

NHS Halton CCG

A strategy for General Practice services in Halton

***Creating sustainable out of hospital care for
the people of Halton***

2014/15 – 2019/20

January 2015

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1. EXECUTIVE SUMMARY

General Practice is the cornerstone of NHS care, yet the demands placed upon General Practitioners (GPs) and their teams have never been greater. NHS England's *Improving general practice – a call to action*¹ was intended to stimulate debate in local communities as to 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. This Strategy has emerged from our direct response to this call to action in August 2013.

NHS Halton CCG has achieved much in its primary care services since its inception in 2013. There are a range of Local Enhanced Services (LES) schemes in place, a number of projects or plans being developed and working relationships already established. At the same time we realised that General Practice services in the borough were not sustainable, for all the reasons outlined in *Improving general practice – a call to action*. This Strategy recognises the challenges General Practice services face but also seeks to address them within Halton by building upon the foundations of good work that are already in place.

This strategy looks at how we can continue to improve the quality, capability and productivity of our General Practice services through a collaborative approach with key stakeholders and, most importantly, with our wider population.

The principle approach throughout the programme of work to develop this Strategy has been about engagement with local practices, NHS England, providers and partners and the public and a range of patient groups. Initially we worked to develop a shared understanding of the problem we wished to solve and then worked on co-designing and co-producing what a sustainable model of General Practice looks like for Halton.

There are a range of national drivers that have influenced the work including NHS E's co-commissioning agenda² and the *Five Year Forward View*³. We believe that the timing of these national programmes complements and accelerates our local work and we have considered and aligned the approach accordingly.

¹ NHS England (2013), *Improving General Practice: A Call to Action*, [Online], Available: <http://www.england.nhs.uk/ourwork/qual-clin-lead/calltoaction/igp-cta/>

² NHS England and NHS Clinical Commissioners (2014), *Next steps towards primary care co-commissioning*, [Online], Available: www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf

³ Care Quality Commission, Health Education England, Monitor, NHS England, Public Health England and Trust Development Authority (2014). *Five Year Forward View*, [Online], www.england.nhs.uk/ourwork/futurenhs/

The future model of service outlined in this Strategy, Multispecialty Community Provision, owes much to the Multispecialty Community Provider approach in *the Five Year Forward View*. We have deliberately referred to Multispecialty Community Provision rather than of a Multispecialty Community Provider as it is important we define the functions we want our model to deliver (provision) before we discuss who it will be provided by and how. This approach is widely supported within Halton and the emergent model has been discussed and created through the local engagement and co-production across range of organisations.

Our Strategy will require General Practices to work more in partnership, ensuring that every resident of Halton has access to the same high quality and standardised services. This will involve harnessing the skills, experience and knowledge of the professionals in Halton. This will require work at four levels – borough wide, town wide, across community hubs of more than one practice and at individual practice level. The advent of community hubs will ensure we are focussing on local communities and we will engage with those local communities as services are developed.

Finally, regardless of whether additional funding is made available or not, NHS Halton CCG and NHS England, through co-commissioning arrangements, will drive the implementation of this Strategy. We are looking to secure non-recurrent funding in 2015/16 through the Prime Ministers Challenge Fund that will support more rapid implementation and the pump-priming of a series of projects that will start to shape the future model of services across Halton.

Dr Cliff Richards
Chair, NHS Halton CCG

Simon Banks
Chief Officer, NHS Halton CCG

2. INTRODUCTION

General Practice is the cornerstone of NHS care, yet the demands placed upon GPs and their teams have never been greater. Primary care sees more patients than ever, with more complex needs; 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 GPs are nearing retirement, the GP workforce is increasingly sessional and/or part-time, and many areas are experiencing difficulty with recruitment.

NHS England's *Improving general practice – a call to action* was a start to stimulate debate in local communities – amongst GP practices, NHSE area teams, CCGs, Health and Wellbeing Boards and other community partners - as to 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 *Improving general practice – a call to action* and to inform the challenges facing primary care and provide a sustainable future for membership practices, NHS Halton CCG began working with its member practices and key stakeholders to undertake a review of General Practice services in the borough and their sustainability. To meet the increasing challenges faced by General Practice there is a need to reshape the range of services offered in out of hospital care, including General Practice, thereby enhancing sustainability whilst preserving the local roots of General Practice that are valued highly by patients.

NHS Halton CCG has achieved much in its primary care services since its inception in 2013 and wishes to build on this to ensure that they reflect the needs of its population. There are a range of LES schemes already in place, a number of projects or plans being developed and working groups already established. This Strategy aims to embrace this work and build upon the foundations that are already in place.

This Strategy looks at how we can continue to improve the quality, capability and productivity of our General Practice services through a collaborative approach with key stakeholders and, most importantly, with our wider population.

It also considers key enablers that are fundamental and underpin successful and sustainable general practice services, including: the use of informatics, high quality and appropriate estates, workforce development and new, more integrated ways of working between practices and across pathways and the role of co-commissioning by introducing more innovative and outcome based commissioning.

The vision of NHS Halton CCG is “**Involving everybody in improving the health and wellbeing of the people of Halton**” with key values focused on **Partnership, Openness, Caring, Honesty, Leadership, Quality and Transformation**

This vision and these values have been at the core of the approach the CCG has taken throughout and this will be demonstrated throughout the Strategy.

3. BACKGROUND

About us

NHS Halton CCG is responsible for planning NHS services across the borough, and work with other clinicians and healthcare providers to ensure they meet the needs of local people.

This includes:

- Elective hospital care
- Rehabilitation care
- Urgent and emergency care
- Most community health services
- Mental health and learning disability services

Creation of CCGs formed part of the Government's wider desire to create a clinically-driven commissioning system that is more sensitive to the needs of the local patients.

The organisation works with patients and healthcare professionals, as well as in partnership with local communities and Halton Borough Council to make sure that health and social care is linked together for people whenever possible. In addition to GPs, the Governing Body will have at least one registered nurse and a doctor who is a secondary care specialist.

NHS Halton CCG is overseen by NHS England, which ensures that they have the capacity and capability to commission services successfully and to meet all financial responsibilities.

What is General Practice?

General Practice is an essential part of medical care throughout the world. General Practitioners (GPs) are the first point of contact for most patients. GPs provide a complete spectrum of care within the local community; dealing with problems that often combines physical, psychological and social components. They increasingly work in teams with other professions, helping patients to take responsibility for their own health.

The wide mix of General Practice is one of the major attractions. There can be huge variation in the needs of individual patients during a single surgery. No other specialty offers such a wide remit of treating everything from pregnant women to babies and from mental illness to sports medicine. General practice gives the opportunity to prevent illness and not just treat it.

Outside normal surgery hours, an Out Of Hours (OOH) service is offered. OOH services usually operate from 6.30pm to 8.00am on weekdays and all day at weekends and on Bank Holidays. GPs can choose whether to provide 24-hour care for their patients or to transfer responsibility for out-of-hours services another provider.

NHS England currently commissions General Practice, with CCGs being required to support NHS E in ensuring that these services provide good quality for the local population. This relationship is now changing as co-commissioning between NHS England and CCGs gathers momentum.

Most GPs are independent contractors to the NHS. This independence means that in most cases, they are responsible for providing adequate premises from which to practice and for employing their own staff.

The diagram below was produced by NHS England following the changes resulting from the NHS Health and Social Care Act 2012. It demonstrates how people and communities are at the heart of the new NHS system with a range of services wrapped around them. This includes General Practice.

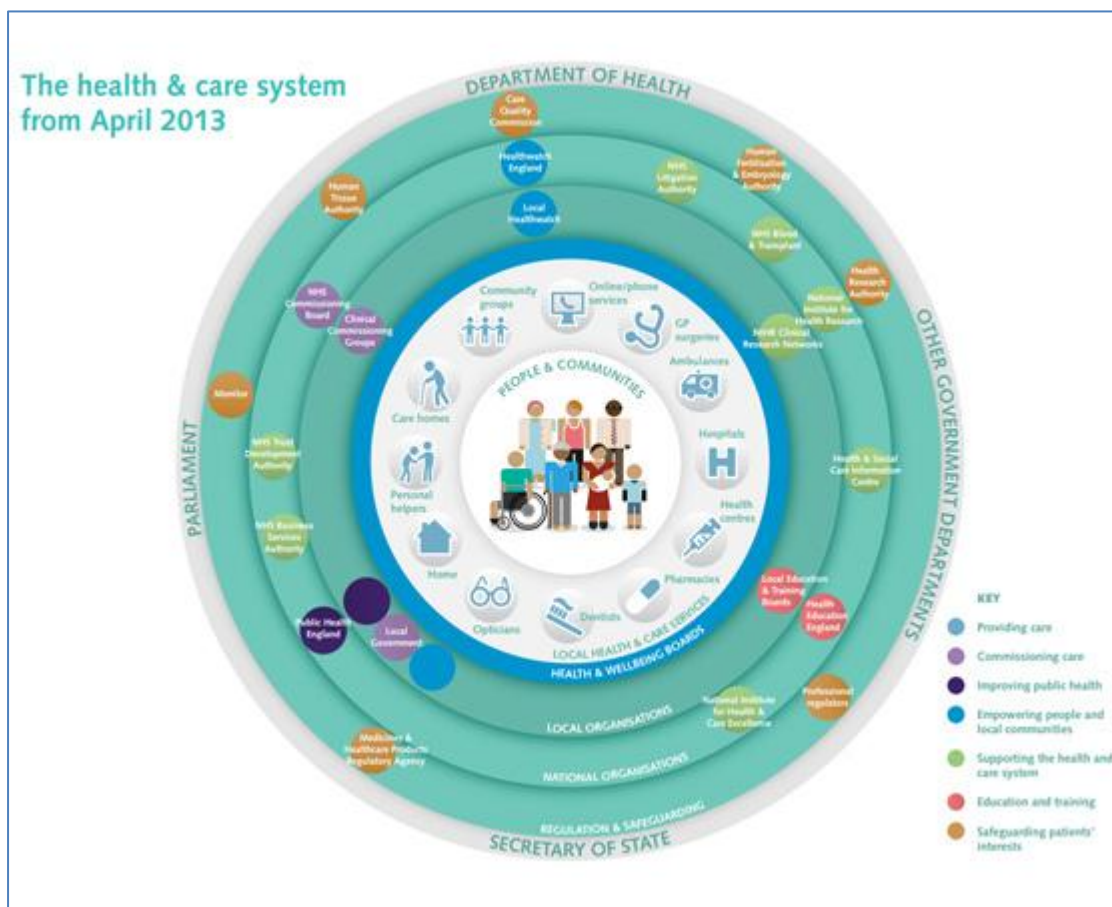


Figure One: The health and care system from April 2013⁴

⁴ Department of Health (2012), *The health and care system from April 2013*, [Online], Available: <http://webarchive.nationalarchives.gov.uk/20130805112926/http://healthandcare.dh.gov.uk/system-overview-diagram/>

Halton in Numbers – summary

- There are 17 GP practices in Halton, serving a population of approximately 128,000. The practices range in size (determined by population list size) from just over 2,000 through to the largest practice which has a list size of over 14,000.
- Across the 17 practices, there are 74 GPs (Headcount) and 52 Practice Nurses (Headcount). 6 of the practices have 2 or fewer GPs.
- There are 8 practices in Runcorn and 9 in Widnes. 8 of the practices are training practices. 14 of the practices have a Personal Medical Services (PMS) contract, 2 have a General Medical Services (GMS) contract and 1 has an Alternative Provider Medical Services (APMS) contract.
- The opening times of the practices are largely standard although Enhanced Services arrangements mean there are subtle variations.
- All of the practices partake in a range of nationally determined and locally set Enhanced Services.
- 16 of the 17 practices operate the same IT clinical system in their practices; EMIS Web, with the other practice using Vision.

Appendix 1 contains a series of tables that set out further details of the shape of General Practice services in Halton.

4. THE APPROACH

The underlying approach in developing the strategy has been based on the stages described within the NHS Change Model⁵.



Figure Two: NHS Change Model

The development of the shared purpose has been essential, carefully considered, widely debated and not rushed. A compelling and locally-oriented case for change was developed that considered the drivers and issues that collectively, helped all parties derive a common conclusion; General Practice in its current guise is not sustainable.

⁵ NHS Improving Quality (2013), *An introduction to the NHS Change Model*, [Online], Available: <http://www.changemodel.nhs.uk/pg/dashboard>

NHS Improving Quality (NHSIQ) was also commissioned to support our change programme. NHSIQ are experts in supporting large scale change and the programme of support they offer is drawn from an experience and understanding of how large scale change happens, informed by tools and techniques of improvement science. The key features of this approach are that:

- It is designed to support CCGs in progressing a locally identified large scale challenge priority, whilst also building capability, competence and confidence to apply learning from this to other initiatives.
- It is based upon the premise that most large scale change, of the degree now required in the NHS, will require collaboration in leadership between one (or maybe more) CCGs and their relevant commissioning partners, e.g. local authority(ies), the Health and Wellbeing Board, commissioning support providers and representation from the NHS England area team.
- It is designed to help CCGs “ringmaster” this collaboration, to help the system achieve transformational change, through engaging, mobilizing, building trust, undertaking a shared development journey, and by jointly focusing on a shared challenge.
- It will help establish solid foundations for this and other priorities, with frameworks for undertaking change, anchored on a clear shared purpose and joint narrative.”

They supported the development of an approach that considered all elements from the NHS Change Model.

The principle approach throughout the programme of work has been an integrated approach engaging everyone, including practices, NHS England, providers and partners and the public and a range of patient groups and working groups. We have been actively discussing this whole agenda with a range of local organisations and individuals including Halton Healthwatch, Halton People’s Health Form, Patient Participation Groups, the CCGs AGM and local engagement events. We have also run specific events around Care Homes, Cancer and Hypertension. All of these meetings, discussions and sessions have been used to gather opinion, views and intelligence, both quantitative and qualitative, to help form and influence the emerging strategy.

The emerging and draft Strategy has been shared and discussed with General Practice, partners and providers and the public to test the proposed principles, approach and model. This is an example of the continual feedback and engagement that has been established from the outset of the programme of work.

A Communication, Engagement and Consultation plan is currently being developed and this is being supported and monitored by the CCGs Consultation Steering Group. Following ratification of the Strategy by the CCGs Governing Body, a

population-wide information campaign will begin to inform them of the direction of travel and it is anticipated that consultation will then take place to determine how to best implement and develop the proposed model of service.

Headline milestones

Milestone	Timescale
Communication, Engagement and Consultation plan to Engagement & Consultation Steering Group.	February 2015
Launch public awareness campaign about new approach.	February 2015
Consultation commencing in (where needed) at Community Hub level.	March 2015

5. THE CASE FOR CHANGE

National context

As set out in *Improving general practice – a call to action*, future trends threaten the sustainability of our health and care system: an ageing population, an epidemic of long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS’s 65-year history.

Key facts – national context

- 86 per cent of respondents to the GP Patient Survey say that their overall experience is good or very good
- A quarter of patients do not rate the overall experience of making an appointment as “good”.
- 26 per cent of people do not find it easy to get through to the surgery by telephone and this figure varies from 8 per cent to 48 per cent in different parts of the country.
- The NHS faces a projected funding gap of £30 billion by 2021/22.
- Between 2003/04 and 2011/12 the number of emergency admissions for acute conditions that should not usually require hospital admissions increased by 34 per cent.
- While the numbers of full time equivalent GPs has grown over the past ten years, the GP workforce has grown at only half the rate as other medical specialties and has not kept up with population growth.

Source: *Improving general practice – a call to action*

In *Improving General Practice: A Call To Action Phase 1 Report*⁶, NHS England set out five ambitions to improve General Practice for “today’s population” and also “to ensure...excellent services for the future.” These ambitions are:

- *Ambition one:* proactive, coordinated care: anticipating rather than reacting to need and being accountable for overseeing your care, particularly if you have a long-term condition.
- *Ambition two:* holistic, person-centred care: addressing your physical health, mental health and social care needs in the round and making shared decisions with patients and carers.
- *Ambition three:* fast, responsive access to care: giving you the confidence that you will get the right support at the right time, including much greater use of telephone, email and video consultations.
- *Ambition four:* health-promoting care: intervening early to keep you healthy and ensure timely diagnosis of illness - engaging differently with communities to improve health outcomes and reduce inequalities.

⁶ Dyson, B. (2014), *Improving General Practice: A Call To Action Phase 1 Report*, London: NHS England, [Online], Available: <http://www.england.nhs.uk/wp-content/uploads/2014/03/emerging-findings-rep.pdf>

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

Improving General Practice: A Call To Action Phase 1 Report set out 7 areas of work where NHS England wanted to take forward change to deliver these ambitions:

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

Personal Medical Services (PMS) contract review

NHS England has begun reviewing PMS contracts to ensure that additional funding meets a set of consistent principles and criteria, agreed as part of the review. This approach has been determined following a national data collection exercise NHS

Employers ran with area teams to help understand PMS contract expenditure and identify its component parts.

The criteria that area teams will apply are that additional funding must:

- reflect local strategic plans for primary care agreed jointly with clinical commissioning groups (CCGs);
- secure services or outcomes that go beyond what is expected of core general practice or improve primary care premises;
- help reduce health inequalities;
- give equality of opportunity to all GP practices;
- support fairer distribution of funding at a locality level.

The data collection exercise identified that the premium element of PMS expenditure nationally is £325 million. That is the value of how far PMS expenditure exceeds the equivalent items of GMS expenditure. This means that NHS England pays, on average, a premium of £13.52 for patients registered with PMS practices. The premium will reduce to around £235 million over the seven years to 2021/22, as the GMS Minimum Practice Income Guarantee (MPIG) is gradually phased out. This reduces the average premium per registered PMS patient to £9.80.

Of the £325 million, around £67 million was identified as linked to defined enhanced services or key performance indicators (KPIs). The remaining £258 million may be associated with enhanced services or populations with specific needs, but it has not been notified as such. Analysis of the data revealed there is no obvious relationship between current PMS expenditure and deprivation.

Given the number of Practices with a PMS contract in Halton, this review presents a potential challenge to the level of practice income. The CCG has been advised that the current amount of funding allocated to practices in total will remain within Halton, however, the outcome of the PMS review may mean that the way in which this total level of funding is allocated amongst individual practices may vary from the current levels.

Co-commissioning

On 10th November 2014 NHS England, in partnership with NHS Clinical Commissioners, published *Next steps towards primary care co-commissioning*. The document aimed to provide clarity and transparency around co-commissioning options, providing CCGs and area teams with the information and tools they need to choose and implement the right form of co-commissioning for their local health economy.

Co-commissioning is seen as a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will

also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

There are three primary care co-commissioning models CCGs could take forward:

- Greater involvement in primary care decision making.
- Joint commissioning arrangements.
- Delegated commissioning arrangements.

The scope of primary care co-commissioning in 2015/16 is General Practice services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints management. However, co-commissioning excludes all functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation). Furthermore, the terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

NHS Halton CCG is, at the time of writing of this Strategy, is preparing a submission to express an interest in undertaking delegated commissioning for General Practice services from April 2015.

Five Year Forward View

The *Five Year Forward View* was published on 23rd October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The purpose of the *Five Year Forward View* is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits for us all. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

A small number of radical new care delivery options will be supported, these options include:

- Multispecialty Community Provider
- Primary and Acute Care Systems
- Urgent and Emergency Care Networks
- Viable Smaller Hospitals
- Specialised Care
- Modern Maternity Services
- Enhanced Health in Care Homes

Whilst new care models will be developed and supported, Five Year Forward View states that the foundation of NHS care will remain list-based primary care. As part of this commitment there will be a 'new deal' for GPs.

At a North Tripartite Event on 4th November 2014, organised by NHS England, Monitor and the Trust Development Authority, there was clear message that 5 Year Forward View requires a period of reflection but that this should be short. Delivery is expected from April 2015, with demonstrable congruence with our existing strategies and plans.

Local Context

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).⁷

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.

The table below summarises key demographic forecasts and changes:

⁷ Halton Borough Council (2013), Joint Strategic Needs Assessment
Available: <http://www4.halton.gov.uk/Pages/health/JSNA/JSNASummary.pdf>

Demographics ⁸

- 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 ⁹. 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%

According to results from the General Lifestyle survey ¹⁰, 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.

In a consultation response from people living with long term conditions ¹¹, they said:

⁸ Office for National Statistics (2014), Population projections
Available: <http://ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Projections#tab-data-tables>

⁹ Halton Borough Council (2014), Quality Outcomes Framework 2012/13

¹⁰ Office for National Statistics (2009), General Lifestyle Survey
Available: <http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2009-report/index.html>

¹¹ Department of Health (2006), Our health, our care, our say: a new direction for community services – consultation responses from people with long term conditions
Available:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/272238/6737.pdf

- 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.

In the Department of Health’s Long Term Conditions Compendium of Information ¹²states that age is a major factor in prevalence of LTCs but also in those who have multiple LTCs and that the number of people with one long term condition is projected to be relatively stable over the next ten years. However, the number of people 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. The document 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. It recommended that plans need to be put in place immediately 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 experience¹³

- 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%

¹² Department of Health (May 2012), Third edition of Long Term Conditions Compendium Available: <https://www.gov.uk/government/news/third-edition-of-long-term-conditions-compendium-published>

¹³ NHS England (July 2014), GP Patient Survey Results. Available: <http://www.england.nhs.uk/statistics/category/statistics/gp-patient-survey/>

- 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 surgery on the phone – very easy	15%	75%	3%
Is the GP surgery currently open at times that are convenient for you? Yes	72%	94%	56%

Urgent care rates

Advancing Quality Alliance (AQUA) data ¹⁴ 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 ¹⁵. Variation can be a positive reflection of decision-making and services aligned to the needs, desires or expectations of a specific population and individual.

¹⁴ Advancing Quality Alliance (June 2014), Quality and Efficiency Scorecard for Frail Elderly

¹⁵ Right Care (September 2011), Unwarranted variation: a reading list produced by QIPP Right Care. Available: http://www.rightcare.nhs.uk/downloads/ER_unwarranted_variation_aug_2011.pdf

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.

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 ¹⁶ 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 ¹⁷, an increasing number of GPs (nationally) are considering their 'Intention to Quit' within the next five years.

¹⁶ Health and Social Care Information Centre (2014) [Online]. Available: <http://www.hscic.gov.uk/workforce>

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 and NHS England) 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. Capita identified that NHS Halton CCG operates within a complex health environment that is served by four main providers – 5 Boroughs Partnership NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, St Helens and Knowsley Teaching Hospitals NHS Trust and Warrington and Halton Hospitals NHS Foundation Trust. Whilst secondary care provision is “dominated” by the latter two organisations, Capita identified that 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 to 2016/17	% change to 2018/19	% change 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%

Tackling health inequalities – our missing 40%

NHS Halton CCG, on the recommendation of Halton Borough Council’s Director of Public Health, has looked into health inequalities in the borough. Professor Chris Bentley, an expert on health inequalities and a former head of the Department of Health’s Health Inequalities National Support Team, supported us in looking at health inequalities, premature mortality and the impact we could have on addressing

¹⁷ Institute of Population Health (August 2013), Seventh National GP Worklife Survey. Available: <http://www.population-health.manchester.ac.uk/healthconomics/research/FinalReportofthe7thNationalGPWorklifeSurvey.pdf>

these areas in our borough. His work left us with two really important headline messages:

- The data demonstrates that people accessing General Practice in Halton are being looked after well;
- However, the data also identifies that about 40% of the population who need to be looked after in primary care, have conditions and co-morbidities, and are not accessing General Practice soon enough. The data identified cancer and hypertension as the two areas where, when compared to a peer population, interventions and changes could make a real difference to the local population. At present, approximately 40% of this cohort of our population are presenting at local A&Es with developed symptoms and conditions of cancer and hypertension, often at a late stage in the disease/condition progression, having not accessed General Practice in the first instance or when symptoms first presented.

Therefore, an essential strand of the approach within this Strategy is to:

- Identify the areas, pathways and conditions where, with further intervention and focus, changes could make a real difference to the health and life expectancy of the local population.
- Undertake engagement and insight work across our community, working with partners and providers and the voluntary sector, as well as the existing patient groups, to understand why so many patients are not accessing General Practice and to work with them to develop new, and possibly innovative approaches to better engage with this cohort of the local population.

Feedback from public engagement

As described previously, NHS Halton CCG has made a significant efforts to engage with the local population to seek its views and experiences with General Practice. To support this approach, as well as visits to the local practice Patient Participation Groups, the CCG worked in partnership with the Halton People’s Health Forum, a group of local public ambassadors, to shape two events in the community that would be informative for attendees but with a real focus on discussion and feedback from the public.

Key feedback themes included:

- Access can be a challenge;
- Care continuity with professionals is very important;
- Working with the younger population now is essential;
- We need to focus on Mental Health services;

- Local services need to be maintained;
- Services working more closely together in the community will help to make a difference;
- Every resident and practice should have access to the same services across the borough;
- Good local transport is essential.

Healthwatch Halton - 'GP access and out of hours provision survey

Between March and June 2014, Healthwatch Halton carried out a survey looking at 'GP access and out of hours provision' across the borough. The survey was distributed to 1200 Healthwatch Halton members by post and email. It was also shared with GP Patient Participation Groups. In total 491 responses were received.

In the main the results are very positive. Whilst people really value a high quality and easily accessible service from their General Practice, there is variation in accessibility across the borough.

Key feedback themes and recommendations included:

- Communication
- Appointment triage
- Opening hours and appointments
- Patient records
- Complaints
- Urgent Care Centres

In response to the survey, an action plan has been produced by the Primary Care Quality & Development Working Group, drawing on the recommendations. The implementation of the actions identified will be closely monitored and aligned to the emerging themes included within this Strategy.

6. THE POLICY CONTEXT

NHS Halton CCG Commissioning Priorities and Principles

As stated above, the catalyst for the discussions that has had during the development of this Strategy was NHS England's *Improving general practice – a call to action*. This supported a conversation in which we were able to consider all the information and evidence and develop facts through engagement with our member practices and other stakeholders. This enabled us to create a shared problem statement, that General Practice in Halton was not sustainable in its current form. Subsequently we agreed together that we wanted to develop a strategy for General Practice services in Halton by January 2015 that would create sustainable out of hospital care for the people of Halton.

We wanted to ensure that our approach to develop a strategic approach to commissioning General Practice was also congruent with the themes in our existing 5 Year Strategy, 2 Year Operational Plan and Better Care Fund. The priorities that we developed from this are:

- *Improved access and resilience* - Commissioning services to ensure the population of Halton can access the right services, at the right time, in the right place. Listening to and working with the population, we want to commission services that are convenient to them both in hours and out of hours.
- *Integrated care* - Commissioning services to bring organisations together and integrate care pathways to wrap around individual patient's needs through improving care coordination and multi-disciplinary team working.
- *New services in the community* - Commissioning and providing more services in the community to support care closer to home. Developing specialist skills in the community and investing in community facilities.
- *Community developments* - Local practices, pharmacies, community health services, voluntary agencies and the local authority work as a group to engage with their community, collaborating with them in asset-based approaches to improving health and wellbeing.
- *Quality improvement* - Commissioning for quality improvements in all services and a reduction in unwarranted variation through a range of measures including the developing of a culture of peer-to-peer challenge and learning, continued personal developments and funding service improvement capacity. Listening to the local population and their feedback and acting and responding to this.

When considering the case for change, population feedback, national and local priorities, it was considered important to identify a series of key principles that would

be fundamental to the future design, configuration, commissioning and delivery of the local General Practice system in Halton. All principles are as important as each other. They are:

- 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 and improved experience, 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.

Five Year Forward View – New models of care

The *Five Year Forward View* sets out the intention of NHS England and the other key national organisations working across the NHS to stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England. Whilst not seeking to impose a one-size-fits-all model, nor to allow “a thousand flowers to bloom”, *Five Year Forward View* does commit to an approach that identifies the characteristics of similar health communities across England, and then jointly work with them to consider which new options signalled in the document constitute viable ways forward for health and care services in that area.

The *Five Year Forward View* commits to several immediate steps to stabilise General Practice, through what it refers to as “A new deal for primary care”. General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts – in part because primary care services have been under-resourced compared to hospitals. The *Five Year Forward View* commits to invest more in primary care and take the following steps:

- Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.
- Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.

- Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.
- Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.
- Expand funding to upgrade primary care infrastructure and scope of services.
- Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.
- Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.

The *Five Year Forward View* is also clear that General Practice needs to be at the heart of out of hospital care. It suggests that there are two main models, above the status quo, that NHS England will be promoting in England over the next five years to make this a reality.

The first new care model is **Multispecialty Community Providers (MCPs)**. This envisages that smaller independent GP practices will continue in their current form where patients and GPs want that. However, as the Royal College of General Practitioners has pointed out, in many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, the traditional model has been evolving.

Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex on-going needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, NHS England will make it possible for extended group practices to form – either as federations, networks or single organisations. These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients:

- As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.
- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.
- They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.

- GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours.
- Inpatient care being supervised by a new cadre of resident ‘hospitalists’ – something that already happens in other countries.
- They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.
- These new models would also draw on the ‘renewable energy’ of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

The second new care model is **Primary and Acute Care Systems (PACS)**. A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures. NHS England will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these ‘vertically’ integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies:

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kick start the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.
- In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.
- At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget – similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

In developing this Strategy we have considered both these approaches. The Strategy recommends the development of a model for Halton that owes much to the Multispecialty Community Provider model.

7. THE FUTURE MODEL OF CARE

The future model of care

Our future model of care is about multispecialty community provision, working with a range of providers including General Practice. NHS Halton CCG believes this will be the best opportunity to harness the integrated approach and way of working, as well as maintaining a community focus and building on the existing strengths of General Practice and our existing providers, as well as harnessing new opportunities for community engagement in health and care provision in out of hospital settings.

Our future model of care will be established with services being centred around people in the community. Delivery may be across the whole CCG on a Halton-wide footprint; by bringing more than one GP practice together to service distinct communities through a ‘hub’ based approach; by sustaining individual practices wherever appropriate and by giving local people and communities more opportunities to self-care and create resilience. The constant in the model is to ensure that everyone’s needs are met through an integrated health and care delivery model. Integration will involve practices working together with acute care, community and mental health providers as well as social care, the voluntary and community sector and a host of other organisations and individuals, as described in the diagram below.



Figure Three: Integrated health and delivery model

NHS Halton CCG in our co-commissioning with NHS England and Halton Borough Council intends to commission and contract for the following services within this model:

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
Children’s Services	Out of Hours provider	Urgent Care Centres
Promotion, Prevention and Screening	Community pharmacy	Outpatient services
Diagnostic services	Voluntary and community groups	

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

- Better and clearer access to local health and 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.

Community Hubs

The model will see local services and teams wrapped around a series of ‘community hubs’. Each hub will comprise of membership including General Practice, ideally made up of more than one practice, as well as the providers of the services listed above. It is recognised that in certain circumstances, it will be advantageous to continue to commission and deliver services across the whole borough of Halton, but this would necessarily engage with each ‘hub’.

Four levels of commissioned services

We believe that we need to commission services as part of this new model at four levels of services within this new approach. This will be determined on a service by service basis and will be influenced by need and resources. These are levels:

- Level 1, practice level – services that are provided within, to or by one practice.
- Level 2, hub level – services are provided across more than one practice, across wards and communities.
- Level 3, town level – hubs work together around the Urgent Care Centres or other delivery points across Runcorn or Widnes.
- Level 4 – borough level – services are developed on a whole-borough basis, with one team or service serving the whole population.

In terms of service delivery, we will set clear commissioning criteria to be met in service provision, but each ‘hub’ will need to determine how to best configure itself to meet the needs of its local population and commissioning intentions. We will support this with advice and guidance not only on service delivery, but also on governance, population engagement, performance management, contracting and strategic planning.

NHS Halton CCG and our co-commissioning partners will work with provider organisations and partners to reflect this approach through its contracts and service specifications. We have already begun this work Bridgewater Community Healthcare NHS Foundation Trust through a joint review of adult community nursing. We will develop a phased approach to rolling out this model with all other providers, including General Practice.

NHS Halton CCG recognises that it cannot mandate practices to work together or join in community hubs. Nonetheless, this is how we intend to commission services in the future and we know that many practices are keen to work together better with each other and with other service providers. NHS Halton CCG considers that the benefits for a practice to join with a community hub outweigh those to not join.

At present, there are 17 practices operating in Halton as 17 separate delivery organisations. Having looked at approaches adopted elsewhere, we aim to create hubs with a population size of 20,000-25,000 registered patients. Our new care 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. This approach means the formation of between 6 and 7 community hubs across Halton.

Future practice operating models

Practices in Halton will need to consider how they respond individually and collectively as providers within the new care model. Practices may want to explore a number of organisational operating models that may support them in responding to this commissioning approach, drawing on examples from elsewhere in England and beyond. These operating models include:

- 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 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. Each approach is underpinned by a shared desire to improve and extend primary care services, develop management and leadership capacity, and assume a more significant role in the local health system – particularly in regard to out of hospital care.

As recognised by the King’s Fund and the Nuffield Trust ¹⁸, all operating models emphasise the need to balance the benefits of organisational scale with preserving the personal and local nature of general practice. Each model seeks to preserve local practices as the first point of contact for patients, strengthen networks of wider advice and support, use organisational scale to enhance (and not undermine) the local accessibility and nature of primary care.

Headline milestones

We recognise that we need to develop a full implementation and evaluation plan for this Strategy. Nonetheless, there are some immediate milestones for the roll out of the new model of care.

Milestone	Timescale
Practices to have determined whether to join a community hub and if so, have agreed community hub configurations	January 2015
Public engagement and consultation on strategy and approach to take place	February and April 2015
Phased approach to service and provider roll-out to new approach agreed	April 2015
Hubs to be established with agreed initial working arrangements (governance, performance management) agreed	June 2015
Hub working arrangements to be in place and operating	October 2015
Hub specific Joint Strategic Needs Assessment (by Halton Public Health team) to be completed	October 2015
Adult Community Nursing services to be	2015/16

¹⁸ Kings Fund and Nuffield Trust (July 2013), Securing the future of General Practice, New Models of Primary Care. Available: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130718_securing_the_future_summary_0.pdf

Milestone	Timescale
operational within new approach	

Priority areas of focus

As well as considering the organisational forms, it has been essential to consider which functional areas, when further addressed, would have the greatest impact on the health of the population of Halton. 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 Borough Council Public Health Directorate has 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; 2 nd and 3 rd biggest contributor locally to DALYs lost., 1 st and 2 nd 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, 4 th largest contribution to PYLL, inequalities gap
Respiratory disease	Large cause of hospital admissions, 4 th largest contributor to disability and 3 rd to mortality locally, 3 rd 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

Using the Joint Strategic Needs Assessments (JSNAs) developed by Halton Borough Council’s Public Health Directorate for Area Forums and individual practices and the information shared with us by Professor Bentley, we will undertake further analysis with each ‘hub’ to determine the priority areas, as in some cases they will not be the same across the whole borough. The solution to tackling each area will be for the community hub to determine, although it would need to be congruent and compliant with the commissioning intentions and contracting approach of NHS Halton CCG and our co-commissioners. The principles of sharing experience and peer review to identify best or successful practice will be encouraged.

NHS Halton CCG has partnered with a company called The Experienced Led Commissioning Programme (ELC) to generate insight into what matters to people in Halton about the range of pathways and disease groups identified above. This involves engagement through co design that will see local people shape the commissioning agenda and service design for each area.

An initial workshop was held in December 2014 for cancer and hypertension because they are the two largest causes of premature mortality in Halton. We also know that significant proportions of people with these conditions do not access primary care services early enough (the “missing 40%”); often end up in A&E and have worse outcomes because of this. We need to understand why people are not coming forward so we can address this.

Experience Led Care (ELC) is a new approach to health system management that puts people and their experiences at the centre of every stage of the process. ELC works in the context of any health and care system. It can be applied to any commissioning challenge because it is person-centred. ELC enables clinical commissioners to drive improvement by putting people and their experiences of care at the heart of commissioning and service redesign.

We will look to run a series of workshops, focussing on each priority area, throughout 2015/16 to co design services and pathways with our local people.

Initial working groups

As part of the work to develop this Strategy, four areas were identified where work had begun. These areas were identified based on information gathered throughout the process and the strong evidence base of where we can make a difference with additional focus and intervention. The areas were:

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

Cancer

The overall aim of the cancer project was to reduce late presentation of patients and improve patient care. NHS Halton CCG has an established Cancer Action Team, managed by a lead GP and the Director of Public Health.

It was decided that this project would integrate into the existing work programme of the Cancer Action Team who have been working with all 17 practices to undertake and complete a Cancer Audit, focussing on all instances of Cancer in 2013. This will provide a rich source of information and evidence to work with and support practices about their current approach and pathways and also identify where cohorts of the population are not accessing General Practice.

Targeted campaigns will then follow, working in collaboration with regional bodies, to raise awareness of the local population on themes including the importance of screening and where to access services.

Hypertension

There were 2 overall aims for this project:

1. Optimise treatment of patients with Hypertension; and
2. Identify and find the missing cohort of patients not accessing General Practice.

To this end, a pilot scheme is being implemented whereby a group of practices have identified patients over the age of 18 years who have not had a blood pressure recorded in the last 3 years. They have planned a campaign to support healthy living, good blood pressure control and the risks associated with uncontrolled hypertension. They are then running weekend clinics, both in practice and in a local community centre, for health checks for this cohort of patients.

The patients will be written to in the first instance. If they do not respond, the practice will work with the voluntary sector to proactively target people in their communities to stimulate interest.

The scheme is due to run through to March 2015, when the impact and results will be analysed and shared with all other practices to determine potential roll-out.

Access to services over 7 days

Given the recent political drive to offer extended hour services in General Practice, it was deemed important to establish a project that focussed on this. There were a wide range of views about how this agenda could be addressed and a key feature was the potential role of the soon to be opened Urgent Care Centres (UCCs) in Widnes and Runcorn.

The UCCs will be fully open from April 2015, they will operate from 7:30am to 10pm, 7 days a week and have a GP on-site. A significant programme structure is already in place to support the development and opening of the centres and this has involved a broad range of local stakeholders.

Furthermore, there has been a need to carefully consider how the UCC align and integrate with General Practice and the local acute providers. To this end, an approach with four levels of resilience and access across the community has been considered.

Level 1 – A focus on the self-care agenda and care at home where the ‘wrap around’ services focus on keeping people as fit and healthy as possible within their own home environment.

Level 2 – The development of General Practice with extended evening and weekend services. NHS Halton CCG will pilot a number of schemes and monitor their effectiveness to determine which best meet the needs of the patients and public, which are most sustainable and which have the greatest impact on the health and wellbeing of the population. We will share the impacts and results with all practices and hubs to allow them to determine which approaches will work best for their populations moving forward.

Level 3 – Extending community resilience through the opening of the two Urgent Care Centres to support the reduction of demand on local hospitals. The Urgent Care Centres will also provide additional community based diagnostic services, accessible to General Practice and the wider ‘wrap around’ services.

Level 4 – Supporting the sustainable future and development of the local acute services for when our population are most in need of urgent and acute intervention. Further discussions are taking place about this approach.

Care Homes

Building on existing work that NHS Halton CCG and Halton Borough Council have been running with a lead clinician, this project was designed to propose a sustainable model of primary care (and associated services) that improves outcomes, care quality and safety for frail older people in care homes. To support this, the NHS Halton CCG worked in partnership with Healthwatch Halton to run an engagement event with care home residents and staff, key providers and partners and other interested parties. Key feedback themes from the workshop included:

- Variation in the way GP surgeries are contacted or issue prescriptions should be standardised to make it a simpler process for care home staff.
- Dedicated phone line for care homes or single point of contact thus making it easier for GPs to be contacted.
- Relationship building of care home staff and other health professionals.
- Clear faster pathways for referral processes, promotion of the services that are available such as the audiology housebound service.
- Mapping exercise for the professionals to avoid duplication in the service that is being provided.
- Improved links with the voluntary sector- for provision of activities within the care homes

This is now being documented, alongside an implementation and action plan and will be presented for approval and roll-out.

Enabling support

In addition to the commissioning priority areas and existing working groups, there are four underpinning key enablers that NHS Halton CCG will drive forward, with partners such as Health Education England, 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, NHS Halton 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 NHS Halton CCG's Service Development Committee (SDC) setting out the principles of workforce planning. It 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 Strategy) 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 IM&T strategy is designed to focus on the opportunities and innovation that Information Technology and information/data management can offer and will set out how NHS Halton 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)

8. FINANCIAL SUMMARY

Financial stability is essential moving forward. As set out by NHS England in the *Five Year Forward View*, they will stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas. Furthermore, NHS England is currently in the process of providing all CCGs with the current expenditure levels on General Practice. This will include expenditure on General Practice contracts, premises costs, enhanced services and Quality and Outcomes Framework (QOF)

In addition, delegated co-commissioning would mean that NHS Halton CCG would have the opportunity to design a local incentive scheme as an alternative to the Quality and Outcomes Framework or Directed Enhanced Services. This would allow NHS Halton CCG to determine how resources could be used differently, considering which elements add real value and need to be maintained and even strengthened, and which could add more value.

The approach to wrap services around community hubs means, in the first instance, the aim is to use existing resources more effectively and efficiently. As the system develops and the community hubs mature, consideration about how the overall shape of services and the associated funding can and will be carefully considered as part of the overall commissioning strategy.

In October 2013, the Prime Minister announced a new £50 million Challenge Fund to help improve access to general practice and stimulate innovative ways of providing primary care services. In September 2014, the Prime Minister announced a new second wave, with further funding of £100 million non-recurrent money for 2015/16. To be successful, organisations will need to outline programmes of work to improve access including:

- Longer opening hours;
- Joining up of services;
- Sustainable solutions;
- Greater flexibility about how people access general practice; and
- Greater use of technology.

In addition, NHS England will welcome applications from practices or more likely, groups of practices that wish to test new models for providing general practice services, with potential benefits not only for patients accessing general practice, but also with benefits to the wider NHS.

NHS Halton CCG is making an application for this non-recurrent money in 2015/16 to support the more rapid implementation of this strategy and a number of supporting projects. The deadline for the application is 16th January 2015 and the CCG is actively working with the practices to collate a bid.

At present, projects included in the application include:

- Project management to support the development and implementation of the community hubs and wrap around model.
- Extended hours pilot schemes for General Practice.
- Insight and engagement work.
- Pharmacy schemes.
- IM&T schemes to both support improved access and also interconnectivity between practices and partner organisations.
- Practice and provider development support.

NHS Halton CCG and our co-commissioners will implement this strategy whether we are successful or not with the Prime Ministers Challenge Fund application. It is important to note that the pace of implementation will be affected if not successful, however, alternative sources of non-recurrent monies will sought to support a more rapid implementation.

9. GOVERNANCE APPROACH

To support the development and implementation of this strategy, including successfully delegated co-commissioning status from NHS England, we have identified five key elements involved in the commissioning and contracting of General Practice:



Figure Four: NHS Halton approach to co-commissioning

Each of these interdependent areas requires clear and distinct governance arrangements. NHS Halton CCG will continue to be responsible for continuous quality improvement with General Practice and other providers through established governance arrangements, particularly the Primary Care Quality and Development Working Group. This Group will be responsible for establishing the relevant impact assessment monitoring arrangements to track the progress each hub is making towards achieving improved outcomes for its local population.

Co-commissioning will be guided by this Strategy and by existing NHS Halton CCG commissioning strategies. New governance arrangements will be established, consistent with guidance from NHS England for co-commissioning and contract management performance. NHS England will initially support this with resources that they will retain within their structure. NHS Halton CCG will also look to resource support for co-commissioning and contracting and put in place new conflicts of interest policies and a new committee, without GP or member practice representation, to make decisions about commissioning and contracting with General Practice.

Provider Development will focus on supporting practices and the community hubs develop as organisations and assist the development of services and standards.

Individual GP performance management (medical performers list for GPs, appraisals and revalidation) will continue to be executed by NHS England.

10. CONCLUSION

Throughout our programme of work to develop this Strategy we have adopted an integrated approach of co-production, engaging everyone, including practices, NHS England, providers and partners and the public and a range of patient groups and working groups.

There are a range of national and local drivers that collectively create a compelling and evidence based case for change in that General Practice in current guise not sustainable in Halton.

Ten key principles have been derived that are considered fundamental to the future design, configuration, commissioning and delivery of the local General Practice system in Halton.

The future model as set out, Multispecialty Community Provision, fully aligns to the approach as set out in NHS England's Five Year Forward View. The establishment of Community Hubs will further strengthen this model and also bring with it, a much greater focus on the communities of Halton. They will also result in General Practice working together in a more integrated and supportive way, with peer review and buddying actively encouraged creating a learning culture.

Co-commissioning will give the CCG a greater role and responsibility in supporting the establishment of this new approach. There will undoubtedly be challenges but the opportunities are significant.

The use of the Prime Ministers Challenge Fund, if successful, will support an accelerated implementation programme and there a number of projects developing that will support and embed this. Sharing the learning from these projects will be fundamental.

Finally, as important as everything else, continuing the engagement is key. This strategy has been co-produced with practices, partners, providers and the public. This has to continue. Insight work will commence to understand why certain cohorts of the population do not access services early enough. We will consult with our population on the new models and how they are best implemented and we will run co-design events around our areas of greatest focus to ensure the local patients and public co-produce the services in partnership with us.

If successful, the principles outlined earlier will be adhered to and will have sustainable General Practice and out of hospital services for many years to come that will support the improvement of the health and wellbeing of the people of Halton.

APPENDIX 1 HALTON IN NUMBERS

General Practice in Halton – fact file

The table below presents key facts on each of the 17 practices in Halton. The data included is valid at the time of producing this strategy.

Practice	Runcorn/ Widnes	Contract type	Population size	No of GPs	Pts per GP	No of nurses	Pts per Nurse	Training practice?	Nursing homes *
Brookvale	Runcorn	PMS	8,141	3	2,714	6	1,357	Y	7
Weaver Vale	Runcorn	PMS	9,149	6	1,525	3	3,050	Y	7
Heath Road	Runcorn	GMS	2,573	1	2,573	1	2,573	N	3
Grove House	Runcorn	PMS	10,677	5	2,135	3	3,559	N	7
Tower House	Runcorn	PMS	13,167	7	1,881	4	3,292	Y	9
West Bank	Widnes	PMS	2,473	2	1,237	2	1,237	N	5
Beeches	Widnes	PMS	7,857	7	1,122	3	2,619	Y	13
Hough Green	Widnes	PMS	3,503	2	1,752	1	3,503	N	5
Upton Rocks	Widnes	PMS	2,800	2	1,400	2	1,400	N	4
Appleton Village	Widnes	PMS	10,859	6	1,810	2	5,430	Y	11
Beaconsfield	Widnes	PMS	11,200	7	1,600	4	2,800	Y	14
Peelhouse	Widnes	PMS	14,140	6	2,357	4	3,535	N	10
Newtown	Widnes	PMS	8,026	4	2,007	3	2,675	Y	7
Oaks Place	Widnes	PMS	2,978	2	2,978	1	2,978	N	9
Castlefields	Runcorn	PMS	11,785	9	1,309	9	1,309	Y	8
Windmill Hill	Runcorn	APMS	2,024	2	1,012	2	1,012	N	3
Murdishaw	Runcorn	PMS	7,268	4	1,817	3	2,423	N	7
Totals			128,620	74	1,738	52	2,711		
					Av.				
						Av.			

Key:

Information obtained from a variety of sources

Contract ¹⁹	Detail
General Medical Services (GMS) contract	This is a nationally directed contract between NHS England and a practice. The new GMS contract was introduced in April 2004. Currently, about 60 per cent of practices nationally are on GMS contracts
Personal Medical Services (PMS) contract	This is a local contract agreed between NHS England and the practice, together with its funding arrangements. In England, approximately 40 per cent of practices nationally are on PMS contracts. The GMS contract has a strong influence on the content and scope of this contract.
Alternative Provider Medical Services (APMS) contract	This allows NHS England to contract with 'any person' under local commissioning arrangements

Training practice – a practice officially approved to teach and train GPs, Nurses and Medical Students

Nursing homes – the number of homes each practice had patients residing in. A snapshot audit undertaken in 2014

¹⁹ British Medical Association (2014),

General Practice in Halton - opening times (un-validated)

	Mon AM	Mon PM	Tue AM	Tue PM	Wed AM	Wed PM	Thur AM	Thur PM	Fri AM	Fri PM	Additional opening	Total hours
Brookvale	8:30 - 18:30		07:30 - 19:00		08:30 - 19:00		08:30 - 18:30		07:30 - 18:30			53.00
Weaver Vale	8:15 - 18:00		8:15 - 18:00		8:15 - 18:00		8:15 - 18:00		8:15 - 18:00		Mon 18:30 - 20:15	50.50
Heath Road	9:00-10:40	16:00-17:30	9:00-10:40	16:00-17:30			9:00-10:40	16:00-17:30	9:00-10:40	16:00-17:30		12.66
Grove House	8:15 - 18:00		8:15 - 18:00		8:15 - 18:00		8:15 - 18:00		8:15 - 18:00			48.75
Tower House	8:30 - 18:00		8:30 - 18:00		8:30 - 18:00		8:30 - 18:00		8:30 - 18:00			47.50
West Bank	8:30 - 18:00		8:30 - 18:00		8:30 - 12:00		8:30 - 18:00		8:30 - 18:00		Mon 18:30 - 20:00	41.50
Beeches	9:00-12:15	15:00-17:30	9:00-12:15	15:00-17:30	9:00-12:15	15:00-17:30	9:00-12:15		9:00-12:15	15:00-17:30		26.25
Hough Green	8:45 - 19:30		8:45 - 18:30		8:45 - 12:30		8:45 - 18:30		8:45 - 18:30			43.75
Upton Rocks	8:00-19:30		8:00-18:30		8:00-18:30		8:00-18:30		8:00-18:30			53.50
Appleton Village	8:30-12:45	13:15-18:00	8:30-12:45	13:15-18:00	8:30-12:45	13:15-18:00	8:30-12:45	13:15-18:00	8:30-12:45	13:15-18:00	Wed 18:30-19:15, Fri 7:00-8:00	46.75
Beaconsfield	8:30-18:30		8:30-18:30		8:30-18:30		8:30-18:30		8:30-18:30		Wed 7:00 - 8:00	51.00
Peelhouse	8:00-20:00		8:00-18:30		8:00-18:30		8:00-18:30		8:00-18:30			54.00
Newtown	9:00-20:30		9:00-18:30		9:00-18:30		9:00-12:00		9:00-18:30			43.00
Oaks Place	9:00-18:30		9:00-18:30		9:00-18:30		9:00-12:30		9:00-18:30			41.50
Castlefields	8:00-13:00	13:00-19:00	8:00-13:00	13:00-19:00	8:00-13:00	13:00-19:00	8:00-13:00	13:00-18:30	8:00-13:00	13:00-18:30	Sat 8:00 - 12:30	54.00
Windmill Hill	8:00-18:30		8:00-18:30		8:00-18:30		8:00-18:30		8:00-18:30		Sat 9:00-13:00, Sun 9:00-13:00	60.50
Murdishaw	8:00-18:30		8:00-18:30		8:00-20:30		8:00-18:30		8:00-18:30			53.50

Information sourced from practice websites and NHS Choices web sites.

General Practice in Halton - Enhanced Services

Practice	NHS England Enhanced Services																		CCG Enhanced Services				
	Alcohol	Learning disabilities	Dementia	Patient participation	Violent patient	Minor surgery	Avoiding unplanned admissions	Childhood flu	Hepatitis B (newborn babies)	Meningococcal C (Men C) Freshers	MMR (aged 16 and over)	Pertussis	Pneumococcal Child PCV	Pneumococcal Adult & At risk	Seasonal Flu	Shingles Routine	Shingles Catch-up	Rotavirus for infants	Extended hours	Unplanned Admissions DES Monthly MDTs	Anti-Coag Levels 1-4	Anti-Coag Level 4+	NPT
Brookvale	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Weaver Vale	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	N	Y
Heath Road	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y
Grove House	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Tower House	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
West Bank	Y	Y	Y	N	N	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y
Beeches	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y
Hough Green	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	Y
Upton Rocks	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Appleton Village	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Beaconsfield	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Peelhouse	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Newtown	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N
Oaks Place	Y	Y	Y	Y	N	Y	Y	Y	N	N	Y	Y	N	N	Y	Y	Y	N	N	Y	N	N	N
Castlefields	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Windmill Hill	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y
Murdishaw	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y

Information sourced from CCG Primary Care Commissioning Team

General Practice in Halton – IT summary

Practice	Clinical Sys.	Version	HIS/CCG Programme														
			GPSoC	COIN	VOIP	Docman	ICE Path	ICE Rad	Elg	EPS 2	SCR	Patient Partner	Medical Messenger	WiFi	BYOD	Win 7 Off 2010	EMIS IQ
Brookvale	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Castlefields	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	P	Y	Y	P	Y	Y	Y	Y	Y
Grove House	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	P
Heath Rd MC	INPS	Vision VES	Y	Y	N	Y	Y	Y	P	Y	Y	Y	Y	Y	Y	Y	n/a
Murdishaw HC	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	P	B	Y	Y	Y	Y	Y	Y	Y
Tower House	INPS	Vision VES	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	n/a
Weaver Vale	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	B	Y	Y	Y	Y	Y	Y	Y	Y
Windmill Hill	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	B	Y	Y	Y	Y	Y	Y	Y
Appleton Village	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y
Beaconsfield	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y
Beeches MC	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Newtown HCC	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	B	Y	Y	Y	Y	Y	Y	P
Oaks Place	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Peelhouse Medical Plaza	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hough Green Health Park	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Upton Rocks Primary Care	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	B	B	Y	Y	Y	Y	Y	Y
West Bank MC	EMIS	EMIS web	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

General Practice in Halton – IT summary

Information provided by the Health Informatics Service (HIS)

Key

Glossary

- GP SoC - GP Systems of Choice
- COIN - Community of Interest Network
- VOIP - Voice over Internet Protocol Telephony
- DOCMAN - Scanning System
- ICE - Pathology electronic ordering and results system
- ICE - Radiology
- Elg - Electronic Archiving and Retrieval system for Lloyd George records
- EPS2 - Electronic Prescribing solution
- SCR - Summary Care Record
- PP - Patient Partner - Automated telephony appt booking system
- MM - Medical Messenger Texting Service
- Wi Fi - Wifi connectivity in practice premises
- Windows 7 /Office 2010
- Emis IQ searches and reports - currently being activated

Key

Y	Live
N	Practice declined
B	Date Booked
P	Planning stage