REPORT TO:	Health & Wellbeing Board
DATE:	14 January 2015
REPORTING OFFICER:	Simon Banks, Chief Officer
PORTFOLIO:	Health
SUBJECT:	General Practice Strategy
WARDS:	Boroughwide

1.0 PURPOSE OF THE REPORT

1.1 To update the Health & Well Being Board on progress with the development of the General Practice Strategy and other key agenda's that influence the Strategy.

1.2 The purpose of this paper is to present the initial thoughts and concepts around the GP Strategy in Halton. It has been developed through local discussion, feedback and research.

1.3 This is a draft paper and it is recognised there are gaps in some areas that need to be completed.

2.0 RECOMMENDATION: That the Board is asked to note the contents of the report and timescales.

3.0 SUPPORTING INFORMATION

None

4.0 POLICY IMPLICATIONS

Five Year Forward View, Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority, 23rd October 2014, www.england.nhs.uk/ourwork/futurenhs/, accessed on 17th November 2014.

NHS England, *Prime Minister's Challenge Fund: Improving Access to General Practice*, NHS England, Gateway Reference 02356, www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/pm-ext-access/, accessed 17th November 2014.

5.0 OTHER IMPLICATIONS

None

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children and Young People in Halton

Children's Services will be an essential element of the future model of services as set out

6.2 Employment, Learning and Skills in Halton

The approach is designed to embrace and involve the broad spectrum of voluntary organisations across Halton

6.3 A Healthy Halton

The approach is designed to improve the health and wellbeing of the population of Halton.

7.0 EQUALITY AND DIVERSITY ISSUES

An equality Impact Assessment is due to be completed in January as part of the broader engagement and consultation approach.

8.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

There are none within the meaning of the Act.

Background

1.1 Appendix 1 contains a draft document that sets out a summary of the draft General Practice Strategy that has been developed for Halton.

1.2 The document is still a work in progress and draft but outlines and identifies the key elements and concepts that are emerging as the strategy develops. The draft summary document has been shared with the practices and partners and formed the basis of a very productive discussion at the Service Development Committee in November.

1.3 This paper is designed to provide an update to the Health & Well Being Board of progress, as well as an update on the current work and next steps.

2. Strategic context

2.1 There a range of current national agenda's and drivers that will heavily influence and affect the development of the General Practice Strategy. These are:

- Five Year Forward View
- Co-commissioning
- Prime Ministers Challenge Fun

2.2 It is important to note that the development of the Strategy is being undertaken in full recognition and awareness of each of these. Furthermore, it is considered that the timing of the three drivers identified above, alongside the development of the General Practice Strategy presents an ideal time to integrate the approach with all four as they have the potential to optimise and compliment the effective delivery and effectiveness of one another.

3. Key elements of the strategy

3.1 There are four key elements to the General Practice Strategy:

3.2 Case for Change – setting out the range of national and local drivers that collectively result in the conclusion that General Practice in its current guise is not sustainable in Halton. This is evidence based and where available, local information and data has been used.

3.3 Principles - ten principles that are considered fundamental to the future design, configuration, commissioning and delivery of local General Practice.

3.4 Service model - it is proposed that a new model is established with services centred around people in the community, ensuring everyone's needs are met through an integrated health and social care delivery model. This will see GP practices working together in a much more integrated way with Community, Mental Health and Wellbeing, Social

Care, Urgent Care, Voluntary Sector and Pharmacy services all wrapped around local delivery points. This concept is described in the Five Year Forward View as a Multispecialty Community Provider (MCP).

3.5 Community Hubs - The model will see services and teams aligned to a community 'hub'. At present, there are 17 practices operating as 17 separate delivery organisations. This model is predicated on the practices starting to work together to create a number of community 'hubs', although the specific configuration of this will be for the General Practices and staff to determine. The aim is for each hub to contain approximately 20,000-25,000 residents, therefore, across Halton, there would be between 6-8 hubs.

4. Current position and next steps

4.1 There is a range of work underway at present including:

- 6 of the 7 workshops facilitated by NHS Improving Quality (NHSIQ) have been completed. The final workshop will take place on 13th January 2015;
- The draft document (Appendix 1) has been shared with practices and partners and feedback is being sought;
- On-going engagement work with practices, including consideration of hub configurations;
- Engagement work with the local population through PPG meetings;
- Running a co-design event with patients suffering from Cancer and Hypertension to use their ideas and experiences to agree actions that can improve access and services in Primary Care;
- Alignment of the approach with the Adult Community Nursing review that is running in parallel;
- Prime Ministers Challenge Fund application; and
- Co-commissioning application.

4.2 Work will continue through the actions outlined above. This will culminate in the development and presentation of the final strategy for the Governing Body in January 2015.

Appendix 1 - NHS Halton CCG General Practice Strategy. Summary document.

1) Introduction and background

"General Practice is often described as the cornerstone of the NHS, with roughly one million people visiting their general practice every day" (NHS England, A call to action, April 2014). Nine in every ten patient contacts are at GP surgeries. "Effective primary care enables improved health outcomes and lower costs" (Starfield at al, 2005; Atun, 2004).

However, the demands placed upon GPs and their teams have never been greater. Primary care sees more patients than ever, with more complex needs and greater expectations; it offers a wider range of services and it is seeking to maintain and improve ever higher standards of care. At the same time, the GP workforce is changing. Significant numbers of experienced GP principals are nearing retirement age, the GP workforce is becoming increasingly sessional and/or part-time, and many areas are experiencing difficulty with recruitment.

GP workload has increased from an average of 4 consultations per person, per year in 1995 to 5.5 consultations per person, per year in 2009 (HSCIC, 2012) and funding of General Practice as a percentage share of total NHS expenditure has reduced from 10.7% in 2005/06 to 8.4% in 2011/12 (GB)

Simultaneous to the collection of challenges described above, the NHS, like all public sector bodies, is considering the electoral policies being set out as we approach a general election in May 2015. A clear focus on the NHS, and more specifically General Practice, is evident from the emerging messages delivered in the 2014 autumn party conferences, whether that is about additional GP recruitment, extended General Practice opening times or the waiting times to access General Practice.

NHS England's 'Improving General Practice – A Call to Action' was a start to stimulate debate in local communities – amongst GP practices, area teams, CCGs, health and wellbeing boards and other community partners. It considers how best to develop general practice services and enable them to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better health outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources.

In response to 'A Call to Action' and to inform the challenges facing general practice and provide a sustainable future for membership practices, NHS Halton CCG has begun working with its member practices and key stakeholders to undertake a review of its services and their sustainability. To meet the increasing challenges faced, there is a need to reshape the range of services offered within general practice, thereby enhancing the sustainability of practices whilst preserving the local roots of general practice that are valued highly by patients.

This strategy describes how Halton CCG is working with its partners and the public to develop and commission standardised high quality General Practice that "…balance the benefits of organisational scale with preservation of the local nature of general practice" (The Kings Fund & Nuffield Trust, Securing the Future of General Practice, July 2013). This

document sets out a summary of the strategy and is intended to stimulate discussion and debate about the themes, proposals and approach set out.

2) National Drivers

It was essential to identify how the current and future national approach, as set out by NHS England, the current lead contractor for General Practice, was being considered.

In 'A Call to Action', Phase 1 report, NHS England set out five ambitions "…to improve services, both for today's population but also to ensure…excellent services for the future"

Five ambitions
• Proactive, co-ordinated care • Holistic, person centred care • Fast, responsive access to care • Health-promoting care • Consistently high-quality care

The document then sets out 7 areas of work where "…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 it is within our overarching ambitions for improved outcomes for all.

"To support these locally-led transformations in primary care, we are focussing at national level on seven main areas of work"

Areas of work	Summary
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 greater choice over the general practice they register with, and transforming patient access to GP services
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
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
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
Supporting investment and redesigning incentives	Supporting a shift of resources towards general practices 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
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
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 solutions

Commissioning for outcomes

A key strand to the strategy moving forward will be how practices and services are commissioned and contracted; this is where the CCG has identified the co-commissioning agenda as a real opportunity to commission services differently.

At present, practices have a number of funding streams that make up their total remuneration. The proposed approach is to work with practices to consider whether alternative contract and funding models can be developed locally to sit alongside the existing GMS/PMS contracts. At present, £xm is spend on enhanced services and £ym on QOF. Examples are being seen elsewhere in the country where these traditional funding approaches are being adapted to develop a more locally-orientated solution.

Such approaches could include commissioning for outcomes rather than processes or inputs, incentivising behaviours including peer review, leadership and responding to feedback and payments for improving access to services.

With the current direction of the co-commissioning agenda moving towards an even greater role for CCGs than first announced, i.e. full delegated responsibility for GP contracting, these options are wholly available to develop with the member practices, partners and NHS England.

3) The Case for Change

As at the 2011 Census, Halton's population was 125,700 (rounded to nearest 100) with 48.8% male and 51.2% female. The population registered with Halton GPs is 128,446 (July 2012) and there are 17 general practices in Halton.

Halton is ranked as the 27th most deprived local authority in England (out of 326 local authorities).

Life expectancy has risen steadily over time. In 2010-12 average life expectancy in the borough was 77.4 years for men and 80.7 years for women. However, the borough is consistently lower than its comparators (about 3 years lower than the England figures).

There are also internal differences in life expectancy, ranging from 71.1 years for males in Windmill Hill to 82.1 years in Daresbury. For females the differences range from 76.4 years in Riverside to 89.7 years in Birchfield ward: a difference of 10.4 years for males and 13.3 years for females

This is a slight narrowing of internal inequalities for men from 11.4 years and widening for women from 9.4 years during the previous reporting period 2008-10.

(Source: Halton JSNA, August 2013)

The table below summarises key demographic forecasts and changes:

Demographics **Source: ONS Population Projections, 2014**
• **The population in Halton will increase in size by 2.8% (3,500 people) between 2012 and 2030** • **Over this time period, the number of people aged over 80 will more than double (from 4,300 to 8,700) and the number aged between 65 and 80 will increase by over 40%** • **During the same time period, this will see a reduction of 3.8% in the under 19 population and a reduction of 8.6% in the 20-59 population**

Long Term conditions and co-morbidities

The table below presents the headline figures of QOF prevalence in Halton against six key QOF disease groups. It demonstrates the prevalence rates compared to the England average and also highlights variation in the levels of prevalence across the GP practices in Halton:

Condition	Halton average	England average	Halton maximum	Halton minimum
Asthma	6.9%	6.0%	9.7%	5.6%
CHD	4.4%	3.3%	5.0%	2.4%
Diabetes (over 17)	7.3%	6.0%	8.0%	4.1%
COPD	2.5%	1.7%	4.0%	1.5%
Hypertension	14.8%	13.7%	17.6%	8.8%
CKD (over 17)	4.5%	4.3%	5.8%	2.5%

Source: Quality Outcomes Framework 2012/13

According to results from the national 2009 General Lifestyle survey, people with long term conditions account for:

- 50% of all GP appointments;
- 64% of outpatient appointments;
- 70% of all inpatient bed days;
- In total around 70% of the total health and care spend in England (£7 out of every £10) is attributed to caring for people with LTCs;
- This means that 30% of the population account for 70% of the spend.

Source: 2009 General Lifestyle Survey

In a consultation response from people living with long term conditions, they said:

- They want to be involved in decisions about their care – they want to be listened to;
- They want access to information to help them make those decisions;
- They want support to understand their condition and confidence to manage – support to self-care;
- They want joined up, seamless services;

- They want proactive care;
- They do not want to be in hospital unless it is absolutely necessary and then only as part of a planned approach;
- They want to be treated as a whole person and for the NHS to act as one team.

Source: Our health, our care, our say: a new direction for community services – consultation responses from people with long term conditions

In the Department of Health's Long Term Conditions Compendium of Information (Third Edition, May 2012), it sets out "Age is a major factor in prevalence of LTCs but also in those who have multiple LTCs" and also that "The number of people with one long term condition is projected to be relatively stable over the next ten years. However, those with multiple LTCs is set to rise to 2.9 million in 2018 from 1.9 million in 2008."

This is based on a national population forecast that "By 2034 the number of people aged 85 and over is projected to be 2.5 times larger than in 2009, reaching 3.5 million and accounting for 5% of the population."

It sets out that "The additional cost to the NHS and social care for the increase in co-morbidities is likely to be £5 billion in 2018 compared to 2011. Plans need to be put in place now to address the health and social care issues facing people with multiple long term conditions."

Patient experience

The feedback from the national General Practice patient survey published in July 2014 set out that the general satisfaction of respondents locally was lower than the national average and peer group (industrial hinterland) average against a number of the questions.

Patient experience **Source:**
• **Q, Overall experience of making an appointment. Answer - Very good** **Halton - 24%, Eng av – 34%, Peer av – 32%** • **Q, Ease of getting through to someone at GP surgery on the phone. Answer – Very easy** **Halton – 15%, Eng av – 26%, Peer av – 25%** • **Q, Is the GP surgery currently open at times that are convenient for you? Answer - Yes** **Halton – 72%, Eng av – 75%, Peer av – 77%** • **Additional opening times that would make it easier to see or speak to someone:** **After 6:30 – 73%, On Saturday – 73%**

However, within the first three questions presented above, there was wide variation in the satisfaction response rate between practices:

Questions	Halton av.	Halton max.	Halton min.
Overall experience of making an apt – very good	24%	80%	14%
Ease of getting through to someone at GP	15%	75%	3%

surgery on the phone – very easy			
Is the GP surgery currently open at times that are convenient for you? Yes	72%	94%	56%

Urgent care rates

The Advancing Quality Alliance (AQUA) Quality and Efficiency Scorecard for Frail Elderly (June 2014) sets out that the Non-Elective admissions aged 65+ per 1000 population in Halton are in the top 19-23 quartile (where a lower rate is considered better) for CCGs across the North West. The average NW admission rate was 295 per 1000 population and the Halton rate was 319.

Looking at similar data (for the over 75s population), the average admission rate in Halton for the over 75s population is 412 per 1000 population. However, there is a significant variation in the levels between practices with the lowest admission rate at 279 per 1000 population and the highest admission rate at 647 per 1000 population.

Referral rates

Data provided the acute providers identify the GP referral rates from 2013/14 for all specialties. It demonstrates that average referral rate per 1000 weighted population across all practices was 179. However, there is significant variation at a practice level with the highest level at 310 referrals per 1000 weighted population and the lowest level at 111 per 1000 weighted population.

Practice variation

There is a range of information available that demonstrates variation across General Practice. Variation can be a positive reflection of decision-making and services aligned to the needs, desires or expectations of a specific population and individual.

There are also instances of unwarranted variation and the causes of this include:

- Variation in the supply of resources, more facilities in one population than another;
- Different definitions of appropriateness for intervention and referral, either by individual clinicians, sometimes even within one institution, or between different groups of clinicians working in the different populations;
- Variations that may be due to attitudes, both individual and population based, for example differences in use of services to different ethnic groups or different age groups. The Inverse Care Law was first described in 1971 and indicates that care may be provided inversely in relation to need because of beliefs and attitudes both on the part of the population itself and professionals serving it.

Source: Unwarranted variation (September, 2011)

No conclusions have been drawn from the above information, other than the demonstration of variation across the practices. Part of the strategy moving forward will be a need to clarify the difference between warranted and unwarranted variation and where unwarranted, consider interventions to reduce it.

Interventions for dealing with variation in clinical practice include:

- Peer review and audit between practices;
- Point of care decision support systems, prompts and reminders;
- The use of explicit care pathways;
- The use of information technology;
- The use of guidelines and audit to measure adherence to guidelines.

Workforce

Data sourced from the Health and Social Care Information Centre demonstrates that as of 30th September 2013, Halton had the following number of GPs (excluding Registrars and Retainers):

Full Time Equivalent

Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	Total
2	9	9	9	10	8	12	5	1	66

This demonstrates that 27.1% of current practitioners in Halton are 55 and over.

Furthermore, according to the Seventh National GP Work life Survey by Hann et all, 2013, University of Manchester, an increasing number of GPs (nationally) are considering their 'Intention to Quit' within the next five years

Considerable/high intention to leave direct patient care within five years	All GPs	GPs aged under 50	GPs aged over 50
2005	19.4%	6.1%	41.2%
2008	21.9%	7.1%	43.2%
2010	21.9%	6.4%	41.7%
2012	31.2%	8.9%	54.1%

Forecast future demand

In May 2014, Capita (commissioned by four local CCGs) produced an End to End Care Assessment Report designed to provide a retrospective, current and future view of health and social care activity, spend and patient flows across the Mid Mersey area.

They set out that the CCG operates within "a complex health environment – Community and Mental Health services are provided…by two main Trusts (Bridgewater Community Healthcare and 5 Boroughs Partnership) – however, while the provision of acute secondary care is dominated by St Helens and Knowsley Trust and Warrington and Halton NHS FT, there is a significant amount of competition from specialist NHS providers on Merseyside as well as local private hospitals".

Based on population forecasts alone, the "Do nothing" scenario when considering the financial implications across the four main care settings for the CCG are set out below:

Care Setting	% change	% change	% change

	to 2016/17	to 2018/19	to 2023/24
Acute	+3.2%	+5.2%	+10.2%
Community	+2.5%	+4.0%	+7.7%
Mental Health	+2.5%	+4.0%	+7.7%
Social Care	+2.5%	+4.0%	+7.7%

Financial overview of General Practice

As set out in the introduction and background sections, funding of General Practice as a percentage share of total NHS expenditure has reduced from 10.7% in 2005/06 to 8.4% in 2011/12 (GB).

NEED TO ADD LOCAL DETAILS

4) Local commissioning response

Having considered the information and evidence available and through a process of engagement with member practices and stakeholders, the conclusion was reached that **General Practice in Halton is not sustainable** in its current guise.

Halton commissioning principles and response

To address the range of issues outlined in the case for change section, the problem statement and to embrace the ambitions and areas of work set out by NHS England, Halton CCG believes the following ten principles are fundamental to the future design, configuration, commissioning and delivery of local General Practice:

- Commissioning and delivering consistent high quality care for every local resident;
- Care continuity for patients with Long Term Conditions;
- Reducing unwarranted variation;
- Strong local clinical leadership;
- Embracing the opportunity to offer services at scale, delivered locally to individual people;
- High levels of population and patient engagement;
- Commissioning and contracting for outcomes, not inputs or processes;
- Services working in greater collaboration in the community as multi-disciplinary teams of care professionals working together;
- Improving access to all services and better coordination of care pathways;
- Focus on prevention.

5) Integrated model

To achieve this, it is proposed that a new model is established with community services centred around people, ensuring everyone's needs are met through an integrated health and social care delivery model. This will see GP practices working together, in a much more integrated way with Community, Mental Health and Wellbeing, Social Care, Urgent Care and Pharmacy services all wrapped around local delivery points.

The diagram below sets out this approach:

What potential benefits will this integrated approach bring…for patients?

- Better and clearer access to local health and social care services;
- Better co-ordination of care, especially for elderly patients, patients with complex needs and those with Long Term Conditions;
- Improved experience;
- Improved communication and information;
- Reduced duplication;
- Reduced number of unplanned admissions

What potential benefits will this integrated approach bring….for professionals?

- Better access to local services and experts for their patients;
- Increased level of peer support and access to expertise;
- Reducing unwarranted variation within services;
- Better opportunity to lead and influence commissioning decisions and strategy for the local population;
- Reduction in crisis management;
- Opportunity to offer more services at scale whilst maintaining local presence;
- Reducing pressure on the workforce;
- Improved use of technology;
- Increased financial sustainability.

Multi-disciplinary team working

The model will see the following services and teams aligned to each community 'hub':

Community nursing	School nursing	District nursing
Community midwives	Health visitors	Social care services
Mental health teams	Well-being services	Sexual health services
Health improvement teams	Urgent Care Centres	Family nursing

Each 'hub' will determine how to best configure itself to meet the needs of its local population. This includes service delivery, governance, population engagement, performance management and strategic planning. It is recognised that in certain

circumstances, it will be advantageous to continue to commission and deliver services across the whole borough of Halton, however, this will be for each 'hub' to determine and influence.

At present, there are 17 practices operating as 17 separate delivery organisations. This model is predicated on the practices starting to work together to create a number of community 'hubs', although the specific configuration of this will be for the General Practices and staff to determine.

An integrated team approach will see care professionals from each organisation and service identified aligned to one of the 'hubs', therefore, operating 17 'hubs' would not be viable with the resource available, whether that be staffing numbers or financially.

Priority areas of focus

As well as considering the organisational forms, it has been essential to consider which areas, when further addressed, would have the greatest impact on the population's health. When considering commissioning for outcomes, it was essential to identify and work on the areas with the highest priority for the local population and the Halton Public Health team have supported this process:

As a result, the following have been identified as priorities.

Area	Rationale
Mental illness	Highest cost to NHS, largest contribution to disability adjusted life years (DALYs) lost in Halton; 4th largest contribution to local mortality
Cancer and CVD	Two largest causes of premature mortality; 2nd and 3rd biggest contributor locally to DALYs lost., 1st and 2nd largest cause of potential years of life lost (PYLL) inequalities gap
Unplanned/urgent care	High rate of 30 day re-admissions
Hypertension	Largest disease register and biggest prevalence gap
Gastrointestinal including liver disease	Worst rate of premature mortality, 4th largest contribution to PYLL, inequalities gap
Respiratory disease	Large cause of hospital admissions, 4th largest contributor to disability and 3rd to mortality locally, 3rd for PYLL, inequalities gap
Accidents	Inequalities gap, Halton is an outlier for children's accidents, inequalities gap-listed under 'external causes 'on life expectancy gap tool

It is acknowledged that analysis will be undertaken with each 'hub' to determine the priority areas for each as they will not be the same across the whole borough. The solution to tackling each area will be for the community hub to determine. The principles of sharing experience and peer review to identify best or successful practice will be encouraged.

It is proposed that 'Action Teams' are established (where not already in place) to focus on each area identified to determine and set appropriate outcome and performance levels and service standards.

Initial working groups

As part of the work to date with the GP Strategy, four areas have been identified where work has begun. These areas are:

- Cancer;
- Hypertension;
- Access to services over 7 days;
- Care Homes.

Further groups will need to be established to ensure all areas identified above are appropriately considered and addressed. It is essential that any new or emerging working areas are aligned to existing projects or programmes of work to avoid duplication and confusion.

Future practice operating models

In response to the approach set out, it is recognised that a number of organisational types exist that practices may want to consider moving forward including:

- The current as-is model;
- Networks or federations;
- Super-partnerships;
- Regional multi-practice organisations;
- Community Health organisations.

Aside from the 'as is' approach, all of these models are "defined by their desire to use greater organisational scale to extend the range of services offered and to diversify income streams, thus enhancing the sustainability of practices. They develop more sophisticated management support to undertake strategic planning and service development, and create new professional, management and leadership roles that offer a new range of career opportunities for professional, managerial and support staff in primary care. It is striking that despite their differing originals and philosophical underpinning, the models of care share a desire to improve and extend primary care services, develop management and leadership capacity, and assume a more significant role in the local health system.

"Critically, they all emphasise the need to balance the benefits of organisational scale with preserving the personal and local nature of general practice. Each of the 'at scale' primary care models…had preserved local practices as the first point of contact for patients, strengthened network of wider advice and support available, and used organisational scale to enhance (and not undermine) the local accessibility and nature of primary care" (Securing the future of general practice, Kings Fund & Nuffield Trust, July 2013)

6) Enabling support

In addition to the commissioning priority areas, there are four underpinning key enablers that the CCG will drive forward to support a sustainable solution. The areas are:

- Workforce
- Estates
- IT and Informatics
- Contracting

Each of the four areas brings its own challenges and opportunities. Working with General Practice and the experts in each area, the CCG will develop a long term approach to each that will support the development and evolution of services.

Workforce

A paper was presented in October 2014 to the Service Development Committee (SDC) setting out the principles of workforce planning. It also stimulated discussion and debate with General Practice around the need to undertake a Halton-wide approach to workforce planning. There was collective recognition of the challenges described in the paper (as well as in this document) and an agreement that further discussions are needed to consider what can be done to address the range of issues.

Essential to those further discussions is the consideration of how the future model of service delivery will affect and influence both the current and future workforce needs, including staffing numbers, staffing types and skill mix.

Estates

Working with local partners and considering the future model of service delivery, the intention of the Strategic Estate Planning process is to support real change in the local estate and to generate strategic estate solutions that drive system wide savings, integration and new service models. Significant savings are achievable through a structured and targeted programme to support the strategic planning of the estate, which will deliver:

- **Increased efficiencies**, through the better use of high-quality primary and community care estate.
- **Better service integration**, driving improvements in service efficiency and better health outcomes for patients.
- **New service models**, supporting the drive to move services into the community from hospitals, replacing outmoded and inadequate premises and releasing capital through a structured programme of disposals.

Information Management and Technology (IM&T)

An IM&T strategy is being developed to reflect the overall strategy, values and aspirations for the future and highlights how Health Informatics and IT can be a significant enabler and driver of improved information flows. This will help effectively measure what we do now, how we communicate and most importantly, how to improve it. It is ensuring that fit for purpose systems are in place which allows streamlined processes and data sharing supported by robust governance arrangements to support clinicians to provide high quality care.

The strategy is designed to focus on the opportunities and innovation that Information Technology and information/data management can offer and will set out how the CCG, practices and partners can deal with rapid changes both in respect of the internal and external environment.

We must ensure that the use of information and information technology to improve patient care, access to care, the patient experience, delivery of clinical outcomes, health record keeping and value for money should be, and will be, a fundamental part of all future of General Practice.

Contracting

To support a number of points made above, it is recognised that "…a new alternative contract for primary care is required (in parallel to the current General Medical Services contract). The contract needs to be crafted by NHS England in a way that encourages groups of practices to take on a collective responsibility for population health (and ideally also social) care across a network of practices, without specifying the detail of implementation – this should be a matter for local determination" (The Kings Fund & Nuffield Trust, Securing the future of general practice, July 2013)

CCG support

In addition, to support the delivery of the strategic vision described for General Practice, it is recognised that the CCG will need to:

- Configure itself to ensure it embraces the opportunities presented by co-commissioning;
- Support the development of community 'hub's;
- Support practices as they consider alternative approaches to working together;
- Support the development of a Commissioning for Outcomes commissioning and contracting approach;
- Support the development of the workforce planning, estates and IM&T strategies;
- Align and integrate the approach within the existing governance arrangements of the CCG.

7) Conclusion

This paper is designed to summarise the key themes and elements included within the General Practice Strategy for Halton CCG. A lot of the content has been derived from conversations with General Practice over recent months.