NHS England

LONDON CCGs

Strategic Commissioning Framework for Primary Care Transformation in London

Better Health for London: A New Deal for General Practice

Draft for engagement

November 2014

Acknowledgement

This *Strategic Commissioning Framework* is presented by the Transformation Board and Primary Care Clinical Board, and has been developed by clinicians, commissioners, patients and other partners across London.

Due to the number of individuals involved, it is not possible to name everyone individually. However without these people, production of this *Framework* would not be possible.

In particular, we would like to extend our appreciation to the:

- Clinical Expert Panels
- Primary Care Transformation Board
- Primary Care Patient Board
- Primary Care Clinical Board
- Primary Care Delivery Group
- Primary Care Transformation Team

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Introduction

Dr Clare Gerada: Clinical Chair for London's Primary Care Transformation Programme

Dr Clare Gerada is a London based GP. She is the immediate past Chair of Council of the Royal College of General Practitioners – the first female Chair for over half a century – and was previously Chair of the Ethics Committee. She established the RCGP's groundbreaking Substance Misuse Unit and also led on the strategic and logistical delivery of the RCGP Annual National Conference. She has held a number of local and national leadership positions including Senior Medical Adviser to the Department of Health. She is Medical Director of the largest practitioner health programme in the country and she has published a number of academic papers, articles, books and chapters. Prior to general practice, she worked in psychiatry at the Maudsley Hospital in South London, specialising in substance misuse. She was awarded an MBE for services to medicine and substance misuse and was presented with the National Order of Merit award in Malta for distinguishing herself in the field of health.

The NHS is unique because of its system of general practice – a medical home for the patient – underpinned by a life-long medical record. General practice is the first point of access for many people, where a high proportion of care is delivered close to people's homes with the potential for a continuous relationship with the same clinical team from birth through to the end of life.

General practice has served patients, the public and the NHS well for over 60 years. It has delivered accessible, high quality, value for money care. However our patients are changing, both in the complexity of their conditions and in their expectations. This means that if the NHS is going to continue to provide the excellent standard of care to which we all aspire, we will have to be more innovative.

Tweaking at the edges is not an option. London needs solutions that will sustain primary care for the next 60 years. We must maintain the integrity and core purpose of general practice (to provide holistic, patient-centred continuous care to patients and their families). But at the same time we must address the need to improve coordination of care, access to services and take a more proactive approach to our patients' health and wellbeing.

I believe that this *Strategic Commissioning Framework for Primary Care Transformation* in London represents a platform where clinicians, commissioners, and other stakeholders can build on the work done to date and find solutions to the challenges for general practice; supporting the healthcare community to make care better for all Londoners.

With the scale of support which has been seen for this developing work, and the opportunity of additional focus on primary care provided by the *NHS Five Year Forward View* and *Better Health for London* from the London Health Commission, now is the time to make these changes together.

Dr Clare Gerada, Chair of the Primary Care Clinical Board

Foreword

We are pleased to present this developing *Strategic Commissioning Framework for Primary Care Transformation* (the *Strategic Commissioning Framework* or *Framework*) on behalf of the London Primary Care Clinical Board[1] and Transformation Board[2]. This document provides both a new vision for general practice, and an overview of the considerations required to achieve it. From December 2014 to April 2015, London's clinical commissioning groups (CCGs) together with NHS England (London) and working with other partners (such as the Care Quality Commission (CQC), Health Education England (HEE), Academic Health Science Networks (AHSN)) will engage locally to fully understand the implications of this *Framework*, and how it fits into the context of wider local plans. During this period, further work will also be undertaken to understand the implications of implementation, and this document will be updated to reflect this.

Transforming primary care is a concept that is rapidly gaining momentum as a key priority area in the NHS – both nationally and across London. Two important pieces of work have recently been published which set the platform for building on this energy and achieving the ambitions that are developing.

1. *NHS Five Year Forward View*[3]

In October 2014, Simon Stevens published the *NHS Five Year Forward View*, developed by NHS England, Public Health England (PHE), Monitor, HEE, CQC and the NHS Trust Development Authority (TDA). This sets out 'a new deal for general practice' recognising the central importance of the registered list and everyone having access to a family doctor. It also confirms the need for greater investment.

2. *Better Health for London*, The London Health Commission[4]

In October 2014, the London Health Commission published *Better Health for London*. The *Framework* closely aligns to, and is supportive of this report, which contained a number of recommendations specific to general practice.

1 See Appendix 1: Governance board membership
2 See Appendix 1: Governance board membership
3 http://www.england.nhs.uk/ourwork/futurenhs/
4 http://www.londonhealthcommission.org.uk/better-health-for-london/

This developing *Framework* provides a response from commissioners across London to these important pieces of work.

Since April 2014, around 1,500 key stakeholders have been engaged as part of a 'pre-engagement' phase. These activities have strengthened our ambitions for describing a new patient offer for all of London.

Throughout the co-development of this *Framework* it has been excellent to see the level of clinical leadership, public and patient contribution and significant commitment from commissioners across London, together with their partners. We have received support from all 32 CCGs across London to enter into the next stages of engagement, which will take place at a local level with GPs, the public and other key stakeholders. There has also been positive support from the London-wide Local Medical Committee, the Clinical Challenge Panel (which was set up for independent clinicians to review the specification (also known as the patient offer) on behalf of the London Clinical Senate) and the CQC, for the aspirations we wish to achieve.

The *NHS Five Year Forward View* and *Better Health for London* provide a new impetus to seize the moment and bring about sustainable transformation of the bedrock of healthcare in London. There are no easy solutions to the challenges we all face in the transformation of primary care but there is a strong belief that by working together and building on the focus and commitment to date, success can be achieved and we can develop services that Londoners deserve.

Dr Marc Rowland

Co-Chair of the Primary Care Transformation Board

Dr Anne Rainsberry

Co-Chair of the Primary Care Transformation Board

Dr Clare Gerada

Chair of the Primary Care Clinical Board

Context

This document, developed by commissioners across London, is both a new vision, and in effect a response to the *Five Year Forward View* and London Health Commission publications. It details a specification for Londoners in the future, and begins to articulate how these changes fit within the wider out-of-hospital context. The document also includes considerations for how this specification might be delivered, as well as sections on current estimations of cost, changes required to primary care workforce, contracts, and other key enablers.

Background: responding to *A Call to Action*

In November 2013, NHS England (London) published *Transforming Primary Care in London: General Practice A Call to Action*[5], which examines the challenges facing general practice in London today. It has been used by NHS England (London) and London organisations to obtain a consensus view on the need for changes to the way general practice is provided.

A ***Call to Action*** showed that London contains world-class examples of general practice but that urgent action is needed to tackle significant variations in quality. The report identified challenges including an increasing workload; an expanding population; people living longer and with increased care needs; all of which have occured whilst investment in general practice has fallen significantly as a proportion of total health spend. The pending workforce crisis was also highlighted, as a large swathe of GPs in the capital are near retirement and practice nurses are becoming increasingly difficult to recruit. The report was a call for bold action to develop solutions that will better meet the future needs of Londoners and provide a sustainable model of general practice for the next 50 years.

During 2014 clinicians, patients and commissioners from across the capital have been developing an ambitious strategy for service improvement in three key areas – proactive care, accessible care, and coordinated care.

In March 2014, NHS England (London) released a pre-engagement draft document entitled *The London GP Development Standards: A Framework for Service Improvement*. The document was developed by a clinical board and three expert panels working in partnership with CCG leads and patients.

Over the summer London CCGs and NHS England (London) worked in partnership with others to ensure that the service changes described in the initial draft would meet the needs of Londoners, address current and future challenges and develop a strong mandate for the overall direction of general practice development across the capital. In addition, there has been further development on answering 'how' this specification could be delivered. It is clear that changes are needed to support primary care in delivering a new vision.

The initial view on the enabling work required is included in this document. This includes, for example, the fact that changes to the numbers, skills and roles in the workforce are needed. There is also reference to the importance of suitable estates, and the fact that this change will need to be underpinned by investment.

Over the summer, two new important pieces of work have been published – from the NHS England Chief Executive, and the result of a piece of work commissioned by the Mayor of London.

These publications provide added impetus for the ideas developed in the *Framework* and will provide a platform for building on these proposals, ensuring that London gets the investment required in order to drive these commitments forward.

5 http://www.england.nhs.uk/london/ldn-call-to-action/gp-cta/

The *NHS Five Year Forward View*

In October 2014 Simon Stevens, the Chief Executive of NHS England, published the *NHS Five Year Forward View* developed in collaboration with PHE, Monitor, HEE, CQC and TDA. This also referred to funding in general practice – mentioning both "Stabilis[ation]" and "new funding". The commitments included are listed below.

In addition to emerging GP federations, networks and super partnerships across London the *NHS Five Year Forward View* identifies two further models which may be applied.

These have been described as Multispecialty Community Providers (MCPs) or Primary and Acute Care Systems (PACs).

A new deal for general practice

Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.

Give GP-led clinical commissioning groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.

Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.

Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.

Expand funding to upgrade primary care infrastructure and scope of services.

Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.

Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.

The London Health Commission

Also in October 2014, the London Health Commission launched its report *Better Health for London*. This report makes several recommendations for general practice, and the *Framework* aligns very well with these recommendations:

- increase the proportion of NHS spending on primary and community services.
- invest £1billion in developing GP premises
- set ambitious service and quality standards for general practice.
- promote and support general practices to work in networks.
- allow patients to access services from other practices in the same network.
- allow existing or new providers to set up services in areas of persistent poor provision.

Additionally, the vision of this *Framework* supports several of the broader recommendations, such as:

- engage with Londoners on their health and care. Share as much information as possible and involve people in the future of services.
- commission holistic services with clearly defined outcomes developed by listening to people who use services.

A Strategic Commissioning Framework for Primary Care Transformation in London

This document builds on work already undertaken and aims to support further development of local plans and other responses that London is making to the challenges currently faced in general practice as well as the two key publications referenced above. The *Framework* aims to complement and enhance other service requirements and standards, such as those published by the Care Quality Commission (CQC) in the *Provider Handbook for Primary Medical Services* (October 2014). Going forward, London's primary care transformation programme and the CQC will collaborate closely to ensure that there is true alignment between the vision set out in this *Framework* and standards articulated by the CQC. This also aligns with the National Institute for Health and Care Excellence (NICE) in their regularly updated guidelines. In summary, the specification outlines a new service design, but this must also be delivered to, for example, the level of safety and quality described by these other standards.

Executive summary

The *Strategic Commissioning Framework* is a developing document which aims to support primary care transformation across the capital. A high-level overview of the content of the *Framework* is included below, however more detail may be found in the full sections of the document.

Future of general practice

General practices in London are under strain and are bearing the brunt of pressures to meet increasing and changing health needs.

This developing *Framework* sets out an ambitious and attractive vision of general practice that operates without borders, and in partnership with the wider health and care system. A patient and their GP should be at the heart of a multidisciplinary effort to deliver patient-centred coordinated care in general practices which are recognised as centres in each neighbourhood, developing community resilience and supporting Londoners to stay as well and as healthy as they can.

The *Framework* focuses on 'function' not 'form' and sets out a new patient offer for all Londoners that can only be delivered by primary care teams working in new ways and by practices forming larger primary care organisations. These organisations will be aligned to a shared geography in support of a population health model with other health, social, mental health, community and voluntary organisations. How this looks will differ from area to area and will be designed and owned locally. It will require an environment which supports innovation; shares best practices and new technologies; and is an attractive place to work for a variety of healthcare professionals.

The service specification (patient offer)

At the core of the *Framework* is a specification for general practice that sets out the new patient offer. This specification is arranged around the three aspects of care that matter most to patients:

- **Proactive care** – supporting and improving the health and wellbeing of the population, self-care, health literacy, and keeping people healthy
- **Accessible care** – providing a personalised, responsive, timely and accessible service
- **Coordinated care** – providing patient-centred, coordinated care and GP-patient continuity

Some elements of the specification have already been achieved and implemented in some parts of London. General practice will be transformed when all patients in London are able to access the care described in this document and when that care is of a sufficiently consistent high quality.

Local planning

This *Framework* is not intended to be a static document but will form the basis of wider engagement over the coming months in each local area, on the changes that are needed. London CCGs with NHS England (London), will lead this engagement as part of developing local plans. It is anticipated that different areas will deliver this patient offer in different ways, at different paces. In order for local populations to be able to take part in discussions to decide what is best for their local community, it is essential that plans are locally designed based on different starting points.

Co-commissioning

NHS England (London), CCGs and local authorities recognise that the vision in this *Framework* will require significant collaboration across all parts of the commissioning system; co-commissioning will be a key enabler. *The NHS Five Year Forward View* sets out the aim to provide CCGs more control over NHS budgets, with the objective of supporting more investment in primary care, and CCGs across London have expressed an interest in becoming more involved in the commissioning of primary care services.

Co-commissioning will allow for a varying level of increased involvement. The options and considerations are described in detail in *Next Steps Towards Primary Care Co-commissioning*, published in November 2014. Currently the possible arrangements include:

- **allow CCGs greater involvement in commissioning decisions**, including actively participating in discussions about all areas of primary care
- **joint commissioning** model that enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or "committees in common"
- **delegated commissioning** offers an opportunity for CCGs to assume full responsibility for commissioning some aspects of general practice services. The exact models for delegated commissioning will need to be worked up in local areas.

Financial implications

The new patient offer and the changes to, for example, the workforce and estates required to deliver it, cannot be made without significant investment.

Further work is required to understand all of the financial implications of this *Framework*, but high level financial analysis has been completed to estimate the cost of providing the new patient offer.

The required additional investment is currently estimated to be in the region of **£310-810 million per year**, which represents a **2% – 5.36% shift in the overall health care budget**. This will need to be phased, and can be achieved, for example, over five years with an average shift of 0.4 – 1.07% per year.

Contracting approach

The specification described here can only be delivered in full by general practice working together at scale and with other parts of the health and care system. The *Framework* proposes new funding, not at an individual practice level but delivered through a wider population-based contract. The exact nature of these arrangements will vary by nature of the provider landscape but the principle of at-scale providers increasingly sharing pooled incentives with shared responsibility and risk for delivery will be a key marker against which investment will be made. Local approaches will be determined through co-commissioning arrangements and in discussions within each CCG area.

It is likely that the contracting vehicle will need to 'wrap around' existing national contracts (unless constituent practices are opting for a full merger/ super partnerships and therefore may voluntarily relinquish their current contract). It may also need to be flexible to wider collaborations and partnerships with other types of providers, for example where the strategic intent locally is for accountable care organisations that can hold capitated budgets and shared risk for whole populations. Although current legislation does not allow it, co-commissioners may also want to consider a future in which the accountability for constituent General Medical Services, Personal Medical Services and Alternative Provider Medical Services might sit with the lead provider/at-scale primary care organisation.

The full contracting approach section outlines example contractual forms and potential initial changes. Many areas already have a strong ambition towards bringing general practice and community services together over the next two years. It is however anticipated that most areas will be looking to contract networks/ federations of general practice as a starting point.

Workforce

A workforce of appropriate number, skills and roles is imperative for transforming care. Bolstering the primary care workforce has been identified as a core objective of Health Education England (HEE) and its Local Education and Training Boards (LETBs).

This document describes a future of more person-centred systems of care and less division between primary, secondary, community, voluntary and social care organisations .Although the way that roles and teams fit together will evolve in local areas, it is anticipated that the roles required will be as shown in the table below.

Within each practice	Aligned to each practice but working across a wider geography / at-scale primary care organisations
GPs, practice nurses, GP nurse practitioners / nurse prescribers, volunteers, receptionists, managers, health care assistants and may also include physician associates	Prescribing advisors, GPs with a special interest (GPSIs), care coordinators, wellbeing teams, and 'super practice managers/directors' with sufficient skills to lead the development and operational management of at scale primary care organisations. **As part of, for example, a wider Multispeciality Community Provider (MCP):** Secondary care specialists, social care, mental health and community services teams, community pharmacy

The full workforce section outlines these in more detail, as well as some of the programmes being taken forward to support workforce development, however it also highlights that there is a great opportunity for partners associated with workforce development in London to collaborate. Ensuring the workforce is appropriate to deliver the specification will be crucial in improving outcomes across the capital.

Technology

This *Framework* does not aim to provide a technology blueprint for London, however it recognises that technology is a key enabler for delivering the specification. This is complemented by the recent publication by The National Information Board, *Personalised Health and Care 2020* which describes the need to better use technology to improve health, transform quality and reduce the cost of health and care services. Technology usage should support organisations working together – allowing less focus on co-location, and a smoother patient journey through the healthcare system. People should also be empowered with information about their care in order to participate in their care planning, set health goals, and better manage their health.

The technology section of this *Framework* identifies ways in which technology can support:

- **Proactive care**, for example through online wellbeing assessments, health improvement resources or support communities
- **Better access**, for example with online service portals, telephone triage and email appointment systems
- **Care coordination**, for example with interoperable systems for information exchange across a multidisciplinary team and with patients through integrated patient-held records
- **Modernising care**, for example, remote monitoring and diagnostic devices.

Estates

The recent London Health Commission (LHC) report, *Better Health for London* presented evidence that the quality of general practice estate in London is highly variable. This results in a poor patient experience and poor working conditions in some London practices and lost opportunities to improve health and healthcare. The specification in this *Framework* does not rely on estate changes, but there are a number of practices in London for which premises solutions are now urgently needed. The estates section of this document outlines some of the findings of the LHC report, and its recommendation for approximately £1 billion to be invested in general practice estates over the next five years.

Provider development

None of the changes set out in this *Framework* will be delivered unless there is significant investment in organisational development and capability building. The real change cannot be delivered by commissioning levers alone but will require providers to grab the development challenge and find successful ways to adapt it in their local area. The provider development section outlines some requirements for example, leadership for change, strategic planning, business development, legal guidance. It recommends a

forum for London's emerging providers and system leaders to share innovation and learning. It identifies the need for a strategic and comprehensive approach to building system capacity and capability for delivering change; an approach that is mapped to a development journey for emerging organisations and which can respond to their evolving needs over time.

Monitoring and evaluation

The purpose of this *Framework* is to improve outcomes, patient experience and working lives. Monitoring and evaluation will be designed to support practice teams working together on quality improvement at a population level. This *Framework* outlines the principles that monitoring and evaluation should build on systems already in place, and also focus on supporting provider development (through best practice sharing and peer learning), as well as commissioner assurance.

Next steps

This developing ***Strategic Commissioning Framework for Primary Care Transformation*** is being shared more widely in each local area of London as part of continuing engagement on the changes needed and to ensure each area can develop robust delivery plans in advance of implementation from April 2015.

Equality impact assessment

Commissioners (CCGs and NHS England) of general practice are required to give specific consideration to addressing health inequalities as stated in the Health and Social Care Act 2012 and requirements relating to people with protected characteristics as outlined in the Equality Act 2010. An equalities impact assessment has been completed to accompany this framework at its current stage, and is available as a separate supplement.

The equalities impact assessment concludes that the *Framework* provides a structure within which a consistent general practice patient offer can be delivered to all Londoners. The delivery and implementation of the specification outlined in the *Framework* has the potential to address health inequalities in London as commissioners work with general practices to secure services that are responsive to different needs and appropriate to all.

The *Framework* particularly notes the requirement for commissioners to give due regard to the reduction of health inequalities and to the statutory requirements of the Equality Act 2010 to consider the impact for people with protected characteristics. It is therefore recommended that local equality impact assessments are conducted to reflect local plans when these are sufficiently advanced. The proactive care specification also outlines the need to give consideration to additional vulnerable groups that have been identified such as travellers, sex workers, people recently released from custody, homeless people, vulnerable migrants or people with learning disabilities.

Future general practice

Patients tell us that they want better continuity of care ("my doctor, my nurse"). They also want better access to services when they need them, to contact a health professional when they need to; to have care closer to home, to stay healthier and more independent for longer, have fewer trips to hospital and more support to enable them to manage their own health more effectively. This latter point is particularly important. As demand for health services grow, patients will need a good understanding of the services and resources available to help them to stay well and look after themselves through minor illness. General practices will be recognised as centres within each neighbourhood that are supporting Londoners to stay as healthy and well as they can be. Local communities, voluntary groups, faith organisations, patients and volunteers are part of a network of support for wellbeing that can work both inside and outside general practice, supporting general practice to connect people to wider resources available in the community and extending its scope to deliver proactive health and wellbeing resources. Partnership working with these groups and with local authorities and health and wellbeing boards will be essential.

At the moment (and for a number of reasons) general practice is not able to deliver this level of care consistently across London. Probably the main reason for this is that funding for general practice has been declining in real terms over the last decade, now receiving just over 7% of the NHS England budget, compared with over 10% a decade ago. Yet primary care continues to deliver the majority of care to patients in the NHS. Increasing funding alone will not solve the problem, general practice still needs to change. Our patients' needs are different now, and keep changing. The systems that are in place to care for them have to evolve to keep pace with this change.

If London is going to meet the challenges we all face there will need to be additional resource, but money is not the only answer. We will also need to achieve significant economies of scale and be more innovative in the way we deliver primary care. There is no 'one size fits all' solution. One of the great strengths of general practice is its variety – reflecting the great diversity of the population we serve in London. How we achieve excellence will be largely dependent on each local area, supported by their providers, their commissioners and their patients. But there are ten common building blocks that we need to address to reach the desired state, which are set out below.

1. The **way we deliver care**: inside and outside of the practice; how we best use skill-mix; how we work in and out of hours; how we work with others – not confined by our individual consulting rooms, practices and organisations; and how we work best with the primary, secondary, community and voluntary and charity sector services.

2. The **way we organise ourselves**. This applies to normal working hours and out of hours; how we deliver unscheduled care and how we organise our physical environment – the buildings we work from. Individual practices may want to form part of something bigger. Across London, practices are already starting to work together.

3. **How we work together** to deliver personalised care for certain groups of patients across a wider population for example:

   a. finding creative ways of connecting with the vulnerable, isolated and socially marginalized who are at highest risk of becoming ill and least likely to seek out support to stay well.

b. developing services across groups of practices where the complexity of care and range of professionals involved is such that it requires a central focus for higher intensity care coordination and frequent specialist input (e.g. complex frail elderly, people living with learning disabilities, people in care homes and prisons).

c. creating alternative access points for high volume, low complexity care services for minor ailments in order to free-up additional capacity in each GP surgery for the patients who need us most.

d. developing expert generalists and arrangements for working with secondary care practitioners such that they become a resource for groups of practices, enhancing the level of care and support offered and providing additional training and development activities for GPs locally.

4. How we **meet the different access needs** by allowing patients to choose from a range of service options (length of appointment, rapid access, booking ahead, GP of choice); choose the way they access general practice (in person, online, by phone, email or video conference); and how we meet any personal accessibility requirements (e.g. physical or sensory disability, language, chaperone/advocacy).

5. **How we use data**. Not simply to identify different patient needs but also to inform us; to provide intelligence that will improve the quality of clinical care; to provide early warning for system failure; to enable us to see patients on different sites; and to help us deliver care in different ways, for example through remote care (e-health and telecare).

6. How we improve ourselves and become a **learning environment**.

7. How we **disseminate innovation**.

8. How we develop a **vibrant attractive workplace** with career prospects for clinical and non-clinical staff (recruitment and retention).

9. How general practice can support patients, families and communities to **stay well and cope with minor illness**.

10. How we create an organisation that **empowers health and wellbeing in our population**.

What will Londoners notice?

People living in London will be able to have the right length of consultation for them provided by the most appropriate health professional, in better premises, using up-to-date technology. There will be more responsive care, which will be delivered in a range of ways, for example online, email and telephone rather than just face-to-face consultations. People will only need to make one call or click to book their appointment and won't be told to call back the next day. There will be no need to take a day off work to see a GP as there will be the choice of early or late appointments or telephone consultations. Those who need to will be able to book appointments up to several weeks ahead at a time to suit them. Care will be centred around each person so they won't need to have multiple appointments about different long term conditions; they will be arranged around them.

Patients will experience better management and care: of long-term diseases; when they are frail and elderly; and at the end of life. Their general

practices will be encouraged to organise themselves so that all patients have a named GP accountable for their care. The need for continuity of care should be defined by the patient and has the potential to be regarded as important irrespective of age. This care might be delegated to other GPs or healthcare professionals in the practice team as appropriate. Continuity of the personal care relationship is especially important for those patients with complex and chronic health care needs. The future practice will provide improved continuity of care for these patients and for those that require more coordinated care.

Multidisciplinary teams will work together to deliver care in- and out-of-hours, and in- and out-of-hospital.

There will be safer, less (unwarranted) variability and better quality care delivered closer to home by highly trained GPs, nurses and other professionals. Patients will not necessarily see "their" healthcare professional for all care at "their practice". They may choose to access an extended range of services at convenient opening times either in their own practices or in those practices linked to it. There will be no gaps for patients who are unregistered to fall through.

Models of care

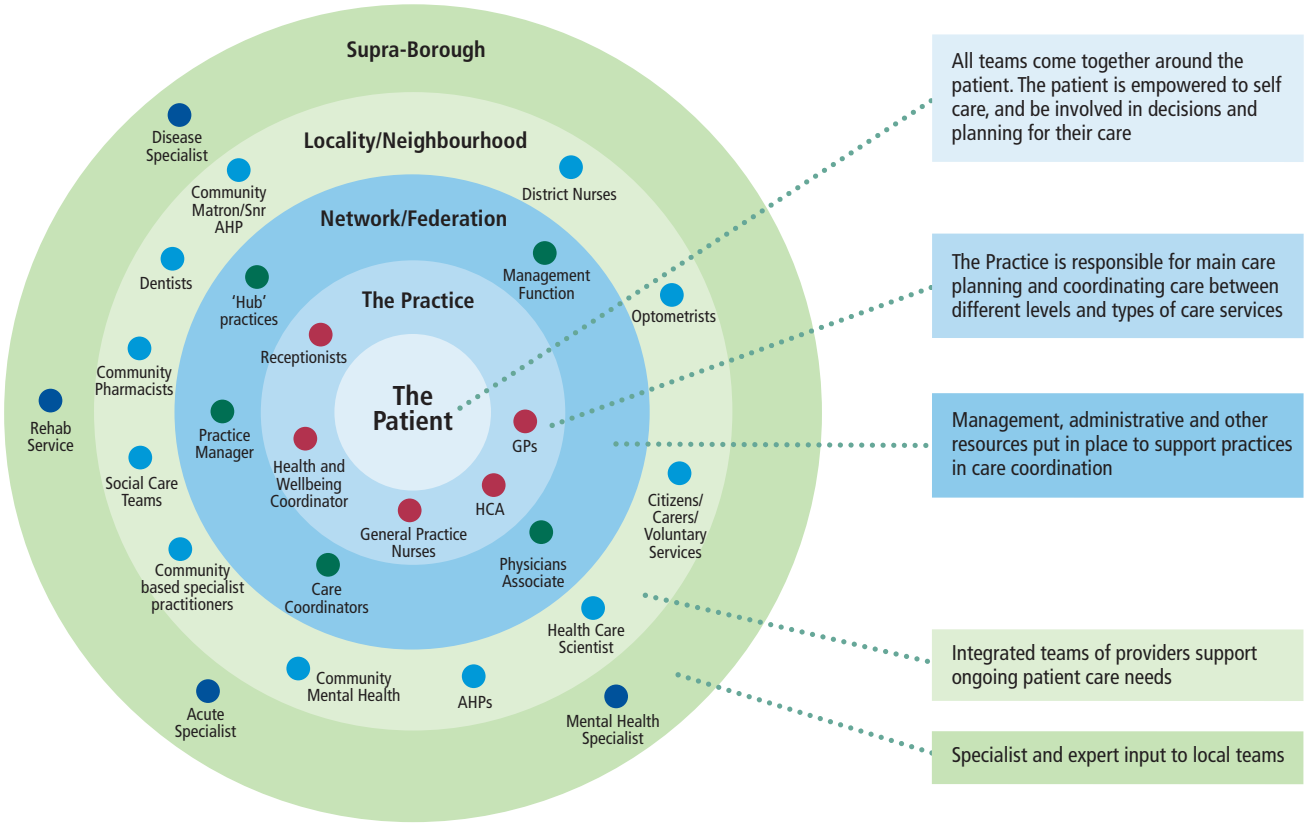
The health system needs to be primary care orientated so that it is focused on improving population health and wellbeing. In order to ensure that patients receive the maximum benefit from this, general practice needs to have a collaborative approach involving, for example: voluntary and community organisations; community health services; community pharmacies; mental health services; social care and other partners. Some elements of the specification can only be delivered by working with patients and other partners to deliver high quality care.

It is likely that general practice will need to work together to form larger primary care organisations if it is to improve sufficiently. This will give groups of practices the opportunity to focus on population health and provide extended opening hours whilst protecting the offer of local, personal continuity of care. What begins as a conversation about greater collaboration, will move towards formation of practice networks that increase joint working and will then go further towards shared teams and infrastructure requiring a single primary care organisation. The *Five Year Forward View* describes this as the development of a Multispecialty Community Provider (MCP) which could offer increased efficiencies through wider collaboration and integration. These organisations are likely to align to a single population catchment or locality with other health, social, community and voluntary organisations. The shared organisation will enable them to: provide a wider range of services including diagnostics; share infrastructure, expertise and specialists e.g. for mental health or children; create career paths; train and learn together.

Shared systems for peer review, developmental and supportive learning should improve patient safety, clinical quality and outcomes for all practices involved. The organisations will contain teams that support care coordination and will have arrangements in place for closer partnership with a wider range of practitioners and specialists beyond general practice.

How this all looks will vary from area to area – local communities and patients will need to be

Illustrative model of care



involved in developing and agreeing these changes. In some boroughs there may be a review of the number and type of practices and other buildings. In areas of poor provision, existing and new providers may emerge and the opportunity described in the *NHS Five Year Forward View*, for acute, mental health and community services to also provide general practices services, may be taken.

The needs of an area will be met perhaps with fewer, smaller practices and some larger health and education hubs with diagnostics, day beds and leisure and exercise facilities for patients and the public. GPs will work together in a single system continuing to deliver first contact care but also providing continuity of care to those that wish to see the doctor of their choice. GPs will be linked together via a single electronic record with other practitioners such as elderly care doctors, paediatricians, palliative care and district nurses helping to deliver 24/7 care to those who most need it.

Patients will benefit through receiving care from a greater range of generalists, more specialist care and improved access to services in a better environment.

We need to work together to achieve this ambitious specification to ensure we can deliver the future requirements of our population.

Dr Clare Gerada
Chair of the Primary Care Clinical Board

The service specification

At the heart of this *Strategic Commissioning Framework for Primary Care Transformation* is a new service specification for general practice. This supports the need to define and commission a more consistent service for all Londoners, e.g. adults, children, young people, carers and families; reducing variations in access, patient experience and clinical outcomes. The specification provides a single definition of high quality care.

Three characteristics are needed for general practice to thrive and deliver the care that patients need and value.

1. **Proactive care** – supporting and improving the health and wellbeing of the population, self-care, health literacy, and keeping people healthy
2. **Accessible care** – providing a personalised, responsive, timely and accessible service
3. **Coordinated care** – providing patient-centred, coordinated care and GP-patient continuity.

The *Framework* covers these three aspects of care and contains a specification of the future patient offer covering 17 aspects of care. The document is informed by the London GP Innovation Challenge (2012) and Prime Minister's Challenge Fund (2013). Some elements have already been achieved and implemented in parts of London. Whilst the *Framework* describes a common patient offer, it is sufficiently flexible and adaptable for groups of practices to design how the service specification might be delivered consistently for all patients. Delivering the specification described in this document will require local planning and customisation in order to ensure that these are provided in the best possible way for the whole population, for example particular differences needed to deliver this for children as well as adults. London's general practice will be transformed when all patients are able to fully access the care described in this document and when it is of a sufficiently consistent high quality.

This *Framework* is about what is delivered and how it is delivered. From the moment a patient begins their interaction with general practice, they should feel they are treated with dignity and compassion. The Care Quality Commission assessment and inspection of general practices places great emphasis on whether patients are experiencing caring and empathetic services.

Evidence supplement

A supplement to this document is available on request (england.londonprimarycare transformation@nhs.net) and provides a compendium of the supporting evidence. This includes:

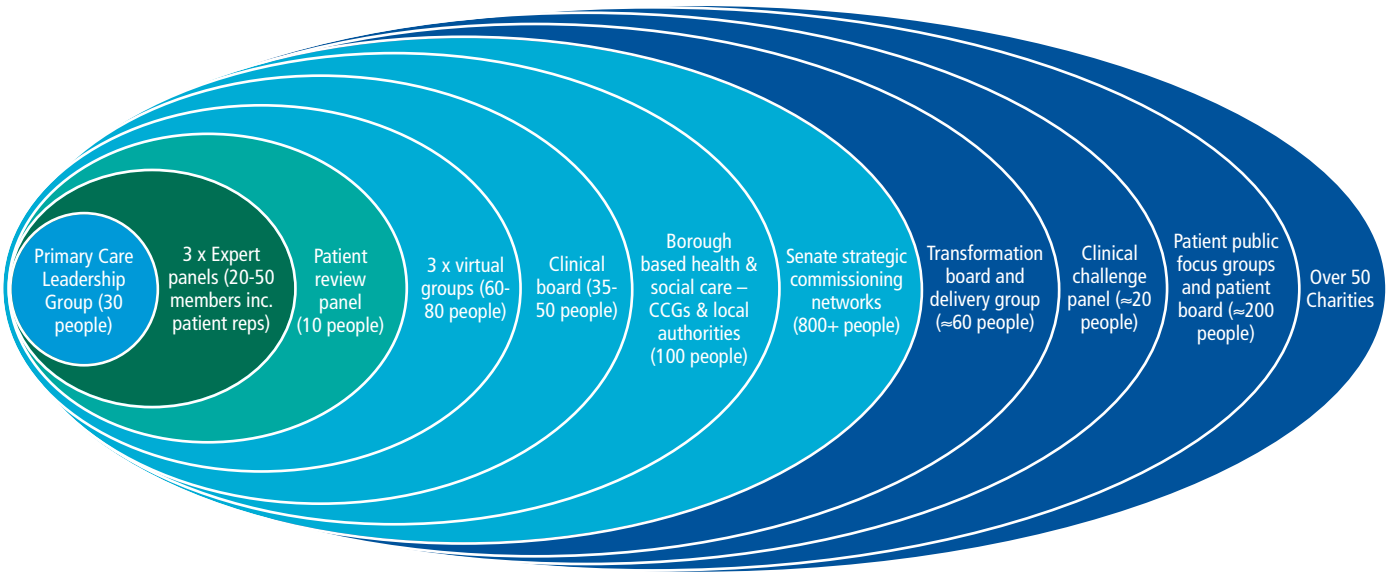
- detailed insight obtained through the pre-engagement activities that have taken place over the summer months and a record of the changes made as a result
- research and evidence gathered from analysis and piloting activities.

Service specification development process

NHS England (London) has worked with London's clinical commissioning groups to lead an open, transparent and collaborative conversation with key stakeholders to identify the primary care services which patients value, what they need to remain healthy and the services that will positively impact on the wider health economy. The service specification has been defined by patient voices, clinical leaders, current best practice, innovation and best evidence.

Around 1,500 people have contributed to drafting, testing and challenging the future service requirements to ensure that they are as robust, ambitious and innovative as possible.

Number of people and groups engaged to develop the service specification



1. Proactive care specification

Proactive Care Expert Panel Chair: Dr Nav Chana

Dr Nav Chana is a GP and senior partner at the Cricket Green Medical Practice where he has been a GP for 22 years. He was previously the Postgraduate Dean for General Practice and Community Based Education at the London Deanery. He is now Chairman of the National Association of Primary Care (NAPC) where he has established collaborative networks to support primary care innovation. Nav's interests include improving the value of primary care through an enhanced focus on population-based healthcare.

Primary care is at the heart of every community, putting it in a unique position to empower patients to keep safe and well, and to lead healthier lives. This is the essence of proactive care. This includes activities and interventions which contribute to improving health and wellbeing by: increasing self-reliance; building greater capacity for health and health resilience in patients, the people who support their care (for instance friends and families); and through partnership with local communities. By supporting people to live well we avoid unnecessary care interventions, improve quality of life and reduce the overall cost of the system for taxpayers.

Proactive care can reduce health inequalities by providing a targeted response to those who are highly reliant on additional support to stay well. People who are at higher risk of deteriorating health due to social isolation, or a lack of personal capacity e.g. homeless people, 'looked after children' and isolated elderly people require a differential level of support to achieve positive health outcomes. This care might be delivered across a group of practices by a team comprising roles such as care navigators, peer advocates, health coaches, wellbeing support workers and community volunteers. Reducing health inequalities is not just about focusing on illness, but providing a holistic response to social issues like debt, housing, employment and substance misuse to improve health and wellbeing.

Proactive care requires moving assets across multiple agencies and community organisations to re-balance the current focus on illness and a clinical agenda aimed at enabling people to live well.

General practice is well placed to improve population health because:

- it is the most accessed part of the health system
- it holds a registered list for a defined population in an immediate locality
- generalists deliver care to people with a full understanding of their social context.

Delivering the proactive care specification will require practices to co-design new approaches to improving health with individuals, families, other health agencies and local community partners. Londoners will recognise general practice as caring about their wellbeing and providing holistic support to enable them to stay well. But delivering proactive primary care will go beyond general practice and will draw on the whole family of primary care services and professionals including those within the voluntary and third sectors.

The nature of consultations will change, to better combine clinical expertise with patients' aspirations for wellbeing. Patients will notice that they are being asked more frequently about their wellbeing, capacity for improving their own health and their health improvement goals. They may be reminded of signs of early disease such as cancer, or be offered support to manage conditions themselves (e.g. health information, advice and equipment) or social prescribing (e.g. debt advice).

Patients will be offered additional services such as coaching, mentoring and buddying from professionals or peers offering support to help build patient knowledge, skills and confidence for self care.

These types of services are already offered by some London practices. Practices in Lewisham have been piloting a service to support patients reach their care plan targets including regular motivational callers (people who phone patients – helping and encouraging them to meet their health goals), self-management demonstrations and role play; and the Well Centre in Streatham has helped 650 young people with complex needs to manage their conditions better, reducing the need for further referrals.

The service specification covering proactive care identifies opportunities for general practice to take a population based approach to improving health and wellness in partnership with local communities. This creates the required social capacity and resources in communities, improves health literacy, and increases the capacity and resilience of individuals for maintaining their health and wellbeing.

Dr Nav Chana

P1: Co-design

Primary care teams will work with communities, patients, their families, charities and voluntary sector organisations to co-design approaches to improve the health and wellbeing of the local population.

Involving individuals and communities in designing services will ensure that approaches are relevant locally; that they do not duplicate (and are integrated with) existing services in the community; and that they are more likely to be successful.

The process of co-design in itself will support improved understanding of health and wellbeing for those involved, support the identification of community advocates and volunteers and further build community resilience.

An example would be engaging young people, schools and youth workers locally in designing new ways of communicating with young people living with a long term condition.

P2: Developing assets and resources for improving health and wellbeing

Primary care teams will work with others to develop and map the local social capital and resources that could empower people to remain healthy, and to feel connected to others and to support in their local community.

Practices will work with local voluntary and community organisations; health, third sector and other organisations; and local authorities to:

- provide additional capacity for improving health and wellbeing (e.g. Citizen's Advice, community pharmacy services and the probation services)
- protect community resources for future generations (e.g. with the Environment Agency)
- test new ways to build and improve relationships with local communities
- build a map of local community assets that can be harnessed for health and wellbeing
- identify and develop local community health and wellbeing champions, advocates and volunteers.

Establishing and maintaining an up to date map of community assets will assist a range of organisations involved in an individual's care. The map will support other 'first contact' providers such as NHS 111 and community pharmacies to offer patients a range of options.

P3: Personal conversations focused on an individual's health goals

Where appropriate, people will be asked about their wellbeing, capacity for improving their own health and their health improvement goals.

Practices will co-ordinate plans of care, particularly for people who regularly visit the practice and whose health is at risk of deteriorating. If relevant, patients will be offered self-management support and/or social prescribing – directing them onto other information, resources and services available in their local communities e.g. debt advice.

P4: Health and wellbeing liaison and information

Primary care teams will enable and assist people to access information, advice and connections that will allow them to achieve better health and wellbeing. This health and wellbeing liaison function will extend into schools, workplaces and other community settings.

These services would offer a range of interventions from brief focused information to more extensive advice and support. Interventions could include group support, 1:1 coaching, signposting and improving health literacy. The service would also build partnerships to build on the contribution to health and wellbeing already made by leisure centres, gyms and voluntary groups.

P5: Patients not currently accessing primary care services

Primary care teams will design ways to reach people who do not routinely access services and who may be at higher risk of ill health

This specification focuses on two key areas:

1. People on the registered list (but not attending the practice)

- Practices will design ways to reach vulnerable patients who may live in circumstances which make it harder for them to access general practice. This includes patients whose language and culture form barriers to receiving care, for instance gypsies, travellers, sex workers, homeless people, vulnerable migrants, people in care homes, and people with learning disabilities or severe mental illness.

  Practices will identify the patients on their registered list who have not been attending and are therefore at higher risk of ill health. These may be people who have declined invitations for services, are reaching crisis, suffering social isolation or stigma.

  These patients will require a more personalised service offer, care coordination and care planning. Using peer advocates who have direct personal experience and can empathise with patients has been shown to be an effective way of engaging with these groups of patients.

- Primary care teams will also design approaches to follow up those patients who might be attending the practices from time to time but are not taking up invitations for services such as screening and vaccinations. Understanding the root causes for non-attendance will be crucial to ensuring maximum take-up of these services in the future; for example, understanding religious or cultural reasons for non-attendance.

2. The unregistered population

- Working collaboratively across a population and across multiple agencies, primary care teams will also design, with the support of their CCG, ways to reach and care for the unregistered population, for example homeless patients and people released from custody or places of detention.

2. Accessible care specification

Accessible Care Expert Panel Chair: Dr Tom Coffey OBE

Tom has been working as a GP in Wandsworth since 1994. He started as a chemical engineer then transferred to medicine at Charing Cross and Westminster medical school. He is a GP partner at Brocklebank Group Practice; a medical advisor to Tooting Walk-in Centre; Clinical Assistant in A&E at Charing Cross Hospital and a tutor at St George's, University of London. Dr Coffey was awarded an OBE for services to healthcare in south west London in June 2009.

Good access to general practice is important to everyone. It's important to patients who may be distressed or who may suffer if diagnosis and treatment is delayed; those who value a continuous relationship with their clinician in order to remain healthy and independent; and people who find it hard to see a GP within current opening times. It's important to practices whose workloads can become inefficient if access is not managed systematically. It's important to the NHS as good access to primary care has the potential to reduce unnecessary emergency admissions and reduce the number of patients attending A&E.

Although there are examples of excellent services at some practices, many London patients report that access to general practice does not always meet their needs. On average, patients in London are less satisfied than those in other parts of England with: contacting the practice; seeing a GP quickly; their ability to book ahead; opening hours; and seeing a GP of choice when they want to.

Patients who cannot access their practice because it is closed or they are unable to get an appointment are more likely to attend A&E with issues that their GP could have resolved. Less than half of patients wanting an appointment in London are seen by the next working day. Phone lines are busy first thing in the morning and same day appointments run out quickly. Many patients are asked to call back the following day. For many patients, access to weekend and evening appointments is limited and many practices still close on a Wednesday or Thursday afternoon.

More London patients report that it is hard to see a preferred GP in London than anywhere else in England. Consequently patients who need regular contact and a continuous relationship with a clinician may not receive the best support to manage their health effectively in the community.

Our proposals

Good access means different things to different people. In developing these specifications we have tried to consider the various needs of different patient groups – whether that is accessing continuity of care, rapid access, out of hours care or online services.

Often patients concerned about a new health problem want to be seen as quickly as possible but are less concerned about who they see. There is also evidence that some patients go to A&E with minor issues because they can't get a same day appointment with a GP – especially at weekends when many practices are closed. So we've proposed that all patients should be able to access a consultation with a GP or senior nurse from their own practice on the same day in routine opening hours and on Saturday mornings. We've also suggested that patients should be able to access a primary care health professional seven days a week, 12 hours a day in their local area.

Commuters with occasional health needs want advice and care quickly, conveniently and in a variety of ways. Patients should be required to only make one call or click to make an appointment, and practices should promote online services including appointment booking, prescription ordering, viewing medical records and email. Many systems make telephone consultations the normal starting point for most patients – linking the two people who need to talk, in the shortest possible time.

Other patients, such as those with long term conditions, tend to need more frequent consultation and value continuity and familiarity – but are willing to wait a little longer to be able to do so. So this specification outlines that patients should be able to book at least four weeks ahead if they wish and see their GP of choice in an appointment with a flexible duration.

We know that patients will have different needs at different times. So we've suggested a specification that patients should be given a choice of access options to select the service that best meets their needs.

We also need patients to use the most appropriate service for their needs. For medical help or advice in a situation that is not life-threatening, patients can call 111 free from any phone. NHS advisers are on the line 24 hours a day, seven days a week and can give healthcare advice or signpost patients to local services.

Patients are often unaware of the range of services that their pharmacy can offer, so many people simply don't consider visiting. But pharmacies can provide medical advice on a range of conditions and can even provide prescription drugs under minor ailment schemes, without an appointment.

The fact that different dimensions of access are valued differently by different people (and by the same people at different times and in different circumstances) presents a real task to the formulation of concrete measures of good-quality access. Our challenge is to design and deliver a truly personalised service that responds to all patients, irrespective of their particular circumstances. We hope that this specification outlines a service which does just that.

Dr Tom Coffey OBE

A1: Patient choice

Patients will be given a choice of access options and should be able to decide on the consultation most appropriate to their needs.

Different patients, in different situations, have different access needs. Some patients value continuity of care over rapid access. Some people place more value on seeing a particular clinician. Others want a more convenient appointment time, or to book an appointment four or more weeks in advance.

General practice should make all these options available to the patient at the point of contact and allow the patient to select the service they want. Practices should also include reasonable adjustments to remove access barriers for patients, such as considerations for the homeless or non-English speakers, as well as adhering to the Equality Act (2010) for physical access needs (ramps, hearing loops etc).

A2: Contacting the practice

Patients will be required to only make one call, click or contact in order to make an appointment. Primary care teams will maximise the use of technology and actively promote online services to patients including appointment booking, prescription ordering, viewing medical records and email consultations.

Currently appointments are often allocated based on who gets through to the practice rather than by clinical need. Many practices hold back appointments so that a patient getting through may be told that there are no appointments left but that they should call back later or the following day when more are released. This increases the number of calls coming into the practice as patients have to call several times before securing an appointment and patients who do call back join the back of the queue.

In future patients would have multiple options for making an appointment, and would only need to make contact once in order to have a discussion with a clinician.

A3: Routine opening hours

Patients will be able to access pre-bookable routine appointments with a primary health care professional (see 'workforce implications' for the proposed primary care team) at all practices 8am – 6.30pm Monday to Friday and 8am to 12 noon on Saturdays. An alternative equivalent patient offer may be provided where there is a clear, evidenced local need.

There is significant variation in opening hours across London. This specification will create an equitable offer to patients across London. During the specified hours, all practices will be open to allow patients to access all services, including attending an appointment, speaking to a receptionist, and collecting or ordering a prescription.

A4: Extended opening hours

Patients will be able to access a GP or other primary care health professional seven days per week, 12 hours per day (8am to 8pm or an alternative equivalent offer based on local need) in their local area, for pre-bookable and unscheduled care appointments.

This service will be delivered by networks of practices working together at scale. In most cases a larger practice in the local community will take the lead to provide this service on behalf of other practices. A suggested offer of 8am to 8pm is described here, however there could be a suitable alternative equivalent offer based on local population needs, for which the totality of the offer (seven days, 12 hours) is not reduced.

A5: Same day access

Patients who want to be seen the same day will be able to have a consultation with a GP or appropriately skilled nurse on the same day within routine surgery hours at the practice at which they are registered (see Specification A3: Routine opening hours).

Patients with new health conditions often want to see or speak to a GP as soon as possible. It's important for patients who may be distressed or suffer if diagnosis and treatment is delayed. Consultations could be face-to-face or on the phone (or video phone) but will be provided by a GP or an appropriately skilled nurse on the same day.

Practices would be encouraged to use a demand-led telephone triage system. These approaches provide a phone conversation with an appropriate clinician throughout the day, often within 30 minutes of the patient contacting the practice. The patient can then discuss their needs with the clinician and between them they can then decide the most appropriate course of action (e.g. face-to-face consultation of appropriate length according to need; referral to community pharmacist, nurse, healthcare assistant or other service; booking for diagnostic tests; and self care).

A6: Urgent and emergency care

Patients with urgent or emergency needs will need to be clinically assessed rapidly. Practices should have systems in place and skilled staff to ensure these patients are effectively identified and responded to appropriately.

In the event that a patient accesses general practice with emergency care needs, there should be sufficient processes and procedures in place to enable all members of the practice to respond to that patient's needs appropriately.

A7: Continuity of care

All patients will be registered with a named GP who is responsible for providing an ongoing relationship for care coordination and care continuity. Practices will provide flexible appointment lengths as appropriate.

All patients should have a named GP for care continuity and coordination. Other GPs or healthcare professionals within the practice team may provide care as appropriate but the named GP will effectively still oversee delivery of the care plan.

General practice will routinely improve continuity of care through a range of mechanisms such as buddying; job sharing; forming 'teams within teams'; developing organised handover systems; enhanced use of communication and record-keeping technology; and increased involvement of patients and carers in care planning. These measures are of particular importance where personal continuity is not possible.

3. Coordinated care specification

Coordinated Care Expert Panel Chair: Dr Rebecca Rosen

Rebecca is a Senior Fellow in Health Policy at the Nuffield Trust, a GP in Greenwich and an accredited public health specialist. Her current policy interests include integrated care, primary care, new organisational models for general practice and NHS commissioning. Rebecca is a clinical commissioner with Greenwich CCG – where she leads on long-term conditions and quality. At her GP practice, Rebecca leads work to improve continuity and quality of care for people with chronic complex ill health. In the past, Rebecca has worked as a Medical Director of Humana Europe; as a Senior Fellow at the King's Fund; and in NHS academic public health departments. Past research interests include the diffusion of new medical technologies, patient choice and primary care policy.

For people with complex health and social care needs, coordinated care is essential to support their health and wellbeing.

One in five Londoners are living with one or more complex conditions. Other people go through periods of severe, complicated, health problems which may last months or years before they are resolved. Changes to the GP contract focus on the over-75s, but in London it is often younger people who live with complex health problems which may be harder to manage because of drug or alcohol dependence, mental health problems or financial and social pressures. Many Londoners, young and old, will be receiving care from several different services, which can become confusing and frustrating if the services don't work in close collaboration.

The National Voices report ***Integrated care: what do patients, service users and carers want?*** provides a powerful narrative which highlights clearly and effectively the kind of relationship people want with their health professionals. It stresses that coordination and care are the two 'top lines' in what people expect and need.

The statement "My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes" summarises the service which we want to outline in this specification. We know this type of service would result in significantly improved health outcomes and patient experience.

In the National Voices document, patients tell us they want a service: where their needs as a person are taken into account; where they are involved in discussions and decisions about their care; where they have regular reviews of their care, treatment and care plan; and where they have the information and support they need in order to remain as independent as possible. We also know patients want a first point of contact from someone who understands them and their condition and who they can go to ask questions at any time.

These are significant challenges for all health and care professionals, including GPs, which will require a fundamental change in the culture of general practice and communications between service users and professionals. New approaches to delivering care are needed, informing patients and their carers about their condition(s) and enabling them to participate effectively in decisions about their health and care.

Our proposals

We want to move away from a reactive system which treats people when they become ill, to one which coordinates care and supports people to stay well.

Firstly we need to identify the patients who would benefit from this approach. Many will be elderly and suffer from multiple chronic conditions while others may suffer from mental health issues or have a set of social circumstances and lifestyle issues which are best addressed though coordinated care.

Secondly patients need a named clinician who will routinely provide the patient's care or act as an advocate, guide and contact for the extended practice team and to the wider multidisciplinary team in line with their needs.

Thirdly we want all such patients to have a personalised care plan and to have played an active role in determining its aims and content – agreeing goals and the support they need to achieve them.

Fourthly we want to create an environment in which patients can maximise the potential of their self-care, lifestyle changes and knowledge to contribute to their own health and wellbeing.

Finally, patients who require coordinated care will need frequent reviews and input from a range of members of a wider team ranging from a micro-team of practice staff, pharmacy and community nursing to a macro-team of health and social care providers. Their provider network needs to be well-connected and their services seamless.

While these challenges sound daunting, a great deal of work has been done on how to deliver high quality services tailored to individual and population health needs and examples continue to be developed across London. The chronic care model introduced the idea of 'informed, activated patients' and a 'prepared, proactive' clinical team. The recently launched *Delivering Better Services for People with Long Term Conditions – Building the House of Care* adapts this model for the NHS, highlighting the four key components of coordinated care: informed, engaged individuals and carers; organisational and clinical processes; health and care professionals committed to partnership working; and effective commissioning.

The ambitions of National Voices' patient-centred coordinated care and the organisational model of the *House of Care* feature heavily in the following specification. They create a framework around which practices can organise themselves to deliver high quality care with a relational continuity (seamless care), focused on the goals and preferences of individual patients and tailored to meet individual needs.

The specification is rightly ambitious and will not be achieved overnight. It requires a new culture for general practice in which the co-creation of health by patients, doctors, nurses and others becomes the norm. The specification addresses what individuals can do to keep themselves well; the ways in which professionals consult with patients; the ways in which practices are organised to support coordinated care; and the ways in which GPs work with other providers to deliver coordinated care. Practices may need additional resources to deliver the specification and these will have to be negotiated and put in place, but we believe achievement of the specification will result in better care for people with long term, complex health and care needs.

Dr Rebecca Rosen

C1: Case finding and review

Practices will identify patients who would benefit from coordinated care and continuity with a named clinician, and will proactively review those that are identified on a regular basis.

Patients with complex conditions who need care from more than one professional or team will be added to a coordinated care register and will be provided with an enhanced level of service.

These patients may have long term conditions but may also be patients with a range of other health conditions and social support needs such as children and families with complex problems; people with mental health conditions; people in nursing homes; people at the end of life; or vulnerable people who find it hard to access services (for example homeless patients; those with learning difficulties or members of the traveller community).

Patients will be identified using a combination of clinical alerts, risk profiling and clinical judgment. Every practice, or network of practices where appropriate, will run a regular risk profiling / risk stratification process in order to identify patients who should be on their care coordination register.

The intensity of care, frequency and duration of contact with patients should be scaled up or stepped down as a result of reviews and patient progress. This should enable practices to identify those who may be, or are at risk of, experiencing an exacerbation of their condition but who have not reached a crisis point to seek treatment.

C2: Named professional

Patients identified as needing coordinated care will have a named professional who oversees their care and ensures continuity.

All patients identified as needing coordinated care should have a named professional from whom they routinely receive their care. The lead GP will provide continuity of care, either personally or in collaboration with a 'micro team' of clinicians and professionals in and around the practice, for example members of the wellbeing team or community pharmacists.

Patients may also be allocated an additional member of the practice team or an additional health or social care professional as a care coordinator to act as their first point of contact if they have questions, concerns or problems.

The person who coordinates their care should work with the patient to achieve their goals. For some patients, this will require extended consultations, for others it will mean regular contact with an extended primary care team. Patients with more complex needs would ideally be able to contact their care coordinator 24/7 for certain periods of very acute clinical risk or towards the end of their life.

The intensity of contact and amount of time spent with the named GP and extended team will fluctuate in accordance with need, as assessed by risk profiling and regular communication with patients and their family and carers.

The GP should act as an advocate and guide and should coordinate care with the extended practice team and a wider multidisciplinary team

as appropriate. If patients go into hospital or transition to other services, general practice should continue to be proactively informed about the patient as they move between services, continuing to coordinate their care if appropriate.

C3: Care planning

Each individual identified for coordinated care will be invited to participate in a holistic care planning process in order to develop a single care plan that can be shared with teams and professionals involved in their care.

Development of the care plan should follow the approach described in *Delivering Better Services for People with Long Term Conditions – Building the House of Care*. This represents a departure from the current focus on individual diseases towards a generic approach in which patients' goals drive care delivery and greater attention is paid to the contribution that people make towards managing their own health.

Care planning should be based on a philosophy of co-created goals for maintaining and improving health. It should be an iterative process that continues for as long as an individual has complex needs.

Patients identified for coordinated care, and their carers, should be encouraged to play an active part in determining their own care and support needs as part of a collaborative care planning process. This should involve discussing care and support options, agreeing goals the patient can achieve themselves, and co-producing a single holistic care plan that includes the needs of family and carers.

C4: Patients supported to manage their health and well-being

Primary care teams will create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing.

A culture of self-management support will underpin care coordination, recognising that the personal information that patients, their carers and families bring to the development of care plans can be as important as the clinical information in medical records.

Practices will develop an infrastructure to provide self-management support for patients with ongoing complex problems and support for their carers.

Following a new diagnosis of a long term condition (or identification of a need for coordinated care such as recovery from cancer), all patients will have at least one encounter dedicated to enhancing their ability to self-care, and then frequently according to need thereafter.

Support for patients could be provided by individual practices or across a number of practices and could for example include internet resources; advice from staff skilled in lifestyle training and/or motivational support; information packs; services provided by volunteers or voluntary organisations and access to patient groups in which patients support each other.

C5: Multidisciplinary working

Patients identified for coordinated care will receive regular multidisciplinary reviews by a team involving health and care professionals with the necessary skills to address their needs. The frequency and range of disciplines involved will vary according to the complexity and stability of the patient and as agreed with the patient/carer.

Patients on the coordinated care register will have a review by a multidisciplinary team involving clinicians from within the practice and from linked services. GPs should be regular, active participants in multidisciplinary reviews of their registered patients who have been identified for coordinated care. The frequency of multidisciplinary reviews will vary according to changing needs.

Multidisciplinary reviews should ideally include professionals from both health and social care. This might include acute care specialists, social services, housing and finance advisors, community matrons, mental health specialists and district nurses depending on the needs of the patient.

General practice should fully participate in multidisciplinary work across the health and care system and use reflective learning to improve patient care and for system enhancement.

This *Strategic Commissioning Framework for Primary Care Transformation* represents a significant ambition for service improvement. Delivering this ambition will require strong collaboration from all parts of the NHS, the CQC, local education and training boards (LETBs), academic health science networks (AHSNs), local authorities, charities and voluntary organisations and health and wellbeing boards (HWBs) in London. This section of the *Framework* provides a strategic London-wide case of the underpinning enablers that will need to be utilised in order to meet the scale of that challenge.

Local plans to deliver the changes

CCGs across the capital will continue to develop (in partnership with NHS England (London)) local plans for delivering these changes. These plans will focus on how to improve general practice and the wider primary care system from April 2015 onwards. The changes required to the system will take a long time to achieve, however some changes and some practices may be quicker to implement than others. In order for local populations to be able to take part in discussions to decide what is best for their local community, it is essential that plans are locally designed based on different starting points.

The *Framework* is not intended to be a static document but will form the basis of wider engagement over the coming months in each local area. There is an expectation that different areas will work at different paces and NHS England (London) will work closely with those areas that are ready, and will share the learning across London. Commissioners across London aim to ensure that in the future, all Londoners will receive the primary care services described in this document.

Co-commissioning

The current commissioning landscape for primary care is complex, with up to three different commissioners (CCGs, NHS England and local authorities) and several different funding streams for some pathways of care. To achieve the transformation of out-of-hospital care and thus improve health outcomes and deliver more care closer to home, commissioners have recognised the need to make it easier for them to work together and to better integrate services. Co-commissioning is a first step on this journey to empower CCGs to have greater influence over the development of primary care services. This will help to ensure local primary care developments are better aligned with CCGs' commissioning plans for hospital-based care and community services and better meet the needs of diverse local populations. Co-commissioning could potentially lead to a range of benefits for the public and patients including:

- improved access to primary care and out-of-hospital services, with more services available closer to home
- high quality out-of-hospital care
- improved health outcomes, equity of access, reduced inequalities
- a better patient experience through more joined up services.

Options for models of co-commissioning

Proposals for co-commissioning arrangements across London, based on local requirements and plans, are being developed and their formulation is supported by national guidance. This national documentation, *Next Steps Towards Primary Care Co-Commissioning* describes several types of co-commissioning model. The exact nature of the arrangements will depend on local preferences but it is anticipated that co-commissioning arrangements with CCGs could be one of the following types:

- allow CCGs greater involvement in commissioning decisions, including actively participating in discussions about all areas of primary care, in order to make better decisions about how resources are allocated across primary care, community services and hospital services and with local authorities.
- joint commissioning model that enables one or more CCGs to assume responsibility for jointly commissioning primary medical services with their area team, either through a joint committee or "committees in common". This would allow CCGs and area teams to pool funding and give them an opportunity to more effectively plan and improve the provision of out-of-hospital services for the benefit of patients and local populations. Together, CCGs and area teams would be able to make better decisions about how primary care resources are deployed, for example by designing local solutions for workforce, premises and technology challenges.
- delegated commissioning model, offering an opportunity for CCGs to assume full responsibility for commissioning some aspects of general practice services. The exact models for delegated commissioning will need to be worked up in local areas.

Commissioners across London have set up a co-commissioning collaborative to develop thinking on some of the key elements required. Areas under consideration include finance, workforce, governance, benefits and contracting.

Financial implications

The changes described in this *Framework* cannot be delivered without significant investment. A high-level financial case has been completed at a London-wide level to estimate the cost of providing the new patient offer.

The financial modelling work has so far focused on the recurrent revenue investment required to provide the service specification for whole populations with differing degrees of care complexity. The modelling has focused on two main areas:

1. **Delivering a new service model.** Supporting clinicians to deliver more person-centred care by analysing the cost of new activities and the potential increase and diversification of the primary care team needed
2. **Increasing patient access to primary care.** By creating additional appointment slots, allowing extended practice opening hours in each area including evening and weekend working.

Financial context

General practice undertakes 90% of first patient contacts, and in London this is done for 7.3% of the capitals's healthcare budget of £15.1bn – based on the combined CCG and NHS England commissioning budgets. Expenditure on general practice services has fallen in real terms between 2010/11 – 2011/12 in comparison to an increased spend in acute and community services.

The new service specification needs to be affordable within current NHS financial constraints, and NHS England and CCG budgets. There is a £2.4bn saving requirement for London by 2021/22, which means that finding ways to use existing resources more effectively is urgently needed.

Within this context there is a strong rationale for re-balancing the NHS investment profile towards primary care:

- **Improving services for patients and creating a sustainable general practice service**
- **Supporting sustainability across the wider health system.** For example there have been estimates that 10-30% of A&E attendances have the potential to be managed as part of a primary care offer
- **Securing better value for money.** Investing in general practice capacity and capability to deliver a higher proportion of activity closer to home would enable acute reconfigurations.

Estimate of the required investment

It is estimated that in order to reverse this trend, meet future population growth and deliver a modern, high quality service for all, £310 – £810 million (representing 2% – 5.36% of total health spend today) will need to be invested annually. This is expected to begin with a gradual shift in total health spend of 0.4% – 1.07% each year over five years. This shift in total health spend has the potential to deliver a significant increase in general practice capacity in the medium term. This will require changes at a local and regional level, both in terms of redirecting funding and supporting the process for doing this (e.g. with co-commissioning).

Caution: This estimate is a very high level calculation for the purpose of assessing the feasibility of the service changes, the methodology used is outlined below.

Financial modelling methodology

In developing the above hypothesis for the funding needed to deliver the envisaged primary care, a methodology was used to estimate the additional cost of delivery of the total specification as compared to current spend.

a) Calculating the additional cost of delivering the **coordinated and proactive** specification. The methodology is based on a differentiation of patients at different levels of need (i.e. some patients will require high frequency and longer appointments because they have more complex care needs, some may only require a quick consultation) and the requirements for involvement of

different members of the practice team. Clinicians then provided estimates based on clinical complexity categories and the complexity bandings associated with patients on different disease registers of the frequency, amount of time and member of the clinical team which would be required to treat each type. These figures were then adjusted to account for their relative proportion of the population (e.g. approximately 80.3% of the population are 'mostly healthy' and not on the disease registers).[6] This allowed an overall cost to be estimated.

b) Calculating the additional cost of increasing **patient access** to general practice. There is a direct cost increase relating to additional opening hours. Extending the opening hours will result in additional workforce and non-pay costs. Two methods of estimating this additional cost are described below:

- Methodology A: calculating the cost of increased demand based on redirection of existing A&E minors
- Methodology B: The cost of increased access based on theoretical current estates capacity.

Summing these methodologies demonstrates that a range of between £310 – £810 million potential investment will be needed in primary care in London depending on the approach.

Cost Type	Annual Cost (£m)
Cost of delivering a new patient offer (excluding access)	250 – 300
Cost of delivering better access. (Methodology A, low end of range)	60[7]
Cost of delivering better access. (Methodology B, high end of range)	510
Total Cost Estimate	**310 – 810**

In addition to this, transitional funding will be required in the first few years to invest in the infrastructure and transition of organisations to these new ways of working.

Current funding opportunities

Current funding opportunities for improving general practice that are already identified include the Better Care Fund (£3.2 billion nationally) and the Prime Minister's Challenge Fund (£50 million 2014/15 expected to rise to £100 million in 2015/16). The *NHS Five Year Forward View* and London Health Commission have identified investment in general practice as a key priority for the health system with additional national transformation funds anticipated. In a survey of 24 CCGs in London, only two areas did not have resources already invested towards supporting

6 As per the Quality and Outcomes Framework database
7 Includes a +20% optimism bias

general practice improvement, and one area had already confirmed a recurrent £4.9 million investment across a number of CCGs to support general practice improvements and wider out-of-hospital changes.

Next step financial modelling

The next phase of financial analysis would involve local scenario testing and detailed work up of CCG area-specific, operational-level financial models. This would include:

- adjusting the financial and activity model to take into account: local factors to underpin the additional access changes and other patient offer changes; the workforce change requirements – consulting with workforce experts; additional clinicians; and local analysis of need
- local (CCG area) estimation of the building, IT and other infrastructure costs, including any additional 'pump prime' or upfront investment in order to implement the specification
- local (CCG area) analysis of cost efficiencies, including what, when and how much effect these would have
- adjusting the modelling to local population demographics, in order to account for local variations in 'healthy' populations, and co-morbidity (multiple disease) duplications across the disease registers
- further analysis of the sources of capital and revenue funding required and potential to release these locally (by strategic planning group area)
- understanding the impact on non-primary care finances (for example adult social care, and the cost of prescribing).

Contracting approach

The service specification for general practice can only be delivered by general practices working together at scale and with other parts of the health and care system. With that in mind the proposal in this *Framework* is that the specification will not be funded at individual practice level but will be delivered through a new contract at a wider population level, offered to groupings of geographically aligned general practices or Multispecialty Community Providers (MCPs) (alternative options might be considered for individual practices that have a significant geographical footprint and alignment with other health and social care providers).

The exact contracting approach used in each place will be determined through co-commissioning arrangements in consultation with each CCG, taking into account local arrangements for delivering against the new service specification.

Potential contractual forms

Contracts will be developed that incorporate the service specification as a distinct, scheduled and incentivised service innovation and general practice collaboration.

Broadly speaking, the following contractual forms are likely to be reviewed and considered for use in commissioning the new service specification for general practice:

- Alternative Provider Medical Services (APMS)
- NHS standard contract
- hybrid of the APMS and NHS Standard Contract (note – this would represent a new form of contracting that would require legislative change).

Whatever contract form is used, it will typically include a phased transition for the primary care organisation/provider. For example, this could include a year on year increase to the contract value as well as greater degree of risk share and pooling of current incentives from constituent practices that might include:

i) complete or phased incentive sharing across constituent practices with regards to Quality and Outcomes Framework (QOF), Local Enhanced Service (LES) and other enhanced payments

ii) increasing the level of shared decision-making across constituent practices with regards to the specification for how current Personal Medical Services (PMS) investment contributes to delivery of the new service specification and specific local needs.

iii) increasing the level of pooled funding across constituent practices with regards to APMS, PMS and General Medical Services (GMS) for example £x per patient is pooled to represent the efficiencies that will be gained from working collaboratively or by delivering current services in different ways.

The contracting vehicle will need to 'wrap around' the existing national contracts unless constituent practices are opting for a full merger/super partnership in which case they may voluntarily relinquish their current contract. Whatever the approach, it will need to provide sufficient new financial incentive to increase the level of collaboration and joint ownership. The exact nature of these arrangements will vary by nature of the provider landscape but the principle of at-scale providers increasingly sharing pooled incentives with shared responsibility and risk for delivery will be a key marker against which additional investment will be made.

Consideration will be given as to whether the accountability for delivering the constituent GMS, PMS and APMS can be attributed to a lead provider within a scale primary care organisation. That type of change would require new permissions and a shift in national policy. It could only be undertaken on the basis that systems for assuring quality and patient safety continue to have sufficient probity and it would require changes in the approach to regulation. There is however some evidence, from Tower Hamlets networks for example, that clinical governance systems that are owned and reviewed across a number of general practices by peers and local training leaders have greater potential to secure improved quality and patient safety.

The contractual form chosen will need to be flexible to allow for wider collaborations and partnerships with other types of providers, for example community services and the voluntary sector. This may be in the form of governance arrangements that reflect the wider partnership. In some local areas the strategic intent may be to take a single step towards a merged contract between general practices and the wider system to form an accountable care organisation that can hold capitated budgets and shared risk for a whole population.

Many areas already have a strong ambition towards bringing general practice and community services together over the next two

years. It is however anticipated that most areas will be looking to contract networks/federations of general practices as a starting point.

Workforce implications

Implementation of the service specification in this *Framework* is set in the context of growing demand for primary and community care, increasing expectation, and the changing patterns of needs of patients with more complex and long-term conditions. These demands, coupled with technological advances and the adoption of best practice across care settings, have important implications for how to develop and train primary and community clinicians and the wider workforce of the future.

General practices are typically small organisations, working in relative isolation from one another, with the exception of some networking for the purposes of out-of-hours cover and involvement in clinical commissioning. Increasingly however this is changing with the rapid formation of at-scale general practice organisations involving closer working and in some areas changes to legal structures to enable practices to come together. However the general practice workforce (including GPs and GP nurses) is under significant workload pressure and many are now considering early retirement[8]. The number of mid-career doctors (under the age of 50 years) considering leaving the profession is also rapidly rising[9]. Nationally the growth in GP numbers has not kept pace with that of hospital consultant numbers (per WTE)[10] and boosting numbers entering GP training is proving difficult. GPs in London are a lower proportion of the total workforce compared to national figures.

Ongoing planning of the future workforce requirements will be at the heart of transforming care. Bolstering the primary care workforce has been identified as a core objective in the Health Education England (HEE) mandate and is also recognised as a key priority for HEE and its Local Education and Training Boards (LETBs). Implementing the general practice specification and planning the future workforce requirements will require alignment of resources to:

- manage immediate and forecasted workforce supply shortages
- reshape existing roles through ongoing training, education and development
- modify core training programmes to align with new service needs
- develop and pilot new roles
- evaluate and research the effectiveness of new roles and workforce configurations
- manage expectations around the pace of workforce change
- develop new primary care learning environments that build on multidisciplinary approaches such as Community Education Provider Networks (CEPNs)[11].

8 BMA quarterly tracker survey: Current views from across the medical profession. Health Policy and Economic Research Unit, 2014
9 Securing the Future GP Workforce. Delivering the Mandate on GP Expansion. GP taskforce final report. March 2014
10 Centre for Workforce Intelligence; In-depth review of general practitioner workforce. June 2014
11 CEPNs: collectives or networks of primary and community organisations working collaboratively to enhance educational delivery in local geographical contexts

Implementation of the service specification in this *Framework* will require practices to offer an extended scope of services; more convenient opening times; personalised care; and an ongoing development of access options to match the needs of the population. Practices of all sizes will be faced with the challenge of how to:

- configure the workforce to ensure safe practice, on-going training and development whilst maintaining continuity of care; and harness the potential of temporary and locum staffing
- expand flexible working arrangements
- prevent professional isolation
- ensure staff are up to date on evidence-based practices, treatment developments, changes in medicines use, technological advances etc.
- efficiently manage workforce demands while ensuring the team has time for organisational development, service redesign and quality improvement.

The future health service will see more person-centred systems of care and less division between primary, secondary, community, voluntary and social care organisations. The developments to commission the future workforce for general practice will be undertaken in the context of overall professional clinical training and increasing multidisciplinary working across organisational boundaries.

Governance arrangements will need to be developed to support the increasing numbers of staff that will be in training, on placement and working independently outside hospital, and in community settings. Delivering integrated primary care using multidisciplinary models of working in community settings will require new approaches to safeguarding, to support safe clinical practice whilst ensuring staff are supported to continually learn and develop.

How roles and teams fit together in delivering future care still needs to be determined and different roles and responsibilities are likely to evolve in each local area as the specification is implemented. Broadly it is anticipated that the roles detailed below will be required:

Within each practice	**Aligned to each practice but working across a wider geography / at scale primary care organisations**
GPs, practice nurses, GP nurse practitioners / nurse prescribers, volunteers, receptionists, managers, health care assistants and may also include physician associates	Prescribing advisors, GPs with a special interest (GPSIs), care coordinators, wellbeing teams, and 'super practice managers/directors' with sufficient skills to lead the development and operational management of at-scale primary care organisations. **As part of, for example, a wider Multispeciality Community Provider (MCP):** Secondary care specialists, social care, mental health and community services teams, community pharmacy.

A number of new roles are appearing in the general practice setting enabling the delivery of high quality care, improved patient experience and improved clinical outcomes. These are additional to what is now considered a core team of GPs, practice nurses and GP nurse practitioners, managers and reception staff. A few examples are provided below to illustrate the functions these new roles are performing and how they are supporting new ways of working both within general practice and across a wider care team.

- **Healthcare assistants (HCA) / clinical assistants**: provide clinical support for GPs to enable them to allocate more time for patients with complex problems.
- **Health and wellbeing coordinators**: enable patients to maintain their health and wellbeing and improve self-management of their condition.
- **Physician associates**: work to the medical model in the diagnosis and management of conditions in general practice and hospital settings, with the supervision of medical practitioners.
- **Care coordinators / navigators**: provide a central coordination role on behalf of the patient, working with their wider care team covering health, social care, voluntary and other local services.

For example, the National Association of Primary Care has joined forces with Health Education England to create a training programme for new Primary Care Navigators (PCN) to support patients with dementia, their carers and families. It is intended that this training will eventually be adapted and used for other long-term conditions.

The table below examines some of these roles and the functions they perform.

Function	Role			
	HCA/ clinical assistant	Health and wellbeing Coordinator	Physician associates	Care coordinator /navigator
Basic clinical checks and tests incl updating clinical records	✔		✔	
Input to diagnosis and treatment planning			✔	
Refer to secondary care (incl A&E)			✔	
Focuses on acute conditions	✔		✔	
Supports patients with long term conditions	✔	✔	✔	✔
Broader assessment of patients' own health goals	✔	✔	✔	✔
Care plan facilitation	✔		✔	✔
Self-management support	✔	✔		✔
Health coaching	✔	✔	✔	✔
Establishing referral pathways to preventative and wellbeing services and activities		✔		
Multi-agency working		✔		✔
Directs patients to additional sources of support and care – health, social care, voluntary sector	✔	✔	✔	✔
Reports primarily to the named GP – largely practice employed	✔		✔	
Reports to the named GP and a wider MDT – largely non practice-based / employed		✔		✔

Planning the future workforce requirement is always challenging and many organisations, institutions and professional bodies are attempting to do this as they develop their long-term plans. Especially important are HEE and the LETBs who are working with patients, carers and other key stakeholders to explore the workforce challenges and find ways of meeting these challenges[12,13,14,15] Sharing and utilising existing learning will be pivotal as prototype delivery and education models are being developed and tested across the capital as part of:

- integration pioneer sites
- Prime Minister's Challenge Fund sites
- LETB development programmes
- Academic Health Science Network (AHSN) primary care development work streams
- Community Education Provider Networks (CEPNs).

In addition, specific LETBs are taking forward programmes to support and enable the workforce.

Health Education North West London (HENWL)

Health Education North West London has invested funds to support all staff working in general practice to access continuous professional development courses which are block commissioned from Higher Education Institutes (HEI). £100,000 has been invested so far for 2014-15 and further funds will be added if demand exceeds this figure. The HENWL board has also funded £1.1 million workforce development activity for primary care for 2014-15, distributed via the CCGs to support the workforce transformation and development activity required to enable GP teams to cope with greater levels of demand and complexity as part of the wider system reconfiguration.

A further £1 million has been invested through the *Shaping A Healthier Future* programme to support the development of community learning networks which will be aligned to the whole systems programme in north west London (beginning with initiatives relating to the over 75s population).

As part of the planning work to inform the *Shaping a Healthier Future* service transformation programme, north west London's (NWL) CCGs commissioned a piece of work called *From Good to Great*, *a workforce strategy to support out-of-hospital care in north west London* which was published in January 2013. The document explores the need for innovative new roles and has been used to shape some of the thinking about demand for new roles in the future NWL health system.

Following the 2014 workforce and education planning activity, it has been recognised that whilst overall demand for staff groups is reflective of the overall transformation programme, the detailed analysis of specific new roles and changes to skill mix are not clear. HENWL has initiated a series of task and finish

12 Skills For Care. Principles for Workforce Integration. 2013
13 Health Education England: consultation on the role of bands 1-4. April – March 2014
14 The Cavendish Report. An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings. 2013
15 Greenaway D. Shape of Training: Securing the future of excellent patient care. An independent review of the way we educate and train our doctors. 2013

groups in 2014 to focus on the requirement for new and different roles to inform workforce development investment and future education commissioning decisions. Primary care will be a key focus of this activity.

Health Education South London (HESL)

Health Education South London's approach to the on-going development of the primary care workforce is twofold, encompassing a short- and long-term view. In the short term, HESL has made a direct Continuing Personal and Professional Development (CPPD) allocation of £1.2 million available for staff working in primary care in both 2013/14 and 2014/15 (a total of £2.4 million over two years). This money has been distributed to CCGs based on weighted capitation. HESL's Primary Care Forum (PCF) which acts as the advisory group to the HESL Board on matters relating to primary care, recommended that CCGs focus the CPPD money on bands 1-4, practice reception staff, HCAs working in primary care, practice managers and practice nurses. The PCF also noted that the funding could be used for clinical staff where no other allocation was available. In addition to the direct allocation made to CCGs, an indirect allocation of £400,000 was lodged with south London HEIs for practice staff to access. In 2014/15 this indirect allocation was overspent for the first time. In the future, the intention is for the CPPD budget for primary care staff to be allocated to the CEPNs rather than the CCGs and for the CEPNs to coordinate the on-going development needs of their local workforce. The above funding allocations were made in addition to funding for general practice nurse training and mentorship training for nurses working in primary care.

Health Education North Central and East London (HE NCEL)

A key priority for Health Education North Central and East London is to support the development of integrated care, especially across organisational boundaries. Local health economies have been invited to bid for up to £250,000 per borough to support education and training interventions that support integrated care based education. This has resulted in significant conversations and partnership arrangements that have previously not been possible. HE NCEL has engaged primary, community, secondary and social care providers in working together on workforce development opportunities. By the end of 2014, there will be a multi professional educator-led CEPN with cross-boundary engagement in every borough across HE NCEL. It is anticipated that as these CEPNs mature they will support local workforce planning, programme coordination, faculty development, support local workforce continuing professional development, and achievement of relevant HEE mandates. It is hoped they will be able to support both future and current workforce development.

The development of CEPNs is being supported through infrastructure funds and peer group support and is linked to a broader movement taking place across all three LETBs in London and Kent, Surrey and Sussex[16].

- Additional funding is likely to be provided to support apprenticeships in primary care (including both general practice and community pharmacy).
- A number of projects cross organisational boundaries and have a general practice element. For example, the mental health programme, which has included a successful

16 www.radcliffehealth.com/community-based-education-providers-network-opportunity-unleash-potential-innovation-primary-care

project to train practice nurses in the foundations of mental health; and the dementia project, which trained over 13,000 staff last year in dementia awareness (including many in primary care) and will achieve the same in 2014/15.

- Leadership development programmes have been commissioned for the broad primary care workforce from the London Leadership Delivery Partnership as well as the Florence Nightingale Nursing Programme. The programmes have been offered to the network of general practice nurses and nurses sitting on governing bodies in north central London.

A number of initiatives are already in place to deliver prototype education and delivery models; for example CEPNs, which are being developed and tested as collectives or networks of primary and community organisations working collaboratively to enhance educational delivery in local geographical contexts. The LETBs believe that the CEPNs offer an unprecedented opportunity for the development of the primary care workforce including the development of new roles where appropriate. By understanding both the local population and the existing workforce within their geographic areas CEPNs will be able to ascertain the development needs of existing staff and be able to identify the future workforce required to deliver on CCG commissioning intentions. This may include new roles such as care navigators or the use of physician associates in general practice depending on local need.

CEPNs are being used as the mechanism to bring workstreams together within a defined geography. Their work currently includes:

- developing testing and evaluating new roles – with higher education provider involvement
- drawing together feedback from engagement with local stakeholders. Understanding future requirements in relation to preparation, supply and development of the primary care workforce
- exploring how to increase undergraduate and foundation placements for doctors to promote positive experiences of primary care and encourage choice of general practice as a career
- explore ways to provide inter-professional learning opportunities in community settings.

CEPN development must include the fostering of learning organisations in primary and community care. Currently LETBs accredit GP practices for training, and HEIs accredit practices and community providers for nurse and undergraduate medical teaching. Other AHPs are trained in a variety of community placements. However the transformation of primary care service delivery requires a transformation in primary care education and training facilities. In the same way that hospitals educate multidisciplinary teams, all primary care and community care providers could become education providers. CEPNs will be well placed to drive this necessary development as both education managers and education providers to their local professionals, commissioned by LETBs.

It is now important for partners associated with workforce development in London to collaborate to ensure a coordinated approach. This will include:

- working together to analyse future workforce requirements in London

- working to improve the recruitment and retention of clinical staff
- developing working practices to support the delivery of person-centred integrated care
- representing London's priorities on national workforce initiatives.

Technology implications

Whilst this *Framework* does not aim to provide a technology blueprint for London, technology and digital health care provision will play an increasingly significant role in general practice service delivery. Technology will be a key enabler to delivering the service specification for proactive, accessible and coordinated care. There is already a considerable spectrum of useful technologies implemented or being implemented across the capital such as those outlined in the National Information Board publication *Personalised Health and Care 2020*. However uptake of the available technology is varied and existing arrangements for information sharing are currently limited.

In order to best address the needs described in this document, there should be a focus on maximising the use of the technology available; empowering the patient, and ensuring that there is interoperability between systems and across providers.

Primary care teams in the future will need to rely less on co-location, but instead will be able to come together virtually around a patient to design services. This does not need to be using the same type of technology, but ensuring that communication can occur seamlessly across systems will improve teamwork and the patient experience.

People should be empowered with information about their care that: supports them to participate in care planning; helps set personal health goals; and enables them to better manage their own health independently.

New advances in digital healthcare will provide patients with more choice about how they access services and what they access. This will require active promotion of the new access approaches available.

Technology to enable proactive care

Proactive care services will be best enabled by the integration of general practice systems with other systems and applications sitting outside of general practice:

- Online wellbeing assessments that identify lifestyle risks and enable people to establish personal goals for staying healthy
- Online resources to support health improvement e.g. apps and information services
- Online communities that enable people to learn and care for each other based on similar experiences of living with, and managing physical, social and psychological challenges.

Existing systems can be used to identify people not making best use of healthcare resources and to reach out to those people not accessing care. Systems can also be enhanced to track patient reported symptoms and investigations, highlighting those at greater risk of, for example, cancer.

Technology to enable access

Providing improved access will require all practices in London to make use of the systems in place for online appointment booking, ordering of repeat prescriptions and giving people access to their care records. These will be provided through a single place for all Londoners via 'Patients Online'. The evidence on the effectiveness of phone and email appointments is still relatively limited. However in this digital age, they are expected to become the norm and are already provided in many practices in London. Video conferencing may also become more commonplace. Other new systems already in operation in some parts of London, that are likely to become more widespread include:

- telephone triage and email appointment systems
- summary care records
- electronic prescribing service
- e-referral service.

Technology to enable care coordination

Coordinating care requires timely information exchange, across a multidisciplinary team, with patients and their carers. This will require general practice to have interoperable systems with other providers to enable shared management of patient information through an integrated patient-held care record.

Technology to modernise care

In addition to the technologies that will enable delivery of the service specification, there are many other examples of new technologies that are modernising care in general practice settings. Just a few examples include:

- online communities of practitioners, building relationships and sharing knowledge to deliver improved care
- remote monitoring and diagnostic devices, enabling patients to be cared for in the comfort of their own home; and new devices bringing hospital-based diagnostics into the general practitioner's consulting room
- hand-held care record devices that allow practitioners to bring care away from the computer and alongside the patient and other practitioners.

Technology strategies

The technology available in each part of London varies and future development strategies for technology will need to be arranged in each local area. However there is a need to work together to:

- ensure wider strategic technology objectives relating to primary care are being met (such as those referenced in *Personalised Health and Care 2020*)
- identify where there may be advantages in implementing some technologies at a greater scale e.g. moving a range of different health, community, mental health and social care providers to a common interoperable system

- agree, across commissioners and providers, key design principles for future technology to enable patient-centred coordinated care and information exchange across organisational boundaries
- encourage the uptake of best practice. These groups will also encourage the uptake of best practice in the use of technologies and this is also reflected in the new approach of the CQC.

Achieving the vision outlined relies on general practice teams across London embracing new technology and ensuring it is used and promoted to patients. A baseline assessment of the current infrastructure in general practice and the extent to which it is used will underpin the development of technology strategies for primary care transformation in London.

The technology changes required to deliver this specification are well supported by the ambitious plans of the National Information Board in their publication *Personalised Health and Care 2020*, which lays out a timeline of technology improvements from now to 2020.

Estates

As evidenced in the recent London Health Commission report *Better Health for London*, the quality of the general practice estate is highly variable and there is a real challenge to improve it. This means poor patient experiences, poor working conditions for London GPs and lost opportunities to improve health and healthcare. In order to deliver the *Framework*, it is expected that modern, state of the art facilities will be required. It is likely that general practice will need to transition out of the existing estate gradually as investment is made in more modern buildings.

Overview Timeline of NIB Framework Milestones

By March 2015 proposals will have been set out to extend and enhance the MyNHS service on NHS Choices.

From March 2015 all citizens to have access to their GP records online.

From April 2015 mandatory use of NHS number as primary identifier in clinical correspondence and for identifying all patient activity.

By June 2015 the HSCIC will develop proposals with industry for personal data usage reporting.

By September 2015 proposals to be published for linking 111 with NHS Choices.

By October 2015 HSCIC, CQC, Monitor and NHS TDA to publish data quality standards for all NHS care providers.

By April 2016 HEE will introduce a new knowledge and skills framework for all levels of the health, care and social care workforce.

By 2018 clinicians in primary care and other key transitions will be operating without the use of paper records.

From March 2018 all individuals will be able to record their own comments and preferences on their care record.

By 2020 all care records will be digital real-time and interoperable.

London's GP practices are largely found in converted residential buildings – many are in poor condition. Many parts of the estate are not fit for the purpose and are underutilised. *Better Health for London* reported that 34% of premises need to be rebuilt and 44% are in need of repair. Often, even the most basic disabled access requirements are not in place. There are two main causes for this state of affairs: insufficient investment and fragmented decision-making on primary and out-of-hospital estate; and a lack of incentives for GPs to move from existing residential conversions to modern purpose-built facilities.

The NHS does not have any new funding to spend on fixing these problems and therefore must look to address the issues within the system. There are huge opportunities in the current (high value, even if it is in poor condition) estate. The estate could be used for health and care but also for public / social sector use, with the possibility of 550,000 new homes by 2021 and 118,000 new school places by 2016/17.

Investment required

Better Health for London set out that approximately £1 billion needs to be invested in the GP estate in London. The commission calculated that this investment, over five years, would secure modern general practice that is accessible to all Londoners.

This scale of investment would represent just 4% of the national NHS capital budget over the next five years, and 26% of London's share of the national NHS capital budget (assuming it is equally distributed across the country based on population).

It is vital that these investments are led through a partnership of CCGs, NHS England, and local authorities. The opportunity to include wider public services – such as leisure facilities, citizen's advice, libraries and education – should be explored.

Better Health for London also recommended that NHS England should reform the rent reimbursement system for GP premises, increasing incentives for GPs to move to more appropriate premises.

Commissioners across London have welcomed the *Better Health for London* recommendation on estates and are currently formulating their response.

Provider development requirements

GP provider development is fundamental to the success of primary care transformation in London and the implementation of the *Framework*. The strategic direction is ambitious, and the operational changes, working routines and learning needs are significant.

General practice teams and their health and care partners need to be supported in owning the new vision for primary care and be clear about the benefits it will deliver. This will require focused support and interventions so that general practice teams can co-develop solutions to the new operational requirements. There will be many attributes and behaviours to nurture in general practice, but the roles of effective leadership and collaboration are fundamental. Development and support programmes and activities should be flexible, tailored and provide practical support to a range of professionals across general practices. The intra- and inter-organisational development needs should not be underestimated, to ensure change happens.

The following diagram, provided by South West London Collaborative Commissioning partnership, identifies GP provider development requirements.

There is not a natural forum in London to bring together and support system change leaders to transform primary care. London would greatly benefit from an agreed forum for commissioners, providers and lead partners such as local authorities and the voluntary sector to share innovation and learning about transforming primary care.

London's NHS should set out a strategic and comprehensive approach to building system capacity and capability for change in partnership with London and national partners. This should include a phased plan mapped to a development journey of emerging organisations which can respond to their evolving development needs over time.

Potential GP provider development requirements

Monitoring and evaluation

Providers and commissioners will be able to consider progress across the capital through a monitoring and evaluation framework. This will have a dual purpose:

A: Information to enable provider development

- To provide tools that support continuous improvement of general practice in both service delivery and health outcomes
- To enable peer learning and development across a wider geographical population

Self-Assessment	Impact	Monitoring	Learning
1. Practices complete an **individual** assessment (how am I doing?) then a **collective** assessment (how are we doing when we consider the network/group together). This can be used for best practice sharing and development discussions	**2.** This can be triangulated with other evaluations and outcome data (CQC, GP outcome standards, high level indicators, GPES, staff survey)	**3.** Additional process measures may be agreed and monitored locally as required for improvement	**4.** Practices across London will be encouraged to share innovative and successful approaches to improvement via learning networks

B: Information to provide commissioning assurance

- To demonstrate value for money from new investments
- To provide information on delivery, learning and impact; evidencing change and improvement

Self-Assessment	Impact	Monitoring	Learning
1. The collective assessment will require the support of local HealthWatch and H&WBB.	**2.** These will be triangulated with CQC evidence and inspection output, GP outcomes standards, high level indicators, and GPES to evaluate impact	**3.** A small number of 'proxy markers' will signal that things are improving. Sample visited or asked to share more detail on improvement work underway.	**4.** Practices across London will be encouraged to share approaches to leverage improvements at pace

The approach will encourage progression towards at-scale primary care organisations (in their various forms). The *Framework* will monitor improvements at both individual practice and at grouped practice/wider population levels. This approach to monitoring and evaluation work supports integrated care and practices working together on quality improvement at a population level. The direct impact that general practice developments have on population health and wider system activity are difficult to isolate from wider system changes. It is therefore important, in developing co-commissioning arrangements, to look towards monitoring the impact of whole systems on population health outcomes (this will be complemented by the work of the CQC in this area) as well as patient enablement and person-centred care and changes in overall activity.

Sources of information

General practices in London are already subject to considerable monitoring and assurance controls. The approach taken will use existing datasets and collection processes in order to minimise additional administrative burden on practices. Information will be drawn from CQC assessments, GP outcome standards, high level indicators, QOF and the national GP patient experience survey; forming a picture of progress to deliver the new service specification. In addition the following will be considered:

- An **extension of the annual self – declaration used by practices to provide assurance of contractual delivery**. This would include an appraisal of progress to deliver the new service specification (unless a suitable alternative approach is available through CQC).
- A small number of '**proxy markers**' identified from existing data sets that provide additional assurance that improvements are having an impact. These act as a signal to undertake further enquiry and evaluation where measures are inconsistent with information provided through self-declarations.
- **Refreshed national GP Patient Experience Survey** to reflect changes in the patient offer (the national team is considering ways in which the survey can reflect different models of care across the country).
- A **new survey of working lives** to monitor the impact of these changes on staff.

The self-assessment tool

As described above, the annual self-declaration could be extended to include an online self-assessment tool. This would form the basis of a self-appraisal that can be undertaken by general practice teams, assured by people working with each practice and shared as a tool for enhanced development. The self-assessment tool will be designed in collaboration with various stakeholders in order to ensure this provides an appropriate reflection of progress and outcomes. The business intelligence team at NHS England (London) will establish a monitoring and evaluation reference group in order to ensure this work continues to align with, and not duplicate, the approach being undertaken by the CQC. An updated CQC assessment framework was published in October 2014. The design group will review this and may conclude that the

CQC evaluation is sufficiently comprehensive and that a new self-assessment tool is not required. The reference group will finalise an approach with the aim to have monitoring tools and processes in place as implementation begins.

Keeping Londoners informed of service changes

NHS Choices provides patients with a single online portal through which they can access information about services provided through general practice. Patients will be keen to know whether services are improving in their local area and what service changes are being planned, including any changes to access arrangements. NHS England (London) and CCGs working with local providers will need to ensure any service changes are well communicated and explained through both NHS Choices and other methods.

Next steps

This *Framework* outlines a specification for general practice which aims to transform primary care. It also provides an analysis of the supporting work required to do this.

It is by definition a framework, as its purpose is to provide guidance for commissioners when making strategic plans and decisions on primary care, and outlines how the vision of a transformed service can be achieved. It represents a new consistent patient offer for all Londoners. However this document is not intended to provide the solution for how these changes are delivered throughout London as local plans are expected to be built on top of this foundation.

In November 2014 this document will be shared with CCGs in London prior to a period of local engagement (expected to be December 2014 – April 2015). This engagement will be conducted with health and wellbeing boards, local authorities and the CQC, as well as the public and member practices. This will help to develop deeper understanding of how the vision and specification can and should be delivered in local areas, including consideration of the fit with wider local plans. During the engagement period, consideration of how the specification will be delivered over a five year period will be discussed and agreed for each local area.

The ambitions outlined in this document will continue to be developed by CCGs and NHS England based on the findings of the engagement and continued consideration of key areas such as finance and workforce. An update outlining progress made on delivery plans in each local area is expected to be released in April 2015.

Investment and development of primary care transformation as described in this document is expected to start from April 2015. Although elements of the specification are already being delivered in some parts of London, in order to realise the vision of high quality general practice for everyone, it is expected to require a long term commitment from all commissioners of health and care in London.

Appendix 1: Governance board members

The below list indicates the membership of the transformation, clinical and delivery group boards as of November 2014. Please note – the patient board members are not included here to protect identities.

Our thanks go out to all board members, past and present.

Primary Care Transformation Board:

Co-Chairs:

- Dr Anne Rainsberry, Regional Director, NHS England (London Region)
- Dr Marc Rowland, Chair of the London Clinical Commissioning Council; Chair, Lewisham Clinical Commissioning Group

Members:

- Dr Sanjiv Ahluwalia, Primary Care Lead, Health Education North Central and East London
- Shahed Ahmed, Director of Public Health, London Borough of Enfield
- Ronke Akerele, Director of Programmes, Change & Performance Management, Imperial College Health Partners
- Caroline Alexander, Chief Nurse, Nursing Directorate, NHS England (London Region)
- Jane Barnacle, Director of Patients & Information, NHS England (London Region)
- Paul Bennett, Area Director for North Central and East London, NHS England (London Region)
- Alison Blair, Chief Officer, NHS Islington Clinical Commissioning Group
- Andrew Bland, Chief Officer, NHS Southwark Clinical Commissioning Group
- Eleanor Brown, Chief Officer, NHS Merton Clinical Commissioning Group
- Dr Charles Bruce, Managing Director, Health Education North West London
- Prof Adrian Bull, Managing Director, Academic Health Science Network, Imperial College Health Partners
- Helen Bullers, Director of HR & OD, NHS England (London Region)
- Conor Burke, Chief Officer, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups
- Helen Cameron, Director of Transformation, NHS England (London Region)
- Jane Clegg, Director of Nursing, NHS England (London Region); Co-Chair, Primary Care Transformation Patient Board
- Karen Clinton, Head of Primary Care Commissioning (NW London), NHS England (London Region)
- Dr Nav Chana, Chair of the Proactive Care Expert Panel; Chairman NAPC; Joint Director of Education Quality for Health Education South London
- Sir Cyril Chantler, Board Member, London Health Board
- Dr Tom Coffey, Chair of the Accessible Care Expert Panel; Co-Clinical Lead for Urgent & Emergency Care, London Region
- Ged Curran, Chief Executive Merton Council; London Chief Executive Lead on Adult Services
- Dr Charlie Davie, Director of the Academic Health Science Network, UCL Partners
- Dr Michelle Drage, Chief Executive, Londonwide Local Medical Committee
- Dr Sam Everington, GP; Chair, NHS Tower Hamlets Clinical Commissioning Group
- Dr Clare Etherington, Head of Primary Care Education and Training, Health Education North West London
- Andrew Eyres, Chair of London Chief Officers Group; Chief Officer, NHS Lambeth Clinical Commissioning Group
- Prof Sir David Fish, Academic Health Science Network, UCL Partners
- Prof Chris Fowler, Managing Director, Health Education North Central and East London
- Professor Howard Freeman, previous Chair, London Clinical Commissioning Council
- Dr Clare Gerada, Clinical Chair, Primary Care Transformation, NHS England (London)
- Jemma Gilbert, Head of Primary Care Transformation, NHS England (London Region)
- Steve Gilvin, Chief Officer, NHS Newham Clinical Commissioning Group
- Claire Goodchild, Chief Officer, London Health Board
- Terry Huff, Chief Officer, NHS Waltham Forest Clinical Commissioning Group
- Aurea Jones, Director of Workforce, Health Education South London
- Zoe Lelliott, Director of Strategy and Performance, Health Innovation Network, South London
- Paula Lloyd-Knight, Head of Patient and Public Voice, NHS England (London Region)
- Dr Andy Mitchell, Medical Director, Medical Directorate, NHS England (London Region)

- Neil Roberts, Head of Primary Care Commissioning (North Central and East London) NHS England (London Region)
- Paul Roche, Programme Director, Primary Care Transformation, NHS England (London Region)
- Dr Rebecca Rosen, Chair of the Co-ordinated Care Expert Panel; GP Board Member, NHS Greenwich Clinical Commissioning Group; Senior Fellow Nuffield Trust
- Thirza Sawtell, Director of Strategy and Transformation, NHS North West London Collaboration of Clinical Commissioning Groups
- Dr Kanesh Rajani, London GP; Governing Body Member, NHS Harrow Clinical Commissioning Group
- Stuart Saw, Head of Financial Strategy, NHS England (London Region)
- Grainne Siggins, Director, Adults Social Care, London Borough of Newham
- David Slegg, Director of Finance, NHS England (London Region)
- Dr Chris Streather, Managing Director, Academic Health Science Network, South London
- David Sturgeon, Head of Primary Care Commissioning (South London), NHS England (London Region)
- Dawn Wakeling, Director, Adults and Community, London Borough of Barnet
- Simon Weldon, Director of Operations and Delivery, NHS England (London Region)
- 3 x patient representatives

Primary Care Transformation Patient Board:

Co-Chairs:

- Jane Clegg, Director of Nursing, NHS England (London Region)
- 1 x patient representative

Members:

- 24 x patient representatives

Primary Care Transformation Clinical Board:

Chair:

- Dr Clare Gerada, Clinical Chair, Primary Care Transformation, NHS England (London)

Members:

- Sheila Adam, Chief Nurse and Director of Governance, Honorary Professor of Nursing Leadership, Homerton University Hospital NHS Foundation Trust
- Eileen Bryant, Nursing Advisor, NHS England (London Region)
- Tony Carson, Pharmacy Advisor, NHS England (London Region)
- Dr Nav Chana, Chair of the Proactive Care Expert Panel; Chairman NAPC; Joint Director of Education Quality for Health Education South London
- Jane Clegg, Director of Nursing, NHS England (London Region); Co-Chair, Primary Care Transformation Patient Board
- Dr Tom Coffey, Chair of the Accessible Care Expert Panel; Co-Clinical Lead for Urgent and Emergency Care, London Region
- Sarah Didymus, Independent Nurse Practitioner; Darzi Fellow in Community Nursing
- Dr Murray Ellender, Liberty Bridge Road Practice, Newham
- Dr Angelo Fernandes, Assistant Clinical Chair, NHS Croydon Clinical Commissioning Group
- David Finch, Medical Director (NW), NHS England (London Region)
- Dr Jane Fryer, Medical Director (South), NHS England (London Region)
- Jemma Gilbert, Head of Primary Care Transformation, NHS England (London Region)
- Dr Jonty Heaversedge, Clinical Chair, NHS Southwark Clinical Commissioning Group
- Dr Isobel Hodkinson, Principal Clinical Lead, NHS Tower Hamlets Clinical Commissioning Group; RCGP Clinical Champion for Person-centred Care and Support Planning
- Dr Sian Howell, PM Challenge Pilot representative; NHS Southwark Clinical Commissioning Group and Bermondsey and Landsdowne Medical Centre

- Dr Jagan John, PM Challenge Pilot representative; NHS Barking and Dagenham Clinical Commissioning Group
- Dr Nicola Jones, Clinical Chair, NHS Wandsworth Clinical Commissioning Group
- Dr Alex Lewis, Medical Director and Director of Quality (Mental Health), Central and North West London NHS Foundation Trust
- Dr Steven Mowle, Board Member, RCGP South London, NHS Lambeth Clinical Commissioning Group
- Maria O'Brien, Divisional Director, Central and North West London NHS Foundation Trust
- Dr Tony O'Sullivan, Community Paediatrician, Lewisham and Greenwich NHS Trust
- Terry Parkin, Director of Children's Services, London Borough of Bromley
- Dr Mohini Parmar, PM Challenge Pilot representative; Clinical Chair, NHS Ealing Clinical Commissioning Group
- Virginia Patania, Practice Manager, Jubilee Street Practice, East London
- Dr Niraj Patel, GP partner, Thamesmead Medical Associates; Visiting Fellow in Health Policy, The Nuffield Trust; Executive Member, NAPC
- Dr Arup Paul, Locum GP, Medical Director at HCML
- Dr Julian Redhead, Consultant in Emergency Medicine and Clinical Programme, Director for Medicine, Imperial College Healthcare NHS Trust
- Paul Roche, Programme Director, Primary Care Transformation, NHS England (London Region)
- Dr Rebecca Rosen, Chair of the Co-ordinated Care Expert Panel; GP Board Member, NHS Greenwich Clinical Commissioning Group; Senior Fellow Nuffield Trust
- Dr Tina Sajjanhar, Consultant Paediatrician, Lewisham and Greenwich NHS Trust
- Dr John Sanfey, Appraisal & Revalidation Lead, North West London Area Team, NHS England (London Region); Freelance Chambers GP
- Grainne Siggins, Director of Adult Services, London Borough of Newham
- Ashi Soni, NHS Lambeth Clinical Commissioning Group; Royal Pharmaceutical Society Board Member
- Dr Mark Spencer, Deputy Regional Medical Director, NHS England (London Region)
- Karen Stubbs, Project Director, First4Health Federation
- Fiona White, NHS Merton Clinical Commissioning Group
- Dawn Wakeling, Adults and Communities Director, London Borough of Barnet
- Jane Wells, Adult Community Services Director, Oxleas NHS Foundation Trust
- 1 x patient representative

Primary Care Transformation Delivery Group:

Chair:

- Paul Roche, Programme Director, Primary Care Transformation, NHS England (London Region)

Members (those not included in Transformation Board):

- Carl Edmonds, Deputy Director of Delivery, NHS Waltham Forest Clinical Commissioning Groups
- Olivia Farnesy, Communications Manager, NHS England (London Region)
- Delvir Mehet, Deputy Head of Commissioning and System Development – OD, NHS England (London Region)
- Ginny Morley, Assistant Director, South West London Collaborative Commissioning Group
- Andrew Parker, Director of Primary Care Development, NHS Southwark Clinical Commissioning Group
- Mike Part, Head of Strategic Systems and Technology, NHS England (London Region)
- Paul Price-Whelan, Senior Financial Strategy Accountant, NHS England (London Region)
- Katie Robinson, Head of Analytical Services, NHS England (London Region)
- Sarah See, Programme Director, Primary Care Improvement, Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups
- Philip Spivey, Regional Head of HR, NHS England (London Region)
- Matthew Walker, Programme OfficeLead, NHS North West London Collaboration of Clinical Commissioning Groups
- Gary Williams, Senior Manager, Analytical Services, NHS England (London Region)

Glossary

A&E	Accident & Emergency
AHP	Allied Health Professional
AHSCs	Academic Health Science Centres
AHSNs	Academic Health Science Networks
APMS	Alternative Provider Medical Services Contract
BCF	Better Care Fund
CCGs	Clinical Commissioning Groups
CCP	Clinical Challenge Panel
CEPNs	Community Education Provider Networks
CQC	Care Quality Commission
CSUs	Commissioning Support Units
DH	Department of Health
GLA	Greater London Authority
GMS Contract	General Medical Services Contract
GP	General Practitioner
GPOS	General Practice Outcome Standards
HCA	Health Care Assistant
HEE	Health Education England
HEI	Higher Education Institutes
HENCEL	Health Education North Central and East London
HENWL	Health Education North West London
HESL	Health Education South London
HSCIC	Health and Social Care Information Centre
HWB	Health and Wellbeing Board
IPC	Integrated Personal Commissioning
KSS	Kent, Surrey and Sussex
LES	Local Enhanced Services
LETB	Local Education and Training Board
LHC	London Health Commission
LMC	Local Medical Committee
London-wide LMC	Londonwide Local Medical Committee
LTCs	Long term conditions
MCP	Multispecialty Community Provider
MDT	Multi-Disciplinary Team
Monitor	NHS regulator
NAPC	National Association of Primary Care
NHS	National Health Service
NHS IQ	NHS Improving Quality
NHS TDA	NHS Trust Development Authority
NIB	National Information Board
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
PACs	Primary and Acute Care Systems
PCN	Primary Care Navigator
PHE	Public Health England
PMS	Personal Medical Services Contract
PPEG	Patient and Public Engagement Group
PPG	Patient Participation Group
QIPP	Quality, Innovation, Productivity and Prevention Scheme
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
SCN	Strategic Clinical Network
SPG	Strategic Planning Group
SWLCC	South West London Collaborative Commissioning partnership
WTE	Whole Time Equivalent