Provider Development Support Toolkit

Overview

This toolkit aims to support provider organisations to develop, and to understand their requirements in order to grow in maturity and readiness.

The contents of this pack include:

- Background to the new model of care
- Provider readiness – *what is the development journey?*
- New provider models – *what are the benefits and challenges of each type of model?*
- Self assessment

Appendix Case studies providing examples of providers working at scale

- Capitation design and financial arrangements

01

Background to the new model of care

Working at scale to deliver a new patient offer

The way general practice services are provided is changing, becoming more centred on users' needs, more accessible both by traditional and innovative routes, and more proactive in preventing illness and supporting health**.**

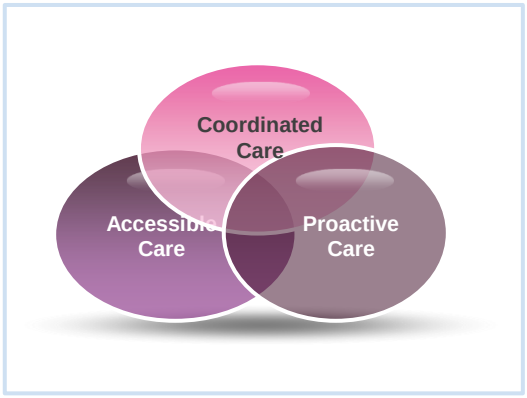
A New Patient Offer*

General practices in London are under strain and are bearing the brunt of pressures to meet increasing and changing health needs. The *Strategic Commissioning Framework for Primary Care Transformation in London* sets out a new patient offer for all Londoners. It incorporates 17 specifications which are focused around:

Proactive care – supporting and improving the health and wellbeing of the population, self-care, health literacy, and keeping people healthy

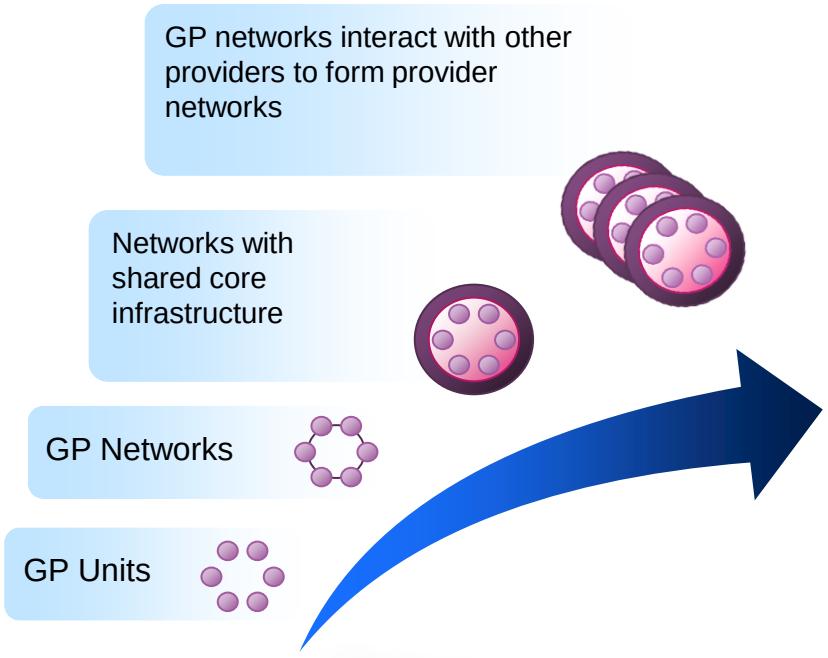
Accessible care – providing a personalised, responsive, timely and accessible service

Coordinated care – providing patient- centred, coordinated care and GP-patient continuity



Working at Scale

General practice will need to work together to form larger primary care organisations if it is to improve sufficiently. This will give groups of practices the opportunity to focus on population health and provide extended opening hours whilst protecting the offer of local, personal continuity of care. GP practices will need to interact as equal partners with other organisations in an integrated health system in order to deliver person-centred coordinated care. The challenge is therefore to develop **primary care working at scale**.



*Refer to the *Strategic Commissioning Framework for Primary Care Transformation in London* for details

Requirements for the new model of care

A primary care orientated health system is focused on improving population health and wellbeing. A patient and their GP should be at the heart of a multidisciplinary effort to deliver patient-centred coordinated care in general practices, developing community resilience and supporting Londoners to stay as well and as healthy as they can.

Accessible	Primary care services are accessible to patients, through multiple channels, 7 days a week, 8 hours a day
Coordinated	Integrated around the patient with a single point of contact and care navigation support
Proactive	Builds capacity for health, health resilience, health literacy and supports health improvement and wellbeing
Patient-centred	Identifies and meets patients personal health goals, offers a holistic response to multi-faceted and increasingly multi-morbid needs
Personalised	To meet the needs of patients with different circumstances and preferences
Responsive	To a patients scheduled and unscheduled care needs as they shift over the course of their lives
Community Orientated	Providers in a community settings working collaborative through a population based approach to delivery care and improve the health and wellbeing
Multidisciplinary	With care team clusters organised around the patient
Technology enabled	Increasing use of technology for both telecare and telemonitoring

Current GP Service Offer

- Traditional10 min appointments
- Smaller size practices
- Space constraints
- Lack of training
- Financial instability
- May not meet patients' needs

Requirements for new model of care

- Flexible appointment length
- Patient focussed holistic care
- Networks of practices
- Proactively caring for patients
- Using skill-mix effectively
- Addressing health inequalities

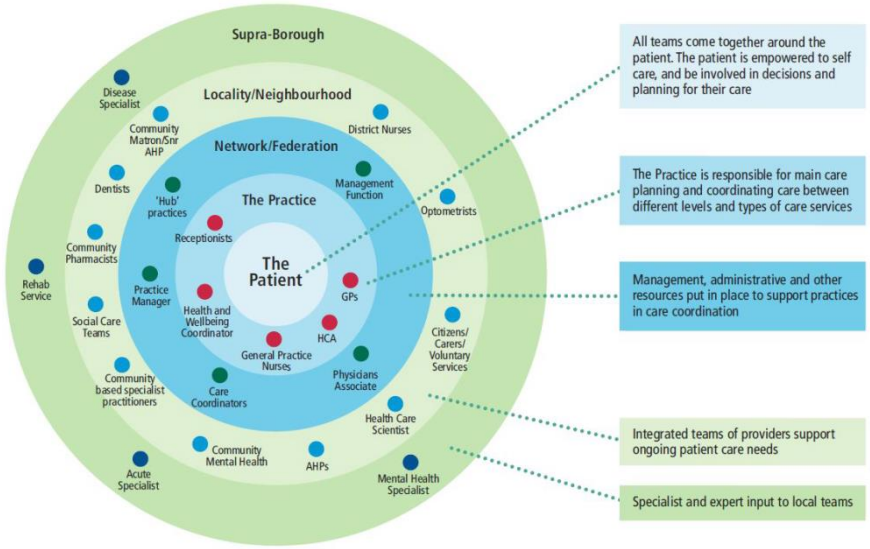
How GPs are responding to these challenges

- Grouped GP teams
- Telephone triage or "doctor first" type appointment systems
- Email/online/phone consultations
- Health coaching
- Increasing availability of online services for patients

Collaborative working will support the new model of care

Patients will benefit through receiving care from a greater range of generalists, more specialist care and improved access to services in a better environment. **We need to work together to achieve this to ensure we can deliver the future requirements of our population.**

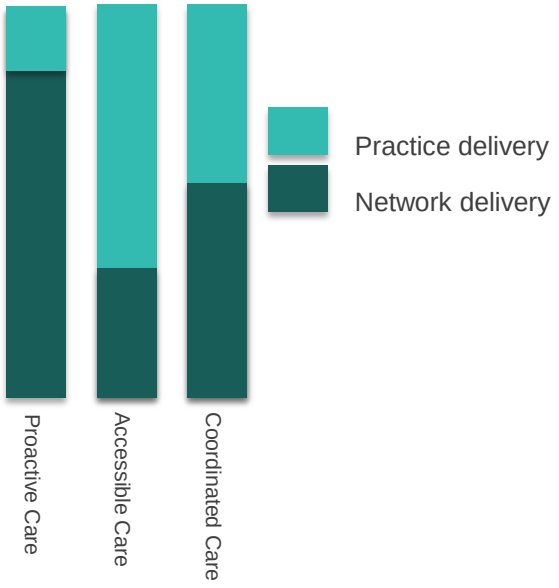
GPs will work together in a single system continuing to deliver first contact care but also providing continuity of care to those that wish to see the doctor of their choice. GPs will be linked together via a single electronic record with other practitioners such as elderly care doctors, paediatricians, palliative care and district nurses helping to deliver 24/7 care to those who most need it.



The specification require practices to work across whole populations as a collective

Most of the specification will be delivered by individual practices, however some elements will only be possible to deliver across a network of practices.

Enablers will be required to ensure delivery ‘at scale’, including a critical mass of practices, appropriate skill-mix of workforce, technology and satisfactory estates.



02

Provider readiness – *what is the development journey?*

Provider readiness criteria

Stage 1 Enabling Development

commissioners can have assurance that these organisations can be invested in, with for example OD, HR, legal support, in order to develop to stage 2

- Practices are geographically aligned with a defined population coverage
- There is a legal form
- CQC accredited as a single provider
- Agreed organisation form, culture and ethos
- Agreed governance and decision making
- Shared incentive agreements
- Effective leadership
- Understanding of efficiency and productivity opportunities to deliver savings
- Map of assets
- Baseline of performance
- Open finance arrangements
- Risk register
- High levels of staff, patient and community engagement
- Business plan to support the commissioner investment

Stage 2 Enabling Service Delivery

commissioners can have assurance that these organisations are able to be commissioned and contracted to deliver outcomes

- 5 year shared vision
- Effective managerial , financial and clinical leadership and the capacity and capability to succeed
- Service delivery approach/operating model-how the provider proposes to deliver the specification, approach to improving quality
- Business continuity and resilience
- Estates strategy e.g. optimising estate utilisation, investment priorities
- Workforce strategy e.g. new roles, succession planning, training etc.
- Technology strategy e.g. utilisation
- of existing systems and new development requirements
- Wider system support and buy-in from the CCG, Health and Wellbeing Board
- Community accountability
- Commitment to data collection to enable monitoring and evaluation of health and quality outcomes
- Able to bid for and provide an outcomes based contract to deliver population health

Note: The criteria is relevant for GP provider collectives, and not on an individual practice basis

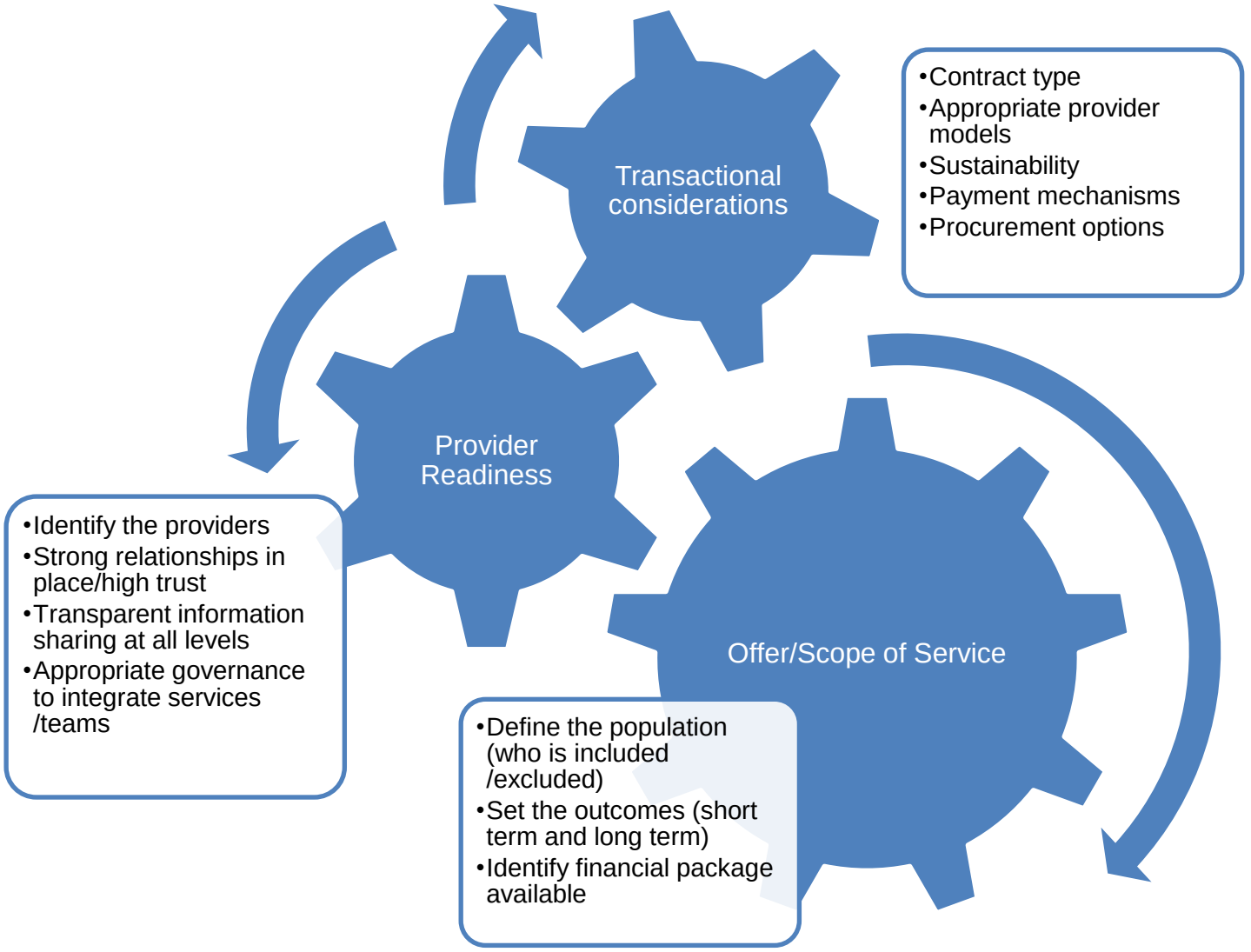
Provider development journey – illustrative example

The journey to at-scale and collaborative models of general practice requires sustained commitment and support for organisational development. It begins with establishing a common purpose - shared goals for collaboration. The following represent some of the development phases providers journey through. This is never a linear process but it does serve to illustrate the breadth of the challenge and range of support required.

	Phase 1 Establishing an at-scale GP entity	Phase 2 GP development strategy	Phase 3 Service Ramp-up	Phase 4 New services in place
Provider Activities	**Illustrative Only:** • Developing a common purpose • Engaging patients and communities • Agreeing a contiguous geography • Agreeing organisation type and establishing legal entity • Inclusivity & diversity of membership • Governance • Registration • Determining requirements for collaboration	**Illustrative Only:** • 5yr practice development plan including: • New shared operating model • Specification delivery plan • Estates plan (e.g. optimising estates utilisation, identifying investment priorities) • Workforce plan (e.g. new roles, succession planning, training) • Technology plan (e.g. effective utilisation of existing systems, moving to one unified system)	**Illustrative Only:** • Prototype service models • Recruit to new staff roles • Training for all staff in all practices • Establish patient feedback loop • Build required infrastructure to support the service • Communicate the service changes to patients	**Illustrative Only:** • Review and evaluate impact, test and refine approaches for continuous improvement
Support Required	**Illustrative Only:** • Funding to free-up time with some external development facilitation support • Organisational development, business development, legal, HR, finance,	**Illustrative Only:** • Planning and administration team in place to work across practices • Service design, estates planning, workforce planning and HR, GP IT support and technology planning	**Illustrative Only:** • Some shared practitioner resources across practices e.g. care navigator • Service design, quality improvement, communications, patient engagement	**Illustrative Only:** • Service design, quality improvement, communications, patient engagement
London Support Offer	**Illustrative Only:** • Provide a self assessment tool for providers moving towards a population health model • Work with CQC to agree a process for accrediting new federations • Share learning across London	**Illustrative Only:** • Provide baseline data on workforce, IT and estates • Provide baseline data on performance and outcomes • Share example approaches on how to deliver the specification • Provide case studies to support contracting for the specification	**Illustrative Only:** • Connect practitioner and teams developing similar services	**Illustrative Only:** • Provide ongoing support for quality improvement, evaluation and sharing learning

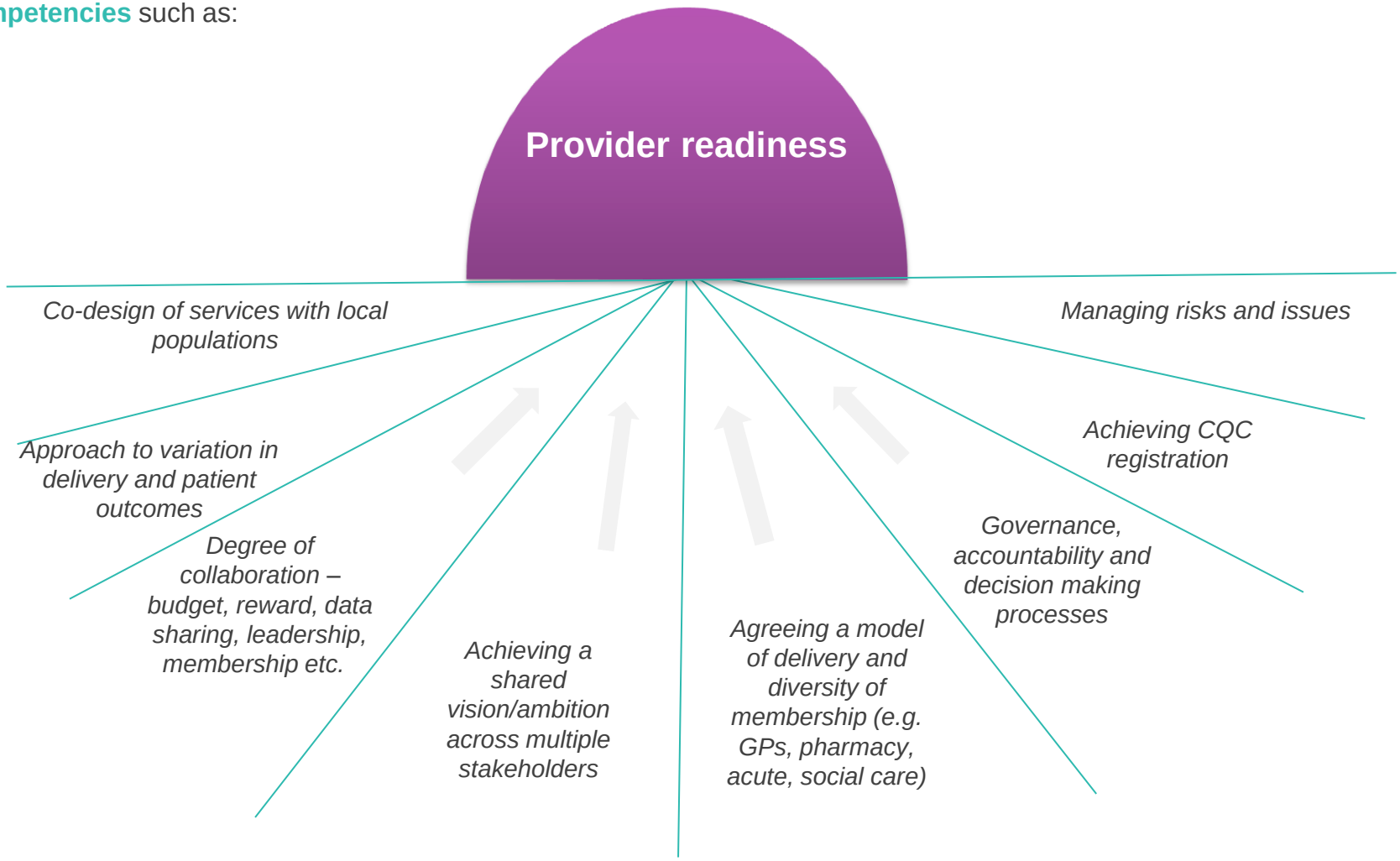
Commissioning for outcomes

Commissioning for outcomes moves from activity based payments to payments for results and outcomes. It encourages the provider to consider the best interventions to achieve outcomes, aligns commissioning for a whole health economy approach and expects greater provider collaboration.



Business competencies to support provider readiness

To reach the required state of readiness, new providers will need to develop **business competencies** such as:



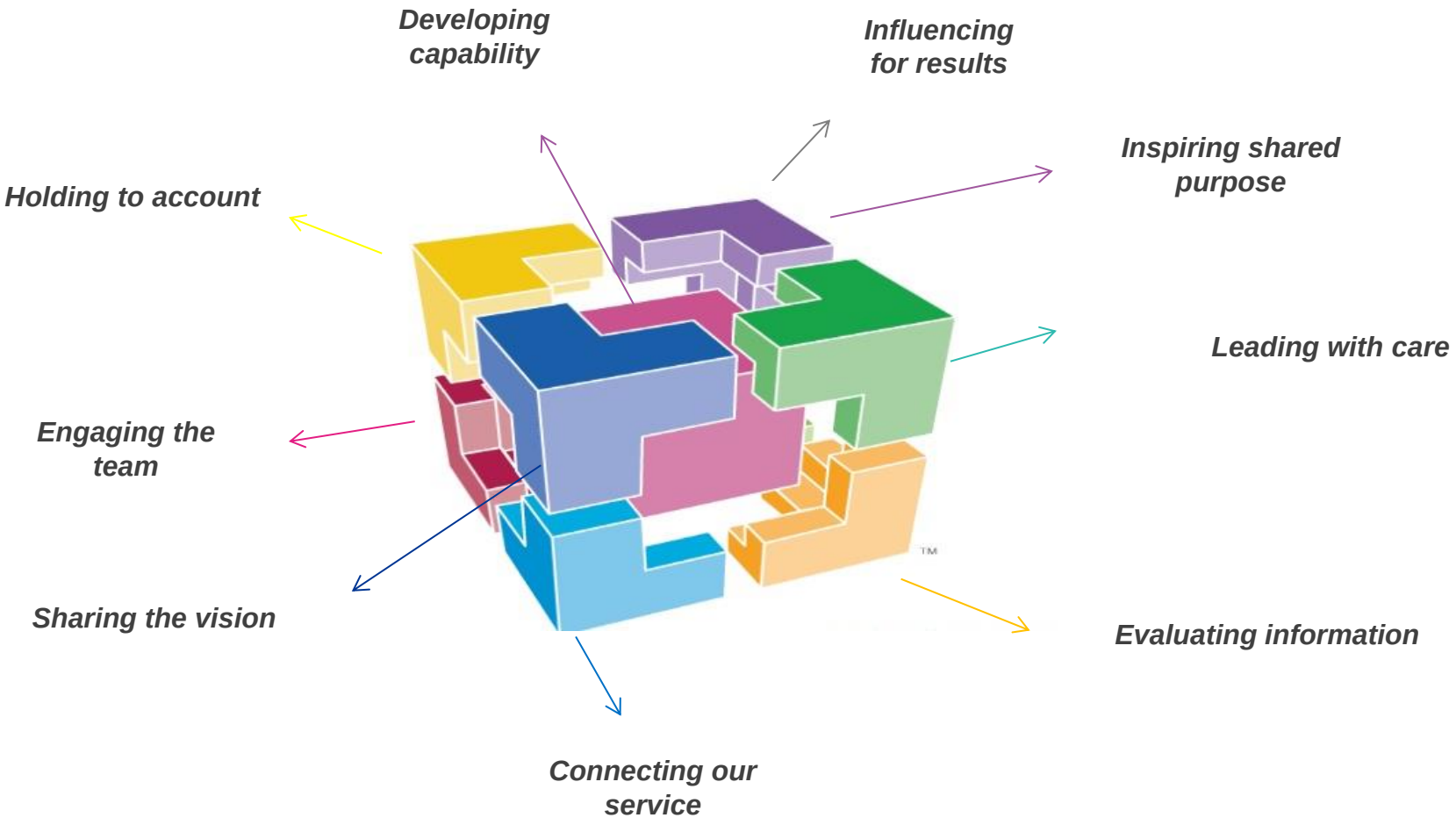
Understanding your learning needs

The NHS Leadership Academy developed a Healthcare Leadership Model which is made of nine leadership dimensions shown in the model below. The model is to help those who work in health and care to become better leaders.

Using the leadership model below:

1. *Prioritise* the order of the nine dimensions against your needs
2. *Identify* the level of personal development required

Further self assessment questions can be found in the self assessment tool.



Healthcare Leadership model – 9 dimensions

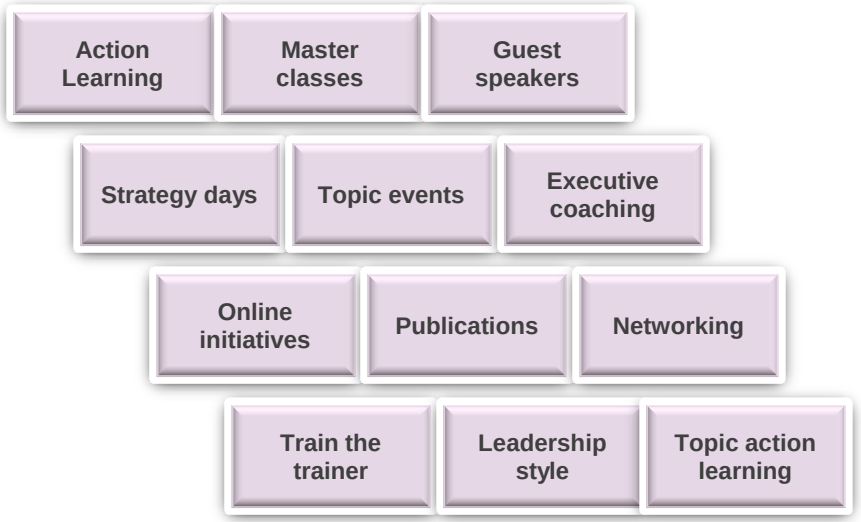
Learning and development partner

A new provider is being procured to **offer a wide range of learning and development opportunities** to give individuals scope to pick and design their own bespoke personal development programme.

The initiative will support 10 individuals (clinicians and non-clinicians) from each Strategic Planning Group in the following ways:

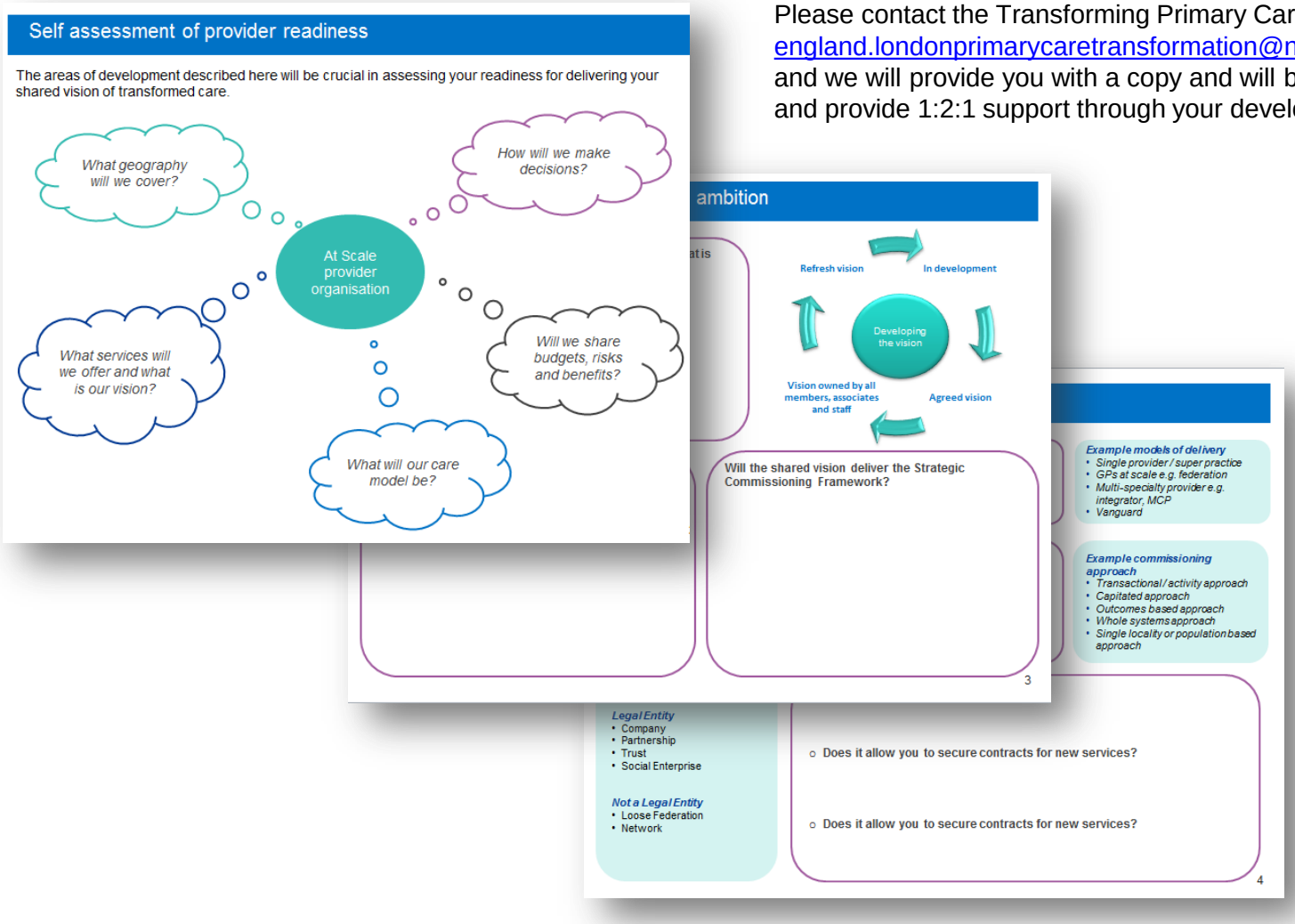
A wide range of transformational development packages will be available to empower participants to devise their own bespoke learning and development programme, underpinned by joining a diverse Action Learning Set.

Transformational development packages



Where is my organisation on this journey?

We've developed a self assessment tool which you can complete with your organisation to understand your level of readiness, as well as your learning needs to further grow in maturity.



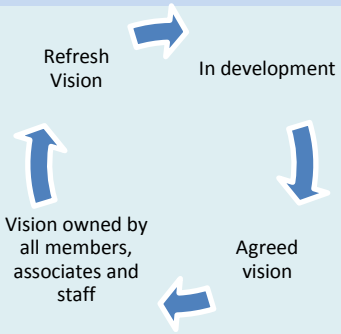
Please contact the Transforming Primary Care programme england.londonprimarycaretransformation@nhs.net and we will provide you with a copy and will be happy to meet with you and provide 1:2:1 support through your development.

Overview of the self assessment tool for provider readiness (1 of 2)

A self-assessment tool has been developed to help you assess where you are right now in your provider / organisation development and articulate where you plan to be in the future. The areas of development described here will be crucial in assessing your readiness for delivering your shared vision of transformed care.

Shared Vision & Transformational Ambition

To what level have provider members developed a shared vision? Is there sufficient transformational ambition within the vision? Is this aligned to the *Strategic Commissioning Framework for Primary Care Transformation in London*?



Model of Delivery

Which provider model is in place or needs to be in place to deliver the shared vision, meet the needs of the local population and deliver the new model of care? Is this model sustainable?

Example Models of Delivery
- Single provider / super practice
- GPs at scale e.g. federation
- Multi-specialty provider e.g. integrator, MCP

Example commissioning approach
- Transactional /activity approach
- Capitated approach
- Outcomes based approach
- Whole Systems approach
- Single locality or population based approach

Organisation Type

What provider organisation is in place or needs to be in place to secure contracts for new services, deliver NHS services legally & offer employees NHS terms and conditions? e.g. pension

Legal Entity
- Company
- Partnership
- Trust
- Social Enterprise

Not a Legal Entity
- Loose Federation
- Network

Inclusivity & Diversity of Membership

What inclusivity and diversity of provider membership is in place or needs to be in place to influence and transform care pathways and address service inequalities?

Diversity of Membership
- Some GP providers in locality
- All GP providers in locality
- Other primary care providers e.g. pharmacy
- Other healthcare providers e.g. community services, acute services
- Social care providers
- Voluntary sector providers

Contiguous (geography)

What level of provider geographical alignment is in place or needs to be in place to provide flexibility for delivering care across a locality or population group? What critical mass is needed for providing a shared function without losing local delivery?

Geographical alignment
- Borough
- CCG
- SPG
- Multiple localities
- Cross boundary (CCG / Borough)
- Clinical Network

Critical Mass
- 60k+
- 50-60k

External Formality

What level of external formality is in place or needs to be in place to meet relevant external governance requirements?

Corporate Governance
- Achieving good financial standing
- Meeting minimum procurement requirements

Clinical Governance
- CQC Registered
- CQC Registered with Conditions
- Not CQC Registered

Overview of the self assessment tool for provider readiness (2 of 2)

Membership Autonomy

What approach has been agreed or needs to be agreed with regard to membership autonomy for decision making, resource management & responsibility?

Autonomous → Surrendered

Full autonomy
- All contracts held at individual provider level

Retained autonomy
- Retained delivery for core services
- Transfer some responsibility for delivery & performance

Surrendered decision making
- All responsibility for delivery assigned to new / single provider

Internal Governance, Accountability & Decision Making

What governance structure is in place or needs to be in place to influence, govern and manage delivery? Will this provide assurance to commissioners?

Informal → Formal

Collective decision making
- Commissioner facilitated
- 1 Member 1 Vote
- Autonomous

Shared decision making
- Nominated Chair supported by committee
- Memorandum of understanding

Delegated decision making
- Chair & Executive Board
- Shared constitution
- Articles of agreement

Managing Risks & Benefits

What approach has been agreed or needs to be agreed to how risks and rewards will be managed and fairly and transparently? Can this approach support business continuity?

Not shared → Shared

Risks & benefits managed at individual provider level

Risks & benefits managed under a formal sharing agreement

Engaging with Patients & Communities

What arrangements are in place or need to be in place for engaging with patients, their carers & families, communities, charities and voluntary sector organisations?

Accountability in decision-making
- Clear representation within governance structures

Co-designing services
- Clear strategy in place for understanding the needs of patients and public
- Process in place for monitoring and responding to patient experience

Consistency of Membership Performance

What arrangements are in place or need to be in place to address variable provider membership performance? Will this provide sufficient assurance to commissioners?

Systems in place
- Data sharing
- Peer support / review
- Benchmarking
- Shared training & learning

Supporting excellent quality & better outcomes
- Quality improvement process
- Patient safety record
- Resilience of system
- Business continuity
- Reviewing serious incidents
- Safeguarding

Collaboration

What level of collaboration is in place or needs to be in place? To what level are the resources of member providers aligned to the shared vision?

No collaboration
- Bound by duty to co-operate

Collaboration (level may vary)
- Membership & workforce
- Budget
- Decision making powers
- Leadership
- Reward
- Incentives
- Risk
- Infrastructure
- Data-sharing

03

New provider models - *what are the benefits and challenges of each type of model?*

Collaborative working will lead to new provider models

Greater collaboration will move towards formation of practice networks and new provider models which increase joint working. These organisations are likely to align to a single population catchment or locality with other health, social, community and voluntary organisations. The shared organisation will enable them to provide a wider range of services including diagnostics; share infrastructure, expertise and specialists e.g. for mental health or children; create career paths; train and learn together. Practices working at scale will have a stronger voice when commissioning with acute trusts.

New provider models will thrive if the right ingredients are in place:

Founded on a consensus:

- ✓ on purpose
- ✓ on function
- ✓ on form

New provider models will support the ability of general practice to transform care

The *London Strategic Commissioning Framework for General Practice* will help secure a focus on service improvement alongside structural changes.

The *Five Year Forward View* describes the development of new models of care such as a Multispecialty Community Provider (MCP) which could offer increased efficiencies through wider collaboration and integration.

Development requires:

- ✓ Strong clinical & provider based leadership
- ✓ Time away from a busy operational environment to make the change
- ✓ Ability to share learning on what works
- ✓ Good facilitation and support
- ✓ Business development support/legal
- ✓ Infrastructure quickly in place to deliver
- ✓ Affordable skill mix of workforce
- ✓ Technology Enabled Care
- ✓ Estates Development

Enablers:

- ✓ **Co-commissioning**: By commissioning primary care services as part of a wider out of hospital strategy
- ✓ **Population based contracts & incentives:** By establishing a route map for developing population based contracts and incentives
- ✓ **Market management:** By tackling poor performance and managing market entry and exi**t**
- ✓ **Evaluating population health outcomes:** By making collaboration essential to achieving population health outcomes
- ✓ **Delivering quality and safety:** By establishing new ways of delivering quality assurance and safety that is supportive of a network based approach

Examining Provider Models

Seven examples of provider models are examined here in detail. These are not exclusive and the provider model that develops will be very dependent on local needs and level of collaborative working between providers. **There is no 'one size fits all'.**

It should also be noted that the provider model **terminology** is still developing and therefore what is outlined here may vary from descriptions being used in different localities.

A number of considerations for provider development include:

How will contracts be designed, developed and applied? This will be influenced by the type of GP practice network selected

What is the optimum size of a GP practice network?

How can the right leadership be nurtured for practice development?

How to approach the fact that each GP practice will be starting from a different baseline?

Inclusivity – how do we ensure localities include practices which are poorly performing?

Which services / aspects of general practice provision will be covered by the network e.g. all functions or only back office?

What are the incentives / levers to ensure each GP practice engages with GP practice network development?

How will the GP practice network link in with the CCG and NHS England?

How can relationships be nurtured?

What organisational development and business planning support is needed and how will this be accessed?

Is it important to ensure general practice has time to decide its own plans before inviting social care into the discussions or should it be simultaneous?

Development of federations - CCG audit against current position, OD and business planning support, conversation regarding the size and scale of practices, re-procurement, contract design, central legal support)

Patient choice, competition and procurement

Patient Choice: How can greater integration/alignment improve patient choice?

- Patients must be involved in the how services develop and have a say in changes to provider models
- Provider Leadership must demonstrate they are listening to patients and taking action where services do not meet standards set by local people
- Commissioners must be willing to intervene where standards are not met

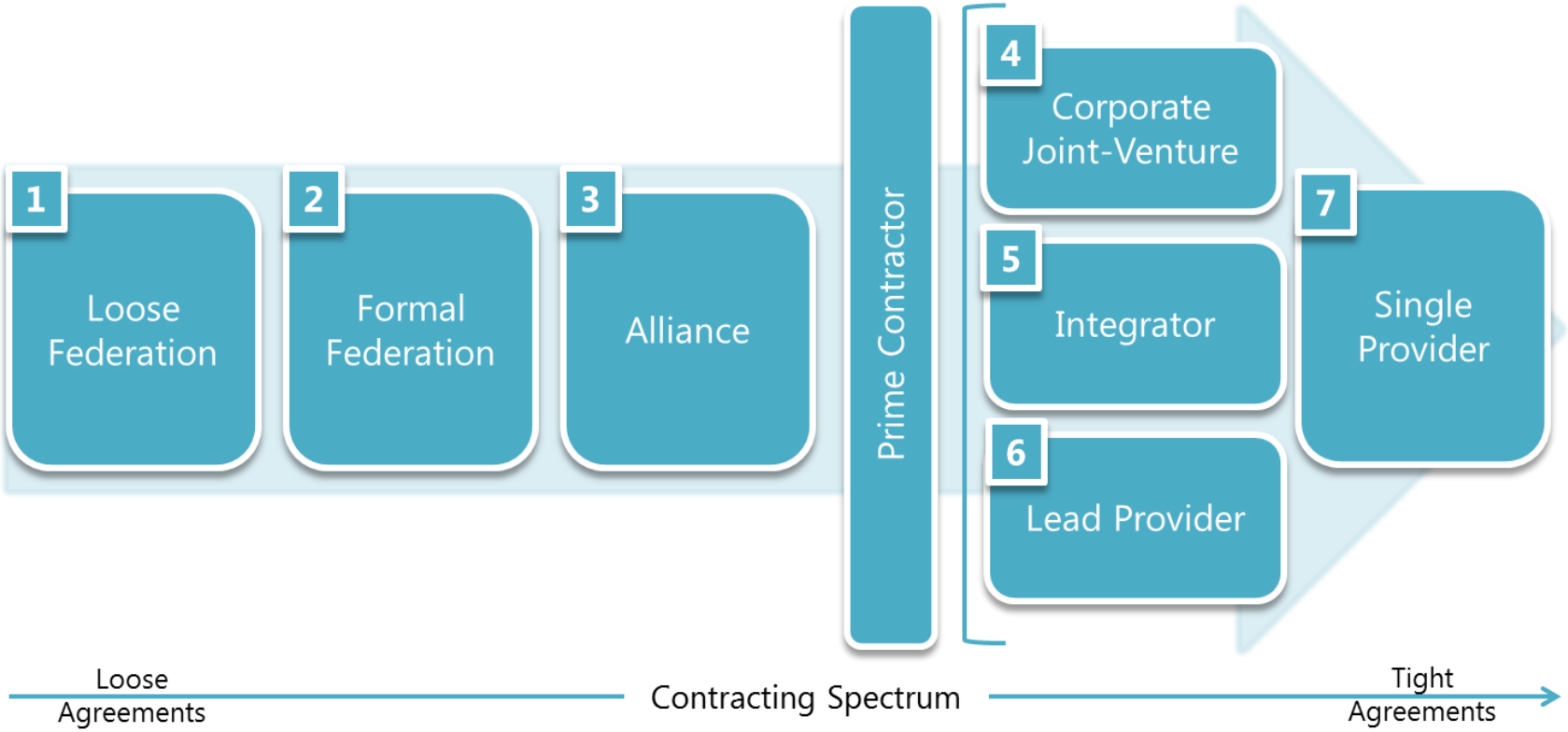
Competition: Does collaboration conflict with competition?

- Competition can encourage collaboration and changes in provider relationships, if commissioners present a good and viable offer
- Collaboration can deliver quality and value for money, reducing the need for frequent recourse to the market
- Collaboration can align incentives around outcomes for patients
- Quality standards will avoid incentives driving unnecessary activity

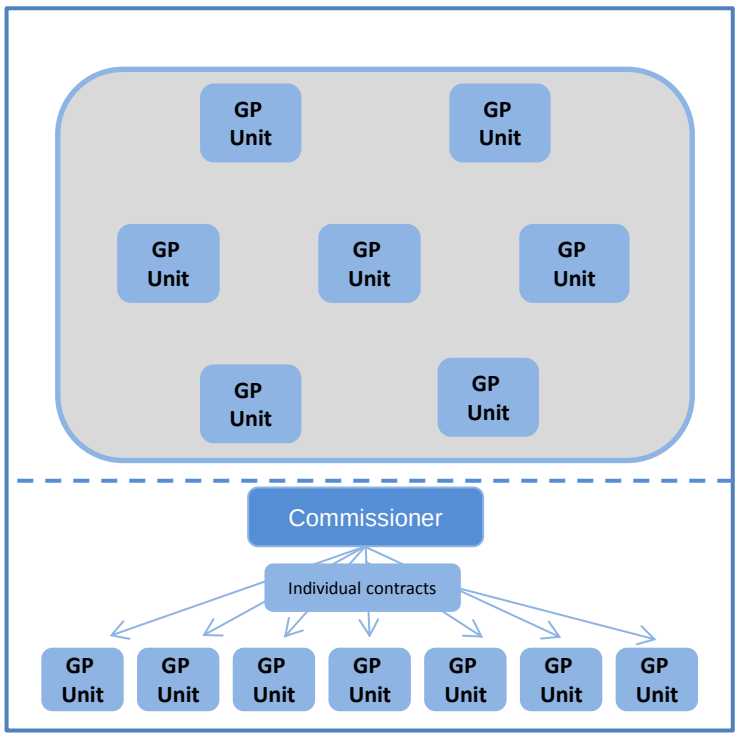
Procurement: Options for commissioners

- Consider competitive dialogue
- Balance benefits of local collaboration against market options
- Ensure contracts are long enough for outcomes to be realised
- Balance incentives with standards so that the right behaviour is encouraged by all providers
- Forced integration could encourage cost inflation and attrition from incumbents

Structures - overview



Loose federation



Provider Model Description

Shared Vision	In development
Provider Contracts	No formal contracts or agreements with other providers
Commissioner Contracts	Unilateral relationships with commissioner
Organisation Type	Not a legal entity
Membership	Includes some or all GP providers in locality
Contiguous (geography)	Geographically or non-geographically aligned
External Formality	No CQC registration
Membership Autonomy	Full membership autonomy
Internal Governance / Decision Making	Informal / No Board / No Leadership Team
Managing Risks & Benefits	Managed at individual provider level
Engaging with Patients & Communities	Managed at commissioner level
Membership Performance	Managed at practice level, accountable to regulator & commissioners
Collaboration	Some integration of funding

Strengths

- Practice based offer of capitation / tariff
- Easy to implement
- Retained autonomy for practices
- Develops leadership & relationships
- Provides high trust peer review and support
- Little or no governance responsibilities for federation
- Choice of GP Practice for patients

Weakness

- May not address variation in membership performance, silo working / limited in scope
- Limited scope for extension of existing contracts
- Limited opportunities for innovation and improvement
- Limited opportunities for economies of scale
- Not transformational

Opportunities

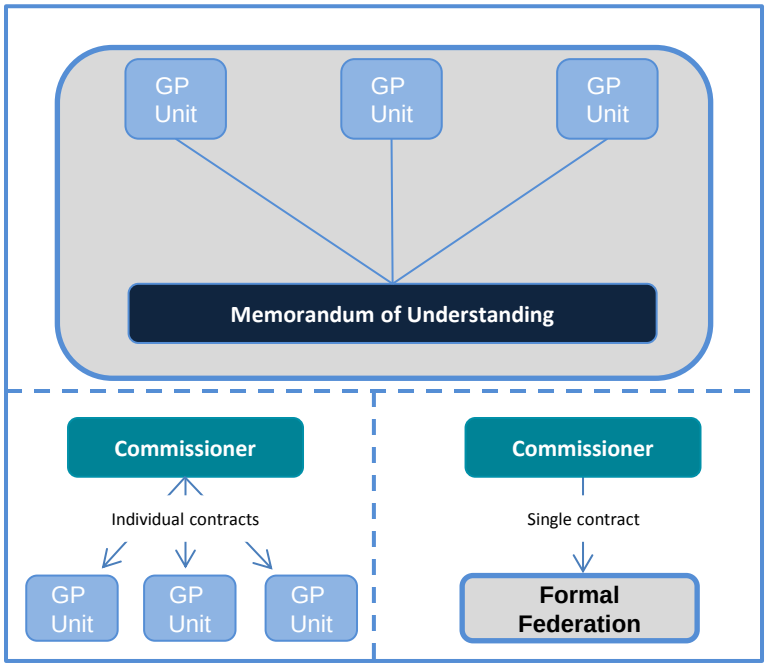
- Incentive schemes
- Development of peer support and review to improve quality
- Supports pathway implementation
- Enhanced Services
- May address health inequalities if universal agreement to information sharing, peer support and quality improvement are in place

Threats

- Performance is managed at practice level and subject to variation
- Not financially viable for commissioners or providers in the long term
- Other organisations will be better placed to deliver value for money collaboration

Formal federation

Provider Model Description



Provider Model Description

Shared Vision	Agreed vision. Members aligned to vision.
Provider Contracts	Memorandum of Understanding in place.
Commissioner Contracts	Individual contracts. May include some hub arrangements.
Organisation Type	Not a legal entity.
Membership	Includes some or all GP providers in locality.
Contiguous (geography)	Geographically or non-geographically aligned.
External Formality	No CQC registration.
Membership Autonomy	Full membership autonomy.
Internal Governance / Decision Making	Elected leadership team.
Managing Risks & Benefits	Limited sharing of risks & benefits. Hub takes risks and benefits for hub services.
Engaging with Patients & Communities	Federation & commissioner led.
Membership Performance	Managed at practice and federation level. Some peer support
Collaboration	High level of collaboration required – limited to new contract opportunities. Increased alignment & information sharing.

Strengths

- Population based and practice based offer
- Members retain autonomy
- Relatively easy to implement
- Encourages shared vision
- Encourages formal collaboration
- Memorandum of Understanding in place to provide limited governance and decision making
- Accountable to members, regulator and commissioners
- Choice of GP Practice for patients

Weakness

- May be limited in ability to offer new services
- May not address variation in performance
- May not address silo working
- Extension of existing contracts permissible but limited in scope
- Limited scope for innovation and improvement
- Limited Economies of scale

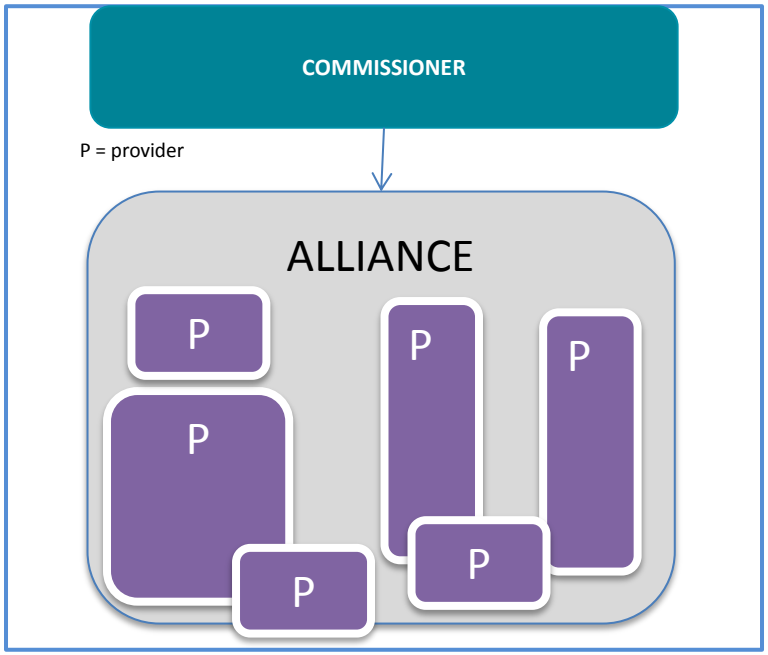
Opportunities

- Population outcomes
- Can hold contracts and deliver horizontal integrations
- Encourages development of leadership and working relationships
- Quality improvement and pathway implementation
- Membership performance managed at practice level but supported by information sharing and peer support
- Improved levels of information sharing to address health inequalities

Threats

- Performance is managed at practice level and subject to variation
- Not financially viable for commissioners or providers
- Commissioner led arbitration
- Vulnerable to larger organisations offering better VFM and integration

Alliance contracting



Provider Model Description	
Shared Vision	Agreed vision. Members aligned to vision.
Provider Contracts	Alliance contract in place
Commissioner Contracts	Alliance contract in place (legal parameters of NHS contracts may require variation of single contracts).
Organisation Type	Not a legal entity.
Membership	2-8 members. GP providers and may also include other additional providers.
Contiguous (geography)	Geographically or non-geographically aligned
External Formality	No CQC registration
Membership Autonomy	Retained responsibility for core services.
Internal Governance / Decision Making	Some formal governance structures in place.
Managing Risks & Benefits	Sharing of risks & benefits for alliance services.
Engaging with Patients & Communities	Alliance & commissioner led.
Membership Performance	Managed at both practice and alliance level.
Collaboration	High level of collaboration required – limited to alliance contract opportunities.

Strengths

- Parity for members
- Member sustainability
- Risk sharing (gain & pain)
- Patient-centred
- High trust relationships
- Open book relationships
- Win-win relationships
- Aligned leadership team able to make decisions

Weaknesses

- Risk sharing
- Collective accountability
- Performance

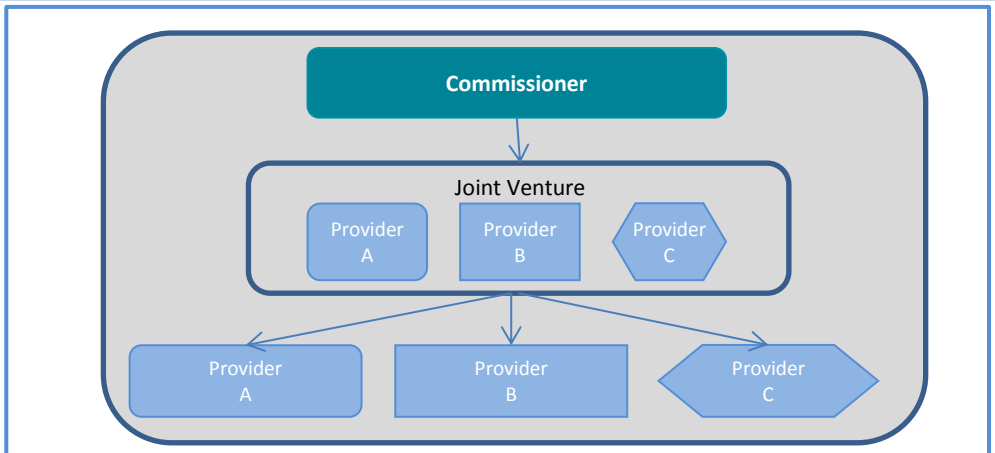
Opportunities

- Single risk-sharing contract
- Integrated governance
- Outcomes based performance system
- Financial risk share
- Innovative
- Quality linked to shared outcomes
- Collaborative Management team
- Co-ordinated operational teams

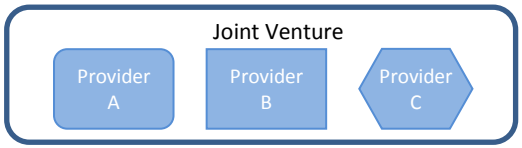
Threats

- Performance assessed collectively
- Collective accountability
- Risk sharing

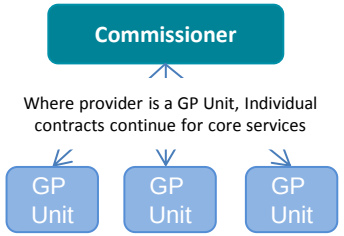
Joint venture



Joint venture holds contract and is responsible for delivery of contract



Bi-lateral agreement in place between joint venture providers



	Provider Model Description
• Shared Vision	Agreed vision. Members aligned to vision.
• Provider Contracts	Wrap around contracts through Bi-lateral agreements between joint venture providers.
• Commissioner Contracts	Individual standard contracts. Single contract with joint venture providers..
• Organisation Type	Not a legal entity.
• Membership	Includes some or all GP providers in locality. May include other providers
• Contiguous (geography)	Geographically or non-geographically aligned.
• External Formality	No CQC registration.
• Membership Autonomy	Retained autonomy.
• Internal Governance / Decision Making	Formal leadership or Board.
• Managing Risks & Benefits	Shared by joint venture providers and collective.
• Engaging with Patients & Communities	Joint venture led.
• Membership Performance	Managed at practice level
• Collaboration	High level of collaboration

Strengths

- Retained autonomy
- Economies of scale
- Allows for diverse membership
- Provides external accountability as a single entity
- Accountable to members
- Vertical integration

Weaknesses

- Complex bilateral agreements needed to manage risk and share rewards
- Assets held by members
- Hierarchical member consent required
- Limited patient choice

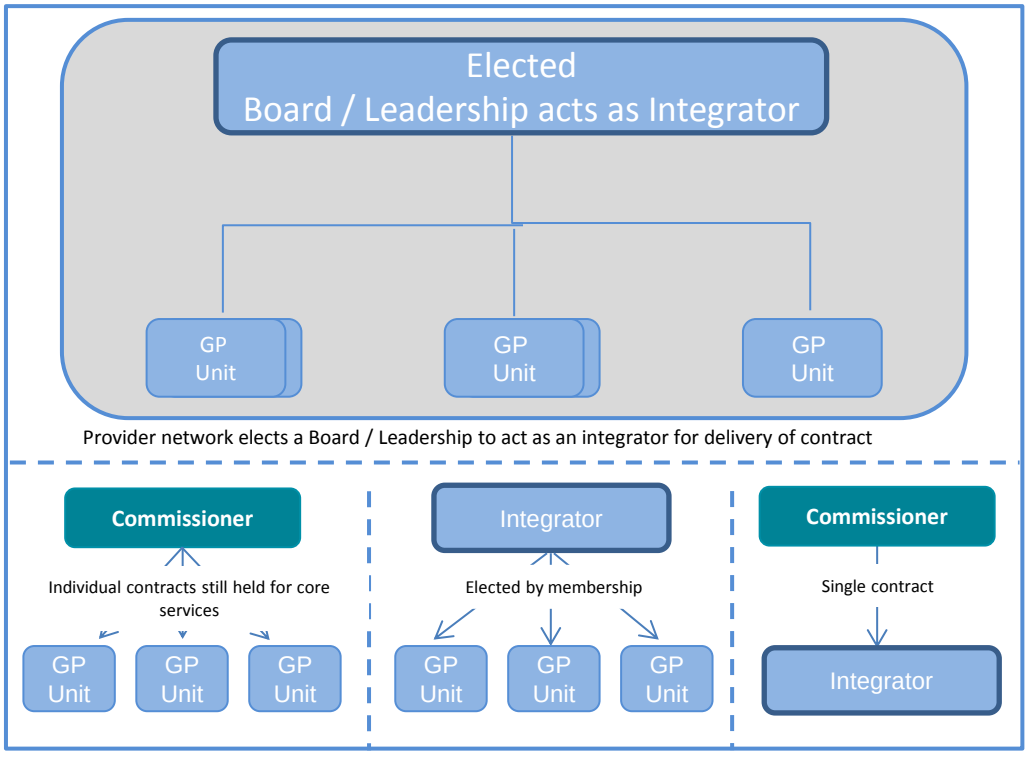
Opportunities

- Population based outcomes
- Delivery of service at scale
- Delivery of whole pathways
- Integrated service delivery
- Quality & Safety measured at practice & federated level
- Performance managed between members.
- Considerable opportunities for innovation & improvement
- Avoidable health inequalities can be tackled through bi-lateral agreements

Threats

- Provides external accountability as a single entity
- Accountable to members, regulator and commissioners.
- Collaborative competition model that may be subject to challenge.

Integrator



Provider Model Description

Shared Vision	Agreed vision. Members aligned to vision.
Provider Contracts	Agreements in place with other provider members and elected Board / Leadership.
Commissioner Contracts	Bi-lateral relationship with commissioner.
Organisation Type	Not a legal entity.
Membership	Includes some or all GP providers in locality.
Contiguous (geography)	Geographically or non-geographically aligned.
External Formality	No CQC registration.
Membership Autonomy	Some surrendered autonomy.
Internal Governance / Decision Making	Elected Board / Leadership. Member consent required. Formal member agreements.
Managing Risks & Benefits	Shared through network agreements.
Engaging with Patients & Communities	Integrator & commissioner led.
Membership Performance	Managed at practice level.
Collaboration	High level of collaboration

Strengths

- Population based outcomes
- Integrated service delivery across pathways
- Economies of scale
- Allows for diverse membership
- Allows for competition
- Unilateral agreements will facilitate choice of providers

Weaknesses

- Layered transactions & relationships
- Integrator cannot hold assets

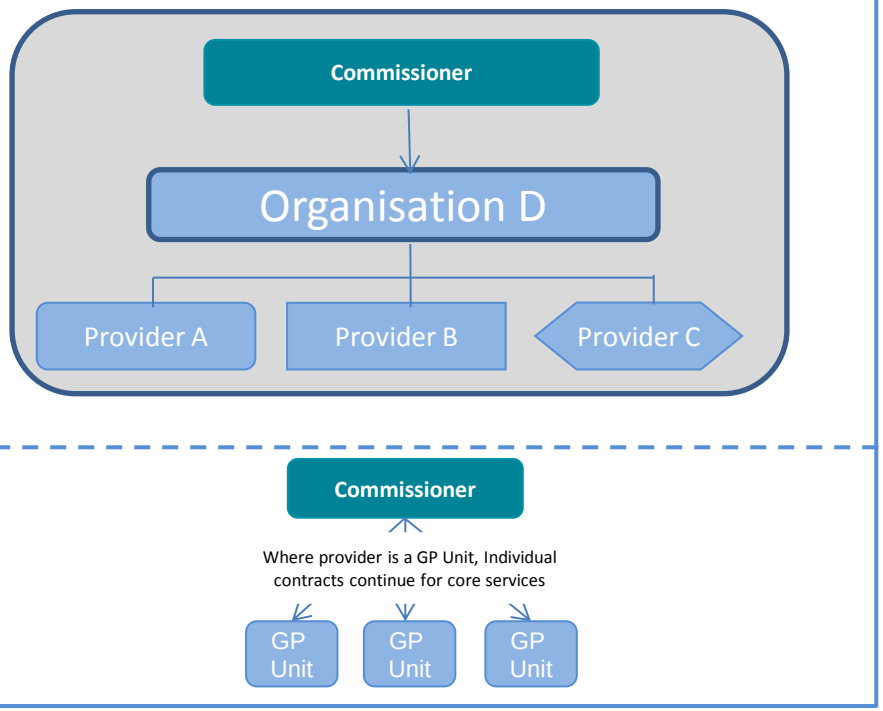
Opportunities

- Performance1 managed by integrator through unilateral agreements
- Quality & Safety measured at practice and federated level
- Independent of members
- Single entity accountability
- Delivery at scale and whole pathway / whole system integration
- Accountability to members, regulator and commissioners.
- Considerable opportunities for innovation & improvement
- Unilateral agreements in place with integrator to deliver consistent patient offer for all services within the pathway

Threats

- Loss of autonomy over performance

Lead provider



	Provider Model Description
• Shared Vision	Agreed vision. Members aligned to vision.
• Provider Contracts	Formal agreements with members and lead provider. Wrap around contracts through unilateral agreements.
• Commissioner Contracts	Single contract with lead provider.
• Organisation Type	Not a legal entity.
• Membership	Includes some or all GP providers in locality. May include other providers.
• Contiguous (geography)	Geographically or non-geographically aligned.
• External Formality	No CQC registration.
• Membership Autonomy	Full membership autonomy.
• Internal Governance / Decision Making	Some formal governance in place. Member consent required.
• Managing Risks & Benefits	Managed through lead provider contract.
• Engaging with Patients & Communities	Lead provider & commissioner led.
• Membership Performance	Managed through lead provider contract.
• Collaboration	High level of collaboration

Strengths

- Population based outcomes
- Integrated service delivery
- Allows for competition and patient choice.
- Economies of scale

Weaknesses

- Start up costs required
- New organisation will need to build standing & reputation

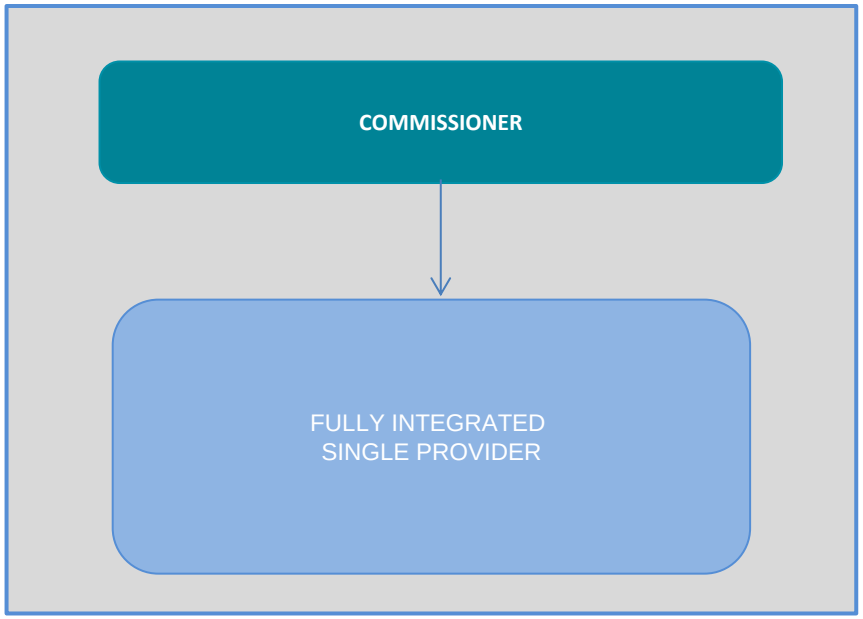
Opportunities

- Performance managed by integrator through unilateral agreements
- Can tackle avoidable health inequalities through unilateral agreements with integrator
- Delivery at scale and whole pathway / whole system integration
- Quality & safety measured at practice and federated level
- Variations addressed through agreement with lead provider
- Accountability to members, regulator and commissioners
- Considerable opportunities for innovation & improvement

Threats

- Loss of autonomy over performance

Single provider or super practice



	Provider Model Description
Shared Vision	Single vision.
Provider Contracts	Single standard contract.
Commissioner Contracts	Single contract.
Organisation Type	A legal entity.
Membership	One provider. May have multiple sites.
Contiguous (geography)	Geographically or non-geographically aligned.
External Formality	CQC registered.
Membership Autonomy	Single member with full autonomy.
Internal Governance / Decision Making	Formal. Accountable to Board / stakeholders, regulator and commissioners.
Managing Risks & Benefits	Managed by single provider.
Engaging with Patients & Communities	Provider & commissioner led.
Membership Performance	Managed by single provider.
Collaboration	High level of collaboration.

Strengths

- Population based outcomes
- Integrated service delivery
- Addresses poor performance
- Full economies of scale
- Can provide consistent service offer
- Diverse leadership
- Accountable to commissioners
- Holds all assets and resources

Weaknesses

- Start up costs required
- New organisation will need to build standing & reputation
- No competition
- Limited choice

Opportunities

- Whole pathway / whole system integration
- Can address variations
- Publicly accountable
- Quality & safety measured at provider level
- Variations addressed.

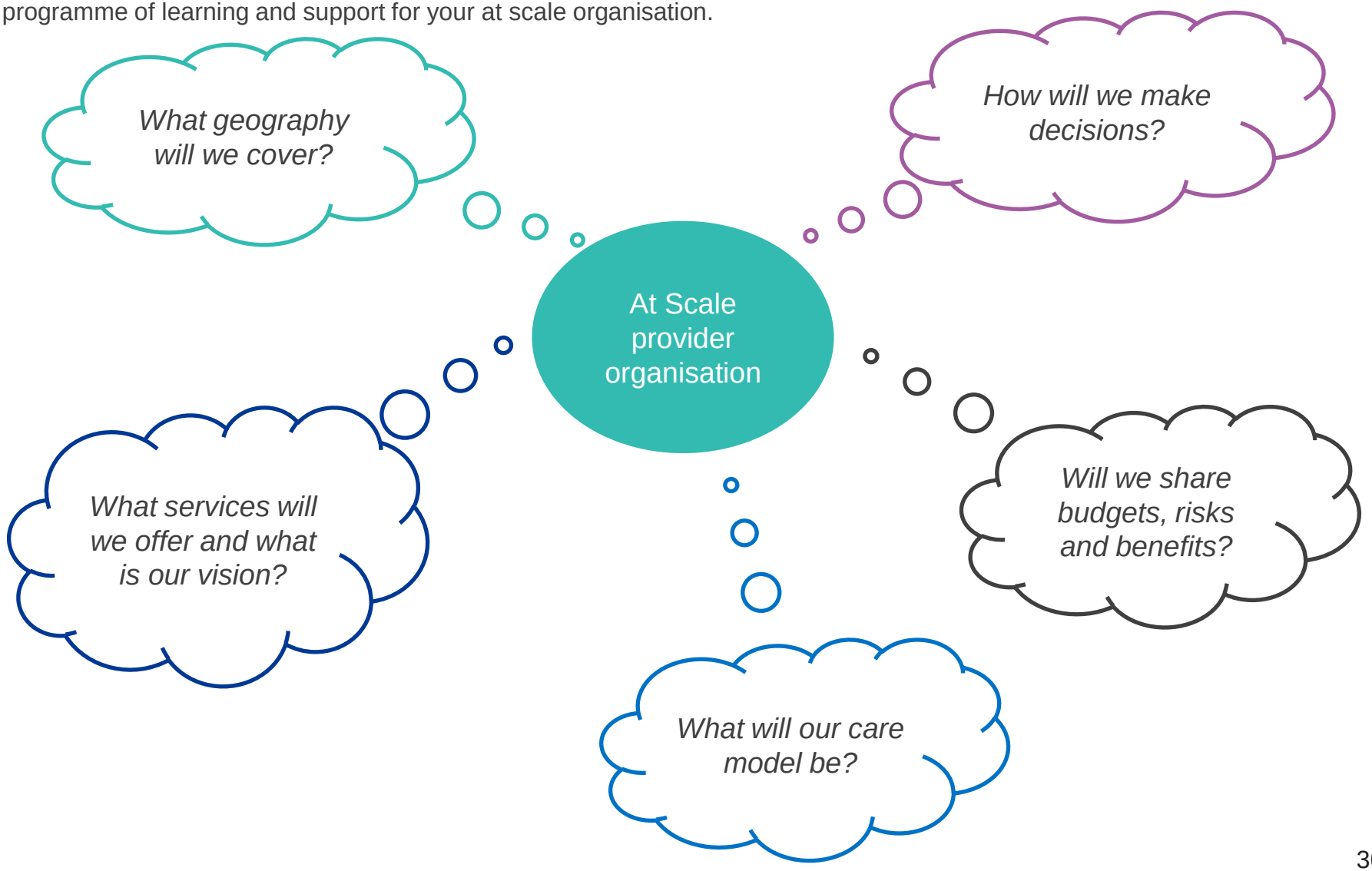
Threats

- Monopoly - needs strong regulation
- Requires strong regulation to ensure quality & safety

Provider development Self assessment tool SPG:

Self assessment of provider readiness

The areas of development described here will be crucial in assessing your readiness for delivering your shared vision of transformed care. The purpose of this tool is to assess where your provider organisation is and include; what you are doing, how you are doing it and what support you may need. The outcome of you completing this will enable us to define a programme of learning and support for your at scale organisation.



Name and contact details

Name of federation/at scale organisation _____

How many practices make up your organisation? _____

What percentage of the local population does your organisation cover? _____

Details of those completing and contact details

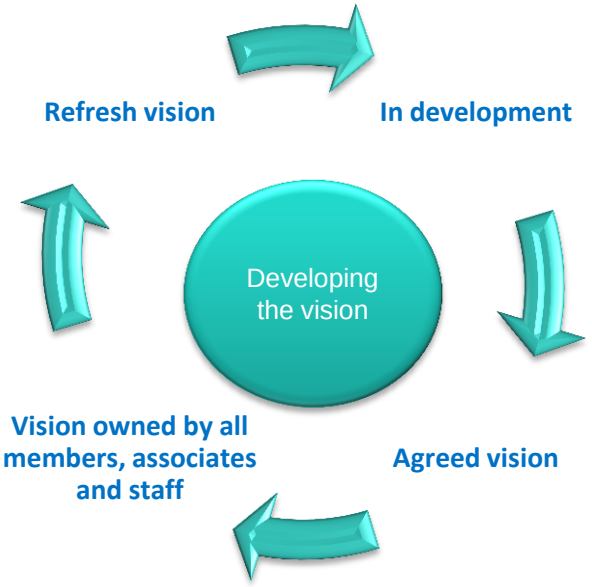
Name and title _____

Email address _____

Contact no. _____

Shared vision and transformational ambition

Does the organisation have a shared vision? If yes, what is that vision?



How will the organisation strategically plan to deliver the vision?

Will the shared vision deliver the Strategic Commissioning Framework? How will you know?

Shared vision and transformational purpose

Is there sufficient transformational ambition in the vision?

What is the purpose of the provider organisation?

What are the benefits of the provider organisation to:

Patients

Staff

Org

Model of delivery

What is your provider model to deliver the vision?

Example models of delivery
- *Single provider / super practice*
- *GPs at scale e.g. federation*
- *Multi-specialty provider e.g. integrator, MCP*
- *Vanguard*

How will the model work? How will it be commissioned?

Example commissioning approach
- *Transactional / activity approach*
- *Capitated approach*
- *Outcomes based approach*
- *Whole systems approach*
- *Single locality or population based approach*

Legal Entity
- Company
- Partnership
- Trust
- Social Enterprise

Not a Legal Entity
- Loose Federation
- Network

What provider organisation is in place?

- **How is this funded / commissioned?**
- **Does it allow you to secure contracts for new services?**
- **Are you CQC registered** **Yes ◯** **No ◯**

Diversity of membership and geographical alignment

Who is included in the organisation's membership?

Diversity of Membership

- Some GP providers in locality
- All GP providers in locality
- Other primary care providers e.g. pharmacy
- Other healthcare providers e.g. community services, acute services
- Social care providers
- Voluntary sector providers

Is the scope sufficient to deliver the vision and influence care pathways?

Geographical alignment

- Borough
- CCG
- SPG
- Multiple localities
- Cross boundary (CCG / Borough)
- Clinical Network

Critical Mass

- 60k+
- 50-60k

What level of geographical alignment is required?

What critical mass of patients is needed to provide various shared functions and service delivery?

Governance and membership

What governance structure is in place, or needs to be in place, to influence, govern and manage delivery?

Will this provide assurance to commissioners?

Corporate Governance
- Achieving good financial standing
- Meeting minimum procurement requirements

Clinical Governance
- CQC Registered
- CQC Registered with Conditions
- Not CQC Registered

Full autonomy
- All contracts held at individual provider level

Retained autonomy
- Retained delivery for core services
- Transfer some responsibility for delivery and performance

Surrendered decision making
- All responsibility for delivery assigned to new / single provider

What approach has been agreed, or needs to be agreed, with regard to membership autonomy for decision making, resource management & responsibility?

Collective decision making
- Commissioner facilitated
- 1 member = 1 vote
- Autonomous

Shared decision making
- Nominated chair supported by committee
- Memorandum of understanding

Delegated decision making
- Chair and Executive Board
- Shared constitution
- Articles of agreement

Informal

Formal

How will risks and rewards be managed fairly and transparently?

Accountability and managing risks and benefits

Accountability in decision-making
- Clear representation within governance structures

Co-designing services
- Clear strategy in place for understanding the needs of patients and public
- Process in place for monitoring and responding to patient experience

Engaging with local population
What arrangements are in place for engaging with patients, their carers and families, communities, is there a mechanism for bringing individual practice PPGs together to share 'at scale' initiatives?

What arrangements are in place for engaging with charities and voluntary sector organisations?

Risk and benefit management
- Risks and benefits managed at individual provider level
- Risks and benefits managed under a formal sharing agreement

Delivery and collaboration

What arrangements are in place to address variation in key patient outcomes, such as: access, chronic disease management, immunisations and vaccinations etc.?

Systems in place
- Data sharing
- Peer support / review
- Benchmarking
- Shared training & learning

Supporting excellent quality & better outcomes
- Quality improvement process
- Patient safety record
- Resilience of system
- Business continuity
- Reviewing serious incidents
- Safeguarding

Collaboration
- Membership & workforce
- Budget
- Decision making powers
- Leadership
- Reward
- Incentives
- Risk
- Infrastructure
- Data-sharing

What level of collaboration is in place?

To what level are the resources of member practices/providers aligned to the shared vision?

…and how are you bringing members/peers together?

Learning needs analysis

Leadership

What leadership infrastructure is currently in place in your provider organisation?

Have you developed an organisational development plan for your provider organisation and what support is needed to build leadership in your organisation (i.e. Board level development, finance etc.)?

Leadership and development needs

- *Clinical leadership*
- *Management leadership*
- *Role design.*
- *Understanding leadership styles*
- *Understanding how to influence*
- *121 coaching*

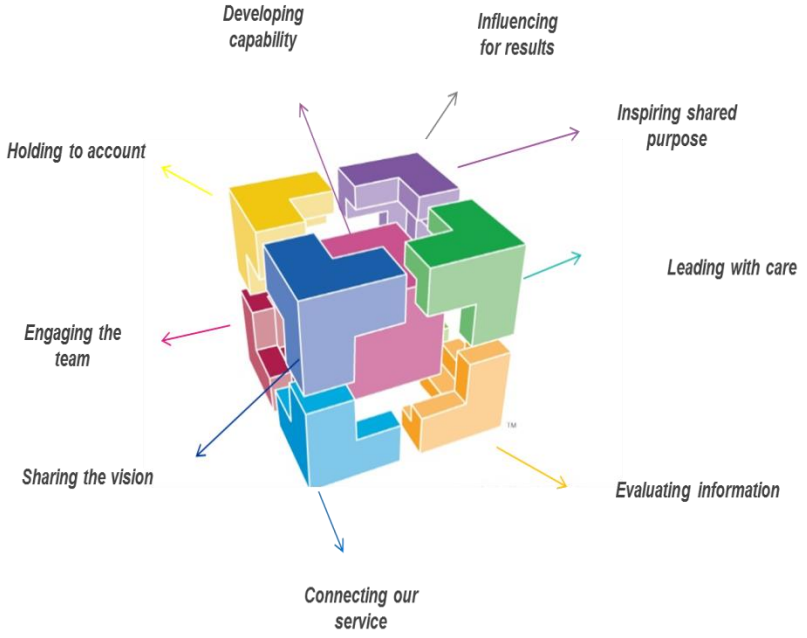
Developing skills to influence change

- *Supporting clinicians and managers to become confident future leaders.*
- *Develop learning communities, with clinical champions local area and pan leadership programmes*

How do you plan to develop the right skills that will for example enable your provider organisation to win new contracts?

Leadership development

Do you or your CCG currently commission learning and development programmes? Please tell us the name of the programme and provider.



Healthcare Leadership model – 9 dimensions

Please list at least three of the learning and development opportunities that have proven to be beneficial to you?

Are you able to access leadership development opportunities, and if so please describe what is available to you?

Learning and development needs

A wide range of learning packages will be available enabling bespoke development plans to devised and underpinned by joining a diverse Action Learning Set.

Please tell us your top 3 learning and development needs to the following headings:

Learning and development needs

Masterclasses - *List your top 3 topic areas, i.e. Leading Change*

1.
2.
3

Leadership - *list your top 3, i.e. Understanding your leadership style*

1.
2.
3.

Strategy Days - *list your top 3 topic areas, i.e. business planning*

1.
2
3

Topic Events
list your top 3, i.e. Accessible Care

1.
2.
3

System wide support

What mechanism do you have in place to share best practice?

What do you value?

TPC HLP will help in establishing a communication approach

- *Sharing innovations*
- *Good practice*
- *Solutions to the challenges*

TPC HLP will help in establishing networks

- *Developing local and London-wide networks including action learning sets, peer reviews, provider readiness, maximising digital and workforce opportunities*

How would you like things to be in the future?

How will you move from where you are now to the future?

Organisational development

What are your plans or thoughts for developing a productive organisation?

What does good look like?

Development
- *Developing the productive organisation*

Describe your plans for supporting service delivery for each of the bullet points listed

How confident are you in your plans?

Supporting the service delivery approach
- *Supporting the service delivery approach*
- *Engaging with local populations*
- *Business planning*
- *Identifying the roles of new "at scale" emerging primary care organisations*

Developing partnerships

Describe your provider plans for delivering population based services?

New models of care

- *Supporting providers to work together to deliver population based services*
- *Building relationships with a wide range of local providers including voluntary, secondary care, community and mental health providers facilitating multi-disciplinary team models and identifying new workforce roles*

How do you move from where you are now to the future?

How will you capture your vision?

What do you need to commit to do collectively?

Are you able to broadly describe your timescales?

Example commissioning approach

- *Transactional / activity approach*
- *Capitated approach*
- *Outcomes based approach*
- *Whole systems approach*
- *Single locality or population based approach*

Overall assessment

On a scale of 1 to 10 please indicate where your federation/network is right now in developing as an at scale organisation?

1 2 3 4 5 6 7 8 9 10

Early stages

Well developed

Do you have any comments?

04
Enabler

Digital Maturity & Transformation

Level 1	Level 2	Level 3	Level 4	Level 5	Level 6
Primary Care providers have access to technology infrastructure they require to deliver safe care within the practice.	Primary Care providers are using the technology infrastructure in the way that it was intended within the practice (Any willing provider should be able to demonstrate compliance). Patients are able to navigate the system.	Patients and clinicians can point to demonstrable improvements in access, care co-ordination and pro-active care (due to increased use of digital services within the practice – e.g. Patient Online, use of electronic appointment booking) Patients are able to establish identity and activate a citizen account.	Patients and clinicians can point to demonstrable improvements in access, care co-ordination and pro-active care (due to increased use of digital services across practice boundaries– e.g. provision of extended access arrangements) Patients are able to use e-consultation.	Patients are able to communicate with clinicians in the practice via multiple channels, and use apps to manage their care. Clinicians are able to communicate with patients, locate and be alerted to the existence of records held in other settings and transact with other care settings without the need for paper/fax	Patients are able to express their preferences with the wider NHS and interact via the channel of their choice. Patients are in control of information sharing and are active participants in care. Electronic communications are fully supporting clinical workflows within and across care settings

Provider Development Appendix

Case Study 1 – Brent GP, Middlesex, UK

Date Established	2008
Legal Status	➢ **Loose Federation** ➢ It is in the process of setting up a provider-arm social enterprise company, limited by guarantee, to enable it to bid to provide an urgent care centre.
Main Drivers	➢ Develop training and education amongst GP practices in primary care
Practices	71 (The five clusters are each comprised of between 10 and 16 practices, and have registered patient populations of between 56,000 to 83,000.)
Number of employees/partners	NA
Registered population	356000((The five clusters are each comprised of between 10 and 16 practices, and have registered patient populations of between 56,000 to 83,000.)
Services offered	➢ The Brent GP Federation supports GP development and training in a number of ways. For example, it has undertaken a skills and capacity audit, which will be used by each cluster to support applications for training or funding; ➢ The Federation is clear that implementing changes to care pathways relies on local GPs having access to appropriate training support.
Identified Benefits/ Outcomes	➢ As a result of its education sessions the Kilburn locality witnessed a reduction in Trauma and Orthopaedic acute referrals of 17.5%
Lessons Learnt	➢ In terms of education and training, Ms Poole say, 'GPs learn from each other and peer learning can really get them debating and change their practice'. Across the Federation data on referral patterns is shared and discussed in an open and supportive way.

Taken from South West London Collaborative Commissioning

Case Study 2 – Tower Hamlets Network 2 London, UK

Date Established	2008
Legal Status	**Formal Federation**- Network 2 formed as a company limited by shares (Tower Hamlet has a total of 8 networks)
Main Drivers	• PCT strategy to improve primary care in Tower Hamlets • Improve local management of long-term conditions • Reduce variations in standards of local practice.
Practices	Network 2 has 5 practices (All 8 geographical networks in Tower Hamlets have 36 practices, 4-5 practices per network)
Number of employees/partners	Each network has a manager, an administrator and a care planning nurse to develop annual care plans for people with long-term conditions.
Registered population	Approximately 34,000. Registered populations range from 24-40,000 across the eight networks
Services offered	• Since 2011, an APMS contract has been held between the PCT (now CCG) and each of the eight networks. • Due to CCGs now not being able to commission with an APMS contract, these services are now commissioned through the NHS standard contract. • The contract is in addition to core GMS/PMS services and sets network average standards (higher than those in existing contracts) for: diabetes, COPD, cardiovascular disease, end-of-life care, immunisation and vaccinations, and drug and alcohol use. These 'network improvement services' require practices to work collaboratively to improve services. • **Thirty per cent of the contact value is paid retrospectively if the average standard for each condition is achieved across the practices.**
Identified Benefits/ Outcomes	• Improved quality and reduced variation between practices • Development of clinical and organisational skills in GPs • Better use of data to monitor care and drive change • Multidisciplinary team with GPs and other clinicians • A culture of collaboration between practices.
Lessons Learnt	• Dr Tzortziou Brown, a GP in Tower Hamlets, says, Strong clinical leadership, agreeing common aims and a close working relationship with the PCT/CCG have been very important, especially in the initial stages of our Federations.' • She adds that the networks have facilitated collaborative relationships not only among GPs and other clinicians, but also with a wide range of partner, including schools and charities.

Case Study 3 – Midlands Health Network, New Zealand

Date Established	NA
Legal Status	**Formal Federation**
Main Drivers	➢ To coordinate primary care activity and developments across the network. ➢ Conduit for practice funding allocated on capitation and delivery of national and local quality indicators. ➢ Operate as an integrated team to provide systematic, comprehensive, proactive and pre-planned care for their patients
Practices	97 practices in Gisborne, Taranaki, Taupo-Turangi and the Waikato (geographically connected)
Number of employees/partners	NA
Registered population	NA
Services offered	• **Creation of a telephone patient access centre (PAC)-**The Patient Access Centre provides a range of outbound health campaign services in support of the practice's quality health care targets. • Patient access to personal health information on-line development of care plans • Formalised practice-initiated patient contacts; visit pre-work • Employment of a clinical pharmacist and medical centre assistants
Identified Benefits/ Outcomes	• A new model of care is in place in 'proof of concept' practices aimed at transforming general practice. This includes a centralised booking system and 'Lean' processes within the practice setting. Programme established to shift care out of hospital into community settings. • As a network, it is able to coordinate practice-based services with community-based services, including population health profiling and management. Provides 24/7 care and virtual consultations for those in rural communities.
Lessons Learnt	• System wide transformation requires long term commitment and partnering • Quality is a powerful motivator and driver for change • Don't underestimate the importance of information technology. IT is most effective as an enabler if it works in collaboration with clinical (re) design, not after • Alliance Contracting and Risk & Gain sharing have great potential, but take time to get right

Taken from South West London Collaborative Commissioning

Case Study 4 – Suffolk GP

Date Established	April 2013
Legal Status	**Formal Federation -** Community Interest company
Main Drivers	➢ Support and strengthen primary care and CCG objectives ➢ Share practice resources to increase efficiency ➢ Increasing clinical workload ➢ Reduced income to general practice ➢ Workforce challenges in GP recruitment and retention ➢ Maintaining practice sustainability.
Practices	60
Number of employees/partners	30 employees plus a board consisting of nine GPs, three practice managers and the Chief Executive.
Registered population	539000 combined
Services offered	➢ Diabetes ➢ Ultrasound ➢ Lymphoedema ➢ Cardiology ➢ Urology
Identified Benefits/ Outcomes	➢ Evaluation Underway
Lessons Learnt	➢ Dr Owen Thurtle, one of the GP directors of IPSCOM says, 'We are GPs, so we understand how pressed for time colleagues are and make sure that our contact with them is kept brief and useful'.

Taken from South West London Collaborative Commissioning

Case Study 5 – ZIO, Maastricht, The Netherlands

Date Established	2006
Legal Status	**Formal Federation**
Main Drivers	➢ National policy on integrated diabetes funding ➢ All practices joined the organisation – which holds the budget for diabetes care – reimbursing practices who deliver the required standard of care and paying for hospital care on a fee-for-service basis where patients need access to specialists.
Practices	60
Number of employees/partners	There are 90 GPs working in 60 practices alongside 52 nurses, 150 physiotherapists and 30 dieticians.
Registered population	100 per cent of the region, totalling 170,000 registered patients
Services offered	➢ Providing integrated care to patients with diabetes, COPD, asthma, cardiovascular risk management, frail elderly care, anxiety/depression ➢ Provides administrative support ➢ Provides education and training ➢ Provides data and IT infrastructure ➢ Premises development advice and other support to GPs
Identified Benefits/ Outcomes	➢ In Maastricht, around 95 per cent of diabetes care is now provided through the primary care network, which includes funding for advisory consultations by specialists. ➢ ZIO negotiates with health insurance companies on behalf of its member GPs and to agree contracts for integrated diabetes services in the community.
Lessons Learnt	➢ Outcomes based incentives help develop a network

Taken from South West London Collaborative Commissioning

Case Study 6 – Vitality Super Partnership, Birmingham, UK

Date Established	2009 Ref -2,5,6
Legal Status	**Super Partnership**
Main Drivers	• Delivery of services at scale – greater potential for expansion • Integrated generalist and specialist care within primary care • Greater ability to bid for Any Qualified Provider services • Scale facilitates longer term financial investment to increase range of services provided • Greater level of local provider influence • Increased patient choice and access with multi-site working • Opportunity to adopt best practice and standardise clinical care and management processes across sites • Future business sustainability due to diversification of income streams – less reliance on core contract.
Practices	8 Practices
Number of employees/partners	200+(15 full equity partners, 3 fixed share partners)
Registered population	51000
Services offered	• General medical services & specialist services with consultants working from practice sites • Enhanced diagnostics including x-ray & private medical services including immigration and aesthetics. • Provides some services to non-registered patients
Identified Benefits/ Outcomes	• 'Back-office' centralisation to realise economies of scale and build efficiencies. • Increased access and reduction in outpatient referrals • Integrated care pathways between generalist and specialist care • Single patient record via EMIS Web • Internal promotion and development of practice staff • New partnership structure to promote recruitment and retention of salaried GPs and GPs with a special interest.
Lessons Learnt	• Ensuring effective communication, both amongst the partnership, and the staff and our patients

Taken from South West London Collaborative Commissioning

Case Study 7 – ChenMed, South Florida, USA

Date Established	NA
Legal Status	➢ **Single Provider (Primary care unit led by physicians)**
Main Drivers	➢ Have a focus towards improving healthcare delivery to moderate to low income senior citizens ➢ Focus on illness prevention (seeing patients at least once a month and stay accountable for long term outcomes) ➢ Lowering patient to physician ratios ➢ Outcomes based incentives
Practices	➢ Manage 25 affiliated primary care centres in Florida ➢ Currently operate 36 staff model medical centres in 8 US markets
Number of employees/partners	NA
Registered population	20600
Services offered	➢ Improve patient outcomes with customised end to end **cloud based technology** that is fully integrated into care delivery system including ➢**electronic health records** ➢**practice management solutions** ➢**patient flow optimisation engines** ➢**quality and cost optimization tools** ➢ Complete service from social care to health care
Identified Benefits/ Outcomes	➢ Doctors spend on an average 168 mins/year face to face with patients compared to national average of 9mins/year ➢ ChenMed patients spend 38% lesser time in hospitals than national average-REF-Health affairs, June 2013 ➢ Doctor: Patients is 1:450 at ChenMed as compared to national average pf 1:2300
Lessons Learnt	➢ Have a focus area (low to medium senior citizens) ➢ Be patient centric, make the patient experience as easy as possible and provide coordinated care ➢ Prevention of illness provided by increased access and information as well as good coordination of care would decrease costs tremendously.

Taken from South West London Collaborative Commissioning