



Commissioning **EXCELLENCE**

Disruptive innovation? Online consultation and general practice

New tools and services are already allowing general practice to work in new ways. They range from systems that enable practices to improve patient flows to AI based apps that do some of the work of GPs and services where the only face to face contact between doctor and patient is on a screen.

Opinion is divided about whether these “disruptive innovations” will revolutionise care or pose an existential threat to cherished institutions. But with services already up and running and IT widely acknowledged as a vital lever for change, there is little doubt that digital technology will have an increasing role in primary care.

This half-day event for primary care commissioners will explain some of the approaches on offer, with examples of products and services in use today.

It will help commissioners to understand how best to support general practices in the deployment of these new tools – including how to spend the £45m earmarked for online consultations in the General Practice Forward View.

It will also help to clarify some of the issues, such as the contractual and financial implications, as well as the wider question of what digital innovation is likely to mean for traditional general practice.

Speakers will include Dr Steve Kell of Larwood, a GP partnership that has twice been rated outstanding by CQC. Kell will explain how his practice has used *askmyGP* to change the way it works with patients.

This system offers patients a choice of ways to contact the practice – online or by phone – and relies on a set of questions to decide if patients need to be seen and how to do so in the most appropriate way.

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Six steps to a practice business plan

Practices hoping to have control over their future development need to plan for it, participants in a recent PCC webinar heard.

Outlining the key steps in developing a practice business plan, PCC primary care adviser Claire Deare emphasised that the process need not be a time-consuming, dry exercise carried out by a select few locked away in an office.



Claire Deare

“GPs and practice managers are really busy people. They often say they don’t have the time to shut the door and write a plan but the whole team can be involved in

developing the business plan. If you don’t plan for the future, how are you going to have any control over it given the current challenges around transformation, doing more for less and the shortage of GPs and nurses?”

Pointing out that many elements of a good practice business plan are already in place or part of business as usual, Deare concluded: “Make it a living, breathing document by getting someone to review it regularly so it doesn’t just gather dust.”

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Six steps to a practice business plan

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Deare set out six steps for developing the initial plan – the first of which is a practice mission statement.

“This describes your ethos. Many practices will already have one. If your practice doesn’t then you could look at adapting your CQC (Care Quality Commission) statement of purpose. That is about starting as you mean to go on and ensuring your business plan is in line with your practice’s core values.”

Deare suggested that the second step – completing a stakeholder analysis – should be “a half hour job” – despite the complications caused by “an increasingly fragmented NHS”.

“You need to list all the organisations and groups of individuals that are affected by your decisions and whose decisions affect you – and how you communicate with them. Keep it simple. You might want to separate internal stakeholders – such as staff – from external stakeholders. You can also break groups down – for example your staff might include nurses and reception staff and your patient groups could include the frail elderly, care home residents, children etc.”

The patient participation group should be among those stakeholders – and consulted on the business plan if they are not involved in its actual development.

Other obvious external stakeholders include neighbouring practices and those who pay the practice – such as the clinical commissioning group, NHS England and any GP federation the practice is a member of.

The third step, Deare suggested, is horizon-scanning through a PEST analysis – listing the potential political, economic, social and technological developments that could affect future workload and income.

Noting that the NHS is increasingly a local health service within a national infrastructure, Deare urged practices to consider how national policy decisions and trends could play out locally.

“We call it a national health service but since 2013 a lot is being driven by CCGs and sustainability and transformation partnerships (STPs).

The PEST factors worthy of consideration at this point include:

- CCG commissioning and estates strategies and the STP’s aims and objectives
- How transformation funding – including that set out in the GP Forward View – is being spent locally
- GMS and PMS contract changes
- Whether the practice list size is growing or shrinking and an awareness of any stressed neighbouring practices which might trigger a sudden influx of new patients
- The impact of austerity on patients who might see the practice as a source of support when facing financial hardship
- Whether the practice is promoting and supporting self-care through the quality of its website and by directing patients to NHS-approved health apps.

The next step – a SWOT (strengths, weaknesses, opportunities and threats) analysis – should draw on the views of staff and others, Deare suggested.

“Involve as many people as possible through team meetings and staff meetings. Ask them what they think the practice’s strengths and weaknesses are – possibly anonymously. Review the clinical and non-clinical skill mix and think about how new roles can be developed.”

From all that analysis it should be possible for the practice manager and partners to identify and agree a few key actions to be completed over the next year or two. Having an action plan with just three to four actions – rather than a long list – and a relatively tight timeframe focuses minds and minimises the risk of slippage, Deare suggests.

“Be realistic about what you can achieve and ensure the goals are written in a clear way that allow you to show you’ve achieved them. It is the partners’ business so they may well want to set the objectives but that doesn’t stop you discussing the possibilities in a team meeting.

“If you’re faced with a sea of blank faces in such meetings you can ask people for one thing they would like to stop doing over the next 12 months and one thing they would like to start doing.”

With the action plan agreed, the final stage is producing a brief executive summary – the part of the document most likely to be read, Deare suggests.

Your plan – the six steps

1. Mission statement
2. Stakeholder analysis
3. PEST analysis
4. SWOT analysis
5. Action plan
6. Executive summary

Disruptive innovation?

Continued from page 1

Patients who use *askmyGP* are called back and seen on the same day.

Larwood's choice of technology reflects a belief that innovation should be about improving the way general practice already works not about imposing a new model.

"I'm not interested in disruption or artificial intelligence. I'm interested in making it easier for patients to see their GP," Kell says.

Robert McGough, a partner at specialist lawyers Hill Dickinson looks at the legal model for e-consultations and the potential implications for contracting. There are potentially wide-ranging implications for CCGs, particularly for online only services such as those that have recently opened in London and involve patients de-registering from their existing practice.

Another case study will be presented by a private provider of an online-only service (speaker to be confirmed).

The session will conclude with a panel discussion to consider the issues raised by the presentations. What will be the impact of digital consultations on existing NHS services? How will handovers be managed between online and conventional services? How will commissioning need to evolve to meet the demands of technology driven change?

Book now to secure your place at this exciting event, which we expect to be heavily subscribed:

London on 17 October
<https://bit.ly/2ySzXpl>,

Birmingham on 7 November
<https://bit.ly/2tP3N8b> and

Manchester on 15 November
<https://bit.ly/2tRbCdF>

Turning collaborative models into reality



Robert McGough

The journey from national strategy or policy paper to implementation is often a tortuous and lengthy one. Indeed, some flagship ideas are never tested in the heat of the frontline.

Well over three years after the Five Year Forward View launched a variety of new care models on the NHS, the pressure to deliver is starting to grow.

Primary care providers, hospitals and commissioners still grappling with the complexities in guidance and legislation as they develop collaborative care at scale are running out of time.

That's why Robert McGough, partner with Hill Dickinson, and other speakers at a forthcoming PCC event will be emphasising the practical.

McGough says: "Local health economies have to consider how they are going to practically implement their new care models. It is complex and a lot of areas are stalling because of the complexities and the interrelationship between guidance and legislation. Primary care is at the centre of this. We are going to be seeing larger primary care organisations delivering at scale whether through merger of practices, new forms of collaboration or foundation trusts.

"I'm looking forward to discussing with people attending these events just how far they have got in, identifying the perceived barriers and then using practical examples to demonstrate how we can overcome many of the challenges that undoubtedly exist."

McGough plans on bringing representatives from organisations who are developing new approaches in their system to each event. They will share the lessons from what went well and what they would do differently if setting out again.

He says: "There is somewhat of an industrial revolution going on in primary care. We are seeing new providers taking over failing practices – and even some successful practices. I want to set out for participants how they can take a collaborative approach and overcome the gaps that exist between the law and national policy. Change is stalling in a lot of areas because of confusion caused within those gaps."

Commissioners, he suggests, need to be clear about how they can work with providers and also commission services in this new collaborative environment when the legal architecture of the commissioner/provider split is still with us.

"That means they have to grapple with decisions such as whether to go for early procurement while making sure they don't act outside their powers.

"If you are a provider organisation you need to ask yourself how you are going to work with commissioners – both clinical commissioning groups and NHS England. You've also got to work out with a range of partners and stakeholders just how formal your collaborative arrangement will be: there's a big difference between a memorandum of understanding and a formal contract covering risk sharing around finances and delivery."

Other speakers at the event include GP and independent primary care consultant Mike Smith and McGough's colleague, Ruth Griffiths. She will explain how primary care is key to developing any new model of care.

Partnering with a purpose: making collaboration work runs in Manchester on 25 September.

For information and bookings:
<https://bit.ly/2KBX16w>

Commissioners urged not to take 'light touch' procurement regime lightly

Health commissioners should not be lulled into a false sense of security around procurement by the title 'light touch regime'.

That was the key message from Hempsons partner Deborah Ramshaw when she addressed a recent PCC workshop in London.

Ramshaw told participants that although the new regulatory regime, which came into force in April 2016, is less prescriptive than the full regulatory regime, commissioners and their NHS partners still face the very real threat of legal challenge if they fail to act reasonably and transparently. The situation isn't helped, she suggested, by the government's failure to deliver guidance on the new regime. This was expected following the transition period for health commissioners which has come and gone.

"The full regulatory regime is very detailed. The light touch regime does tell you what you have to do at the beginning (advertise in OJEU) and the end (place a contract award notice in OJEU). But what you do in the middle is entirely up to you. The only thing the regulations say is that you have to be compliant with the Treaty (of Rome) principles by being transparent and by treating bidders equally – even when you have an incumbent provider."

"Any relevant considerations" – including, continuity, accessibility, comprehensiveness of the services and the involvement and empowerment of users".

The regulations and the transparency requirement do mean that commissioners involved in procurement need to keep – and make available to unsuccessful bidders if requested – clear evaluation sheets with a full audit trail and also avoid contract variations that substantially alter the contract.

The light touch regime does however mean commissioners can now take into account "any relevant considerations" – including, continuity, accessibility, comprehensiveness of the services and the involvement and empowerment of users.

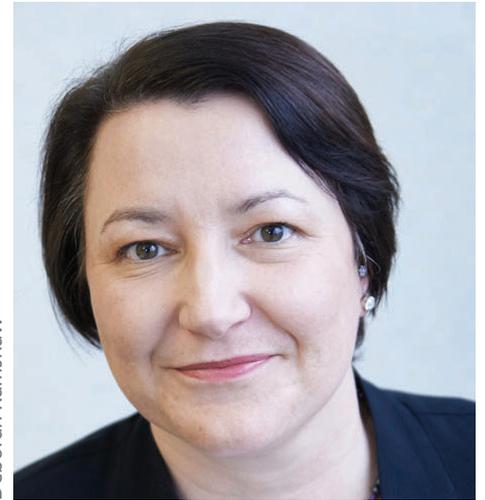
"You can think outside the box a bit more than with fully regulated procurement but remember that some aspect of the regulations will still apply," Ramshaw said.

Commissioners relying on exemptions from having to run a tendering process - such as there being only one suitable provider - should test the market if they have any doubts, Ramshaw suggested.

She cautioned that unsuccessful bidders are increasingly likely to challenge procurement decisions.

"Procurement has become a lot more contentious for a range of reasons. This is still a fairly new regime without any case law. Bidders are getting more information on why they lost a contract and there is court guidance saying they expect you to provide complainants with information if a complaint is made. The tougher economic climate is also making each bid more important to bidders and bidders are far more clued up than they used to be."

She warned commissioners that courts could impose severe financial penalties based on the potential profits a complainant may have made and order a re-run of all or part of the process.



Deborah Ramshaw

This reflected a growing perception that the integration agenda – which often conflicts with procurement law and tendering requirements – is not necessarily a Trojan horse for privatisation.

"From the private provider's perspective it can seem just the opposite – especially if services that the private sector has traditionally provided are suddenly wrapped up in a bundle with services where the public sector has the expertise and experience. Putting all your acute and community services together could be seen as artificially limiting the range of bidders even though it is also promoting integration." Therefore thinking carefully about the justification for that "bundle" is key.

Don't use new money to grow old NHS, warns NHS England boss



Matthew Swindells

NHS England's operations director has warned that the five year investment plan announced in June must avoid the mistakes made when the health service last experienced a significant and sustained funding rise.

Matthew Swindells said that the big increases before the financial crisis in 2008 had been spent on "expanding the hospital base and employing more consultants" – resulting in "a bigger, old NHS".

He said that the average annual funding rise of 3.4% up to 2023 announced by prime minister Theresa May should be directed to primary care where professionals 'acting at the top of their licence' should manage population health by making best use of data.

Addressing a recent event on financial sustainability, Swindells pointed out that the five year funding rise hardly represents a bonanza – not least because it is below the health service's historic average rise in spending.

Urging his audience to continue to embrace innovation in the search for efficiencies, he noted that the increase did not apply to this financial year and it would only have a real impact if the health service changes.

"We need to get patients to the right place for getting the right care to stop waiting lists growing, to prevent A&E departments being

jammed up and to ensure primary care is not in crisis. We need to be working now to ensure that the extra funding is an investment in the future and not just a patch for short term problems. We cannot relax. We need to be brave about change."

Benchmarking and embracing the work of programmes such as NHS RightCare and Getting it Right First Time (GIRFT) could help local health systems achieve sustainable finances while maintaining and improving services, he said.

Pointing to one clinical commissioning group (CCG) which had consulted on cutting IVF services last year to save £700,000, he said analysis of the area's finances had shown it was spending £23 million more on outpatient appointments than comparable CCGs.

"Even if they removed just 5% of that figure they wouldn't need to be talking about cutting IVF services," he said.

"We need to be working now to ensure that the extra funding is an investment in the future and not just a patch for short term problems. We cannot relax. We need to be brave about change."

STP won't become ICS without primary care

Simon Stevens has made it clear that there is "no plan B" if the NHS does not embrace integrated care systems (ICS). With the first

ICS areas already announced, one of their major challenges is to understand and engage fully with primary care.

Without general practice and other primary care professions as willing partners, ICS will remain no more than an acronym.

There are two big challenges for ICS areas. The first is understand how primary care works – the contracting and financial levers and impediments to progress, premises funding and regulation, and the workforce and

leadership issues that need to be addressed.

The second is to ensure that local primary care organisations are onboard: How many understand the local ICS plan? How many are signed up to it? How many are involved at all? PCC is already working with some STP/ICS areas.

We can help you understand the issues and facilitate the relationships you will need if ICSs are to flourish. Email enquiries@pcc-cic.org.uk to find out more.

Matching the needs of practices and patients is the real point of the GP Forward View

More than two years on from publication of the GP Forward View (GPFV) it is perhaps inevitable that some of the shine has come off a document that got a warm reception.

Speakers at a PCC event to be held in Manchester and London in September can help practice managers and GPs rekindle that warm glow for a vision that promised to help them manage rising demand and other pressures.

Sheinaz Stansfield, who leads the Oxford Terrance and Rawling Road Medical Group practice in Gateshead, will outline the redesign and innovation around staff roles, social prescribing and care navigation over the last five years that ensured her colleagues had something of a head start in responding to the forward view.

She explains: "We looked at population needs rather than simply trying to manage down the GP workload which is the idea behind a lot of the workforce development strategy such as clinical pharmacists. When GPs' vacancies arose, we looked at the needs of the population and saw the value of a highly skilled nursing team for house bound frail elderly people, alongside care navigators to support their health and wellbeing needs through social prescribing. Meeting those needs is a core component of what we do and we have gone from the highest number of referrals and A&E attendances amongst that client group in the clinical commissioning group to the lowest."

Stansfield argues that the focus on population need and integration rather than employing or positioning staff with an eye principally on hitting QOF targets is crucial.



Sheinaz Stansfield

And that means redesigning roles and investment in staff training.

"You need to make roles in general practice more interesting and exciting. We trained our health care assistants to work part-time in that role and part-time as care navigators so they have more varied jobs. We've also trained staff in social prescribing and self-management so they can support patients – especially those with long term conditions, to care for themselves or alongside support from voluntary groups, and specialist clinical support when needed."

Building up links with the third sector is a vital component of that aim.

"We engage with voluntary sector providers and our health and wellbeing co-ordinator makes sure their details are kept in our dynamic directory of services."

A Productive General Practice audit identified that some patients were attending 20 appointments or more a year to have individual long term conditions monitored; these patients also had high attendances to A&E.

Stansfield says practice staff are now skilled in managing the person rather than the condition. "The Year of

Care approach has been important to us in managing people with long term conditions (LTC). Really good relationships with patients is a key component of this and they have become active participants in their own care. Patients now attend the practice about three times a year to have their LTC monitored through longer appointments. We provide support for carers too."

At the September events Stansfield will emphasise that practice managers and GPs need to embrace the GP Forward View's ten high impact actions that free up GP time to care for those with the most complex needs.

Another key speaker, Dr Steve Kell, GP partner in Nottinghamshire, will also emphasise the need to focus on workforce. His group has taken on three clinical pharmacists and three paramedics in response to GP recruitment and retention difficulties. He favours a team model that involves all staff and concentrates on the systems and processes needed to keep everything going, including a clear view of what data you need to tell if it's working. "Measure what you value," he advises, "and ignore the noise in the system."

While Steve has been a supporter of the National Association of Primary Care's (NAPC) "primary care home" and other initiatives, his message is to keep things clear and simple. "Keep it all as light as you can. In most cases, the issues will be access and sustainability. If GPs want to take control of their own destiny, that's what they need to be addressing."

The event – The real GP forward view: what practices can do now – is in Manchester on 4 September and London on 20 September. For more details, see our event calendar: <https://bit.ly/2IH3sRp>

'THINK LIKE A COMPANY' – FEDERATION LEADER WHO GOT LONDON GPS BACK IN BUSINESS

Necessity has proved a very fruitful mother of invention for GPs in a particularly diverse area of inner London.

Faced with local health and public health commissioners seeking to contract with a single organisation in 2014, the City and Hackney Local Medical Committee's then chair, Dr Deborah Colvin, toured the area's practices to build support for a GP federation.

Today, Colvin chairs the City & Hackney GP Confederation CIC.

The organisation has won a string of contracts which has produced additional income for its member practices, improved access and seen City and Hackney Clinical Commissioning Group (CCG) transform performance against key Quality and Outcomes Framework (QOF) indicators (see box).

Federation chief executive Laura Sharpe says that those successes are part of a wider cultural transformation.

"We have been really successful in securing work. Indeed, people come to us now more and more and we are seen as the place to discuss primary care development ideas. We have 100% population coverage so if a practice does not want to provide a particular service that is fine but we tell them that we have a duty to make it available to their patients through another practice – or, occasionally, by providing it ourselves. From a commissioning point of view that is amazing because they can commission for an equitable service across all practices."

Although by no means the first GP federation, Sharpe and her colleagues faced the challenge of developing a structure, constitution and ethos for an organisation whose very nature was a novelty to its GP members and stakeholders.

"The main challenge is to think like a company rather than the NHS. Our first decision was our ethos about profit. We are now a community interest company but we are not averse to making a profit which goes back into patient care and service development.

That was a very overt first principle discussed with our member practices early on."

Such thinking permeated decision-making on other issues – including the make-up of the board.

"We proposed a GP chair and a GP majority – after all the GP partners are our shareholders – but we also wanted the voice of practice management and practice nursing on the board, as well as lay input and specialist finance input.

"We had to be very clear from the beginning that how we assess payments to practices was robust and free of conflict. Our finance director chairs both our audit committee and ultimately they are in charge of payments to practices after reviewing all practice performance at the end of each year. Our GP board members are nowhere near those decisions."

Sharpe is one of four executive level employees, each of whom works three days a week. There are five other staff, including a business development manager, a contract manager and a practice support manager.

The constitutional and structural niceties sorted, Sharpe and her colleagues started winning contracts from both the CCG and the London Borough of Hackney before running into what, at times, seemed like a brick wall in the form of the NHS pension scheme.

Much of the organisation's paperwork had to be re-done after it was discovered that by allowing four 'corporate' practices to be shareholders the organisation had effectively barred its employees from membership of the scheme.

"We had to ask those practices to resign as shareholders – although they remain members and have full access to our contracts," Sharpe explains.

Almost simultaneously, the federation realised that the income practices receive through the federation's contracts was not pensionable.

This time the federation, working with solicitor Hempsons, took on the law and won.

"We lobbied NHS England after persuading the practices to give us a year to sort it. We threatened a very public closure of our organisation and eventually they actually changed the NHS pensions regulations."

With such painful teething problems behind them, the confederation returned to winning contracts and supporting member practices to deliver them.

"We needed to prove that we could deliver. Our role supporting and advising practices can be culturally tricky because it is not what they are used to doing. We do it in a supportive way so they see us as part of the primary care landscape and on their side – which of course we are."

However, despite having secured a change in the law and won and delivered on many contracts, Sharpe and her colleagues know that in today's NHS, change is a constant.

"The GP confederation is currently the right thing for the City and Hackney. However, we are now starting to work with our practices around the 30,000 to 50,000 population models and I can see that things will change. They are willing to be guided by us about how to stay strong and viable to provide an excellent quality and wide range of services to their patients."

QOF health gains: City and Hackney national ranking

	2013	2016
Atrial fibrillation anticoagulants	29	2
CHD BP control	35	1
Hypertension BP control	128	1
Stroke BP	50	1
Diabetes BP control	78	1
Diabetes cholesterol control	30	2

Trust chief unapologetic about going on the GP acquisition trail

“Ask for forgiveness rather than permission,” is the advice of an acute trust chief executive who has blazed a trail in acquiring GP practices with a combined list size of some 140,000.

David Loughton, chief executive of the Royal Wolverhampton NHS Trust, says the idea of vertical integration in his patch began with the securing of local community health services in 2011 and approaches from small GP practices.

“Having the community services contract is very important because that is where a lot of the scope for integration is,” he says.

Of becoming a large primary care provider, he says: “GPs approached us and they came to us for a variety of reasons. These were the good practices where the GPs were not making any money because they were employing nurses and pharmacists when their income was going down.

“In June 2016 we had a list size of 23,000; now it is 140,000. It generally takes six to eight weeks to bed a practice down and sort out the governance. What we have done is at the wider edge of what the legislation allows: we have a sub-contract of the GMS contract. Primary legislation would be nice but we worked with what we have.”

As Loughton points out, the GPs and practice staff enjoyed the recent pay increase awarded to NHS staff covered by Agenda for Change.

“GPs are no longer running their own small businesses with things like HR to sort out. The younger GPs in their 30s are not expecting to sign a contract and be in the same place for decades.”

Trusting Loughton and his colleagues to provide oversight, the Care Quality Commission sees the trust’s collection of practices as a single entity.

The trust runs its own training scheme – currently providing 114 places for junior doctors who can choose between primary care and hospital-based training and education.

But what does all this mean for patients? The acute trust call centre now handles all calls to the practices – ensuring it can offer a rapid appointment at a nearby practice if one surgery is fully booked, with beneficial knock-on effects for A&E attendance.

GPs can book patients directly into hospital beds – which are turned around in 32 minutes. That speed of turnaround, Loughton says, is faster than north American hospitals manage. The acute trust has turned one of its hospitals into an elective care centre where orthopaedic surgery waiting times are down to two weeks.

Social services staff work from the ‘command centre’ and Loughton claims a visitor would be unable to distinguish between NHS and local authority staff. Meanwhile, a public health consultant and registrar employed by the trust work to ensure practices are up to date on issues that can help improve health and reduce demand for services.

Given the frequent bad press around the acute sector with claims it sucks up a disproportionate share of health spending, it was important to get patient groups on board.

Loughton says: “We’ve invested £2million into primary care

for additional services such as physiotherapy, advanced nurse practitioners and social prescribing.”

GPs are also provided with a live dataset showing their patients’ contacts with acute, primary and community services.

The result, as well as more relaxed GPs, is good for the local health system finances. A&E attendance and emergency admissions covering patients registered with the trust practices have fallen by 14% and 12% respectively.

Loughton thinks those figures should earn him a little forgiveness.