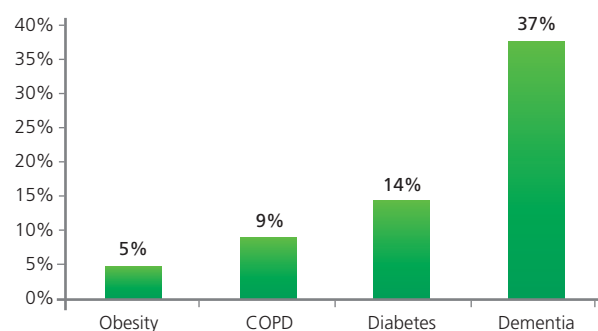
The King's Fund has shown that consultations are outstripping population growth.⁷ The consultation rate per patient was 5.5 in 2009 compared to just 3.9 in 1999.⁸ And there was a 15% growth in GP consultations nationally between 2010/11 and 2014/15.⁹ This reflects higher public expectations of the services that general practices should provide. It also reflects the needs of an ageing population and a growing trend towards moving care out of hospitals and into community or primary care organisations.

A struggling workforce

Working at greater scale supports the aim for an excellent and consistent work offer and experience for all doctors, nurses and other teams working in general practice across London.

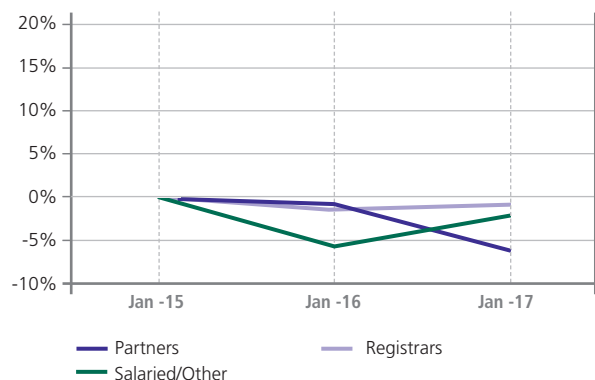
London growth in long-term conditions 13/14 to 16/17

Source: NHS Digital, Quality and Outcomes Framework Data, 2017.



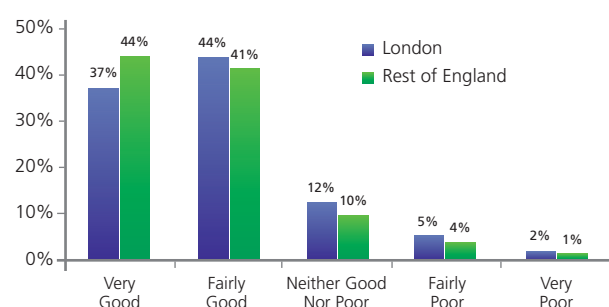
London growth in GP workforce types

Source: NHS Digital, General and Personal Medical Services Statistics, INTREPID workforce reporting, 2017.



Overall patient experience

Source: GP Patient Survey, NHS England, 2017.



Integrated Care Systems (ICS)

These organisations:

- tackle the challenges facing local health and care systems by helping organisations to develop more robust cross-organisational working
- combine different services for people who are at risk of developing acute illnesses or going into hospital. This helps organisations to manage the health of whole populations
- offer more care by redesigning community based and home based services. These services are often provided in partnership with social care, and the voluntary and community sectors
- let systems take collective responsibility for their health outcomes, and for how well they perform financially and operationally.

An unsustainable balance

In London, we have a higher proportion of GPs and nurses aged over 55 than in other regions, and more practitioners retiring early than ever before.¹⁰ Meanwhile, recruitment is falling nationally, although we are still filling our London training posts.¹¹ In addition, fewer GPs are seeking partnership, with 25% of the national workforce choosing sessional work in 2014, compared to 8% in 2003.¹² In a recent survey of London trainees, just 5% said that they wanted to become a GP partner.¹³

We have a challenging target to increase the London GP and GP nurse workforce by 2021.

Supported by the resources made available through the *General Practice Forward View*, we are taking targeted steps to recruit more GPs

and nurses both here and from abroad (see, for example, the General Practice Nursing 10 Point Action Plan¹⁴, and GP Career Plus¹⁵). We are also working to retain our current workforce, by giving them more development opportunities.

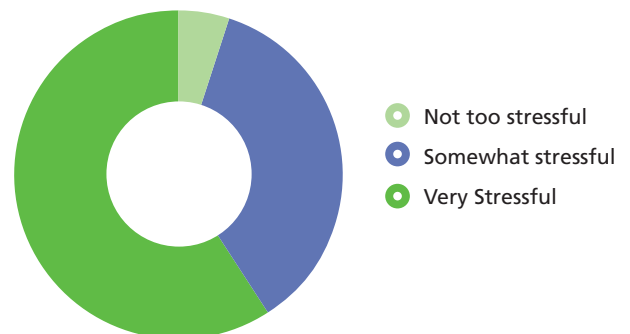
Low morale

We know that low morale is widespread. England's GPs, nurses and practice managers are more stressed than ever before, and general practice is a less enjoyable place to work, which is also having a direct impact on patient satisfaction and experience.¹⁶

The resilience of practices across the capital is being tested, in some cases to breaking point. We must improve the working lives of clinicians and practice teams. And we must do it now.

How stressful is your job as a GP (UK-wide)?

Source: Commonwealth Fund International Survey of Primary Care Physicians in 10 Nations, 2015.



A high-quality service

Despite growing demand, the majority of London's general practices continue to provide a high-quality service to patients – an achievement we must not take for granted. But a higher proportion of London practices are also rated 'requires improvement' by the CQC than in the rest of England.¹⁷ Patients should expect the same experience of care no matter where they are registered.

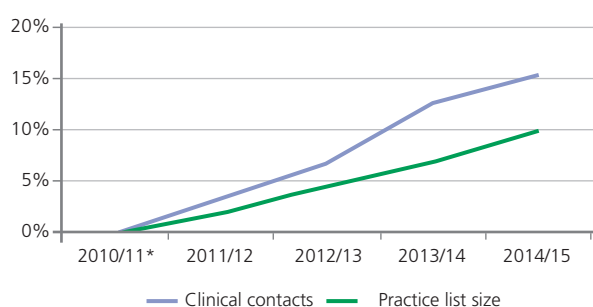


“Transitions to integrated, capitated and accountable care will only be effective if coordinated by primary care.”

National Association of Primary Care

Percentage change in clinical contacts and patient list size

Source: Understanding pressures in general practices, The King's Fund, 2016.



An evolving care sector

Tech-savvy patients

Social and technological advances are changing patients' expectations of general practice. This will impact the way in which general practice is provided. The way in which care is delivered will also continue to evolve.

Though clearly important, this is not simply about patients increasingly seeking different ways of consulting with healthcare professionals, such as telephone and mobile video. Sources of information, advice and support regarding patients' health and wellbeing are also now far more varied. This places renewed importance on the role of general practice in providing and coordinating trusted, accessible, proactive care that is integrated across all parts of an increasingly complex health and care system.

Evolving organisations

Sustainability and Transformation Partnerships (STPs) across London have all identified that resilient, effective primary care is key to the future of the wider system.

STPs are beginning to evolve into Integrated Care Systems (see the box on p.13), in which commissioners and NHS providers work closely with the rest of the care system. They take shared responsibility for using their collective resources to best serve their local populations.¹⁸

The need to lead

The success of Integrated Care Systems will depend on thriving, innovative general practice that does not just participate in the design and delivery of care, but actively leads it.¹⁹

To be able to do this, general practice must develop its leaders, while deepening and broadening its understanding of the local population's needs and health.

General practice will continue to strengthen its partnerships with other providers, the clinical teams in general practice will broaden to strengthen the contribution of nurses, pharmacists and other health professionals, and care will move into new settings. As these changes happen, leading the coordination of care across the system will become an increasingly integral part of general practice's work.

We know how challenging this transformation will be. But it is without doubt the right direction for general practice to move in.

It is right for our teams, right for patients and right for the wider system.

Collaborating to strengthen general practice

General practice must respond to the immediate and longer-term challenges it faces. This will mean deeper, more formal collaboration between practices and other providers. Working at greater scale is not without its risks, and we must address these so that we do not lose the unique values and strengths of general practice. But successful larger-scale general practice organisations recognise and protect these elements and, as these organisations are maturing, we can also learn from a growing body of research and case studies.²⁰ Done right, collaboration can help us to strengthen general practice for patients and teams, and give our health and care system the local leadership it needs.

Proactive, accessible, coordinated care

Our commitment to deliver the quality of care outlined in the Strategic Commissioning Framework (2015) is still as strong as ever. But we know that we cannot achieve our aims with practices working in isolation, and with inconsistent investment in our people, technology, and infrastructure.

Collaborative general practice will build on the strength of the practice-based, registered list. This will form the foundation of a more consistent local care model across London that is proactive, and that reflects the local population and communities it serves.

Better for our teams

Combining our resources makes sense. It helps us all to learn from best practice, develop new skills, and build a happier workforce, so that we can deliver the best possible care.

By working at scale, general practice organisations can access the right information to treat and predict the needs of different patients, and design local services that meet these needs and improve patient outcomes.

New clinical and non-clinical roles can be created to reflect the population we serve and ensure that we make best use of the wider workforce. This will create new development opportunities for practice teams, and reduce demand on clinicians – ensuring they have time to care, and enabling them to provide leadership within their organisation and the local system.

By sharing information in ‘real-time’ with other health and social care professionals we can coordinate care, work together more effectively as a multi-disciplinary team, and continuously improve the quality of our services.



“Tweaking at the edges is not an option. London needs solutions that will sustain primary care for the next 60 years.”

Claire Gerada, former Chair of the Royal College of General Practitioners, 2015

The benefits of general practice at scale outlined in the *General Practice Forward View*

- **A developed workforce** – new training, support systems and roles for current team members, and new specialists, like clinical pharmacists, joining the workforce.
- **System partnerships** – built by an empowered workforce that speaks with a collective voice, and that integrates its work within the rest of the system.
- **Economies of scale** – efficient creation of policies and procedures, combined purchasing power, and more.
- **Better care and new services** – like extended access.
- **Better quality improvement** – thanks to collaboration among the members of a Primary Care Network or other team.
- **Greater resilience** – by sharing back-office functions, pooling team members and developing business intelligence systems.

Better for patients

It is more effective to invest in a broader, more multi-disciplinary workforce that includes non-medical support workers. This type of workforce gives patients the right kind of support and more time with the right people.

Closer integration with local partners also helps us to involve patients in their care, and to connect them with the full range of community, statutory, third sector and mental health services. The success of such collaboration could also let us focus more on developing prevention, wellbeing and self-management strategies.

Thanks in part to funding from the *General Practice Forward View*, London has led the country in providing extended access to general practice. All patients registered with a GP in the city can now get an evening or weekend appointment. This achievement shows how collaboration can give local populations extra services that would not be possible if practices were working alone.



“Navigators in general practice have proved to be an important resource for GPs accessing social support for their patients and, as a result, more vulnerable older people are able to benefit.”

Safe and Independent Living, a voluntary sector partnership across Southwark and Lewisham



“We never thought working at scale would work – now we can’t live without it.”

GP at Improving Health, Federation of GP practices, Southwark



“Working together has given us resilience [...] the concept that we’re all in it together, including our clinical and non-clinical staff.”

Dr Sunando Ghosh, The Midlands Medical Partnership

Better technology

By combining their resources, general practices are also able to invest in new digital technology, and some parts of London are already exploring what this can offer to general practice. One clear benefit is more efficient ways of working, from record sharing (One London Local Health and Care Record) and electronic prescribing to online consultations and appointment booking. All of which means better access, better care, and a better experience for patients.

Clever use of our information and skills

If we are to deliver truly coordinated care, we must also make more intelligent use of the information we have, to design and deliver joined-up services.

By working within Primary Care Networks, in teams drawn from an increasingly multi-disciplinary workforce, we can start to reimagine the way that care is delivered. GPs and other healthcare professionals can coordinate care, using the skills of the whole primary care, voluntary and social-care workforce to give individuals and different parts of the population more tailored care and better outcomes.²¹

Practices and other providers can use the data they have to inform service delivery, reflect on operational performance, improve quality, and reduce unwarranted variation in care outcomes – enabling them to create the best possible care and care pathways.

But to do this they need support. We must help them by making information readily available and creating a culture of continuous improvement.

Supporting innovation and resilience

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A resilient system

Collaboration at scale is already boosting the resilience of general practice. Organisations are becoming large enough to broaden their clinical and administrative workforce and to create innovative new roles. This frees up GPs and practice teams for the work that most needs their expertise.

Practices can also give each other more support, through sharing team members and working together to improve their services. System partnerships are helping to radically shift workforce boundaries between sectors.



“Recruitment of doctors is proving increasingly difficult. To combat this, we’ve restructured our workforce to include a number of new healthcare professionals with specific qualifications.”

The Haxby Group Superpartnership, Yorkshire



“We have moved from the brink of closure to confidently looking forward to the future with a sustainable business model.”

Fleetwood Community Care, Lancashire

A resilient workforce

Collaboration helps existing practice teams to feel happier and more secure. They have the time and opportunity to build stronger, more trusting, and more communicative relationships, both within their practice and with other practices and community services, which helps them feel less isolated. They can also get support when planning and delivering care to patients with complex needs, or making difficult professional decisions. This allows them to share the risk of their decisions, as well as the intellectual and emotional load.

Closer collaboration also makes it easier to recruit new clinical team members. The number of GPs working on a sessional basis is growing, and at scale working makes it easier for organisations to offer this flexibility. What’s more, sessional GPs are still looking for the opportunity to lead and to progress their careers. By offering a greater range of roles, and having the resources to support training and development (from undergraduate through to leadership mentoring), working at scale can help to attract and retain ambitious clinicians and create a new generation of system leaders.

Innovating to secure our future

Collaboration stimulates innovation and learning in a number of ways.

It lets organisations and teams share their professional development. When practices collaborate within networks, they increase their scale, meaning they can engage with Academic Health Science Networks and Community Education Provider Networks, and take a more involved role in research and training.

Networks can also deliver more specialist services and support to patients and clinicians in their communities, enhancing care for patients and creating more varied career opportunities within the primary care workforce.

Tighter collaboration between general practices allows for more innovative ways of working, making practices more efficient and cost-effective. Collaborating practices are able to:

- share risks (like taking on extra contracts together) and combine their purchasing power to reduce costs and maximise income
- create policies and procedures once, to use across multiple organisations

- share specialist expertise for difficult financial, legal and workforce situations
-
- pool resources to improve information systems, meaning more efficient day-to-day administration, a lighter workload, and better service delivery.



Source: Releasing time for care: 10 High Impact Actions for General Practice, NHS England, 2016.

Lifting spirits

Collaborating to improve innovation and resilience is not just about keeping general practice going. It is about lifting morale and enabling practice teams to do the job they love. Collaborating will help us to achieve the national 10 High Impact Actions and maximise NHS England's wider General Practice Development Programme²². As a result, we can give practice teams more time to care, and ensure that general practice is a happy and rewarding place to work.

Leading local systems of care

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Evidence from other parts of the world is showing the importance of putting primary care at the heart of new models of integrated care.²³ With Integrated Care Systems now emerging across England, we must develop a more coherent and collaborative voice for general practice. With this voice, we will not only participate in the delivery of services in the new care landscape – we will lead the way.

The benefits for the rest of the system are just as important and exciting. By working more collaboratively with other providers, and developing an extended range of services in the community, we can co-create care that best meets the needs of our local populations. Which will in turn optimise value for the NHS.

Ultimately, this moves us towards a more sustainable system. A system in which general practice, our communities, and wider health and care providers all share responsibility for the health of our population, as well as sharing the resources we have available to care for them.

“Place general practice at the heart of STPs to ensure its voice is heard and acted on.”

King's Fund, 2016

Supporting collaboration at scale in London

London's practices are already finding ways to collaborate. Now we must deepen these arrangements, and secure the benefits of working at scale. We are making a clear commitment to strengthen collaboration in general practice in a way that is positive for both patients and our teams. We will continue to work with STPs to find additional resources to stabilise general practice, while allowing practices to develop networks and larger-scale general practice organisations more quickly. This will let them participate in and lead local system transformation. We will keep working to support best practice, test and measure new models, and make it easier for practices to share their learning.

Celebrating our successes

A growing body of evidence, including case studies from across England, has shown that greater collaboration is improving patient care, organisations' resilience, and the wellbeing of our teams.²⁴

Most practices are already part of a larger-scale general practice organisation, which has led to important innovation and improvement in recent years. Record sharing, virtual clinics with secondary care providers, and telephone and online consultations are now far more common. Our information systems and software applications are better able to communicate with one another, and to exchange and use data.

We also have a much broader workforce with significantly higher numbers of allied health professionals.

Confronting the uncertainties

But we still have questions to answer. We must use academic rigour to measure the value of greater collaboration to the system, and the operational efficiencies that a greater skill mix would bring. We must also look at how much goodwill is created by the independent, small-practice model.²⁵

General practice at scale coverage in London

Key population coverage

- Greater 75% coverage
- Full coverage



Source: Transforming Primary Care, Healthy London Partnership, 2017.

We know that some colleagues worry about the core values of general practice being eroded. Values like GPs' deep sense of professional responsibility for their patients, their willingness to manage risk every day, and their whole-person approach to care.

It is precisely these concerns that we believe greater collaboration has the potential to address – as long as we continue to reflect and learn as we progress.



“Action can be based on past experience and good theory. But rigorous evaluation using the full range of available theories and methods is essential.”

Professor Martin Marshall, Professor of Healthcare Improvement, University College London

Evaluation, flexibility and patience

.....

It is essential that, as new models of care emerge, we assess the impact on patients and practice teams. Local Medical Committees, academic institutions, and the Royal College of General Practitioners will continue to work closely with commissioners and local systems to evaluate changes and share emerging evidence.

One of general practice’s greatest strengths is its diversity, and practices must keep their individualism and their ability to adapt to their own circumstances and patients. So, rather than promoting a ‘one size fits all’ approach, we will make sure that STPs, larger-scale general practice organisations, Primary Care Networks (serving populations of 30,000-50,000), and individual practices are free to drive forward the right changes for their local communities and populations, and to innovate and learn.

Being both ‘big’ and ‘small’ at the same time is challenging, but it is central to our ambition. And whilst there are some emerging principles on which we can build, there is no right answer. Crucially, we will put practices and clinical leadership at the heart of change.

Perhaps most importantly, we cannot achieve broader and deeper collaboration overnight. It is built on strong relationships between individuals, practices and professions, and a deep trust that is earned over time. As such, our commitment to working at scale does not mean that we expect things to change straight away. Rather, it means that we will give our support for as long as it takes for this crucial transformation to happen.



“Emerging organisations will need sufficient time to develop the necessary skills, knowledge and working relationships.”

The Nuffield Trust, 2016



Section 2

Benefits of working at scale

Comprehensive population-based care

This section focuses on larger-scale general practice organisations. They are formed by multiple practices coming together to support care delivery at practice and network levels, create efficiencies of scale, and build leadership in the system. We will cover their characteristics and benefits, from their scale to how they make care more proactive, accessible and coordinated.

The benefits of larger-scale general practice organisations

Patients get – more consistent and accessible care, delivered by a multi-disciplinary team with the combined skills to meet their specific needs.

Team members get – a more fulfilling work life that lets them share expertise, work in a collaborative environment, use their specific skills, and spend more time on the things they were trained to do.

What should a larger-scale general practice organisation look like?

There is no particular size of population that larger-scale general practice organisations should serve, and no particular form that they should take. However, using the varied experiences of existing organisations, we have developed some principles on which all larger-scale general practice organisations should be founded.

Larger-scale general practice organisations will vary in size according to a range of factors: the services they deliver, local demographics and commissioning arrangements, existing relationships, and local communities. They should be big enough to create economies of scale (see *Organisational Capabilities* on p.37) and are essential for making general practice sustainable. Where possible, these organisations should also work within the same boundaries

as other local health and care systems. This will let them partner more easily with other providers and be part of any new systems of integrated care.

Primary Care Networks

Practices within a larger-scale general practice organisation are organised into Primary Care Networks, which The National Association of Primary Care suggests should look after populations of 30,000-50,000 people. This lets practices and local health and social care providers collaborate, building multi-disciplinary teams that meet the whole-person needs of their local population. London's Clinical Pharmacy Programme, for example, is working towards having one pharmacist for every 30,000 patients as part of PCN. Special pathways can also be created to give specific patient cohorts the right clinical expertise, resulting in better care. (*Illustrative model of care* See the diagram on p.7).

Providing primary medical services

Larger-scale general practice is not just a way of delivering more services to the community; it is at the heart of new models of population-based care. For everyone to have equal access to high-quality medical services and to get the best health outcomes, we need larger-scale general practice organisations to help improve the wellbeing of the whole population, and to share responsibility with other providers for the services people receive in their local area.

These should include the essential change services to aspects of general practice, as well as any extra local services. All practices in the larger at scale organisation should also be supported to constantly improve the three core aspects of quality: patient safety, clinical effectiveness and patient experience.

Both service delivery and the pursuit of clinical quality should be underpinned by an evidence-based understanding of variations in outcomes, workforce capacity and capability, and operational processes across all practices in the organisation.

Sunderland GP Alliance

The vital statistics: An alliance of general practices serving 284,000 people through five localities of 50,000-80,000.

The challenge: To give better levels of care than practices could achieve by working alone.

The solutions:

- Working with third and public sectors to address the wider causes of ill health, and using the latest technology to deliver care.
- The Enhanced Primary Care programme – a single, integrated pathway and referral tool, to help GPs decide on the right point of care for the patient, at the right time.
- Workflow coordinators in each practice, for administration like processing clinical correspondence from secondary care.

The results:

GPs can make faster decisions and have more time for clinical work. And Sunderland's practices are more flexible and resilient.



“Practices are encouraged to work together serving a combined patient population of 30,000 – 50,000. This is the right size [...] for developing highly effective, unified, multi-professional teams.”

National Association of Primary Care

Population-based proactive care

Understanding the specific health needs of the local population will become ever more important as new systems of integrated care emerge. Using this understanding, we must design services that proactively meet patients' needs, promote wellbeing and prevention, and encourage patients to manage their own health. This will give all patients the best possible short- and long-term health outcomes.

Practices already have a strong understanding of their patients and of what causes ill health within their local population. But this understanding should be strengthened by the use of wide-ranging data, including:

- physiological and psychological measures related to particular conditions, or to general health and wellbeing
- social and demographic factors
- behaviours that may contribute to ill health
- how patients use services and access care and support
- other needs and experiences that patients tell general practice teams about.

Deeper insight can help general practice teams sub-divide the local population based on the kind of care they need. There are many ways of doing this – an illustrative example from the National Association of Primary Care is included in end notes²⁶ and an example of this can be seen in the *Population health cube* illustration.

This then forms the basis for designing services within Primary Care Networks that proactively target the specific needs and risk profiles of the local population, and that are geared towards specific goals.²⁷ These could include:

- giving 'healthier' people access to advice and support to help them stay well
- giving people with complex conditions more multi-disciplinary, on-going, whole-person care
- supporting the practice workforce to use their clinical skills more effectively.²⁸

Fleetwood Community Care

The vital statistics: The three general practices in Fleetwood, Lancashire, came together to collaboratively deliver primary care to the local population of 30,000.

The challenge: To look at ways to strengthen the local primary care workforce and pathways to support practices in the delivery of core primary care services.

The solutions:

- Sharing the risks associated with employing a more diverse workforce and investing in infrastructure.
- The skill mix of general practice has been broadened to include paramedics delivering home visits for acute patients, specialist nurses triaging all mental health patients, and clinical pharmacists providing repeat prescribing.
- Integrating the medical records system (including read/write access) has enabled clinical pharmacists to take responsibility for the management of many patients with long-term conditions (e.g. COPD).
- Range of other collaborations with other providers and the community.

The results:

- It has radically transformed the delivery of core primary care services in the area.
- General practitioners have been released to work at the top of their license, and provide greater clinical leadership to the local health and social care system.

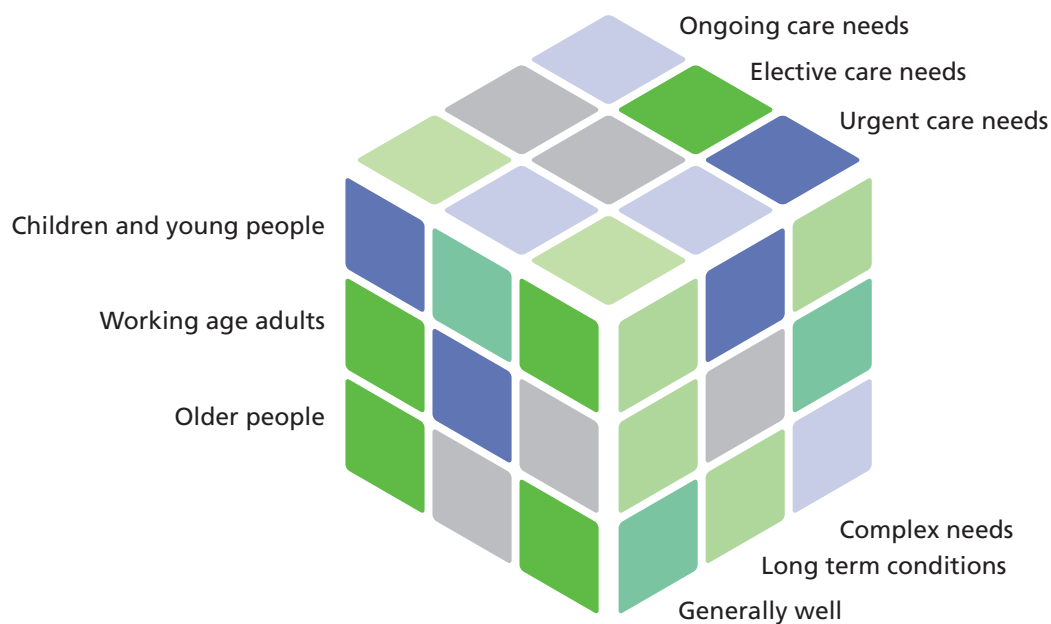
Population-based accessible care

Thanks to greater collaboration, everyone registered with a general practice in London can now see a healthcare professional in the evenings and at weekends. We can build on this success, deepening our collaboration to make general practice more sustainable for the future.

There are many opportunities now available to help us do this. Working at scale enables practices to create a broad mix of clinical and non-clinical roles, and to develop the infrastructure to offer different types of appointment, including over the telephone and online, as well as longer face-to-face consultations where needed. This broader and more flexible system of access makes it easier for general practice teams to work with patients' circumstances and meet their specific needs.

Population health cube

Source: National Association of Primary Care, 2017.



“Historically, GPs have been quite isolated in delivering care for their own communities [...] we need to collaborate with our neighbour to deliver the services that we cannot deliver on our own.”

Prof Helen Stokes-Lampard, RCGP Chair

By taking responsibility for a larger geographical population, larger-scale general practice organisations can support practices and networks to give these patients more consistent, fair and flexible access. People who need more time with a care professional, more intensive support, or a different way to access care, will get it. Which means better and more consistent outcomes for patients, and a better experience for patients, carers and healthcare professionals.

Population-based coordinated care

Thanks to their knowledge of the local health and care economy, and their strong patient relationships, general practice teams can coordinate individual care, helping patients to navigate the broader system. Larger-scale organisations can use this unique position to influence, design and align services across providers. This strengthens relationships, gives patients more integrated care and better outcomes, and makes it easier for teams to coordinate care by reducing duplication of effort.

A coordinated system

To create successful systems of integrated care, larger-scale general practice organisations must work with partners to build integrated processes and care pathways for their whole population. To achieve this, they need:

- consistent clinical and non-clinical care pathways
- simple ways of transferring care
- IT systems that let organisations share information easily
- collaboration between everyone to deliver and plan coordinated care. For example, through shared care records
- trusting relationships, nourished within practices and networks
- an agreed clinical improvement model with trusted data processors and clinical data advisors to support change.

A coordinated workforce

The multi-disciplinary workforce we can create by collaborating at scale (see *What should a larger-scale general practice organisation look like?* on p.23) is also crucial for delivering coordinated care. This workforce can be employed by practices working at scale, or through partnership with other local providers. Either way, its size and skillset should ideally reflect the local population's demographic and needs, and take into account its team members' capacity, capability and development needs.

Tower Hamlets GP Care Group

The vital statistics: A federation of the 37 general practices in Tower Hamlets, caring for over 312,000 people.

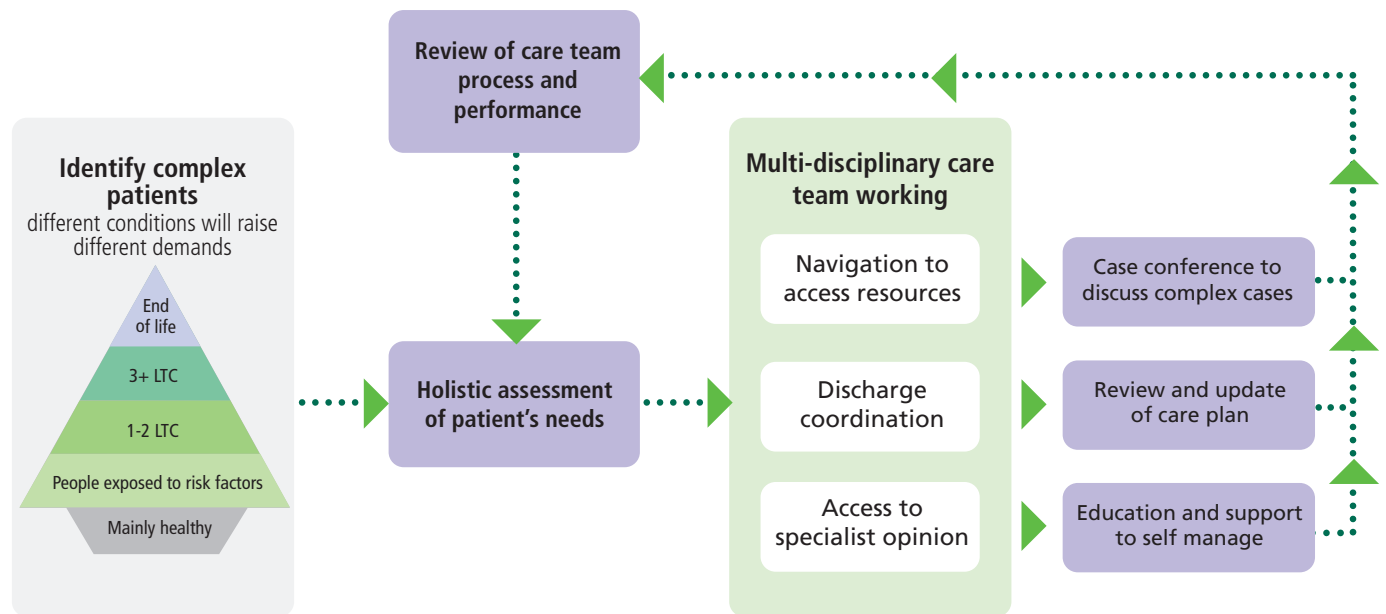
The challenge: A large variety of patients and a high proportion of part-time team members, impacting continuity of care.

The solution: 'Micro-teams' – groups of clinicians (and administrative team members) that offer direct, patient-facing functions, so that all patients can be assigned a named GP.

The results:

- Complex cases can be peer reviewed, meaning increased safety for patients.
- Team members give each other emotional support, improving resilience in the practices.
- Practices can take advantage of the economies of scale the federation provides. But can also keep the 'small is beautiful' aspects of general practice.
- More coordinated personal care, and a more rewarding workplace for teams. All thanks to being both 'big' and 'small'.

A model of comprehensive population-based care



Alongside the introduction of new non-clinical roles, a broader workforce can relieve GPs and other clinical team members of administrative tasks, and release their time to focus on providing the whole-person care that is at the heart of effective general practice.

New models of delivery are also demonstrating how multi-disciplinary workforces can be arranged into micro-teams (see *Tower Hamlets GP Care Group* on p.27).

These teams:

- include outside specialists when needed
- concentrate on patients that particularly benefit from continuity of care, and connect them with a named healthcare professional, even as flexible working becomes more popular²⁹
- promote clinical review
- let team members support each other and share advice and clinical risk, so they feel less isolated when giving complex, intellectually-challenging care
- encourage patients, carers and clinicians to make decisions together, so they can agree on the outcomes they would like and how to achieve them using the local services
- empower patients and carers to be involved in all decisions around healthcare. These could include how the systems work, how services could be changed and improved, and how to raise awareness about the services that are available.

Systems, information and quality improvement

The benefits of robust data and technology

Patients get – care that is designed and delivered to suit their needs, provided by the right clinician, and accessed through a range of easy-to-use methods.

Team members get – a trusting, transparent workplace where they can constantly learn, where systems and processes are always improving, where the burden of administration is reducing, and where resources are used in the best way.

This section focuses on the importance of accurate, meaningful data and strong information systems as we move towards at scale collaboration in general practice.

Service planning and delivery

As we have discussed, to build new models of care, we must design services that meet the needs of local people, and that use our clinicians in the best way, so that patients receive the right care from the best person. However, this cannot be achieved without robust information systems giving us the data we need to make the right decisions.

Storing and sharing data

Through closer collaboration and with the right support, larger-scale general practice organisations can invest in electronic records

and appointment systems that store a range of clinical, demographic and activity data, updated in 'real-time'.

There is greater value to be had from practices and other care providers sharing patient data. This gives a much more detailed picture of the circumstances, risks and needs of the local population.

Data-sharing agreements between practices must be created with the support of experts, who can make sure that legal and ethical boundaries are clear, practices are not carrying unnecessary risk, and the public do not lose trust in the profession.



"Safe and appropriate data sharing in the interests of the individual's direct care should be the rule, not the exception, including risk stratification for case finding."

Health and Social Care Information Centre

One Care Consortium

The vital statistics: A collaboration of over 100 practices in South West England.

The challenge: To use data more intelligently.

The solutions:

- Data shared between the practices, with new indicators to measure quality of care and the impact of clinical decisions. These included patient experience, demand, demographics, and prescribing.
- Easy-to-digest reports for each practice, showing where it stands against peers.
- Workshops on how GPs' activities and decisions impact other care settings.

The results:

- Practices can identify their differences (like consultation rates for elderly patients) and focus on the areas that most need improving.
- The consortium is building a business-intelligence platform to help practices standardise the quality of their data and how they manage it.
- There is a culture of data-driven change.

Granta Medical Practices

The vital statistics: A super-practice of four Cambridgeshire practices, with shared values and goals. They have merged their finances, lists, contracts, systems and buildings.

The challenge: to use at scale working to create a truly patient-centred service that responds flexibly to key patient concerns.

The solutions:

- A renewed focus on quality. Named doctors oversee clinical standards, using extensive data on performance, and working with struggling practices.
- A diversified workforce, including paramedics, meaning home-visits happen in the morning. This avoids hospital admissions from late referrals.
- More time for clinicians to care for complex patients, and an annual notes review of people with long-term conditions.
- On-the-day, on-site appointments for all patients, with a dedicated rapid access team that is flexed in size to meet demand.
- Goals set with help from patients. E.g. patients thought that reducing waiting times to below 15 minutes was a reasonable target. The average wait is now 4.6 minutes.

The results: The organisation has an outstanding rating from the CQC, positive patient feedback, and a waiting list of doctors wanting to work there.

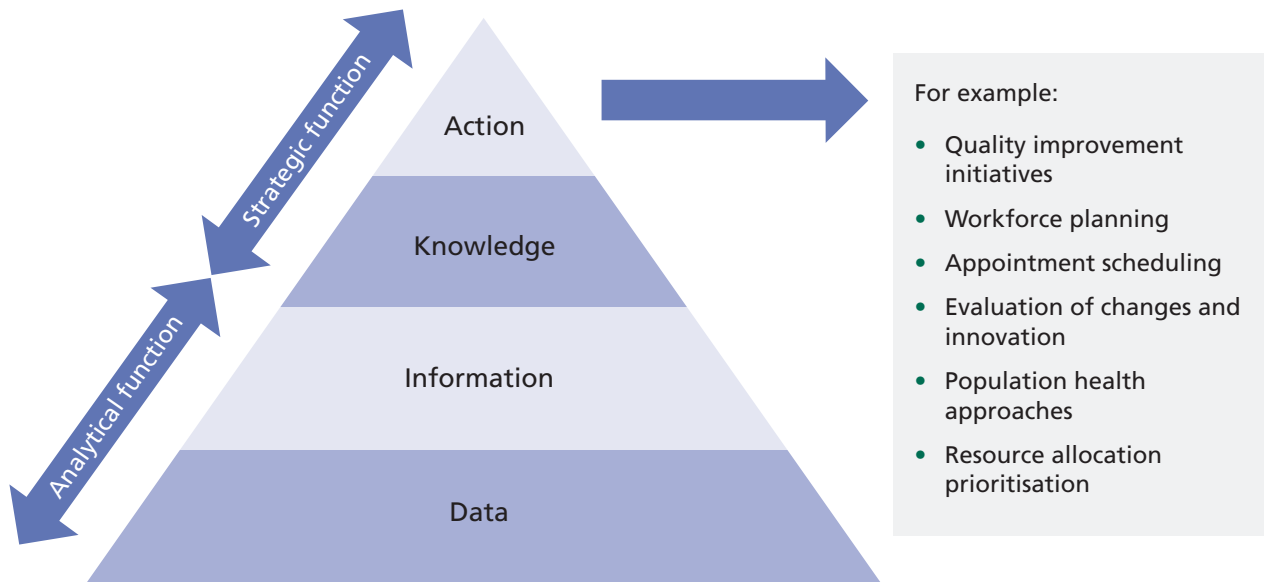


“Good evidence is the currency for informed debate and effective decision-making.”

Rick Stern, Director of the Primary Care Foundation

Application of the Data to Action Triangle

Source: Transforming Primary Care, Healthy London Partnership, 2018.



Making use of data

While data often exists, practices cannot always gather, analyse or use it in the best way. We must connect them with informatics experts (either inside or outside their organisations). These experts can analyse data and translate it into information that makes sense to clinicians and decision makers at every level of an Integrated Care System.³⁰

This requires good usability and simplicity of frontline systems, high quality information including consistent reasonable approaches to coding data, and agreed standards to support interoperability between systems.

Evidence also shows that a richer understanding of patient diagnoses and demographics through data analysis can help health and care systems to effectively allocate resources and plan care for a population.³¹ It can also help them to evaluate services and pathways strategically, and to

improve operational delivery. For example, they can access real-time and forecast data about clinical capacity and demand across their population. This allows them to plan the use of their workforce more accurately, so that they can meet patients' needs day-to-day, and week-to-week.

Administrative and operational efficiency

With resources in general practice increasingly stretched, it is more important than ever that we use our workforce as efficiently and effectively as possible. Investing in new technology will let us improve the experience of patients. But it can also help us to reduce the administrative burden on our workforce, giving general practice teams more time to care, and making general practice a more satisfying place to work.



“All patient records can be accessed from any site, which is of tremendous benefit, not only to our patients but also to our staff.”

Dr Sunando Ghosh, MMP Medical

Quay Health Solutions GP Federation

The vital statistics: A federation of 20 member practices in South East London.

The challenge: Working in partnership with NHS England’s Sustainable Improvement team to implement a quality-improvement change programme.

The solutions:

- 17 improvement leaders, nominated by their individual practices.
- Service Level Agreements between the federation and practices, releasing leaders for training and giving them time to share their learning with colleagues.
- Tools to help leaders run their projects.
- Support from other federation practices.

The results: Capability in and time for quality improvement is improving across the federation, rather than just in a few individuals. This means that more projects are happening at a faster rate. One practice has released the equivalent of six sessions of appointments per year by focussing on just eleven frequently attending patients.

Boosting efficiency and quality

Planning demand and capacity lets organisations allocate the most appropriate clinician to a patient, but it also helps them to use their team more efficiently. Within Primary Care Networks, practices can schedule clinical capacity to meet varying patient demand. This means that clinicians are less over-worked (or, conversely, under-utilised) and that the skills of different types of care professionals are used most effectively.

They can also combine meaningful data with robust methods of quality improvement to make sure that particular service areas are as effective as possible – whether that means tracking follow-up rates or spotting high numbers of patients not attending.

The right tools

There are also new technologies and systems that could reduce clinicians’ administrative workload.

These include:

- online advice and guidance
- e-prescribing
- online referral tools
- digital record sharing with other providers.

More flexibility

With the right technology, controls and support, clinicians can also follow up diagnostic results and do virtual consultations from home. This gives them more flexibility with their administration and work schedules, which can transform their daily routine.³²

Effective and efficient patient care

To give our London patients the high-quality, proactive, accessible and coordinated care we want to, we must have a joined-up system, and use our technology effectively.

London's population includes people from all demographics, who need and expect different ways to access services. Sharing records and appointment systems can help us to achieve this. But it also lets teams make the most of extra capacity.

Better for patients

Bringing together information about available local services is helping patients to more easily find the best places to get help. They can use online triage and navigation tools, for example, which link to trusted advice and guidance from NHS Choices about symptoms and self-care.

Better for our teams

Integrating electronic systems and sharing patient information between multiple providers is giving clinicians the right information to provide care wherever and whenever they need to. It also lets a range of healthcare professionals contribute to patient care – safely, effectively, and in a fully informed way.

Five uses of data

- 1 **Real-time data sharing** – an integrated patient record, accessible by partners and patients, to make individual care safer.
- 2 **Near-real-time data** – to help providers plan and coordinate individual care.
- 3 **Near-real-time intelligence** – to help systems operate smoothly and to monitor the effectiveness of healthcare delivery.
- 4 **Longer-term intelligence** – to review the delivery of services and to improve quality of care and planned service change.
- 5 **Longer-term research** – to identify cohorts of patients that could be used in clinical research, trials and surveillance.

Tower Hamlets GP Care Group

The vital statistics: A federation of the 37 general practices in Tower Hamlets, caring for over 312,000 people.

The challenge: To address key operational issues and to help create financial stability.

The solutions:

- Quality improvement (QI) methodology, using the best insights from global evidence to drive their approach to change. The federation identified issues with quality, worked to understand them, tested and implemented change strategies, then made sure they kept reaping the benefits.
- Sustainable change through a two-year programme, which will include:
 - training in consistent approaches to QI methodology for practices
 - team and individual development
 - shared data to let practices compare benchmarking and share learning
 - a central team to support practices in implementing change
 - practices collaborating to support each other's development.

The results:

- The discovery (through analysis) that approximately 45% of patients seen by GPs could see another team member, or self-manage. The federation shifted suitable work to practice nurses, making a small saving and freeing up GPs to focus on other patient issues.
- Faster changes, because practices are collaborating.
- Monthly sessions to share lessons learned from recent pilots or changes.
- Annual QI show-and-tell exhibitions.

South Warwickshire GP Federation

The vital statistics: A federation of 34 general practices, covering 270,000 patients.

The challenge: To improve quality of care by sharing learning between practices.

The solution: Learning in Action – part of NHS England's Time for Care programme.

- A series of workshops to give practices the 'headspace' to share their experiences and insights, to learn from each other, and to build a community that supports each other to make change happen.
- QI tools and techniques to help unblock change.
- Support to embed the tools and create a culture of continuous improvement.
- Sharing resources from the workshops (like standard operation procedures) across the federation, including any the practices developed themselves.

The results:

- Fewer inappropriate appointments due to better signposting.
- Less time dealing with paperwork.
- Full commitment to the programme from the whole federation, thanks to a focused clinical communications campaign.



“There is huge value in bringing people with different skills and perspectives together. By working collaboratively they can learn from each other and become a more efficient and sustainable group of practices.”

Tim Morris, Managing Director, South Warwickshire GP Federation

Quality improvement and clinical governance

There is still a pressing need for practice teams to be able to identify areas that could be improved in their practices, and to know how to go about making this happen. But a lack of knowledge, resources and time is stopping them.³³ We must address these issues, supporting teams to provide the very best care for their populations.

As well as using the deeper, broader data that collaboration offers, practices and other providers can also use their combined expertise to improve quality and services. This could include training team members in quality improvement methodologies, building an in-house team to lead transformation, or calling on external specialist support. Whatever they choose, they will be able to achieve much more than an individual practice could on its own.

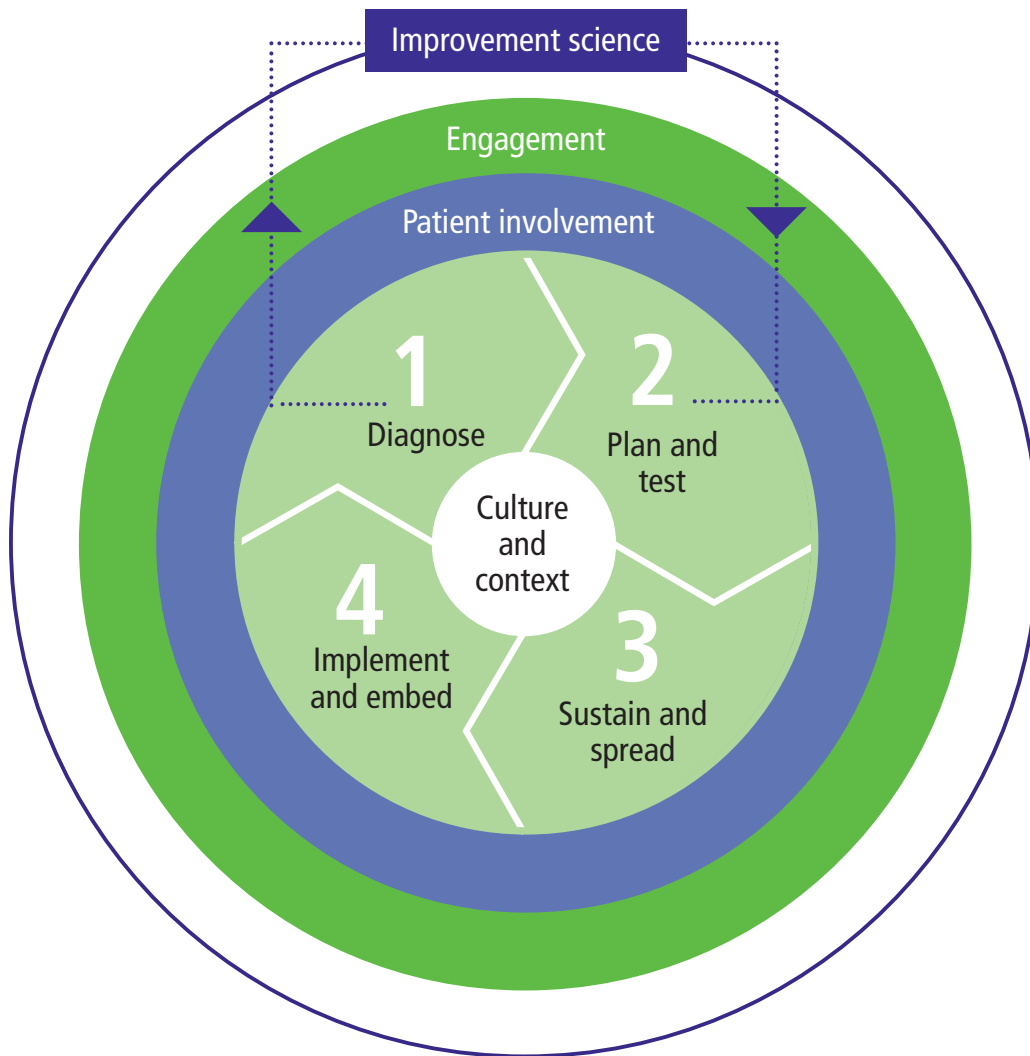
To encourage this, Primary Care Networks and larger-scale general practice organisations will need to:

- connect teams with senior decision makers so that changes can be made quickly and effectively (see *Effective governance and stewardship* on p.41)
- empower clinical and administrative team members by including them all in the QI approach
- support clinicians to lead organisational change and quality improvement, looking at quality indicators within their practice, and learning from other practices
- collaborate at scale to allow practices to develop more specialist skills and resources
- create a culture of continuous learning, built on trust, transparency and collaboration.

Clinical governance is intimately linked to QI and can also be improved by collaboration. Dedicated resources can be used to manage risks, incidents, complaints and clinical audit, or to develop shared processes, protocols and policies. Clinical governance processes can therefore make more impact with less administration.

Quality Improvement Wheel for Primary Care

Source: Royal College General Practitioners (2015) Quality Improvement for General Practice.



"Quality Improvement has to be at the heart of general practice at scale but, equally, it has to be about making a difference for patients and their families."

Janet Williamson, Deputy Chief Inspector, CQC

Organisational capabilities

The benefits of building more capable organisations

Patients get – clinicians who are motivated, happy, effective and focused on delivering care rather than drowning in administration.

Team members get – opportunities to develop professionally and personally, deepening and broadening skills and advancing their careers. They also get professional support when navigating clinical and non-clinical situations as well as information and expert advice to help them make decisions.

In this section we will discuss how closer collaboration can help us to build better organisations through economies of scale. This should result in greater financial and legal security, enhance system value, and create happier, more resilient teams.

Business development

Through greater collaboration, larger-scale general practice organisations are achieving a more sustainable, financially efficient, and clinically effective business model, which is better for patients and teams. But all of this depends on having employees with the skills and time to manage existing services and processes, to spot opportunities for improvement, and to deliver change.

By working at greater scale, practices can help each other to better understand their own activities, and to spot opportunities to improve quality and efficiency.

Larger-scale general practice organisations can also provide the clinical leadership to enable the robust assessment of different options, and provide business cases for out-of-hospital services or operational change. They might do this by developing 'in-house' services, functions

or expertise, or by contracting with external partners. Decisions should be geared towards improving the quality, resilience, sustainability and value of the system, and the work life balance of their teams.

To make this possible, larger-scale general practice organisations will need to properly engage and collaborate with teams, patients, the local community, and partner organisations. With the help of these groups, they can make the best possible changes and support practices to enhance their services.

As well as meeting relevant statutory equalities and health inequality requirements. Larger-scale general practice organisations should consider all opportunities to focus on strengthening equalities and addressing inequalities. This should be embedded into core values and built into planning, processes, services and care delivery. This is important to their workforce and will help to improve access, health outcomes and meet the diverse needs of local populations.

Workforce wellbeing and resilience

In London, we urgently need to grow and maintain our general practice workforce but we are struggling to do so. Greater collaboration could hold the answer to building happier workplaces, and attracting and keeping the key personnel we need.

The importance of managing our human resources better

By sharing risk and combining resources, larger-scale general practice organisations can source specialist HR expertise. This will help to reduce clinicians' administrative load, and develop consistent contracts, policies and procedures that drive a refreshed approach to recruiting and supporting teams.

Line managers and employees will also get expert advice and support in dealing with issues like performance, sickness, conduct and appraisals.

We can sustain a healthy workforce through:

- robust planning
- helping students to see the benefits of working in general practice, and offering more placements and ways of working
- reviewing our skill mix
- designing innovative roles, including portfolio roles
- developing new approaches to recruiting permanent team members.

Good HR support is becoming more important as the number of non-GP care professionals increases. These professionals, like clinical pharmacists, may need employment arrangements to be put in place that practices are not familiar with. The same can be said for employment arrangements that let practices share team members with other providers.

Harness GP Co-operative Federation

The vital statistics: A federation of 21 general practices in North West London with a combined list of 115,000. Formed in 2008, it is evolving towards becoming a super-practice.

The challenge: To improve services, recruitment rates and to widen remit.

The solutions:

- Extended access (08:00-20:00), GP hubs seven days a week, a GP-led health centre, and Local Authority-contracted public health services.
- New organisational capabilities, including in-house expertise in contract and project management to boost quality and performance; new measures to attract and support team members, including:
 - mapping current competencies and finding skills gaps
 - comprehensive policies and procedures
 - an award-winning apprenticeship scheme with 40 graduates to date
 - developing new roles for HCAs, like working with the third sector to support isolated people
 - better induction, continuous personal development, supervision and mentorship.

The result: A wider range of services, new models of care, and more job posts filled.

As well as dealing with these issues, HR experts can also help to develop and deliver training, development, coaching, and peer-working programmes. These should be tailored to teams' needs and support their professional and personal development. There is also the potential to diversify and expand leadership and management opportunities in the context of fewer GPs seeking a partnership role.

Bringing back joy

Collaborating at greater scale can do so much more than just reduce workload, support team members' development, and create more innovative roles in general practice. We have the opportunity to boost team members' wellbeing, resilience and joy in what is often a stressful working environment. Larger-scale general practice organisations will have the capacity to develop programmes to:

- **promote healthy living** – creating schemes to help team members eat well, stop smoking, or stay active
- **protect team members** – with occupational health services like hepatitis B immunisations
- **support people** – when they are unwell or need help returning to work
- **mentor junior team members** – asking senior colleagues to help them develop and guide them through the challenges many of us face in our early careers
- **offer flexible working** – to give employees a better work-life balance, and to increase retention.

Leading from the top

To make our workplaces more joyful we also need commitment from the leaders of each organisation. They must:

- 1 Engage colleagues to identify what matters to them in their work.
.....
- 2 Identify the processes, issues, or circumstances that are impediments to what matters — the “pebbles in their shoes” that get in the way of meeting professional, social, and psychological needs.
.....
- 3 Work in partnership with multi-disciplinary teams from every level of the organisation to come together and share responsibility for removing these impediments and for improving and sustaining joy.
.....
- 4 Ensure that leaders and teams use improvement science together to accelerate improvement and create a more joyful and productive place to work.³⁴
.....

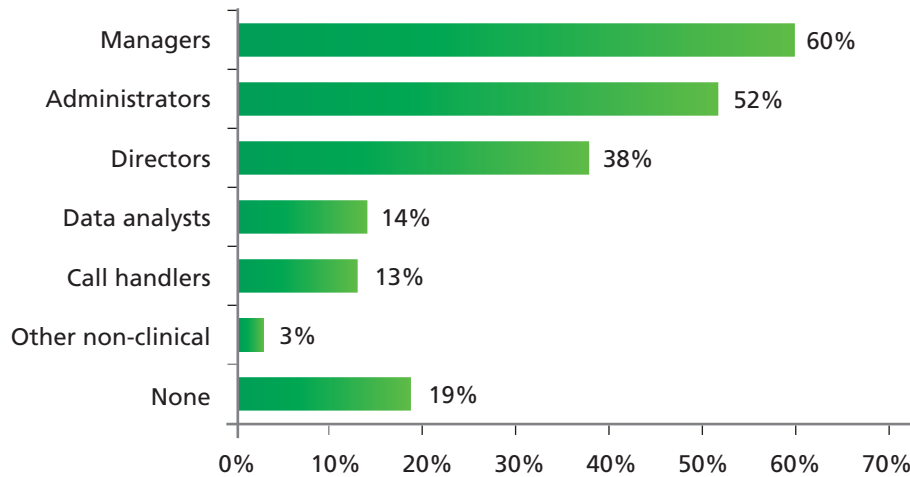


“We are rolling out projects to deliver back-office efficiency, such as bulk buying, shared indemnity cost, CQC compliance, HR support, IT systems and financial management.”

MyHealthcare Federation, Birmingham

GP at scale organisations with non-clinical roles (England)

Source: Collaboration in general practice: Surveys of GP practice and clinical commissioning groups, Nuffield Trust, 2017.



Finance and contracting

Collaborating at scale is also improving the way practices run, develop and work with other organisations, by giving them access to technical expertise.

Larger-scale general practice organisations can give their practices access to additional professional advice and support where needed. Good governance (which we discuss further on p.6) is key to making sure this happens.

Professional advice helps organisations to create more transparent, trusting and secure agreements, which are the foundation for effective collaboration.

This could, for example, include:

- funding arrangements
- governance structures
- contracts for joint provision
- subcontracting services
- memoranda of understanding between practices and other providers.

Robust financial arrangements are key to the success of larger-scale general practice organisations. They will be large enough to ensure expert financial help is embedded in their governance and teams. This expertise will enable coordinated purchasing power, procurement processes and accounting to support the efficiency, value and viability of their organisation.



“No more need to worry about paying business bills, cash-flow, payroll and book-keeping – all of that is done centrally by Modality’s back office.”

Dr Vidhu Mayor, GP partner, Modality

Effective governance and stewardship

The benefits of effective governance and leadership

Patients get – the chance to be represented and involved in decisions relating to their care, have clear expectations of the service they receive, and can co-design changes to these services.

Team members get – a shared purpose and values, making them more engaged in the operations and development of the organisation, and more attuned to the broader care system. Skills and team members are shared between practices to deliver more personalised care to patients.

In this section we will discuss how important it is for larger-scale general practice organisations to govern themselves in the right way, to interact with patients and stakeholders in the right way, and to develop their leaders. It helps them to build an organisational model that delivers effective patient care, enhances resilience, brings joy to the workplace and puts general practice at the heart of systems of integrated care.

Accountability and leadership

Successful larger-scale organisations share the values of trust, transparency and accountability. Accountability of the board to the team and, through delegated authority, accountability of every team member to the values and aims of the organisations. This enables every team member to understand their stake in the organisation and their role in improving patient care. These values can only be achieved with strong and accountable leadership, especially clinical leadership.

The way that larger-scale general practice organisations choose to govern themselves will vary according to the way they are set up and their local circumstances. As such, we cannot prescribe a defined model. But it must be led by local clinicians, with accountability to practices. We see time and again that multi-disciplinary leadership teams (usually forming a board) create strong larger-scale general practice organisations. These teams tend to include GPs from each of the Primary Care Networks within the organisation, non-GP care professionals, and executive officers with operational, financial and strategic expertise.

Diverse experts

From talking to established larger-scale general practice organisations, we are starting to understand the benefits of having independent or non-executive specialists on boards and sub-committees, to help make decisions and represent patients and partner organisations.

Improving Health Ltd

The vital statistics: A federation of 20 general practices in South East London, grouped into four clusters of around 30,000-40,000 patients.

The challenge: To use their data, structure and collective resources to improve the local population's health.

The solutions:

- Cluster meetings every six weeks, with agendas based on information about the local population's health in each practice, cluster, and in the federation. Members:
 - compare progress and offer support
 - decide where targeted interventions are needed, and whether practices can share resources and team members, or use federation-employed practitioners.
- A Population Health Delivery Group, with a board of four elected GPs, a practice manager and the federation managing director. They look at progress reports and projections, and make recommendations.

The results:

- An extra £170,000 of contract income during 2016/17, which they invested in further improvements.
- Future commercial opportunities in the pipeline, like joint ventures and alliances, to strengthen at scale working.

This is also a characteristic of successful organisations in the private sector and wider care system, who effectively balance clinical leadership with independent expertise at executive and board levels.

Sub-committees, designated executive leads and audit committees underpin good working arrangements for effective clinical and financial governance, for high performance, and for transparent accountability.

Leadership at all levels

Multi-professional clinical leadership throughout the organisation is vital. It should run both vertically between larger-scale general practice organisations and practices, and horizontally across pathways or services, and should encompass all care professions. This lets the board see all aspects of the organisation more easily, makes sure that the views of the whole workforce are represented, and makes it clear who is responsible for addressing certain issues or delivering particular improvements.

In turn, the leadership team must be able to understand and talk confidently about key areas like finance, operational performance and quality. This lets them demonstrate to their colleagues that they are acting in the best interests of patients and teams, and that resources are being used in the best way possible. It also helps them to reassure patients, commissioners, partner organisations, and regulators that they are meeting all of their statutory obligations.

Strategy

If organisations want their teams and patients to commit to collaboration, they'll need a clear strategy and a strong vision. This will give people from diverse backgrounds and professions the shared values, approaches, and sense of purpose needed to improve the lives of patients and team members.

The strategy should be constantly reviewed and improved by clinicians, with help from the wider

system. It should look for future opportunities to innovate and improve patient care, and it should also increase the organisation's resilience by planning how it will cope with future scenarios. Any strategy for a larger-scale general practice organisation should include how it will:

- support practices to improve patient outcomes
- improve the working lives of all team members, giving them fulfilling careers in a supportive working environment
- lead new models of integrated care to drive changes to services across the care sector
- give team members goals that clearly show how they can improve patient outcomes, helping to spark people's natural drive to work towards a common good
- measure progress against these goals wherever possible, to monitor the impact on patients and on the working lives of all team members, and to see how the strategy should evolve.

Culture

There is clear evidence that a happy workforce means better patient outcomes, and that the best place to receive care is also the best place to work. A positive culture is one of the key factors in creating joy in the workplace.³⁵ And these cultures thrive under strong, trusted leadership, and a strategy that prioritises team wellbeing. This is the case at practice, network and larger-scale levels.

The strategy and culture of organisations should be rooted in core NHS and general practice values: to consider patients as people, to be moved by their suffering, and to be their companions on life-changing journeys.

This culture of empathy should place patient care at its heart, and it should apply just as strongly to the way teams and other stakeholders relate to each other. We must create more time, opportunities and ways for people to build strong professional relationships, emphasise what unites us and start to better understand each other's

City and Hackney Confederation

The vital statistics: A federation of 43 general practices which was established in 2014 as a Community Interest Company. It is a not-for-profit organisation in which each practice pays an annual membership fee based on their registered list size.

These practices provide services to a registered patient list of around 307,000.

The challenge: To develop governance structures, vision and strategy for the organisation.

The solutions:

- The confederation put an agreed constitution in place that was consulted on and agreed with member practices.
- The governing body was established. Its Clinical Board (the Board of Directors) is made up of five elected GPs.
- On inception, a clear vision and strategic aims were defined. The vision is to make a positive difference to the quality of primary care, to influence the development and redesign of local services through a collective voice for primary care in the local care system, and to ensure that local communities have access to the best quality local healthcare.
- Strategic aims were developed which include:
 - The role as a local provider of out-of-hospital services and local preventative services,
 - The capacity and capability of the local primary workforce,
 - The role in relation to public health and health promotion.

The results: A strongly organised and engaged collaborative group of practices who are clear about their shared goals and focus.

challenges. This will help us to build an environment of trust, transparency and willingness to share challenges. This will lead to the closer collaboration we need to improve and sustain our system of care.

But we must also respect differences in people's backgrounds and approaches, and let teams and practices serve their communities. By listening to team members when they advise different approaches, we can design services that best suit local groups and populations.

Intelligence

For organisations to improve the quality and consistency of their care, and manage their workflow better, they must have the capacity and expertise to get real-time information and analysis about how they are performing.

Data should be available at practice, network and larger-scale levels to empower all team members to lead quality improvement. Data and the information we derive from it can give teams the clinical insight and context they need to spot opportunities for improvement.

To make sure everybody trusts the data, it must be clear how it has been gathered, what it is being used for, and whether there were any limitations when it was being interpreted.

Organisations should work transparently, with partners and patients, to decide which measures they will use to assess themselves, and they should share agreed outcomes to support quality improvement.³⁶

What is the best way to run a larger-scale general practice organisation?

The question: The Nuffield Trust wanted to find out if there was one particularly successful model for running a larger-scale general practice organisation.

The exploration: They looked at four sites and saw many different structures, including:

- a limited for-profit company (AT Medics, 20 practices)
- a for-profit company limited by shares (GP Care, 100 practices)
- a group of companies (Harness Group, 21 practices)
- a super-partnership (Modality, 16 practices), where partners have put lifelong contracts into a limited liability partnership.

In some sites, the member practices held the contracts for core services, and in others they were held by the central organisation. This influenced how the board and executive team were able to work with individual practices.

The trust also saw that the structures changed in response to periods of growth or failure. New board members were sometimes appointed, typically to bring extra skills and experience to the board.

The answer: There is no 'off-the-shelf' model that will work for every organisation; each structure offers its own unique benefits. Each organisation must design a model that works for its own individual goals and values.



"You need a coalition of the willing [...] culture is key. People have got to want to change."

Joseph Besford, Innovation Programme Manager, RCGP

These measures will cover common areas like care quality, patient experience, team satisfaction and wellbeing, and operational performance. Wherever possible, the organisation should be measured on specific outcomes. However, organisations should also capture other things that show they are progressing towards their specific goals – like improved processes, related achievements and general high performance.

Sunderland GP Alliance

Sunderland GP alliance has demonstrated an effective leadership development approach, comprised of four key domains.

- **Individual effectiveness of the leader:** Myers-Briggs Type Indicator personality preference, 360 degree feedback.
- **Relationships and connectivity:** coaching to explore the health of relationships and connections across the system with specific work on strengthening relationships that add value to the service user.
- **Innovation and improvement:** explore the skills and capacity of the staff to problem solve, service improve, and signpost to developments already available within the system.
- **Learning and capacity building:** coaching around how new ideas, research and skills could be diffused and shared within and between the five locality teams across the city.

Some of the beneficial outcomes identified so far include:

- Greater understanding of different roles and increased collaboration.
- Staff more satisfied with quality of care and support they can offer patients.
- Improved sense of pride.
- Increased sense of unity and a feeling of being one team.

Engagement

The health and wellbeing of patients, and the quality and financial sustainability of general practice all improve when people are involved in their own health and care.³⁷ As we collaborate more with other parts of the care system, leadership teams must also start to work with provider partners wherever they can. Through working with partners in the wider NHS and social care system in planning services, making decisions and reviewing progress, general practice will play its part in creating truly joined-up, patient-centred care.

General practice teams have immense insight into the care that patients need and should be involved in designing any changes that will impact their work or environment.

The leadership team should seek input from system partners, including statutory and voluntary sector organisations, before making major changes to their strategy or mandate. How much input will vary according to the organisation's structure and legal obligations.

The leadership team should speak to and ask for input from patients, the public, the community, and system partners when thinking about making changes to services. They should communicate with their team and their patients about how new models of care will affect them. This will make people more likely to accept and use the new models.

Finally, communication should also flow the other way. Insights from patients, the local community, clinical teams, other team members, and partner organisations should be used to shape improvement opportunities and inform the organisation's strategy, objectives, and on-going evaluation and learning. This input can be gathered both confidentially and in open forums. As a minimum, the leadership team should discuss this feedback regularly and publish it whenever they can, along with how they are going to use what they have learned.

Context

At its best, general practice offers a highly localised service, while building strong relationships with other local care providers, and maintaining an awareness of both the regional and national context. The importance of these different layers of engagement will become even more important as general practice takes a central role in collaborating at scale. It will help practices, networks and larger-scale general practice organisations to listen to and meet the needs of patients, teams and the system, especially when making decisions that will affect them.

Playing a role in the wider system does not mean that local circumstances, or the relationships that practices have with their patients, are any less important. In fact, effective collaboration will improve individualised, whole-person care. It will let us learn from each other to develop services and new processes that build on what already works well, and that recognise local circumstances.

Putting general practice centre stage

In the next section we discuss how important it is for general practice to be at the heart of system partnerships and leadership. Larger-scale general practice organisations can help make this happen by governing themselves in the right way. They can:

- strengthen the voice of practices by, for example, creating steering groups to represent the interests of the whole organisation
- understand national, regional and local policies and strategy, so that they can take advantage of the changing health and social care landscape, and influence and interpret it locally
- consider wider economic factors, like changes to public funding and workforce issues, when making strategic decisions.

Modality Partnership, Birmingham

The vital statistics: A partnership that was founded in 2009 with just two practices, and now has over 35 sites, serving more than 300,000 patients.

The challenge: To form a collaboration that would provide better general practice and more diverse services to a larger population.

The solutions:

- A designated partner (with support from management), devoting time, money and energy into merging the services.
- Effective communication, between the partnership, their team members, and their patients.
- Monthly newsletters and regular email updates to share information.
- Patient participation groups to gather feedback and find out which services they would like to see in the future.
- Aligning of team members' contracts early on.

The results:

- New patient services.
- A more corporate focus to make sure the partnership delivers on its business case.
- Improved quality metrics.
- Happier GPs with less admin and more time to enjoy their work.
- The know-how to advise and support others practises in forming a partnership.



"At scale has to be built with people, rather than done to them."

Dr Andrew Wilson, Sandbach GPs

Building and leading collaborative system partnerships

The benefits of leading collaborative system partnerships

Patients get – great care for life, from a joined-up, sustainable, high-quality, local network. This is thanks to new models of care and Integrated Care Systems with deep links to communities and a perspective that takes into account the whole population.

Team members get – closer collaboration across providers. This gives them a more supportive, less isolated, multi-disciplinary approach, and lets them offer better care.

Systems of integrated care will only thrive if general practice leads the way. There is no other healthcare profession with our unique perspective on the whole-person needs of populations. This section discusses how, by strengthening collaboration between practices and developing their capacity to lead, we can begin to take on this vital responsibility.

Leading a larger-scale general practice organisation

We have discussed how important good governance is to the success of larger-scale general practice organisations. But running these organisations well has an added benefit: it shows the wider care system that we have the consistency, capability and credibility to lead.

By building robust governance, larger-scale general practice organisations can gain the trust of their member practices. Once they have, leaders should feel empowered to speak and act for and on behalf of the whole organisation, knowing they have their support. They should also be able to confidently share with other local health and care providers the responsibility for the services the local population receives.

Leading care systems with other providers

Using general practices unique whole-person perspective of the patient, larger-scale general practice organisations must be ready to play a leading role in all new models of care. Their involvement is one of the best ways to make sure that these models are sustainable and effective for patients.

Having established clear leadership internally within general practice, larger-scale general practice organisations should work with partners in other sectors to build a coherent approach to delivering better patient care and outcomes. To do this, they will need to have credibility and influence. This comes from proving to the wider system that they genuinely represent their local population and all its general practices.

Northumbria Primary Care

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The vital statistics: A single legal entity formed of the local acute foundation trust and seven general practices.

The challenge: To give extra support to the primary care sector.

The solutions: Back-office support for practices including governance, payroll, financial services, HR, and estates.

The results:

- Strong, localised care, since each practice continues to operate independently.
- Better purchasing power.
- Expertise from acute colleagues, helping practices to lower their costs, generate new income streams, and win more contracts.
- High patient satisfaction and CQC ratings.
- A broader workforce with new roles.
- Improved access times (76% better in one practice).
- Lower monthly expenditure (£6,000 lower in one practice).
- Stronger links between primary and secondary care, partly by helping the progress of the integrated primary and acute care systems (PACS) vanguard project, which started in Northumbria in 2015.

The Symphony Programme, South Somerset

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The vital statistics: A partnership between two acute Trusts, a federation of 19 general practices, and the local council. It is chaired by a GP, with three board members also from general practice.

The challenge: To solve rising demand, rising costs, and a staffing crisis in general practice.

The solutions:

- Collaboration – GP-led working groups and joint analysis of the population.
- Combined data for extra insight.
- Strong GP leadership.
- Added secondary care resources.
- The willingness to reflect on feedback.

The results:

New organisational forms and new models of integrated care, including:

- Health coaches working in teams with GPs and other practice team members, to discuss patients, agree actions, and support them to manage their conditions.
- Virtual diabetes MDTs with consultants.
- Hot respiratory clinics giving patients that need urgent care access to a specialist at short notice.

Building an expert team

Practices and Primary Care Networks should take a central role in every aspect of local patient care: physical and mental health, self-care and medical management, prevention and end-of-life care. Larger-scale general practice organisations must support them in doing this – helping them to give the best care at practice and network levels, challenging the status quo and designing new models of integrated care across all stages of the patient pathway. This could involve partnerships with a range of providers and sectors, for example:

- children’s social care, educational institutions and community providers – to support challenged families
- mental health services and the voluntary sector – to give joined-up, lower-intensity support to patients with common mental health issues, adult social care, acute-care-of-the elderly physicians, community providers and voluntary services – to help identify frail elderly people early on and assess their risks.

Working together

To make sure that these models of care are successful, larger-scale general practice organisations and Primary Care Networks must create clinical and patient-identified outcomes to work towards. They should decide on these with their patients and their partners in other sectors, and take shared responsibility for their delivery. Everyone should be ready to make substantial decisions together about change across the system – both around new models of care and how they will manage resources. Providers might, for example, consider pooling incentives such as outcomes-based payments, and taking collective ownership of shadow whole population budgets, supported by virtual or partial contractual models of integration. This should be the foundation for any integrated care system that is based on value.³⁸

Dudley Multi-specialty Community Provider

The vital statistics: A proposed network of integrated, GP-led providers across health and social care, serving 60,000 people each. Collectively reaching over 318,000 in total.

The vision:

- To develop a front line of care, working as ‘teams without walls’.
- To take mutual responsibility for delivering shared outcomes.
- To ‘fill the cracks’ in order to give patients high-quality, timely care.
- To create multi-disciplinary teams in the community, including specialist nurses, social workers, mental health services and voluntary sector link workers.
- To develop more interventions like the 24-hour rapid response and urgent care centres. This provides a single, coordinated point of access for 999 cases that are not in need of urgent, acute care.

The lessons learnt so far:

- Clinical leadership is vital and can be boosted with monthly leadership sessions.
- It is important to consult patients on proposed and upcoming changes.
- Communication is crucial, and channels that have worked well so far include newsletters and patient groups.
- Culture is key. People have to want to change.

Being a leading provider

To successfully lead care systems with other providers, larger-scale general practice organisations must develop strong relationships across the care system and take on greater responsibility for the cost and the care of their population. This will be an evolutionary process, and larger-scale general practice organisations will need to invest their time and resources to drive it forward.

To go further, larger-scale organisations will need to build on the characteristics outlined above to represent the interests of individual constituent practices by providing a collective voice, and demonstrate substantial leadership of networks of providers within emerging Integrated Care Systems. They will need to work together to meaningfully transform services, enhance the integration of care, improve system performance and value, and ensure the delivery of agreed population outcomes. This will require taking shared responsibility for a whole population budget and outcomes-based payments. This can and should be allied to on-going efforts to maintain and enhance the care that single constituent practices provide.

Fylde Coast Local Health Economy

The vital statistics: A vanguard of six partner sites, serving 320,000 people in a mix of coastal towns and rural villages.

The challenge: To develop healthcare that 'wraps around' the patient, delivering more support closer to people's home and less in hospitals.

The solutions:

- Extensivist – a community-based service, proactively supporting people aged 60 and over, who have two or more long-term conditions.
- A harmonised team of professionals working to keep people out of hospital.
- Help for patients to understand and manage their health conditions, and to live a healthier life.
- Local neighbourhood care teams, for people with one or more long-term conditions that need to be managed.
- Shared electronic care records and a single point of contact for all out-of-hospital services on the Fylde Coast.

The results:

- Patients feel empowered to manage their conditions and stay healthy,
- Better coordination and fewer unnecessary hospital admissions, meaning less pressure on the system.
- A better, more streamlined experience for patients through a single point of access and shared electronic care records.

Summary

This document describes a bold ambition for change. This change has started across London and the UK, but at different paces and in different ways. The learning from the innovators of collaborative working is a thread throughout this document, as is the need to build on this learning and to support practices across London to participate in and lead new models of health and social care.

Challenges for general practice are described both in the document and widely elsewhere. Working more collaboratively with other practices and providers in the wider health, voluntary and social care sectors will enable general practice to stay true to its values, while building a strong and sustainable future for its patients and teams – ensuring an excellent and equitable 21st-century general practice offer to all Londoners.

Collectively, primary care leaders from across the capital have set out to describe a journey that will support general practice to build on its unique strengths and develop a coherent vision of collaboration to underpin, and accelerate health and care system change in London. We have pledged to support this journey with additional resource and by sharing best practice.³⁹

We recognise that there is no one size that fits all, but hope that by providing support and shared learning with local knowledge and experience, we can develop an environment that supports all those continuing or receiving care in the region to work together to secure a sustainable future for our health and social care services.

Transforming Primary Care Programme, Healthy London Partnership

Glossary

- **Academic Health Science Networks (AHSNs):** Organisations that align education, clinical research, informatics, innovation, training and education, and healthcare delivery. They translate research into practice, and develop and implement integrated healthcare services – all to improve patient and population health outcomes.
- **Accessible care:** Care that is personalised, responsive, timely and easy to access.
- **Care Quality Commission (CQC):** The independent regulator of health and social care providers in England.
- **Clinical Commissioning Group (CCG):** A statutory organisation responsible for commissioning most health and care services for patients. Its members are GPs.
- **Coordinated care:** An approach to healthcare in which all of a patient's needs are coordinated with the assistance of a primary point of contact, ensuring that care is patient centred, integrated and keeps a continuous relationship with a healthcare professional.
- **Community Education Provider Networks (CEPNs):** Dynamic and innovative networks, bringing together primary, secondary, community and social care organisations to collaborate on workforce development, education and training. Each CEPN has its own operating model based on local circumstances.
- **Community Interest Company (CIC):** A business that invests some of its profits either into the community or into making the business more able to help with social issues.
- **Integrated Care System (ICS):** A collective term for both devolved health and care systems and for those areas previously designated as 'shadow accountable care systems'. ICSs can be considered as advanced forms of Sustainability and Transformation Partnerships (see definition below). In them, commissioners and NHS providers work closely with GP networks, local authorities and other partners, to share responsibility for planning and commissioning care for their populations, and for providing system leadership.
- **Larger-scale General Practice Organisation (LGPO):** This term does not refer to a particular type of organisation or contract. Rather, an LGPO is a body within which practices come together to serve a large population in a geographically aligned and inclusive way. In London this usually happens at a borough level. This sort of collaboration can happen in different ways (see the *Larger-scale General Practice Organisational Forms* diagram on p.6). But in this document, we identify some common characteristics of these organisations, including the development of Primary Care Networks (see definition below).
- **Local Medical Committees:** Bodies that are recognised in statute (NHS Act 2006 as amended) as Local Representative Committees. They are the only independent, elected body for local GPs and practice teams, and provide independent advice, guidance and support on all issues that affect general practice. They can operate at borough level and broader cross-borough levels.
- **Micro-team:** A small team which can be made up of GPs and other clinical and non-clinical practice team members. A patient may be assigned to the micro-team, which discusses reviews and plans their care together. These teams are able to contribute to the planning and continuity of a patient's care.
- **Multi-specialty Community Provider (MCP):** An organisation that delivers both primary care and community-based health and care services. It also incorporates a wider range of services and specialists where they are needed. This is likely to mean providing some services that are currently based in hospitals. These might include outpatient clinics; care for frail, older people; diagnostics; day surgery; mental health services; and social care services.

- **Multi-disciplinary Team (MDT):** A team made up of people from different professional backgrounds, with different areas of expertise, which treat patients needing help from more than one kind of professional. Multi-disciplinary teams are often discussed in the same context as joint or partnership working, and interagency work.
- **Population health:** An approach to health that aims to improve the health outcomes of an entire population and to reduce health inequalities among population groups. In order to achieve this, it looks at and acts upon the broad range of factors and conditions that have a strong influence on health outcomes.
- **Primary and Acute Care (PAC) system:** A new way of 'vertically' integrating services. PAC systems can give foundation trusts more flexibility to invest in and work with primary care. They can also make contractual changes to let hospitals provide primary care services in some circumstances. At their most radical, PACs could take complete accountability for a registered list.
- **Primary Care Network (PCN):** A grouping of practices in the same area that gives comprehensive, multi-disciplinary care to populations of 30,000-50,000, in partnership with other local community providers. Primary Care Networks sit within larger-scale general practice organisations (see definition above).
- **Proactive care:** Care that supports and improves the health and wellbeing of the population, including by teaching self-care and health literacy, and by intervening earlier in the course of an illness to prevent a deterioration in health.
- **Quality Improvement (QI):** Continuously improving outcomes and quality of care for patients. This can also be applied to the use of QI methodology, which involves a systematic approach that uses specific techniques to improve quality.
- **Quality and Outcomes Framework (QOF):** A financial incentive scheme available to all general practices, based on their achievement against evidence-based indicators of quality. These include clinical, public health, quality, productivity and patient experience indicators. QOFs are voluntary but most practices participate in them.
- **Staff:** In this document, the term 'staff' is used in an inclusive way and refers to partners, employed GPs, nurses and other members of the general practice team.
- **Smaller viable hospitals:** Smaller local hospitals in which NHS England tests new models to keep these hospitals and their services running. This is because they provide the best clinical solutions at an affordable cost, and are supported by the community and commissioner.
- **Sustainability and Transformation Partnerships (STPs):** Partnerships in 44 areas, covering all of England, where local NHS organisations and councils have drawn up plans to improve health and care in the area. STPs are now beginning to evolve into Integrated Care Systems (see definition above). STP can also stand for 'sustainability and transformation plan', which are the plans drawn up in each area.
- **Systems Leadership:** Leadership across organisational and geopolitical boundaries, and beyond individual professional disciplines. The leaders are often from a range of organisations and cultures, and work together on issues of mutual concern that cannot be solved by any one person or institution.
- **Vanguard:** A group of organisations that come together to pilot new ways to improve healthcare, including new models and systems. These pilot initiatives are often funded by national funding initiatives.
- **Whole Population Budget (WPB):** One budget for all of the services that a provider has been contracted to deliver for its population. These budgets encourage providers to find integrated ways to manage their whole population, prevent illness, and promote self-care. They also encourage providers to focus on the outcomes they need for their population. Ideally, the whole population is covered within the WPB, but providers have some flexibility to develop different care models to meet local needs.

Bibliography

Publications

- British Medical Association (2015) *2014 UK Medical Workforce Briefing*.
- Colin-Thomé, D. & Fischer, D. (2013) 'General practice of the future', *NHS Alliance*.
- Department of Health, *Confidentiality and Information Sharing for Direct Care: Guidance for health and care professions*.
- Department of Health (2012) *Long Term Conditions Compendium of Information*.
- Feeley, D. & Swensen, S.J. (2016) 'Restoring joy in work for the healthcare workforce', *Healthcare Executive*, 31(5).
- Gillam, S. (2014) 'Evidence-based healthcare and quality improvement', *Quality in Primary Care*, 22.
- GP National Recruitment Office (2015) *Committee of GP Education Directors*.
- HSCIC (2013) *A guide to confidentiality in health and social care*.
- Londonwide LMCs (September 2013). Securing the Future of General Practice in London. https://www.lmc.org.uk/visageimages/Policy/EPI%20Final.pdf?dm_t=0,0,0,0
- Londonwide LMCs (May 2016). Securing the Future of General Practice in London: Maximising the Value of General Practice in London. <https://gpsoe.org.uk/gpsoe/assets/Maximising%20the%20value%20of%20general%20practice%20in%20london.pdf>
- Macinho et al. (2003) 'The Contribution of Primary Care Systems to Health Outcomes within Organisation for Economic Cooperation and Development Countries', *Health Services Research*, 38(3).
- Marshall, M. (2015) 'A precious Jewel – The Role of General Practice in the English NHS', *The New England Journal of Medicine*, 372.
- Marshall, M. & Gray, D.P. (2016) 'General practice is making a leap in the dark', *British Medical Journal*, 355.
- McWilliams, J.M. et al (2016) 'Early Performance of Accountable Care Organizations in Medicare', *The New England Journal of Medicine*, 374.
- National Leadership Council (2012) *The Health NHS Board: Principles for Good Governance*.
- NHS England, *Retaining the current medical workforce*. Available at: <https://www.england.nhs.uk/gp/gpfv/workforce/retaining-the-current-medical-workforce>.
- NHS England (2014) *The Better Care Fund: Population Segmentation, Risk Stratification and Information Governance*.
- NHS England (2015) *Transforming Primary Care in London: A Strategic Commissioning Framework*.
- NHS England (2015) *Using case finding and risk stratification: A key service component for personalise care and support planning*.
- NHS England (2016) *General Practice Forward View*.
- NHS England (2016) *Releasing time for care: 10 High Impact Actions for General Practice*.
- NHS England (2017) *Sustainability and resilience data*.
- NHS England (2017) *Involving people in their own health and care: statutory guidance for clinical commissioning groups and NHS England*.

- NHS England (2018) *Refreshing NHS plans for 2018/19*.
- Perlo, J. et al. (2017) 'IHI Framework for Improving Joy in the Workplace', *IHI White Paper*.
- Pettigrew, L.M. et al (2018) 'The impact of new forms of large-scale general practice provider collaborations on England's NHS: a systematic review', *British Medical Journal*. Available at: <https://doi.org/10.3399/bjgp18X694997>.
- Reeve, J & Byng, R (2017) 'Realising the full potential of primary care: uniting the 'two faces' of generalism', *British Journal of General Practice*, 67 (660).
- Rosen R (2018), *Divided we fall: getting the best out of general practice*. Research report, Nuffield Trust.
- Royal College of General Practitioners (2015) *Quality Improvement for General Practice: a guide for GPs and the whole practice team*.
- Sansom, A. (2018) 'Why do GPs leave direct patient care and what might help retain them? A qualitative study of GPs in South West England'. *BMJ Open* 8(1).
- Starfield B et al. (2005) 'Contribution of primary care to health systems and health', *The Milbank Quarterly*, 83(3).
- The Institute for Employment Studies, *Senior management reward in the public sector: are Remuneration Committees the answer?*
- The King's Fund (2011) *Quality improvement in general practice*.
- The King's Fund (2013) *The quest for integrated health and social care: A case study in Canterbury, New Zealand*.
- The King's Fund (2016) *Understanding pressures in general practice*.
- The King's Fund (2016) *The digital patient: transforming primary care?*
- The King's Fund (2017) *Accountable care organisations (ACOs) explained*.
- The NHS Information Centre (2009) *Trends in Consultation Rates in General Practice – 1995-2009*.
- The National Advisory Group on Health Information Technology in England (2016) *Making IT Work: Harnessing the Power of Health Information Technology to Improve Care in England*.
- The Nuffield Trust (2016) *Is bigger better? Lessons for large-scale general practice*.
- The Nuffield Trust (2016) *Large-scale general practice: what can we learn from the literature?*
- The Nuffield Trust (2018) *Divided we fall: Getting the best out of general practice*.
- Wiering et al. (2017) 'Patient involvement in the development of patient-reported outcome measures: a scoping review', *Health Expectations*, 20(1).
- Zielinski, A. et al (2009) 'Validation of ACG Case-mix for equitable resource allocation in Swedish primary health care,' *BMC Public Health*, 9.

Additional Data Sources

- NHS Digital, General and Personal Medical Services Statistics.
- NHS Digital, *Quality and Outcomes Framework Data*.
- Health Education England (2017) *General Practice Forward View (GPFV) Primary Care Nursing Workforce Analyses*.
- Health Education England (2017) *General Practice Forward View (GPFV) Workforce Reporting Tool*.
- Health Education England (2017) *Trainee GP Careers Survey*.

- INTREPID workforce reporting.
- NHS England (2017) *CQC GP Ratings Report*.
- NHS England (2017) *GP Patient Survey*.
- NHS England (2017) *GPFV Workforce Reporting Tool*.
- NHS England (2017) *STP GP Workforce Demand & Supply Tool*.
- The Commonwealth Fund (2015) *International Survey of Primary Care Physicians in 10 Nations*.
- The Nuffield Trust (2017) *Collaboration in general practice: Surveys of GP practice and clinical commissioning groups*.
- The Office for National Statistics (2016) *Population estimates for England*.

Case Studies

- All Together Better Sunderland (2017) *All Together Better Sunderland: A Vanguard Multi-Speciality Community Provider; The Importance of Being ODD*. Available at: <http://www.necsu.nhs.uk/wp-content/uploads/2017/11/Workshop-6-ODD.pdf>
- Central London Healthcare. Available at: <https://www.centrallondonhealthcare.co.uk>
- City and Hackney GP confederation. Available at: www.cityandhackneygpconfederation.org.uk
- Creaser, J. *Central London Healthcare CIC*. Interviewed by: Erne, F. (15 December 2017).
- Fleetwood Community Care. *The Fleetwood Story*. Supplemented by information in presentation at the NHS England Transformation Champions event, 22nd November 2017.
- Healthy London Partnership (2017) *NHS Accelerator Support Pack 1, Module 1: Understanding New Care Models and Workforce Implications, Appendix 1: Case Studies*. Available at: <https://www.healthylondon.org/wp-content/uploads/2017/11/Case-studies-Understanding-new-care-models.pdf>
- NHS England. *General Practice Case Studies: Building capability for quality improvement across a GP federation* [available at: <https://www.england.nhs.uk/gp/case-studies/building-capability-for-quality-improvement-across-a-gp-federation/>]
- NHS England. *General Practice Case Studies: New Models of Care – the Symphony Programme* [available at: <https://www.england.nhs.uk/gp/case-studies/the-symphony-programme/>]
- Modality Partnership. *About Us*. Available at: <https://modalitypartnership.nhs.uk/about-us>
- Primary Care Home *The Thanet Way*. Available at: <https://www.hfma.org.uk/docs/default-source/our-networks/healthcare-costing-for-value-institute/institute-event-outputs/thanet-pch-06-07-17.pdf?sfvrsn=2>
- Smith, N. *Improving Health*. Interviewed by: Igra, A. (30 November 2017).
- Smith, R. (2017) 'Where general practice is flourishing', *British Medical Journal Opinion*.
- Teasdale, T. *Sunderland GP Alliance*. Interviewed by Igra, A. (23 November 2017).
- The Nuffield Trust (2016) *Is bigger better? Lessons for large-scale general practice*.
- Tower Hamlets Health and Wellbeing Board (2017) *Life and Health in Tower Hamlets*. Available at: <http://www.sehta.co.uk/wp-content/uploads/2017/06/Dr-Somen-Banerjee-Virginia-Patania.pdf>. Supplemented by content shared by Virginia Patania.

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Footnotes

- 1 NHS England (2015) Transforming Primary Care in London: A Strategic Commissioning Framework
- 2 NHS England (2016) *General Practice Forward View*
- 3 For example: Macinho et al. (2003) 'The Contribution of Primary Care Systems to Health Outcomes within Organisation for Economic Cooperation and Development Countries', *Health Services Research*, 38(3); Starfield B et al. (2005) 'Contribution of primary care to health systems and health', *The Milbank Quarterly*, 83(3).
- 4 Marshall, M. (2015) 'A precious Jewel – The Role of General Practice in the English NHS', *The New England Journal of Medicine*, 372.
- 5 The Office for National Statistics (2016) Population estimates for England.
- 6 NHS Digital, Quality and Outcomes Framework Data; Department of Health (2012) Long Term Conditions Compendium of Information.
- 7 The King's Fund (2016) Understanding pressures in general practice.
- 8 The NHS Information Centre (2009) Trends in Consultation Rates in General Practice – 1995 – 2009.
- 9 https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf
- 10 NHS England (2017) Sustainability and resilience data.
- 11 GP National Recruitment Office (2015) Committee of GP Education Directors.
- 12 British Medical Association (2015) 2014 UK Medical Workforce Briefing.
- 13 Health Education England (2017) Trainee GP Careers Survey.
- 14 <https://www.england.nhs.uk/wp-content/uploads/2018/01/general-practice-nursing-ten-point-plan-v17.pdf>
- 15 <https://www.england.nhs.uk/gp/gpfv/workforce/retaining-the-current-medical-workforce/gp-career-plus/>

- 16 The King's Fund (2016) Understanding pressures in general practice; Sansom, A. (2018) 'Why do GPs leave direct patient care and what might help retain them? A qualitative study of GPs in South West England'. *BMJ Open* 8(1).
- 17 NHS England (2017) CQC GP Ratings Report.
- 18 NHS England (2018) Refreshing NHS plans for 2018/19.
- 19 The King's Fund (2017) Accountable care organisations (ACOs) explained.
- 20 The Nuffield Trust (2016) Is bigger better? Lessons for large-scale general practice; The Nuffield Trust (2016) Large-scale general practice: what can we learn from the literature?; The King's Fund (2016).
- 21 Reeve, J & Byng, R (2017) 'Realising the full potential of primary care: uniting the 'two faces' of generalism', *British Journal of General Practice*, 67 (660).
- 22 <https://www.england.nhs.uk/gp/gpfv/redesign/gpdp/>
- 23 McWilliams. J.M. et al (2016) 'Early Performance of Accountable Care Organizations in Medicare', *The New England Journal of Medicine*, 374; The King's Fund (2013) the quest for integrated health and social care: A case study in Canterbury, New Zealand.
- 24 The Nuffield Trust (2016) Is bigger better? Lessons for large-scale general practice; The Nuffield Trust (2016) Large-scale general practice: what can we learn from the literature?; The King's Fund (2016).
- 25 Marshall, M. & Gray, D.P. (2016) 'General practice is making a leap in the dark', *British Medical Journal*, 355; Marshall, M. (2015) 'A precious Jewel – The Role of General Practice in the English NHS', *The New England Journal of Medicine*, 372; Pettigrew, L.M. et al (2018) 'The impact of new forms of large-scale general practice provider collaborations on England's NHS: a systematic review', *British Medical Journal*. Available at: <https://doi.org/10.3399/bjgp18X694997>.
- 26 NHS England (2015) Using case finding and risk stratification: A key service component for personalise care and support planning.
- 27 NHS England (2014) The Better Care Fund: Population Segmentation, Risk Stratification and Information Governance.
- 28 The Nuffield Trust (2018) Divided we fall.
- 29 The Nuffield Trust (2018) Divided we fall.
- 30 Gillam, S. (2014) 'Evidence-based healthcare and quality improvement,' *Quality in Primary Care*, 22.
- 31 Zielinski, A. et al (2009) 'Validation of ACG Case-mix for equitable resource allocation in Swedish primary health care,' *BMC Public Health*, 9.
- 32 See, for example, Frome Medical Practice in Somerset: <http://bit.ly/2p56qBr>
- 33 The King's Fund (2011) Quality improvement in general practice.
- 34 Institute for Healthcare Improvement, IHI Framework for Improving Joy in the workplace, 2017 <http://www.ihl.org/Topics/Joy-In-Work/Pages/default.aspx>
- 35 Perlo, J. et al. (2017) 'IHI Framework for Improving Joy in the Workplace', IHI White Papers.
- 36 Wiering et al. (2017) 'Patient involvement in the development of patient-reported outcome measures: a scoping review', *Health Expectations*, 20(1).
- 37 NHS England (2017) Involving people in their own health and care: statutory guidance for clinical commissioning groups and NHS England.
- 38 <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>
- 39 Transforming Primary Care Healthy London Partnership online resources at <https://www.healthylondon.org/our-work/primary-care/>

