Report No. **London Borough of Bromley**

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date: **January 2015**

Report Title: Overview of Primary Care Developments

Report Author: Mark Needham, Director of Commissioning, Bromley CCG

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1. SUMMARY

Bromley CCG is developing an ambitious Primary Care transformation programme to support local practices and achieve the best outcomes for patients. This is part of the national and London policy agenda which consists of two key initiatives.

- Primary Care co-commissioning
- London Primary Care framework

And one local initiative

- Review of Primary Care contracts

Detailed papers are attached on the first two

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

For engagement and to note as per NHS England recommendations

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3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSTITUENT PARTNER ORGANISATIONS

The board is asked to note the developments and feedback on key areas as part of the engagement process to inform the development of the Primary Care vision in the Borough.

Health & Wellbeing Strategy

In principle all:

1. Related priority: Diabetes, Hypertension, Obesity, Anxiety & Depression, Children with Complex Needs and Disabilities, Children with Mental & Emotional Health Problems, Children Referred to Children's Social Care, Dementia, Supporting Carers

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Financial N/A

Supporting Public Health Outcome Indicator(s)

N/A at this point

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4. COMMENTARY

Primary Care co-commissioning

CCGs nationally and in London are submitting an expression of interest to NHS England (30th January 2015) to take on responsibilities around the commissioning of primary care.

- The options are: 1) maintain current arrangements 2) joint commissioning with NHS England 3) delegated commissioning (CCG taking everything including the GP contract)
- As a membership organisation the Governing Body felt it was important to call a **vote** to ensure full engagement and support for our preferred option, as well as implications for changes in our Constitution.
- Potential issues are **perceived conflicts of interest** (ie GPs being part of a commissioning organisation that would hold contracts with their practices) and ensuring robust overall **governance arrangements** with meaningful engagement with local stakeholders and patient groups.
- The CCG is working through the issues at a SE London level and also through a local engagement process including the Health & Wellbeing Board and other forums.
- Our GP members are fully briefed on the process as the topic has been subject to debate at the local Commissioning Clusters and Membership Body meetings
- Whilst we will be guided by our members, our **Executive view** is option a) would not enable us to achieve the scale of our ambition for Primary Care development. No CCG will be allowed to move to level 3 automatically. There is an option, being considered by other CCGs in SE London, to select option 2 (joint) with the intention to move to level 3 in year (delegated).
- Financial risk –the financial risk of taking back responsibilities for the GP contract at this point is significant, as it is not known how the indicative budgets we have received actually

relate to the real cost of Primary Care contracts that we would hold responsibility for under option 3 (delegated commissioning)

- CCGs would take on commissioning responsibilities from 1st April 2015.

London Primary Care Framework

In parallel, the CCG is engaging in January on the development of the framework which outlines key standards or characteristics of primary care provision. This has been developed by NHS England, with significant involvement from stakeholders and clinical leaders.

The framework sets out an ambitious set of challenges for primary care, with the high profile issue of **8am-8pm access to Primary Care.**

Whilst the framework provides a helpful starting point to initiate the debate with our members and stakeholders, it is important that we develop a shared vision of how **Primary Care in Bromley** should look in the next 5 to 10 years. Including, the role of Primary Care in relation to: Integrated networks of health and social care (Local Care Networks) and public health and prevention.

The framework includes an outline of financial resources required to deliver this type of vision, which is aligned with the CCG's aspiration to transfer up to 5% of the operating budget into Primary Care provision over the next 5 years, based on sound, evidenced based business cases. This will require significant system transformation to ensure acute resources are redeployed effectively and appropriately into an out-of-hospital model of care without destabilising the hospital base.

Local initiatives - review of Primary Care contracts

The CCG is also currently reviewing the c£1m of local contracts with Practices (formerly known as Enhanced Services). This will ensure all contracted services are of standardised quality and access for patients across the Borough.

5. FINANCIAL IMPLICATIONS

N/A

6. LEGAL IMPLICATIONS

N/A

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

The Members' decision on Primary Care Co-commissioning will be discussed in public at the CCG Governing Body 22nd January 2015.

8. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

Insert text here - please include a short comment from your respective organisation director.

Non-Applicable Sections:	[List non-applicable sections here]
Background Documents: (Access via Contact Officer)	[Title of document and date]

Primary Care Co-commissioning

Informing membership engagement

November 2014 to January 2015

1. Membership engagement

The purpose of this document is to support member practice engagement in our developing approach to the co-commissioning of primary care in Bromley.

We want practices and patients to shape our approach to co-commissioning as a CCG and help us decide how we should best use the current opportunity for CCGs to take greater control of the commissioning of local primary care services to improve the health of our population.

We had a very useful discussion at our membership meeting on the 26th November and would now like further discussions to take place in practices. We hope this document will be helpful in generating and informing your discussions. We will also be engaging with patients and the public over this period to ensure that their voices are heard.

We first discussed co-commissioning with you in June. Since that time this policy has developed nationally and over the last few months more concrete proposals have been produced by NHS England to inform our decision-making, culminating in the publishing of guidance to take this forward.

The NHS has now published a Five Year Forward View. This document makes clear that a new deal must be created for primary care to secure a sustainable future for the NHS and that co-commissioning of primary care should be established in one form or another across England. National policy appears to have shifted from a position of possibility to a place of certainty.

We are very keen to hear your views. There are a number of aspects to this decision that need to be considered and advantages and disadvantages to each. It is essential that we take this time to thoroughly examine these proposals and make a decision in the best interests of our patients.

2. Primary Care co-commissioning

Primary care co-commissioning provides an opportunity for CCGs to take greater control of the planning, strategic direction, priority setting and decision making around primary care services in their local area.

Although it is referred to as co-commissioning of 'Primary Care' the current opportunity outlined by NHS England is focused on general medical services only, at least for 2015/16.

We now anticipate that some form of co-commissioning will exist in every part of the country but it is clear that the level of involvement in this can be determined by CCGs. The options are:

1. Greater Involvement in NHS England decision-making
2. Joint decision making by NHS England and CCGs
3. CCGs taking on delegated responsibilities from NHS England

The remainder of this document refers to these as the levels of co-commissioning and it is this level of involvement that is central to this engagement process. We must give focus to one overriding question:

What form of co-commissioning of primary care services in Bromley would deliver the best outcomes for patients in Bromley

3. What is the wider context?

This discussion is not held in isolation. It sits as part of a drive towards the alignment and focus of decision making of the various parts of the health and social care system towards meeting the needs of a local population – across primary and community care, social care, acute, mental health and specialist care. This is often referred to as 'Place-based commissioning'.

Importantly it seeks to identify and bring commissioners together to use one pot of money to meet the specific needs of the local population, whilst recognising that budgets for all parts of the system are shrinking. In the context of a reducing 'pot' it is critical we can all demonstrate the best possible value is being derived from every pound spent. We believe that in order to do that funds will need to be shifted to those parts of our system that represent the best value.

It is our long held belief that best value is derived from preventative and early action in all parts of the system and through the enhanced delivery of community based and integrated care.

The Five Year Forward View (October 2014) also describes the need for new models of care to which primary care will relate and it outlines 'A new deal for primary care' – See the extract at **Appendix One**. Amongst the steps it outlines to achieve this it includes:

Give GP-led Clinical Commissioning Groups more influence over the wider NHS Budget, enabling a shift in investment from acute to primary and community services (p19)

4. What are the stated aims of co-commissioning?

The overall aim of primary care co-commissioning is to harness the energy of CCGs to create a joined up, clinically-led commissioning system which delivers seamless, integrated out-of-hospital services based around the needs of local populations.

NHS England identifies the potential benefits as:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- High quality out-of-hospitals care;
- Improved health outcomes, equity of access, reduced inequalities; and
- A better patient experience through more joined up services.

And co-commissioning is…

…the beginning of a longer journey towards place-based commissioning.

…a critical enabler of the *NHS Five Year Forward View*: both to implement the new deal for primary care, and to support the development of new models of care…

5. Does this advance our local commissioning goals?

Primary care transformation - At present our commissioning strategy is to transform and ultimately invest more in the primary care system for Bromley believing this will allow us to improve services and the outcomes they secure for our population. At present our ability to do that is limited to those areas where we can make decisions in respect of primary care such as the Local Improvement Scheme. We are unable to take decisions about the wider investment of primary care funds or to determine the proportion of overall NHS spend they represent. This is important as under current arrangements the allocation of funds to primary care, as a standalone national budget, is likely to reduce in future years.

Integrated care and commissioning for outcomes - In terms of integrated approaches to care delivery we have been clear that we wish to commission all providers to work together and be rewarded for the outcomes they secure for residents. Primary care is currently commissioned in isolation from the rest of the local system.

At present we are unable to determine local outcomes that will be rewarded in contracts or to align them with other parts of the system.

Enablers of change - In terms of those things that enable and support change we are unable to agree and fund areas like estates development, IT and workforce changes in a locally responsive way – different parts of the system are responsible for these changes in silos and creating an agreed and localised approach may be advantageous.

Incentives - Where incentives or contracts do change we do not have decision making power in this area. Should PMS be reviewed or QOF arrangements change - this is

currently without reference to local circumstances. Co-commissioning could allow us to localise these levers for change.

A primary care system that is shaped by local commissioning intentions is likely to enhance our ability to achieve progress in these areas or to mitigate the consequences of the current financial challenges the country faces.

6. How is Primary Care commissioned now?

The current commissioning landscape for primary care is complex, with up to three different commissioners – CCGs, NHS England and local authorities… The NHS has recognised the need to make it easier for commissioners to work together and better integrate out-of-hospital services.

Primary Care is commissioned and contracted by NHS England. The commissioning (planning, determination of priorities etc.) of these services is undertaken on a national basis – once for England. The contracting of these services is also undertaken by NHS England but the actual contract management happens regionally and for us this is undertaken by an Area Team for South London. Neither process is currently adjusted for local circumstances – the arrangements are often referred to as a Single Operating Model or SOM.

Importantly co-commissioning offers the opportunity to localise much of this activity and focus it upon local circumstances and population need.

The commissioning and contracting of Optometry, Community Pharmacy and Dentistry is not currently part of the co-commissioning 'offer' and will continue to be undertaken in this way.

Contractual payments, revalidation, appraisal and related activities would also be excluded from this development and would be undertaken by NHS England going forward.

At the current time CCGs do have some involvement and are required under law to 'support' NHS England in improving the quality of primary care services in their local areas.

The CCG has interaction with NHS England around local primary care issues BUT we have no decision making power and our position is one of influence only. In this sense we believe we are already at the first level of co-commissioning.

7. What will be different under co-commissioning of primary care?

The three levels of co-commissioning impact on how things will be different:-

Primary care function	Greater involvement	Joint commissioning	Delegated Commissioning
General practice commissioning	Potential for involvement in discussions but no decision making role	Jointly with area teams	Yes
Pharmacy, eye health and dental commissioning	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role	Potential for involvement in discussions but no decision making role
Design and implementation of local incentives schemes	No	Subject to joint agreement with the area team	Yes
General practice budget management	No	Jointly with area teams	Yes
Complaints management	No	Jointly with area teams	Yes
Contractual GP practice performance management	Opportunity for involvement in performance management discussions	Jointly with area teams	Yes
Medical performers' list, appraisal, revalidation	No	No	No

So what about the hoops to jump through?

At the greater involvement level there is no significant offer made to CCGs. As a result there are few if any 'hoops' to jump through.

Under the joint decision making arrangement we will be asked to create governance and delivery arrangements that are fit for purpose and this would be designed and agreed in partnership with NHS England.

Under delegated arrangements we would be subject to an assurance process that tested our ability to take this responsibility and hold us to account for undertaking it effectively.

8. A 'SWOT' analysis

An analysis of the options has been carried out across South East London in relation to Options 2 and 3, to support your discussions. We have not completed this for Option 1 – greater involvement as this gives minimal change locally.
.
We believe that the remaining two options do represent an enhanced opportunity to make a difference for patients through a different commissioning arrangement and the record of views below provides further detail in that context:

Option 2: Joint decision making

Strengths	Weaknesses
• Enhanced ability to achieve locally responsive, higher quality, equitable and accessible primary care services • Joined up approach to the commissioning of integrated care and pathway delivery that will drive better value and experience of care • Greater opportunity to shift funding from acute to primary and community care settings • Allows a phased approach to co-commissioning with opportunities to learn from the experience of others with delegation as they test the new system – This model allows for greater responsibility to be taken in future • Limited approach may be commensurate with the resources available locally. • The model offers more 'structured influence' in comparison to current arrangements. • Mitigates risk of any transition period where NHS England commissioning roles are changing and of any future policy development post-election	• Fails to maximise local decision making power with shared decision making with a national body • This option may have low impact on changing the health system as a whole in Bromley. • There is less opportunity to influence primary care transformation without full control over commissioning. • Potential NHS England organisational destabilisation could jeopardise their effective involvement in this arrangement. • Model remains more complex than other levels and potentially harder to engage with • Model does not include community pharmacy.
Opportunities	**Threats**
• Opportunity for a phased approach to taking on all primary care commissioning. • To work collaboratively across south east London and benefit from knowledge and experience of NHS England commissioning staff and leadership. • A gradual approach would reduce the risk of us losing sight of the important things we are currently doing. • The CCG would do a better job than NHS England in making primary care commissioning work well and link effectively to our current strategic plans. • Enhanced opportunity to deliver local, south east London and now Five Year Forward View for primary care transformation	• Working with NHS England, where there is a low level of local knowledge or potentially low level of capacity to apply local commissioning intentions. • Taking on additional financial risks. • CCG may be less well-resourced under this joint approach to co-commissioning as opposed to full delegation. • Conflicts of interests are heightened although less so than under full delegation. • Potential to change the dynamic of the CCG as a membership organisation.

Option 3: Delegated responsibilities

Strengths	Weaknesses
• Enhanced ability to achieve locally responsive, higher quality, equitable and accessible primary care services • Joined up approach to the commissioning of integrated care and pathway delivery that will drive better value and experience of care • Greater opportunity to shift funding from acute to primary and community care settings • Offers good strategic fit with the CCG in terms of our programme boards and the local development of population based budgets and commissioning. • It's a high impact model, offering the CCG greater influence (e.g. over QOF and future primary care investment more directly). • Offers the CCG clarity in regard to its responsibilities. • Would support improved engagement of primary care. The CCG understands and therefore can better shape general practice and primary care services. It is also better placed to understand the drivers of variation and take appropriate and proportionate action to address it. • This model would give us more influence over enablers such as premises development.	• There is a challenge in taking on contract management of CCG member practices. • Potentially for more conflicts of interests for CCG governing body members and the wider membership. • Clear uncertainty over whether the CCG will have the workforce capacity and capability to assume full responsibility. • This represents a more significant change in the roles and responsibilities of the CCG at pace. • Model does not include community pharmacy.

Opportunities	Threats
• The CCG is well placed to identify more productive and efficient ways forward for primary care in Bromley. It offers the opportunity to support innovation in practice. An opportunity to commission primary care services which are responsive to local need. • To align Key Performance Indictors and incentives to local need and local priorities. • Offers further opportunities to give additional support to general practice and shift resources / care into the community.	• Conflict of interest may weaken clinically-led commissioning. Public perception of conflict of interest. • Potential to change the dynamic of the CCG as a membership organisation. • Significant extra administrative burden for additional assurance processes. • Lack of capacity and a threat to our ability to complete other important work. • Lack of capacity to work effectively with poorly performing practices in need of support.

9. What else should we be thinking about?

It is important that we are aware of a number of issues that will be critical to making any form of co-commissioning work. We also have to be honest in saying things may change.

As a result those areas are outlined below along with emerging thinking in these areas where it is developed. It is important member practices are engaged in these areas as well.

Financial impact

At present the CCG is not in receipt of the indicative budget it would receive for co-commissioned areas. Ahead of any decisions being made the CCG would want absolute clarity on this and any future commitments or liabilities that may have been made ahead of April 2015.

We do not believe ambiguity in this area should slow our thinking and engagement on what is best for our patients - the financial position for primary care will, in very general terms, be similar at the start whether we co-commission in the ways described above or not.

Our discussions therefore surround the best way to address financial issues and with what level of CCG involvement.

Managing Conflicts of Interest

There is no doubt that with co-commissioning, at any level, conflicts (perceived or actual) heighten. We have robust mechanisms for dealing with this now and we would need to consider how best to enhance them.

However our guiding principle is to retain the maximum possible clinical input.

Resourcing

Primary care is not currently commissioned by the CCG and the management costs of running the organisation do not reflect this responsibility. All parts of the NHS administration are shrinking – CCGs will have reduced their running costs by 10% by 1 April 2015 and NHS England must make greater reductions -15% in the same timeframe.

In any scenario we would need to find efficient and effective ways to manage the system we are either responsible for or working with.

Working together

In light of some of these constraints and issues there is currently active consideration being given to the operation of some functions to support co-commissioning across the six CCGs in south east London – this may allow economies of scale and more objectivity in reviewing conflicts of interest for example. However, an important principle remains – irrespective of shared functions or joint working there would always be a borough focused set of commissioning intentions and local autonomy in decision making.

We would collaborate where it makes sense or works.

10. Where to find out more? What are other CCGs saying?

The LMC has information available on its website –

www.lmc.org.uk

NHS England have also published its next steps guidance which provides a good overview:-

http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf

Guidance is also available from NHSCC:-
http://www.nhscc.org/policy-briefing/things-consider-making-decision-ccgs-involvement-primary-care-commissioning/

Although we know that CCGs across England are considering and reconsidering their positions on co-commissioning we do know that the expressions of interest submitted nationally in the summer indicated the following spread of views across England and London.

Commissioning Form	England	London
A – Influence	19	3
B – Joint Decision making	103	27
C – Full delegation	74	2

Appendix One

Five Year Forward View (October 2014) Extract Page 19

'A new deal for primary care'

General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care.

Steps we will take include:

- 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.

Strategic Commissioning Framework for Primary Care Transformation in London

Briefing for the Bromley membership
January 2015

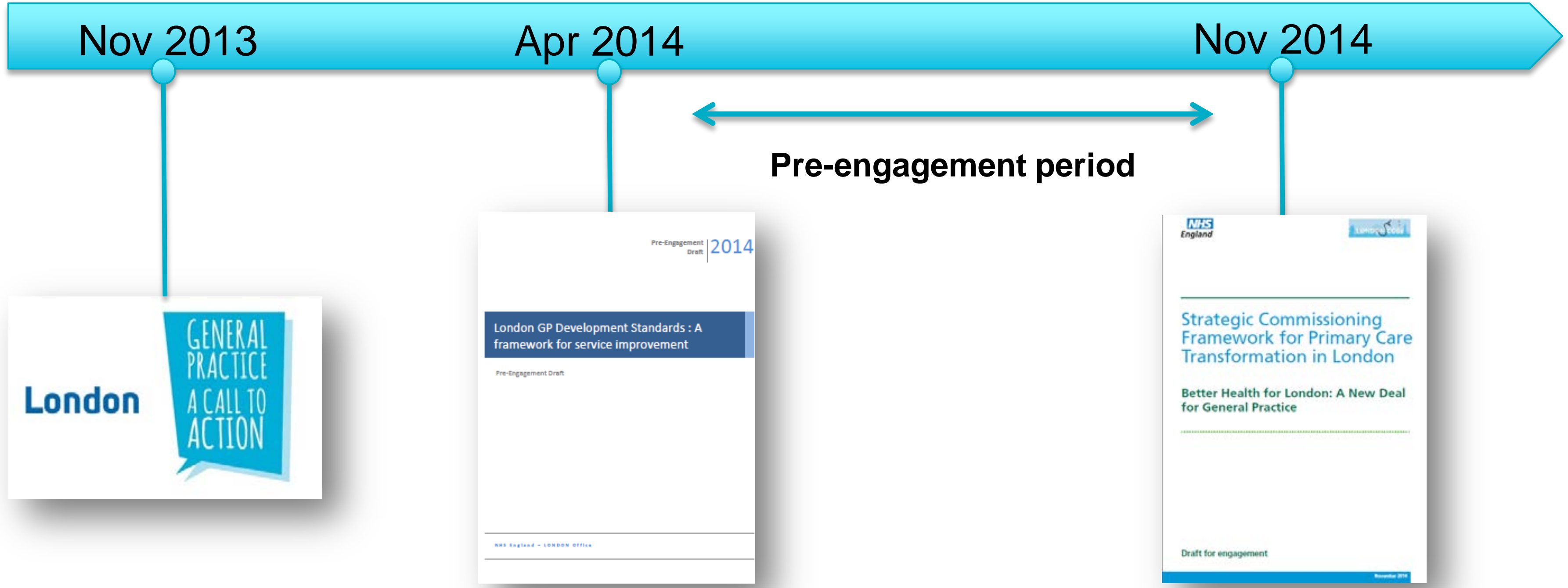
There is significant focus on the need for change in Primary Care

Both the Five Year Forward View and the London Health Commission report set out several objectives for Primary Care:

- **Stabilise core funding for general practice and review how resources are fairly made available**
- **Give CCGs more influence over the NHS budget – investment: acute to primary & community**
- **Provide new funding through schemes such as the Challenge fund – innovation, access**
- **Expand as fast as possible the number of GPs, community nurses and other staff.**
- **Design new incentives to tackle health inequalities.**
- **Expand funding to upgrade primary care infrastructure and scope of services**
- **Help the public deal with minor ailments without GP or A&E**
- **Potential new care models** such as Multispecialty Community Providers (MCPs) and Primary & Acute Care Systems (PACS)

- **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**

London has also been working on how some of the challenges faced by general practice could be mitigated



The ***Call to Action*** outlined some of the challenges of General Practice in London..

In April a draft publication was released, which outlined **a new patient offer.**

Since then there has been **considerable engagement** to **further strengthen this offer**, and understand the necessary **considerations for delivering it.**

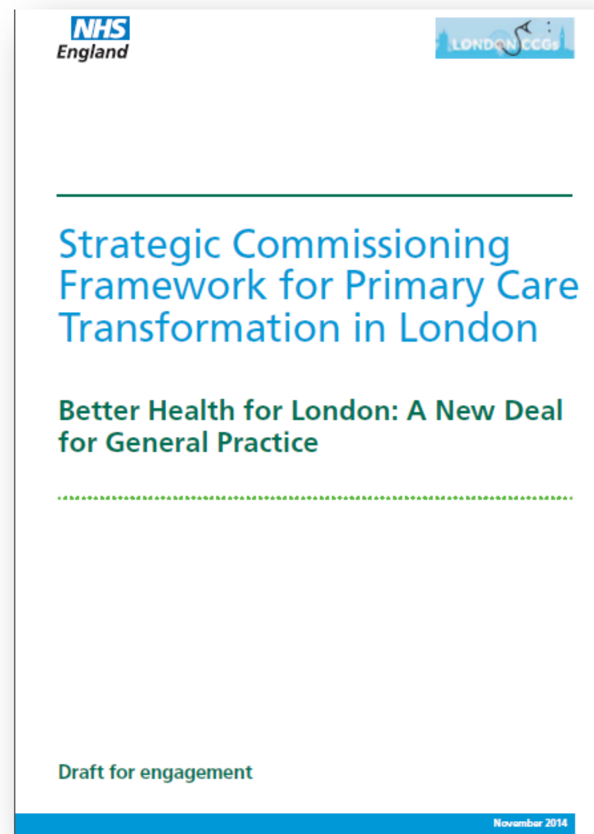
The Strategic Commissioning Framework

The result is a draft *Strategic Commissioning Framework*, aiming to support transforming primary care in the capital

A new vision for General Practice

A new Patient offer described in a general practice specification

A description of considerations for making it happen



A new vision for General Practice in London

Patients and clinicians alike have told us about the importance of three areas of care. This forms the basis of the new patient offer (also called the specification)

Accessible Care

Better access primary care professionals, at a time and through a method that's convenient and with a professional of choice.

Coordinated Care

Greater continuity of care between NHS and other health services, named clinicians, and more time with patients who need it.

Proactive Care

More health prevention by working in partnerships to reduce morbidity, premature mortality, health inequalities, and the future burden of disease in the capital. Treating the causes, not just the symptoms.

What is the… Accessible Care Specification for the Service Offer

The Accessible care specifications for service offer describes changes to enable patients to feel confident that they **can access general practice in a way which meets their needs**

The expert panel that developed these was chaired by **Dr Tom Coffey,** a GP Partner at Brocklebank Group and Chair of NHS Wandsworth CCG.

• **Patient choice**	• Patients are given a choice of access options and can decide on the consultation most appropriate to their needs
• **Contacting the practice**	• Patients can make appointments with only one click, call or contact and can access more services online
• **Continuity of care**	• Patients have a named GP who is accountable for their care and can book appointments up to 4 weeks ahead. Practices provide flexible appointment lengths as appropriate
• **Routine opening hours**	• Patients can access pre-bookable routine appointments 8 am – 6.30 pm Monday to Friday and 8 am – 12 pm on Saturdays
• **Same day access for urgent conditions**	• Patients with urgent conditions can access a consultation on the same day within routine surgery hours
• **Emergency care**	• Practices have systems to ensure patients receive appropriate care and in appropriate time in the case of emergencies
• **Extended opening hours**	• Patients can access primary care 8am – 8pm every day in their local area for immediate, urgent and unscheduled care

..But what does this mean for patients?

"I will be able to book ahead with my GP, at least four weeks ahead"

"I will only have to make one call or click in order to make an appointment"

"I will be able to have consultations via telephone, email or skype"

What is the… Coordinated Care Specification for the Service Offer

The Coordinated Care specifications for service are about outlining a way that clinicians, patients, and others come together to better **help patients achieve their desired health outcomes**

The expert panel that developed these was chaired by **Dr Rebecca Rosen,** a senior fellow in Health Policy at the Nuffield Trust and a General Practitioner in Greenwich

• **Case finding and review**	• Practices identify patients who would benefit from coordinated care and proactively review them on a continuous basis
• **Care planning**	• Patients identified for coordinated care have a care plan
• **Patients supported to manage their health and well-being**	• Practices create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing
• **Named clinician**	• Patients needing coordinated care have a named GP/lead clinician and team from which they routinely receive their care
• **Multi-disciplinary working**	• Patients needing coordinated care receive multidisciplinary reviews

..But what does this mean for patients?

"I will be supported to manage my own health with greater confidence, knowledge and responsibility"

"My care will be coordinated, rather than fragmented and transitions between services will be seamless"

What is the… Proactive Care Specification for the Service Offer

The Proactive Care standards aim to outline how general practice can better support patients in **staying well**

The expert panel that developed these was chaired by **Dr Nav Chana**, a GP and senior partner at the Cricket Green Medical Practice, Mitcham

Proposed standards	Description
• Co-design	• Primary care works with patients, their families and communities to co-design approaches to improving health and wellbeing
• Developing assets and resources for improving health and wellbeing	• Primary care works with others to develop assets and resources that will empower people to remain healthy and connected with their community
• Personal conversations focused on individuals' health goals	• Patients are routinely asked about wellbeing and their capacity and goals for improving their health
• Health and wellbeing liaison and information	• Patients have access to wellbeing liaison and information helping them to achieve health and wellbeing
• Patients not currently accessing primary medical care	• Primary care reaches out to people who have difficulty accessing services or would benefit from greater access. Practices have a plan for unregistered people

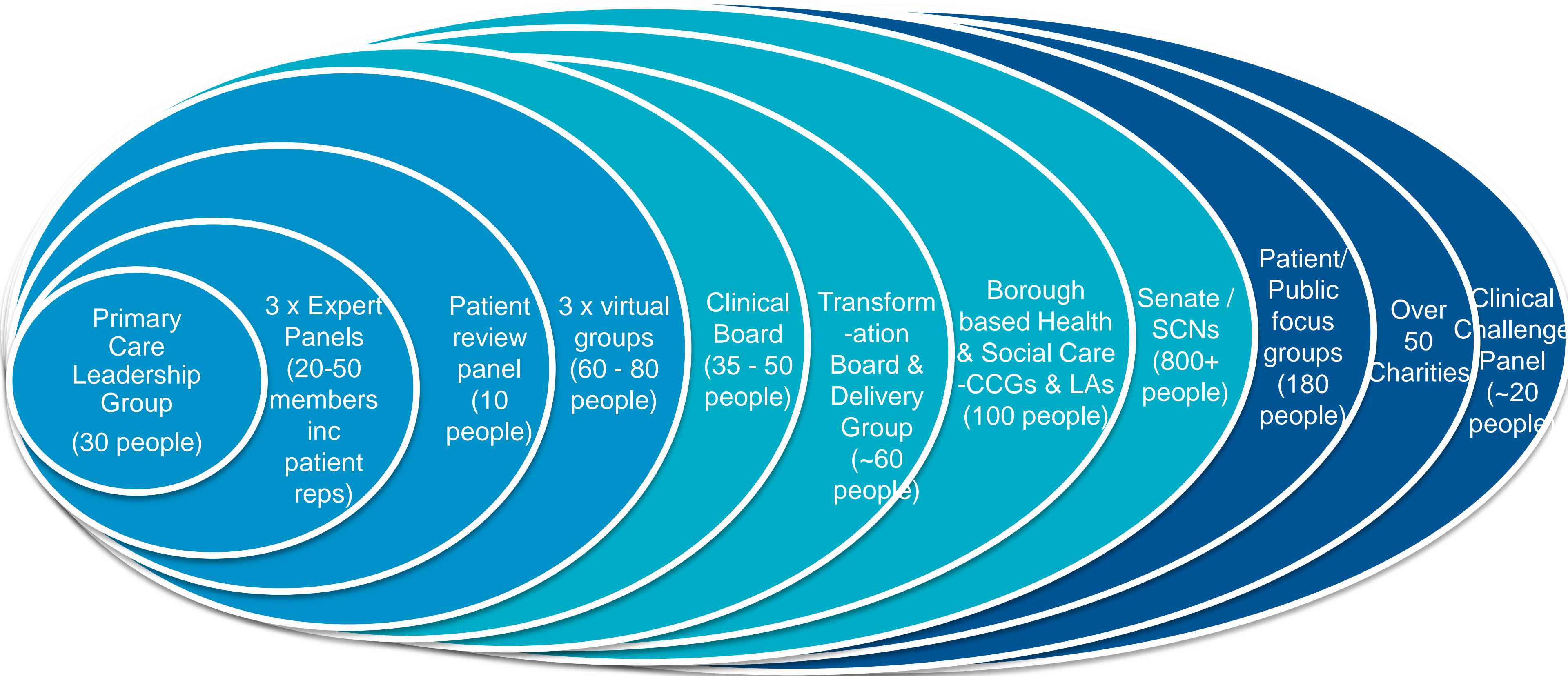
..But what does this mean for patients?

"I will have information tailored to my needs on when, where and how to access health and wellbeing support in my community"

"My local practices will work with our local communities to discuss the population's health needs and co-design new services in the community that support people to stay well

..Which has been widely tested

Following an initial development stage, the specification has been tested with a widening range of patients, clinicians and other stakeholders. Around **1,500** people have now been involved in testing this.



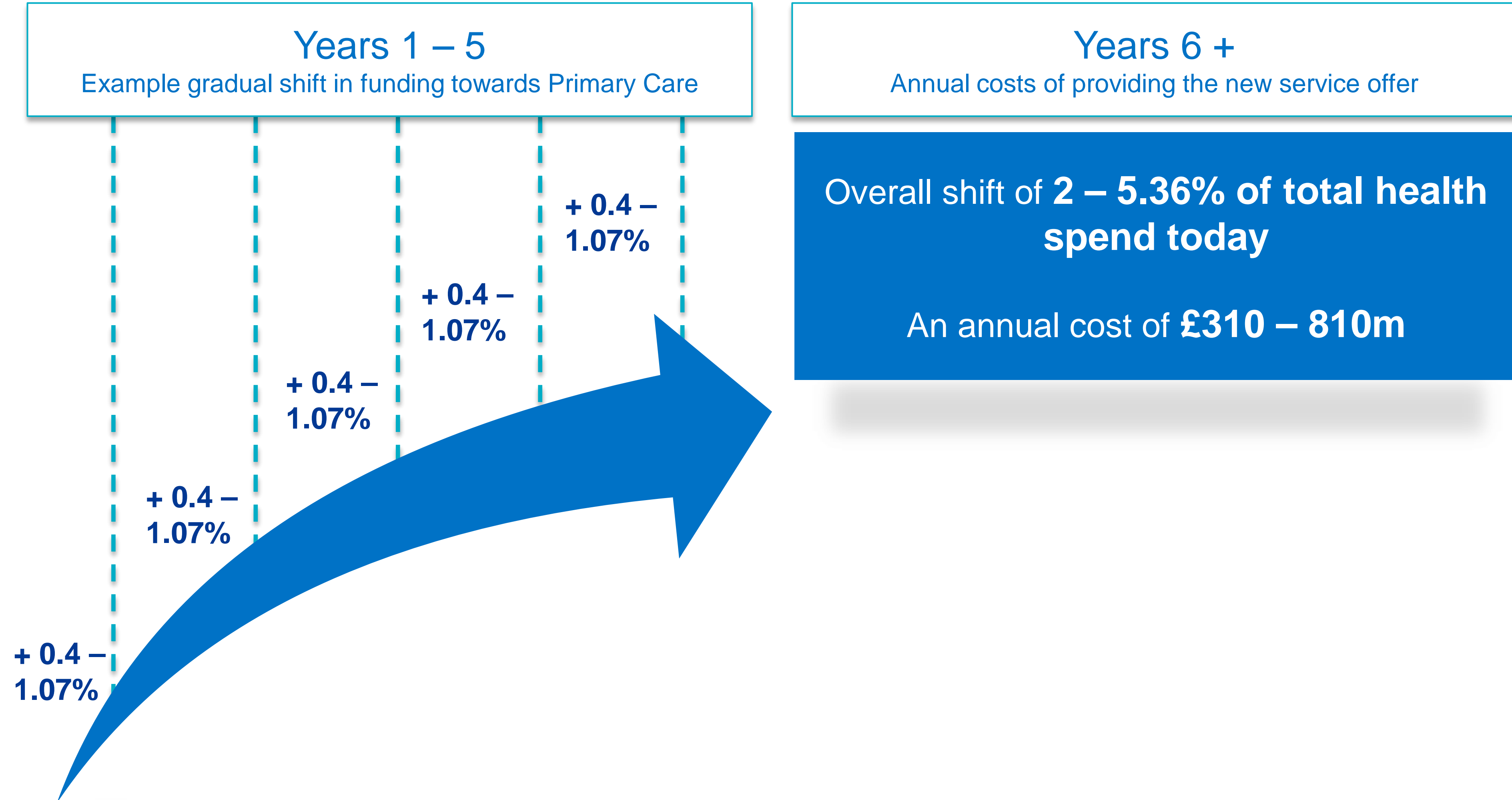
The *Strategic Commissioning Framework* which has been released for engagement reflects the feedback gathered from the above discussions.

The Framework includes several areas of focus to support delivery of the specification

Area	Description
Models of Care	• This area proposes collaborating across groups of practices, and with other partners
Commissioning	• This area outlines the importance of supporting commissioners to work together and support to CCGs taking on co-commissioning
Financial Implications	• This includes the estimated cost shift towards Primary Care required to deliver the new specifications, and the year on year funding shift to achieve this (see next slide)
Contracting	• This area looks at contractual considerations of delivering the specifications e.g. contracting at a population level
Workforce Implications	• This area looks at the need for the right roles and skills in a practice and as part of a wider team
Technology Implications	• This area looks at the ways technology could be used to deliver the specifications and maximising its use to support empowerment and innovation
Estates Implications	• This area references the findings of the London Health Commission in terms of the variability of Primary Care estate and recommendation for investment
Provider Development	• This area outlines the importance of supporting providers to deliver the specifications and some of the potential areas for development
Monitoring and Evaluation	• This area outlines ways in which tools (largely already existing) can be used to support faster adoption of best practice, as well as for commissioner assurance

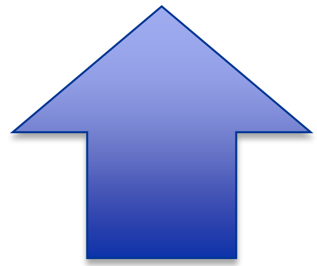
The specification will require investment…

A **high level estimation** of the cost of delivering the new service has been made. This will be further developed in parallel to the engagement phase, but indicates what a gradual shift in funding might look like, and an overall year on year cost increase



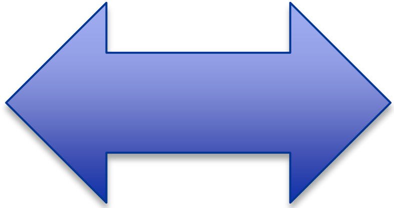
…and changes to the workforce..

The *Framework* also outlines that to deliver the specification, a larger and more diverse workforce is required.



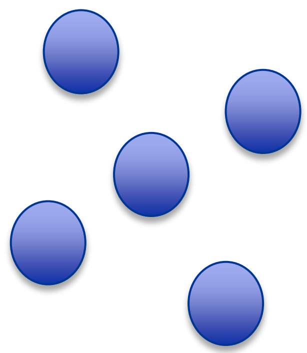
INCREASE EXISTING ROLES..

We will need more GPs and nurses to deliver the change

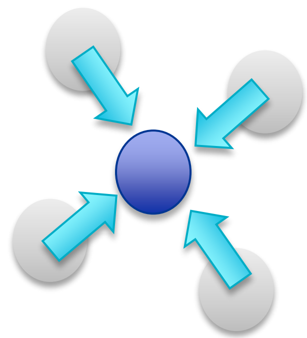


BROADEN THE TEAM..

There will need to be more new roles to support the clinicians



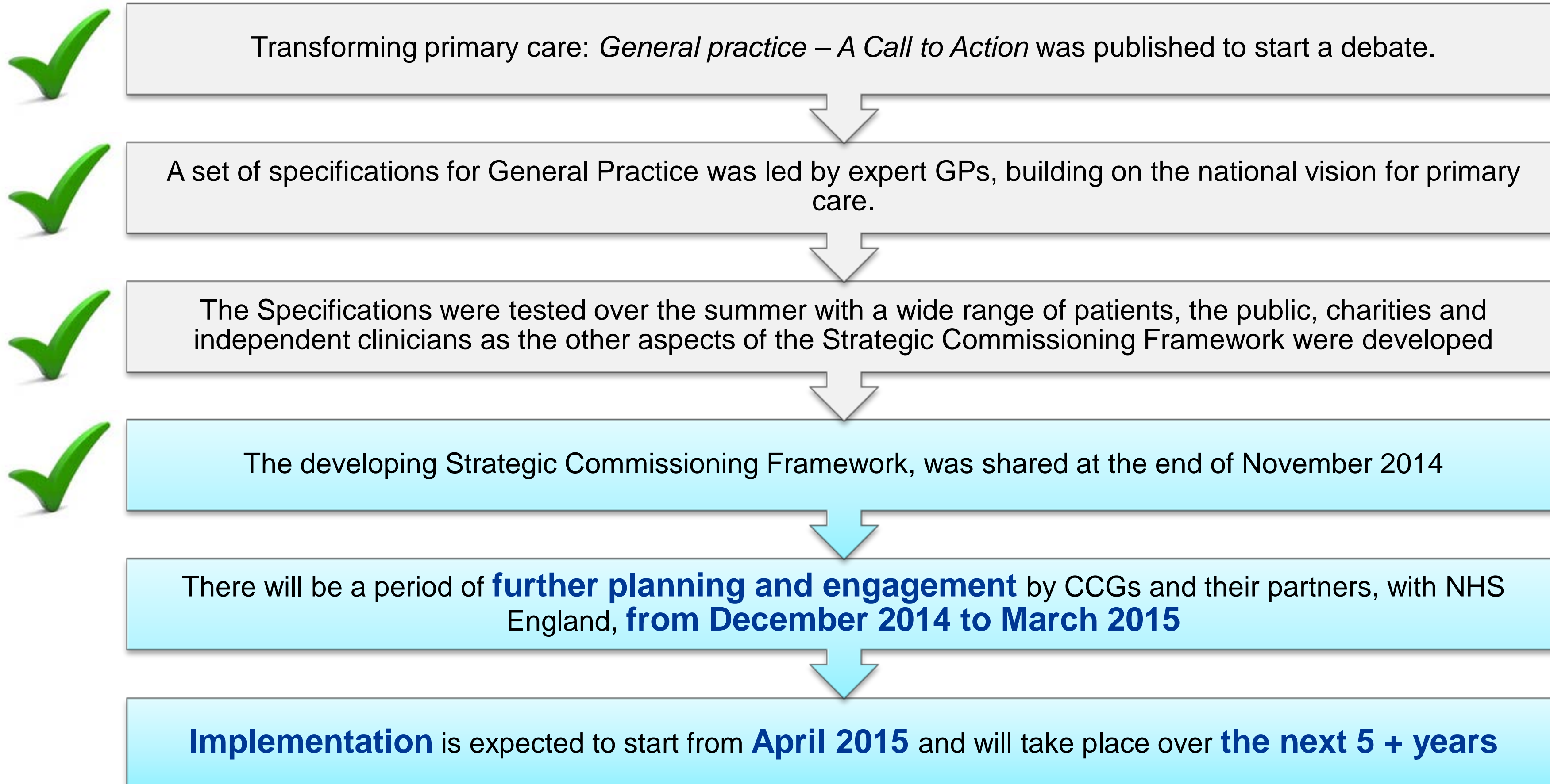
…AT A PRACTICE LEVEL



..OR ACROSS SEVERAL PRACTICES

Next Steps

The next stage of engagement has begun, and is expected to continue until April 2015. This document will be refreshed and reissued at the end of that period.



Bromley CCG Members are asked to consider…

1

- Confirmation that the *Framework* covers the correct areas?

2

- Are there other areas that should be considered in the *Framework* that currently aren't?

3

- How could the *Framework* be strengthened?

4

- What could help general practice deliver this specification?
  - What provider development is needed?
  - What workforce is needed?
  - How can technology support?