

Improving General Practice

A CALL TO
ACTION
PHASE 1 REPORT

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Description This report focuses on the central role we want general practice to play in wider systems of primary care, and it describes our ambition for greater collaboration with CCGs in the commissioning of general practice. Transformational change will be led locally, but we outline the work underway nationally to support it.

Cross Reference Improving general practice – a call to action
The NHS belongs to the people: a call to action

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Introduction

1. General practice is often described as the cornerstone of the NHS, with roughly one million people visiting their general practice every day. NHS England has responsibility for commissioning these core primary medical services, and spends in the region of £7 billion a year across England.
2. Last August, we launched “*Improving general practice – a call to action*” to support action to transform services in local communities and to stimulate debate as to how we can best support the development of general practice to improve outcomes and tackle inequalities, both for today’s patients and for future generations. It echoed the case for change made by other organisations, such as the *Royal College of General Practitioners’* report “*A Vision for General Practice in the Future NHS*” (May 2013). We supported our engagement with a national online survey and a national stakeholder event.
3. Our stakeholders had much to tell us. A report of an independent analysis of responses submitted by individuals can be found [here](#)* and the submissions made by organisations can be found [here](#)** and [here](#)***.
4. We have also published “*Improving community pharmacy*” (December 2013) and “*Improving dental care and oral health*” (February 2014) to stimulate similar action and debate for other parts of primary care. We will bring together the outcome of all of these calls to action, together with a fourth on eye health, in the autumn of 2014 when we will publish our strategic framework for the commissioning of primary care – covering the total £13 billion of primary care services directly commissioned by NHS England.
5. This report focuses on general practice and the central role we want it to play in wider local systems of primary care. It sets out our emerging thinking on the commissioning of general practice services. It describes the kind of general practice we want to see in the future, and the work needed to develop the necessary clinical and organisational models. It sets out the key ways in which this will be led locally, and then outlines the work underway nationally to support it.
6. This is still subject to further engagement at national and local level. This report is therefore intended to provide an update on the work so far.
7. In particular:
 - We want to test our emerging ambitions for general practice, and the work we have started to support local communities in achieving these ambitions.
 - We want to explore further how our national partners can help us deliver the vision – and how we can support our partners.
 - We want to test further whether we have identified the right priorities for the national work to promote and remove barriers to local innovation.

* Independent analysis of responses report: <http://www.england.nhs.uk/wp-content/uploads/2014/03/imp-gp-cta-analysis.pdf>

** Organisation responses 1: <http://www.england.nhs.uk/wp-content/uploads/2014/03/resps-2013-1.zip>

*** Organisation responses 2: <http://www.england.nhs.uk/wp-content/uploads/2014/03/resps-2013-2.zip>

CHAPTER ONE

Does general practice need to change?

8. The wider context facing England in the provision of health care was set out in NHS England's "Call to Action". This summarised the challenges associated with demographic changes, growing public expectations and the economic and financial context, and the scope to improve outcomes and tackle unwarranted variation and inequalities across England through the way that we respond to these challenges.
9. **Demographics:** The population in England is growing and people are living longer. Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older¹ – the most intensive users of health and social care. The health care needs of the population are changing. In England 53 per cent of people report that they have a long-standing health condition, including mental health conditions, and the number of people living with more than one long-term condition is set to rise from 1.9 million in 2008 to 2.9 million in 2018.² These are very different needs from twenty years ago, and to meet these changing needs the current pattern of services and models of care will need to change.
10. **Outcomes:** General practice has a key role to play in securing better outcomes for the population, but there are unwarranted variations in the services that patients currently receive which can impact on the outcome of their care. We heard from the first inspection report from the Chief Inspector of General Practice in December 2013 that there are a small minority of practices where there are serious failings in the provision of care. Overall satisfaction with general practice services remains high – 86 per cent of respondents to the GP Patient Survey say that their overall experience is good or very good.³ However there are growing challenges in relation to patient experience of access to care. A quarter of patients do not rate the overall experience of making an appointment as "good"; 26 per cent of people do not find it easy to get through to the surgery by telephone and this figure varies from 8 per cent to 48 per cent in different parts of the country.
11. **Financial constraints:** The NHS faces a projected funding gap of £20 billion by 2021/22.⁴ Primary care potentially has a key role in helping reduce this gap by providing more personalised, accessible community-based services for patients that help improve community health and reduce avoidable pressures on hospital resources. This will involve changing the way care is provided and prioritising the services that patients need and want within the available resources.
12. **Impact on other parts of the system:** Between 2003/04 and 2011/12 the number of emergency admissions for acute conditions that should not usually require hospital admissions increased by 34 per cent.⁵ The causes for this are complex and multi-factorial and will certainly be a reflection of the rising acuity of some patients' needs. But it may also partly reflect the perception of the ability to access wider out of hospital services, whether community, primary or social care, and the extent to which these services are able to support individuals before they need emergency care.

"We need to invest in primary care by offering relaxation of rules that stifle innovation"

response to engagement

1. ONS National Population Projections, Table A2-4, Principal projection, England population in age groups, 2012 based
 2. Long Term Conditions Compendium of Information <https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition>
 3. Ipsos MORI, GP Patient Survey, December 2013: <http://www.gp-patient.co.uk/>
 4. NHS England (2013), The NHS belongs to the people: A call to action: http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf
 5. HSCIC indicator portal, 2003/04 to 2011/12
 6. NHS staff 2002-12, General Practice. Table 7.

13. Workforce: While the numbers of full time equivalent GPs has grown over the past ten years, the GP workforce has grown at only half the rate as other medical specialties and has not kept up with population growth. A gradual increase in the proportion of GPs working part time is creating longer-term sustainability pressures: the peak age band for female GPs leaving the workforce is currently 35 - 39 years whereas the peak age band for males leaving is 55 - 59 years.⁶ Within the wider general practice workforce there has been only a marginal increase in the number of practice nurses.

Factors affecting change in general practice

14. In addition to these wider drivers, there are several factors which shape how NHS England can support and drive improvement in general practice.

15. Local services, national contractual frameworks – general practice is above all a local service, provided by around 8,000 independent contractors. However, through the national GMS (General Medical Services) contract and the associated PMS (Personal Medical Services) contracts, all contracts are based on nationally developed contractual frameworks. Our national approach to commissioning general practice needs to strike the right balance between, on the one hand, national consistency and, on the other hand, providing space for local innovation, local leadership and sensitivity to local needs.

16. Integrated services, different legal framework – the rise in the number of people with long-term conditions, including those with mental health needs, has significant implications for how general practice organises itself, and co-ordinates the services it provides with other services provided in the community. Yet there is a different statutory basis for our commissioning of general practice and for CCGs' commissioning of other community services. We are committed to working collaboratively with CCGs to commission

integrated services for the individual, and enhance the central co-ordinating role that the general practice can play in supporting people and their families.

17. CCGs as clinically led membership organisations – for the first time in the history of the NHS, every practice is formally a member of a local clinical commissioning group, led by clinicians, with expert management support. Whilst NHS England is the statutory commissioner of core primary medical services, CCGs have a duty to improve the quality of primary medical care. CCGs have a major opportunity to use their clinical leadership and relationships with member practices – if given the right tools, information and incentives – to help transform primary care.

18. Retaining the strengths of the generalist system – Most of the population is registered with a general practice, and this is recognised internationally as a powerful tool in the co-ordination and continuity of care. Coupled with the highly systematic use of technology to support the management of long term conditions and track changes in health status, general practice can play the central role in providing support for people with chronic disease, and in identifying those at risk of developing ill health. It also plays a key role in enabling effective population health interventions such as screening and immunisation.

19. In summary, there are four key reasons **why** we need to support changes in general practice: to meet the changing needs and expectations of our population; to improve outcomes and tackle inequalities; to maximise limited resources across the system, and to secure a sustainable service for the next decade. There are particular factors that will shape **how** we approach that – ensuring that we build on the many strengths of the current system of general practice in this country.

CHAPTER TWO

Our ambitions for general practice and wider primary care

20. Our initial findings, from both this phase of engagement and from the national survey and the comments and complaints received more generally, have highlighted five areas where we believe we need to improve services, both for today's population but also to ensure we have excellent services for the future. Much of this is built on great work already happening in general practice, but not consistently across the country.

21. These are:

Ambition one: proactive, coordinated care: anticipating rather than reacting to need and being accountable for overseeing your care, particularly if you have a long-term condition.

Ambition two: holistic, person-centred care: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.

Ambition three: fast, responsive access to care: giving you the confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations.

Ambition four: health-promoting care: intervening early to keep you healthy and ensure timely diagnosis of illness - engaging differently with communities to improve health outcomes and reduce inequalities.

Ambition five: consistently high-quality care: removing unwarranted variation in effectiveness, patient experience and safety in order to reduce inequalities and achieve faster uptake of the latest knowledge about best practice.

Responsive to the needs of all – and reducing inequalities

22. These ambitions are designed to meet the varied needs of all our communities across the country. We want to ensure that everyone gets access to the same excellent high quality services. This is as true for general practice services and wider out-of-hospital services as any other. It also needs to be sensitive to the different requirements of different parts of the population. For example:

- more proactive, coordinated care will be of real benefit for frail older people and other people with complex needs;
- more person-centred care for people with long term health conditions and people with mental health problems;
- responsive care for the general population, including same-day access to services for people with urgent care needs; but also different ways of accessing services may benefit other groups such as young people;
- preventative care, advice and interventions that will support communities and individuals to better manage their own health to avoid becoming ill, and prevent unnecessary interventions.

“Be more open and listen to what people are saying, respond with simple language; start from the assumption that you do not have the answers”

response to engagement

Frail older people and other people with complex needs

There are 4.2 million people aged over 75 years in England. Although only 8 per cent of the population, they account for around 30 per cent of emergency admissions to hospital, and they have more than twice as many GP consultations as the rest of the population. The majority of people aged over 80 years have one or more long term conditions. Population forecasts predict a significant rise in the number of people aged over 75 in the next 20 years and in the prevalence of long term conditions. We need to strengthen and redesign primary care services to enable us to meet these major demographic challenges. The changes agreed to the GP contract for 2014/15 include ensuring that everyone aged 75 years or over has a named, accountable GP to oversee their care – and that practices provide a tailored programme of proactive, personalised care and support for those patients with the most complex health and care needs (to include at least two per cent of each practice's registered patients). We are planning further work with the *Department of Health* and with patient and professional groups to look at how to extend this approach more widely.

People with mental health problems

A quarter of the population will experience mental health difficulties this year, and around 90 per cent of them will be managed in primary care. The incidence of people with mental health difficulties is expected to rise to reflect an ageing population and an increase in the number of people with long term physical conditions. People with long-term physical conditions, people from more deprived areas and unemployed people are more likely to need longer term care for mental illness than the general population. Area teams and CCGs will explore innovative ways to provide care and support for mental health needs that build on the distinctive role of general practice in providing continuity of care. At national level we will establish a development programme to share examples of successful innovation, including how non-medical interventions such as social prescribing can contribute to primary care teams meeting the physical, psychological and social care needs of an individual in the round.

Children and young people

Children and young people account for nearly a quarter of the population, and account for up to 40 per cent of consultations in general practice. In many parts of the country around half of GPs have had no formal training in paediatrics⁷. Yet there is compelling evidence of how tailoring general practice services to the needs of children and young people can dramatically address the sustainability issues facing the NHS and improve health outcomes. A national review in 2010⁸ identified that children, young people and their parents or carers are often unwilling or unable to gain access to the care of a GP and that they choose to go instead to the A&E department of a hospital. The *National Children's Bureau* has highlighted that nearly a quarter of all those attending A&E services are under 16 years of age, and that the number of attendances and emergency admissions are rising for this age group⁹. This creates obvious pressures on hospital services and exposes children and young people to acute hospital settings unnecessarily. We will work with CCGs to help make general practice and wider primary care more suitable for the health needs of children and young people. On *Children's Takeover Day* in November 2013 the NHS England Executive Team heard directly from young people about how they thought general practice could be more responsive to their needs by allowing them to email their concerns in advance, rather than have to tell their story out loud for the first time to the GP.

People with long term conditions

The 15 million people in England with long term conditions have the greatest healthcare needs of the population (15 percent of all GP appointments and 70 percent of all bed days).¹⁰ It is clear that current models of dealing with long term conditions are unsustainable. Rather than people having a single condition, multimorbidity is becoming the norm.¹¹

People have told us that they want person-centred coordinated care to manage their long term conditions. This will enable individuals to make informed decisions which are right for them, and empower them to manage their health in partnership with health and care professionals.

NHS England and partners are using the 'House of Care' model as a framework to help deliver high quality person-centred coordinated care. The House relies on four key components: commissioning; engaged, informed individuals and carers; organisational and clinical processes; and health and care professionals working in partnership.

7. "Getting It Right for Children and Young People" (p6); Professor Sir Ian Kennedy; 2010

8. "Getting It Right for Children and Young People"; Professor Sir Ian Kennedy; 2010

9. "Opening the Door to Better Healthcare", May 2013

10. Department of Health (2011) Ten things you need to know about long term conditions. Available at: www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthings-youneedtoknow/index.htm

11. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012) Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet*, 380:37-43.

23. But it's not just about responding to the varied health needs of our communities. It's also about putting equality at the heart of the NHS, its values, processes and behaviours. People have a right to high quality services, irrespective of who they are, their social status, where they live, or what needs they have. In commissioning primary care services, we are committed to ensuring a particular focus in improving access to high-quality services for:

- people from more deprived backgrounds with poorer health outcomes;
- people from black and minority ethnic communities;
- people with physical or learning disabilities.

24. We also need to improve access for groups who face particular difficulties in accessing services including homeless people; sex workers; gypsies and travellers; and people in prisons and offender institutions. For these groups, experience of general practice is often worse than for the population at large because it is not sufficiently tailored to their specific needs. So our ambitions for primary care are particularly important for making sure that we meet the needs of these groups in society.

25. Our area teams are working with CCGs to develop primary care strategies that draw on the insights and experience of people across all these different groups and support a more integrated approach to providing care and support across primary care, community health services, social care, the voluntary/charitable sector and specialised services. We will use the *Equality Delivery System* to guide us in helping make services more responsive to people's individual needs and promote more equitable health outcomes.

26. In developing joint plans with CCGs, area teams are working with *Health and Wellbeing Boards* to ensure that plans are based on a clear understanding of access and health outcomes across different population groups, including gaps in life expectancy and their causes, incidence of 'killer' diseases at local community level and inequalities across the most and least well off neighbourhoods.

27. In order to reduce inequalities, we are also reviewing the formula used to weight the capitation payments made to general practice. The formula already includes adjustments to reflect the age of registered patients, relative levels of deprivation, and rurality factors. We are working with the *British Medical Association's General Practitioners Committee* to improve the weighting given to deprivation factors and help ensure that there are appropriate incentives to improve access to people from more deprived communities.

"Involving GPs and other healthcare professionals in care pathway re-design, as is now happening through CCGs, is creating clinically-led innovation"

response to engagement

Wider primary care, delivered at scale – future models of care

28. In order to support delivery of our ambitions, we believe that general practice will need to operate **at greater scale and in greater collaboration** with other providers and professionals and with patients, carers and local communities. At the same time, general practice will need to preserve and build on its traditional strengths of providing personal continuity of care and its strong links with local communities.

29. Many practices in England are already looking to adopt new approaches to self care, communications technologies and clinical collaboration. They are also exploring ways of improving clinical effectiveness, safety and patient experience. These often involve looking more broadly at primary care and other community-based services. This is about a bigger perspective and ambition, and a step change in partnership working, both across practices and with their community partners.

30. This does not necessarily have to involve a change in organisational form. It can be achieved through practices coming together in networks, federations or 'super-partnerships', or as part of a more integrated model of provision. It is likely to have a range of benefits including:

- **Better outcomes**

- pooling of clinical expertise, offering a greater range of generalist and more specialist services delivered by a larger multidisciplinary team
- improved patient access, including greater availability of consultations outside traditional opening hours, and consultations outside of the surgery
- local systems of extended primary care that work to prevent unnecessary hospital admissions and support safe hospital discharge seven days a week

- **Better partnerships**

- a more innovative approach to planning and delivering services by way of shared learning and ideas
- a more systematic approach to governance and risk assessment
- opportunities for innovative diagnostic, treatment and care pathways

- **Better value**

- economies of scale in administrative and business functions

- **Better for the workforce**

- better development opportunities for GPs, practice nurses, practice managers and other staff and ability to support students
- more effective peer support and mentoring

31. We plan to work with national and local partners to identify the best emerging examples of service models that deliver these outcomes and improvements. Service models need to be locally designed and need to be sensitive to local needs, priorities and circumstances: what may be suitable for a very transient community in an inner city may not be right for a very stable population dispersed across a large rural area. There can be therefore no single blueprint. We will publish emerging examples of these potential models to help support those leading change at a local level, and to ensure that we are clear about the clinical, patient and economic benefits of different ways of organising care, and the workforce implications. Some early examples are set out in [Appendix A](#).

32. We believe our ambitions for general practice will not be met simply by local strategies alone. The combination of factors affecting general practice set out in chapter one highlight the need for some national enabling work to support the champions of change, and to build the foundations nationwide for better primary care to deliver great outcomes for everyone. This is covered in our next chapter.



CHAPTER THREE

Meeting our ambition

33. This chapter sets out the ways in which we are already taking steps to enable general practice to meet these ambitions, and the work we have planned for the future.
34. NHS England commissions primary medical care through 27 area teams across England. Each of these area teams has been engaging with local communities, CCGs and other stakeholders to discuss how we can respond to A Call to Action. It is at this local level that plans translate into real changes for patients.
35. For example, in London we have worked with CCGs and other community partners to develop “Transforming Primary Care in London: General Practice – A Call to Action”¹². This includes new ambitions for primary care in London, built from patient and public views, led by clinicians and focused on more proactive, coordinated and accessible care for all.
36. In Greater Manchester we have worked with CCGs and other partners to develop a five-year strategy to develop new quality assurance systems, give people the information and choice they need to manage their own health, provide integrated care teams for people with long term conditions, develop new forms of rapid response to urgent care needs, and enable people to access a wider range of out-of-hospital services in their local community.
37. All of our area teams are working with local communities to translate the general ambition into specific concrete strategies for their populations. This reflects the different starting points and the different needs of communities; but is set within our overarching ambitions for improved outcomes for all.
38. To support these locally-led transformations in primary care, we are focusing at national level on seven main areas of work. These are:
 - I. **Empowering patients and the public:** enabling patients and carers to play a more active role in their own health and care, involving local communities in shaping services, giving people greater choice over the general practice they register with, and transforming patient access to GP services.
 - II. **Empowering clinicians:** ensuring high-quality support for innovation and improvement, developing networks to allow more rapid spread of innovation, supporting general practice in developing new models of provision, and releasing time for patient care and service improvement.
 - III. **Defining, measuring and publishing quality:** improving information about quality of services both to strengthen accountability to the public, clarity on what the public can expect, and to support clinical teams in continuous quality improvement.
 - IV. **Joint commissioning:** working with CCGs to develop a joint, collaborative approach to commissioning general practice services, with a stronger focus on local clinical leadership and ownership and allowing more optimal decisions about the balance of investment across primary, community and hospital services.

V. **Supporting investment and redesigning incentives:** supporting a shift of resources towards general practice and ‘wrap-around’ community services, developing the national GP contract to support our five ambitions, and developing innovative new forms of incentives that reward the best health outcomes.

VI. **Managing the provider landscape:** ensuring that all general practices meet essential requirements, responding effectively to unacceptably low quality of care, and enabling new providers to offer their services to the public.

VII. **Workforce, premises and IT:** working with national and local partners to develop the general practice workforce, promote improvements in primary care premises and sustain improvements in information technology services.

39. In the pages that follow, we set out some of the work that will follow in each of these seven areas.

(1) Empowering patients and the public

Enabling patients and carers to participate fully in managing their own health care needs, and in developing personalised care plans, lies at the heart of our vision for health care, not just general practice. Patient, public and carer voices will be central to the planning and commissioning of general practice services and wider primary care.

40. By April 2015 all patients, who wish to do so, will have online access to their own records in general practice, including test results.

41. We will make sure that patients who manage their own care have access to high quality information, such as expertise in the interpretation of diagnostic tests, through our strategy for “information as a service” and through our “shared decision making” toolkits.

42. We will publish a *best practice standard* in the summer of 2014 that describes a good personalised care planning process, to support implementation of proactive coordinated care planning for frail older people and other people with complex needs.

43. We will provide guidance by the summer of 2014 on how the primary care team can use peer support and social prescription services to support patients in achieving long-term behaviour change and building social networks of support.

44. We want to promote innovative forms of patient participation that reflect the specific needs of local communities. We will work with the *National Association of Patient Participation* and other partners such as *Healthwatch* to support practices to develop inclusive and insightful approaches to building participation.

45. We will provide more opportunities for patients to give feedback on general practice services: from December 2014 the *Friends and Family Test* will be extended to general practice services.

“Involve patients in the design of services. It is not rocket science to look at the best customer service in the outside world and apply those lessons across the NHS”

response to engagement

We will give people greater freedom to choose the GP practice that best meets their individual needs.

46. We will ensure clear information about the choices already available to members of the public through *NHS Choices* by publishing an increasing range of information to support patient choice and by working with the *Care Quality Commission* to support its new work around the rating of individual practices.
47. From October 2014 practices will be able to accept patients onto their registered lists from outside their traditional boundary or catchment areas (with alternative arrangements in place where patients need urgent care closer to home); this will particularly benefit people who move house and want to stay registered with their existing general practice, and people who want to register with a general practice near their place of work. We will explore new forms of online patient registration to ease the process of switching practice.
48. We will more fairly reward practices that take on more patients by continuing to increase the proportion of funding that follows a patient when they switch practice – for instance through phasing out the Minimum Practice Income Guarantee and seniority payments and recycling these resources into the capitation payments that all practices receive to reflect the numbers of patients on their registered list, weighted by age, morbidity and other factors.

We will enable patients to access services in ways that better reflect their needs and preferences – whilst ensuring that patients access the most appropriate service, at the right time and in the most appropriate location

49. Over 2014/15 we will develop quantifiable ambitions for improving overall patient experience of general practice services. This will focus on improving experience of access to services, which we know in turn is particularly linked to convenience of getting an appointment, ease of getting through on the phone and the helpfulness of receptionists.
50. We will use the £50 million made available under the Prime Minister's Challenge Fund to enable groups of practices around the country to pilot new ways of working that transform patient access to services. In December 2013 we began the process for identifying a number of pilot practices, and a rolling programme of pilots will commence from April 2014 that will test how to improve access to general practice, which could include:
 - access between 8am-8pm on weekdays and at weekends
 - flexible access including consultations by telephone, email, and Skype; electronic prescriptions and online booking of appointments
 - easier, online registration and choice of practice
 - joining up of urgent care and out of hours care
 - greater flexibility in how people access general practice, including freedom to visit a number of GP surgery sites in their area
 - better access to 'telecare' to help manage patients in their own homes, as well as promoting healthy living 'apps'.

51. From April 2015, all practices will offer patients the opportunity to book appointments online, order repeat prescriptions online, and have access to their medical records online.

52. We are working with CCGs to develop primary care strategies that address barriers to access for vulnerable populations, such as the homeless, and access to treatment for hard to reach communities who are often not engaged in proactive long term management of their conditions.

URGENT AND EMERGENCY CARE

The initial conclusions of NHS England's review of Urgent and Emergency Care are that the NHS must do better to help patients with urgent care needs to get the right advice in the right place, and that we must provide highly responsive urgent care services close to home so that people no longer choose to queue in A&E. Our current model for providing urgent and emergency care is not sustainable. General practice and other primary care services are well placed to respond to the challenge of ensuring safe and sustainable urgent care services outside hospital that are responsive to the needs of individual patients. However, at the moment patients contacting their general practice with an urgent problem receive a variable response, and may be directed elsewhere inappropriately. In some cases patients do not even think to approach primary care services in urgent situations, and instead choose to queue at A&E services. This is particularly true of parents seeking urgent care for infants and children. We will support general practice in working innovatively with out-of-hours providers, community health teams, acute hospitals and NHS 111 to deliver a better service that ensures that patients with more urgent care needs receive prompt attention at all hours of the day or night. CCGs are already developing strategic plans for improving urgent care, and the proposals set out in this document will help us work alongside CCGs to implement the eventual recommendations of the Urgent and Emergency Care review.

(2) Empowering clinicians

To make sure we drive up improvement across general practice for each of our ambitions, we will support the development of networks to allow more rapid spread of innovation. We will support practices in releasing time for patient care and service improvement. We will make more data available to support clinicians in continuous quality improvement.

- 53. We will reduce unnecessary burdens on general practice and support more efficient ways of working so that practice teams can devote the maximum possible time to patient care. We are simplifying the Quality and Outcomes Framework from 2014/15 to reduce bureaucracy and to free up time for GPs and practice staff to provide more proactive, person-centred care, with an initial focus on frail older people and other patients with more complex needs.
- 54. We are exploring how the wider primary care and community workforce can support capacity in general practice. *“Improving patient care through community pharmacy – a call to action”* highlights the potential for community pharmacy teams to play a bigger role in supporting patients with long-term conditions.
- 55. The call to action – and the responses we have received – has identified a pressing need to invest in the ability of general practice to release capacity and implement innovative service models for wider primary care.
- 56. We are considering a range of measures to support the spread of innovation, for confirmation in April 2014.

“Integration will come from better understanding of the whole – more shadowing of roles across disciplines”

response to engagement



SOCIAL PRESCRIBING

In order to make general practice more sustainable we need to ensure that people get the most appropriate help at the right time, and this includes making more use of non-clinical interventions when this is appropriate. Social prescribing is an innovative approach that harnesses the unique expertise and resources within the voluntary and community sector for people with non-clinical needs and is particularly effective as an intervention for people with mild to moderate mental health issues. It is also effective for groups who are at risk of social exclusion and who consequently are frequent attenders at their local practice. Common examples are self-help groups, education classes, clubs, discussion groups and other hobby-related activities. Current provision of social prescribing is variable, and we want to disseminate great practice where it exists and is shown to deliver better outcomes and better value. We will work with our voluntary and community sector partners to encourage a move to social prescribing and to develop pathways that enable people with non-clinical needs to access voluntary services and community groups.

(3) Defining, measuring and publishing information on quality

We will turn our ambitions into clear standards, and work with partner organisations to define more clearly what patients and the public should expect from high-quality general practice and develop a better range of measures that can be used to gauge how well practices are meeting these standards.

57. In collaboration with the CQC, NICE, the *Health and Social Care Information Centre* and other organisations across healthcare, NHS England has established the *National Network of Quality in Primary Care* to define and promote quality in primary care.
58. Through this network, we are bringing together in one place – and continuing to develop – standards that describe the key characteristics of high-quality primary care in the following domains:
 - a) clinical effectiveness, including (i) reducing avoidable mortality; (ii) improving quality of life for people with long term conditions; (iii) providing swift and effective responses to acute illness or injury;
 - b) patient experience, including experience of access;
 - c) patient safety.
59. We will also ensure that for each of these areas there is a consistent set of metrics that enable us to provide comparative information for GP practices, CCGs, and patients and the public as to how well practices – or groups of practices – are performing against these standards.
60. These quality standards will draw on pioneering work already taking place around the country between CCGs, our area teams and local communities to define better what to expect from high-quality primary care and to develop more stretching ambitions for what can be achieved from wider primary care, delivered at scale.

We will improve information about the quality of general practice services to: strengthen accountability to the public; support clinical teams in continuous quality improvement; support patients in decisions about their care and in exercising choice; and increase transparency of health information for the benefit of patients and the public.

61. We will publish accessible and meaningful information so that patients are able to make better decisions about their health and care, and citizens are able to participate more fully in conversations about the design and quality of local services and hold them to account. Publishing this kind of data also enables expert third parties to contribute to the transparency and quality agendas by scrutinising the data in novel ways and publishing their analyses. Together with other sources of data, it also has the potential to provide GPs themselves with the analytical tools to understand and improve their own practice.
62. New data on general practices was added to a special 'accountability' section of the *NHS Choices* website in December 2013. We will engage further with key stakeholders to identify and publish more information.

We are taking particular steps to help improve patient safety in primary care

- 63.** To support our proactive approach in monitoring safety we have established a *Primary Care Patient Safety Expert Group* to provide senior clinical advice on patient safety issues and provide advice and guidance for commissioners and providers. The Expert Group is developing a strategy for improving patient safety in primary care, including improving patient safety incident reporting, improving culture and improving the safety of the discharge process from acute care. This will support everyone working in general practice to undertake improvement activity and increase their use of information to drive continuous reductions in harm.
- 64.** In response to the Francis and Berwick reports, we are investing £12 million on a major programme of patient safety improvement through the creation of around 15 patient safety collaboratives covering every part of England. These collaboratives will be locally led and nationally supported to spread best practice and build safety skills. The collaboratives will:
- bring together frontline teams, experts, patients, commissioners and others to tackle specific patient safety problems, develop and test solutions, and learn from each other to improve safety;
 - address patient safety issues across acute, community and primary care services.
- 65.** This will require the full involvement of general practice providers and will support the whole primary care sector in addressing patient safety issues.

(4) Joint commissioning of general practice services

To deliver our ambitions, we have heard that a collaborative approach to commissioning general practice services between NHS England and CCGs would be more effective.

- 66.** We have heard consistently that to meet the needs of a population with an increasing rise in long term conditions general practice wants to – and needs to – play a stronger role at the heart of more integrated networks of community-based or ‘out-of-hospital’ care. At its best, general practice already plays a pivotal role in connecting people to other community services that help them stay healthy and manage long term health conditions – and in working with a range of partner organisations to improve the health of local communities.
- 67.** Developing more integrated services will depend ultimately on the leadership and cultures of the different provider organisations involved – and we are already seeing great examples of general practice starting to come together with community health services, social care and specialist services to do this. To support these changes, however, we need to ensure that we commission services in a holistic way, based on the needs of a given locality.

68. To do this, NHS England intends to move towards joint arrangements with CCGs for commissioning general practice services. This will:

- allow NHS England and CCGs to pool resources, where appropriate, and make more optimal decisions about how resources are allocated between primary care, community health services and hospital services;
- strengthen local clinical leadership and ownership of plans to transform general practice services, and ensure they are aligned with the wider strategic plans for that community;
- strengthen the links between in-hours general practice services and wider out-of-hours services;
- support development of more integrated arrangements for providing general practice and community health services (for example in linking the work of general practice, district nurses and palliative care nurses in end of life care);
- allow a more cohesive approach to incentives for general practice and other local health organisations, so that providers are held to account for – and rewarded for – similar outcomes, e.g. for population health;
- support joint working with local authorities to commission more integrated health and social care for local communities and support outcomes that address social and economic disadvantage (such as housing and education) to improve community health and wellbeing;
- provide greater confidence that, where local plans require additional investment in general practice services, this investment is being made in ways that do not give rise to perceived conflicts of interest for GPs involved in clinical commissioning.

69. To support this approach, we are expressing primary care allocations at a CCG population level. This will enable CCGs and NHS England to look at the resources available to spend on general practice alongside resources for hospital and community services in each locality.

70. We are also developing a national governance framework to enable this to happen at a pace that can be led locally and is appropriate to local circumstances.

“Part of the problem is that CCGs do not commission primary care, they cannot, due to conflict of interests. Before you can get integrated care you need to have integrated commissioning”

response to engagement

We shall use new forms of collaborative commissioning to help tackle health inequalities

71. Joint commissioning offers the potential to:

- commission services focused on vulnerable populations with high health-care needs but who traditionally have poor access (such as the homeless and migrants);
- involve communities in co-designing services that meet their wider health and social care needs;
- commission integrated primary care as a gateway to non-clinical and community services that address the social determinants of health.

(5) Supporting a move of resources and re-designing incentives

To deliver our ambitions, we believe we need to see a shift of resources from the acute sector towards general practice and 'wrap-around' community services

72. We have heard a strong view that, if we are to develop a more sustainable health service that helps to keep people healthy, there needs to be a significant shift of resources from acute services to out-of-hospital care. The *Better Care Fund* - a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities - will provide significant opportunities for CCGs and local authorities to work together to effect this change.
73. We have also heard that there needs to be local flexibility as to how far this is achieved. CCGs are already developing strategic plans that place a much greater emphasis on care outside hospital, and many intend to use general practice as a major component of more accessible and integrated systems of care.
74. NHS England's planning guidance for 2014/15 describes how CCGs will provide additional funding of around £5 per head to support practices in transforming the care of patients aged 75 or over and in reducing avoidable admissions. This funding could be used to commission new services from general practices or invested in community services to improve integration with primary care. Practices should have the confidence that, where these initial investment plans successfully reduce emergency admissions, it will be possible to maintain and potentially increase this investment on a recurrent basis.
75. This local shift of investment, combined with more collaborative working between CCGs and area teams, will increasingly allow us to set more stretching ambitions for primary care.
76. In support of joint commissioning and a more specific focus on the needs of local communities we will provide greater clarity about the different ways in which area teams and CCGs can make safe, controlled investments in general practice services, including:
 - services commissioned by CCGs under the NHS Standard Contract;
 - services commissioned as variations to General Medical Services (GMS), Personal Medical Services (PMS) or Alternative Provider Medical Services (APMS) contracts, managed by NHS England but potentially drawing on funding that has been pooled with CCGs.

“First of all we need to work out how to disinvest money from secondary care without destabilising the hospitals we need”

response to engagement

We will continue both to develop the national GP contract and to develop innovative new forms of incentives that reward the best health outcomes.

- 77.** This is not just about new investment. The forecast funding gap for the NHS of £20bn by 2021/22 means that we urgently need to use existing resources more effectively. We have heard considerable frustration from CCGs and general practice about the number of current incentive schemes, the need for greater cohesion and the desirability of adapting incentives to reflect local priorities.
- 78.** To allow a more cohesive approach to incentives, we will:
- continue to develop the national GMS contract framework so that it provides equitable funding for the essential services that all general practices should be expected to provide and helps drive continuous improvements in quality of care and value for money;
 - continue to develop the *Quality and Outcomes Framework* with a view to a stronger focus on outcomes rather than processes of care and a continued push to remove unnecessary bureaucracy;
 - review local PMS contracts to ensure that, where NHS England is providing extra funding for primary care services locally, it is invested in services that go beyond what is expected of core general practice and supports locally agreed plans for developing primary care;
 - use PMS or APMS arrangements to stimulate innovation and quality improvement to meet local needs and reduce health inequalities, based on local CCG strategies and, where appropriate, using pooled funding.
- 79.** We will also develop and test innovative approaches to incentives, for instance by:
- using PMS or APMS flexibilities to design more holistic incentives that reflect local needs and support integration;
 - developing practical tools to support area teams and CCGs in innovative forms of contracting that support greater integration in the provision of general practice and other services.



(6) Managing the provider landscape

Our ambition to ensure that everyone, wherever they live, can access consistently high quality care means that we need to set clear expectations for the standards that patients should be able to expect from all general practices; respond effectively to poor quality of care; and enable new providers to offer their services to the public, particularly where current services are not providing good quality.

80. *Monitor's* recent report¹³ set out a number of recommendations for how we can best manage our relationship with existing and potential future providers of primary care services to improve quality for

patients. Those recommendations have informed these emerging findings, and we will continue to work with *Monitor* and other partners to take forward the action described below.

We will take a more consistent, rigorous and risk-based approach to monitoring quality

81. Every general practice is required to meet essential national standards around quality and safety in order to maintain its registration with the *Care Quality Commission* (CQC). We are working with the CQC to ensure a shared approach to monitoring, maintaining and improving quality in general practice.

83. To complement the CQC's plan to have inspected and rated every practice in England by 2016, each area team will during 2014/15 identify those practices in each locality that cause most concern in terms of quality and work with those practices to determine the most appropriate action for improvement.

82. NHS England has a key role to play in ensuring safety and quality, working alongside the CQC. Our risk-based assurance process for general practice enables us to monitor practice performance against a range of outcome standards and performance indicators and to take action where there are concerns about performance. Our approach reflects the five key questions that the CQC asks about each general practice:

Questions	Actions
Is it safe?	➡ Assurance
Is it effective?	➡ Support where possible
Is it caring?	➡ Intervention
Is it responsive?	➡
Is it well led?	➡ Closure if necessary

13 "Discussion document following Monitor's call for evidence on GP services", February 2014

We will work with the CQC to take a more rigorous and coordinated approach to respond to evidence of poor quality

- 84.** Reporting on the CQC's first 1,000 inspections of GP surgeries in December 2013, the Chief Inspector of General Practice concluded that a minority of practices (around one per cent) present serious failings in the provision of care. Where a practice is providing poor quality care, we will take the following action, working as appropriate with the CQC:
- Where the CQC has judged a practice to be "inadequate" but has not removed registration we will work with the practice to determine the action that is needed to improve quality of care within a stipulated time frame and monitor progress.
 - We will support practices, where necessary and appropriate, in accessing external support to help them make the necessary improvements.
 - We will ensure that patients are informed of other practices that they could choose to join, if they have concerns about quality following a CQC assessment.
 - Where appropriate, we will work with practices to consider if quality of care for patients could be improved by joining a network or federation of other practices, or through merger with another local provider to create a single management structure.
 - Where there is a serious risk to patient safety, we will halt the provision of services at that practice.

Where practices close, we will either bring in a new provider or seek to consolidate services with another local practice, whichever is in the best interests of patients

- 85.** There are a number of scenarios in which GP practices are unable to carry on providing services to patients. This could be because a practice chooses to close, or because – in the event of serious failure – the CQC removes their registration or NHS England removes their contract.
- 86.** In these circumstances, our immediate priority will always be to ensure that local patients have continued access to services, typically by arranging for another provider to take over the practice on a short-term basis to provide continuity and by ensuring that patients have information about other practices with which they could choose to register if they wish.
- 87.** The longer-term approach to replacing services will depend on the local circumstances. Where the practice serves a relatively small population, we will, where possible, make arrangements for an existing provider to take over the practice on a permanent basis, in line with our view that general practice is more likely to deliver high quality, cost effective services when operating at greater scale. Where the provider serves a larger population we will generally look to commission a new provider through an open and transparent procurement process.

We will bring in new providers on a targeted basis where this will have the greatest impact in improving quality and choice for patients

88. In addition to bringing in new providers to replace any failing practices, we will work with *Health and Wellbeing Boards* to assess current and future needs and to assess how well these needs are being met through existing services.
89. In order to improve quality and reduce inequalities in access, we will take targeted action to bring in new providers in two main circumstances:
 - first, where new services are needed to respond to growing population, particularly where existing practices are unlikely to be able to absorb this growing demand;
 - second, in those specific localities where there are comparatively low numbers of GPs and primary care staff per head of population, where CQC inspections have indicated poor quality of existing services and where patients have limited choice (i.e. significant numbers of closed lists).
90. Wherever we are considering bringing in new provision in this way, we will also work with existing providers to help identify how they can better meet demand or improve quality, for instance through introducing new service models.
91. We will ensure new providers are introduced through open and transparent procurement processes designed to identify the providers that will offer the highest quality services within the standard price for GP services. In the past, contracts for APMS have tended to be for about five years, but we intend to introduce longer-term contracts, where possible, for new providers in the interests of long-term continuity of care and value for money.

(7) Developing infrastructure

Our ambitions cannot be realised without the right people and the right tools. We will work with national and local partners to develop the general practice workforce.

92. We face four key challenges in relation to workforce:
 - i. we need to help address the short-term pressures that many general practices are facing in recruiting and retaining GPs and practice nurses;
 - ii. there is a pressing need to improve recruitment to some elements of the community health workforce, particularly district nursing;
 - iii. we need to address long-standing inequalities in numbers of GPs and practice nurses per head of population
 - iv. we have heard consistent calls for developing a fresh approach to how we plan and train the future community workforce to support more proactive, coordinated and accessible care.
93. These are system-wide training challenges that will rely particularly on the leadership of *Local Education and Training Boards* and *Health Education England* (HEE) to address.

94. We are working with HEE and other partners including the national professional bodies to determine how we can best support these workforce improvements. Our current focus is on working with CCGs to ensure that HEE and *Local Education and Training Boards* have a sufficiently clear view of future service plans to be able to translate these into longer-term plans for growing the primary care workforce. We will publish a toolkit in spring 2014 to support CCGs and area teams in working with LETBs to translate plans into workforce strategies.

“NHS England and CCGs have to work together to decide to plan premises based on future requirements in terms of size of population and how services are to be commissioned”

response to engagement

95. Whilst others have the leading role in supporting training, recruitment, retention and return to practice, we will prepare a detailed plan by summer of 2014 that describes our own specific role including:

- improving the recruitment of GPs and practice nurses in communities where this has been challenging;
- promoting safe, effective and proportionate routes for GPs wishing to return to practice;
- supporting the retention of the existing GP workforce;
- supporting the development of community, district and practice nurses through our *Community Nursing Strategy Programme*;
- encouraging more effective use of skill mix in general practice and encouraging practices to make the best use of community assets; and
- supporting practices to be good employers

We will promote improvements in primary care premises.

96. We want to ensure that patients receive care in safe, accessible and suitable premises that offer value for money for the taxpayer. Investment in primary care estate has lagged behind investment in secondary care capital expenditure. As a consequence general practice is often still working from inadequate buildings which offer limited facilities and a poor environment for patients and staff. Under-developed premises have inhibited development of primary medical care and its integration with other community providers. Much of the primary care estate is out of date, under developed and no longer provides an appropriate environment for modern clinical care.

97. We have heard consistent messages about the importance of developing new approaches to primary care estates, both to enable a greater range of services to be provided in community settings and to support members of multidisciplinary teams (who may be drawn from different provider organisations) to work alongside each other more closely.

98. In order to release resources to allow additional revenue funding for premises, the two most critical factors will be our ability to support more efficient and effective use of existing community assets and the ability of CCGs to release revenue funding from other sources to support the move towards wider primary care.

99. In order to support new solutions we will:

- work with CCGs, *Health and Wellbeing Boards* and other local partners to ensure that joint strategic plans for developing primary care and wider community-based services identify where premises developments are needed to support these strategic plans and how the capital and revenue consequences of these premises developments is going to be met;
- work with CCGs to support them and providers in making more rational use of existing community-based estates, working with LIFT companies, *Community Health Partnerships*, local authorities and NHS Property Services;

- support practices in working at greater scale (through federations or networks) to facilitate a more effective and cost-efficient use of estates;
- publish a new framework to underpin decisions on general practice premises reimbursement, ensuring more effective prioritisation of any new revenue funding and better alignment with local CCG strategies for out of hospital care;
- work with the Government to review the current system of general practice premises reimbursement to identify opportunities for improving value for money and promoting more innovative use of estates;
- work with the *Care Quality Commission* to help ensure that there is a consistent approach in its inspection criteria and our criteria for general practice premises.

We will sustain improvements in the use of information systems to improve patient care.

100. We are working with the *Health and Social Care Information Centre* to ensure that we continue to develop high-quality information systems in general practice and that we make more effective and consistent use of systems that allow information to be shared between health and care providers to improve quality of care for patients. Shared and summary care records are being developed to support the sharing of information between different health care providers. The 'NHS number' is key to the sharing of information between healthcare providers and NHS England is working to ensure it is consistently used across primary care healthcare providers.
101. We have already taken steps to ensure more consistent information sharing between providers through changes to the GP contract that will improve patient safety, support more joined-up care, and make NHS services more efficient. Under these new arrangements, all practices will:
 - use the NHS number in all clinical correspondence
 - upload information onto the Summary Care Record each working day to support the sharing of up-to-date information between different healthcare providers
 - transfer records electronically when patients change their general practice.
102. The new framework for providing GP clinical IT systems (the *General Practice Systems of Choice* replacement framework) will be designed to enable general practice in this country to extend its world-leading position in the use of electronic systems. It will also be designed to allow increasingly rich online services for patients, helping patients to become more closely involved in their own care and in shared decision-making with GPs.
103. We have delegated responsibility for local operational management of general practice IT services to CCGs. This enables local clinical leaders to play a stronger role in developing patient online services and in improving information-sharing with other providers to support joined-up care.
104. In the summer of 2014 we will publish a revised operating model called "*Securing Excellence in General Practice Information Technology*" which will:
 - provide a strategic direction for the development of general practice IT systems
 - set technology standards
 - introduce, over a two-year period, a more equitable distribution of investment between CCGs to support more consistently high quality of IT services
 - give CCGs freedom to innovate to support service redesign
 - simplify processes for allocating resources and providing assurance about how they are spent.

CHAPTER FOUR

Next steps

- 105.** We have set out here:
- The drivers that mean general practice will need to change and develop; and the particular factors that pertain now to the way in which that will happen
 - Our five ambitions for improvement, which will help to secure high quality care for all, now and for future generations
 - Our proposed work programme at a national level to put in place some of the important enablers for local leadership to take forward their ambitions for local communities.
- 106.** Our area teams are already working with CCGs to reflect the direction of travel set out here in local strategies for primary care services, as described in our NHS planning guidance for 2014/15, *Everyone Counts*.
- 107.** But we know there is more work to do to build the national foundations for sustainable primary care, delivered at scale. We want to continue our discussions with key stakeholders on our emerging views. This period of engagement will run from March to June 2014. We intend to publish the resulting strategic framework for commissioning primary care in the autumn of 2014, covering not just general practice but wider primary care services including dental services, community pharmacy and eye health services.
- 108.** General practice, at its best, has been described as the jewel in the crown. But without change, and without support, it will not be fit for purpose or sustainable for the next decade. And there is much to do now to tackle current unwarranted variation. We welcome further thoughts on how we can work with you to create a consistently high quality, effective and sustainable service for the future.



Timeline

FURTHER STAKEHOLDER ENGAGEMENT	April 2014	Introduce new GP contract arrangements, including new enhanced service to provide proactive, tailored care for patients with the most complex needs
	April 2014	Begin to roll out the <i>Prime Minister's Challenge Fund</i> pilots for improving access to general practice
	April 2014	Commission general practice development programme to support the Prime Minister's Challenge Fund
	April 2014	Commence collaborative work with CQC, NICE and other stakeholders to improve range of metrics for quality and outcomes in general practice and wider primary care
	May 2014	Publish practical toolkit (with <i>Health Education England</i>) to support CCGs and area teams in working with <i>Local Education and Training Boards</i> to translate five-year strategic visions into workforce development plans
	June 2014	Publish framework, supported by practical guidance and resources, on joint commissioning, CCG investment in primary care services, flexibilities for area teams/CCGs to design local alternatives to national contract arrangements, and other innovative forms of contracting
	June 2014	Area teams deliver 5-year strategic plans for primary care
	June 2014	Publish GP IT strategy
	July 2014	Publish guidance on practice mergers and new market entry
	July 2014	Publish policy on responding to concerns highlighted by CQC assessments
	July 2014	Review outcomes of 'calls to action' for dental services, community pharmacy and eye health
	September 2014	Publish strategic framework for commissioning primary care services
	October 2014	Publish potential models for wider primary care at scale
	October 2014	Implement new arrangements to extend patient choice
	December 2014	Implement Friends and Family Test for general practice
	April 2015	Implement arrangements for patients to have on-line access to records
	April 2015	Freeing up time in general practice study - identifying how we can go further in freeing up clinical time to provide more proactive, person-centred care and improve access

APPENDIX A

WIDER PRIMARY CARE DELIVERED AT SCALE

There are a number of elements which providers include as they create wider primary care at scale. The choice of specific solutions will depend on the needs of local people, the features of existing primary care services and other aspects of the local health and care system. We expect the process of designing the future primary care system to be a collaboration involving local people, commissioners and providers.

Listed here are some of the approaches practices may consider. They are not mutually exclusive. Many are already being employed or considered by providers and commissioners in England.

Improved access and resilience

- **Extended hours.** A group of local practices establish a rota system for providing consultations outside of current opening hours. This makes it easier for working people to see a GP, and for acutely unwell patients to receive a general practice consultation rather than attend A&E. While the patients may not see their own GP, they will benefit from consulting an expert generalist who has access to their full record and who is able to arrange ongoing investigations and care.
- **Responsive urgent care.** A group of local practices operate a rota for providing immediate appointments for acutely unwell patients. Patients from all of the participating practices are able to access the appointments. A broader skill-mix may be deployed, including creating a minor illness service for rapid access to appropriate advice and treatment.
- **In-house staff bank / emergency cover.** A group of local practices pool their resources to provide emergency relief for one another in the event of staff sickness. This may involve clerical staff working in another practice for a short period, or patients from one practice being able to access appointments with clinicians at another. Cover can often be arranged at very

short notice, and patients are able to access help without needing to attend A&E if their own clinician is unwell.

- **Business economies of scale.** A group of practices collaborate in the procurement of services and supplies, and delivery of back office functions. This may include clinical administration, business planning, HR, finance, information and legal services. In addition to the financial benefit, there will often be more direct benefits for patients resulting from greater inter-practice communication and collaboration, and the establishment of common procedures, including a greater standardisation of certain care processes.

Integrated care

- **Care coordinators.** One or more specialist care coordinators work across a group of local practices to support patients with multiple complex health and social care needs. The coordinators act as a resource for patients, carers and staff; support patients and carers to make choices about their care; and coordinate the contributions to patient care made by the inputs from different agencies.
- **Multi-professional integrated community team.** Local practices collaborate with community nursing, social care, voluntary/charitable providers and other local partners to create a common system of coordinated health and social care, based on shared working practices and shared records.
- **Community hospital / virtual ward / intermediate care.** Local practices are able to provide rapid access to intensive out-of-hospital nursing care and therapy services, provided in the patient's own home, care home or another neighbourhood facility. Practices may use a rota system to ensure round-the-clock medical cover, supported by video technology.

New services in the community

- **Advanced skills.** GPs who have developed more specialist skills provide advanced diagnosis and treatment without patients needing to attend hospital. The 'specialist GP' has access to the patient's records, thus improving safety, reducing delays and providing more seamless care.
- **Community diagnostic services.** Local practices collaborate to arrange diagnostic services in the community, reducing travelling for patients and speeding access to results. These may include blood tests, adult and children's phlebotomy, ultrasound and, skin biopsy. and INR testing.
- **Enhanced access to care professionals and therapists.** Mental health, occupational therapy, community nursing or social care staff are directly attached to practices, enabling patients to receive a wider range of services as an integral part of the services at their local surgery or health centre.
- **Access to specialist advice.** Practices are able to obtain rapid remote advice or on-site consultation from medical specialists without the patient needing to travel to hospital or have their care handed over.
- **Patient (and family) support and education.** Local practices collaborate with community health services, social care and voluntary and community services to provide group support and education sessions for patients and families. This may include visits to school and community groups, as well as targeted group consultations for people living with long term conditions.

Community development

- Local practices, pharmacies, community health services, voluntary agencies and the local authority work as a group to engage with their community, collaborating with them in asset-based approaches to improving health and wellbeing.

Quality improvement

- **Peer-to-peer challenge and learning.** A group of practices establishes a learning network to share and test ideas and compare performance. This facilitates the development of new ways of working and, the spread of successful innovation. With a continual focus on improvement it provides practices with a supportive professional framework in which to test and promote new ideas and a continual focus on improvement.
- **Service improvement capacity.** A group of practices, not necessarily in a single geographical area, share a common pool of expertise in service redesign and improvement. This may include the use of common processes and protocols, supported by in-house experts in improvement science and change management. Economies of scale also make it easier to invest in information and analysis infrastructure for strategic planning and continuous quality improvement.
- **Continual professional development.** A group of practices pool their resources to plan and deliver relevant professional development for their staff. This can easily be aligned with existing priorities for service improvement, and integrated into wider moves to establish a culture of continual learning and improvement. It is easier to ensure it is relevant to the needs of primary care and may be cheaper and more convenient than external CPD opportunities.

These options represent a range of potentially radical changes to how general practices collaborate with each other and with other health and social care providers, helping general practice to fulfil more of its potential as part of more integrated systems of care outside hospital.

We will promote these innovations and help spread examples of best practice in improving care for patients and local communities.

