Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group Governing Body Meeting In-Common

Date: Tuesday 3rd October 2017

Time: 13.30

Location: Clevedon Hall, Elton Road, Clevedon, BS21 7RH

Agenda item: 7.5

Proposal to establish a Locality Transformation Scheme in support of the implementation a new integrated community model in Bristol, North Somerset and South Gloucestershire (BNSSG)

Report Author: Justine Rawlings
Report Sponsor: Julia Ross

1. Purpose

The purpose of this paper is to set out, for approval, a BNSSG framework for implementing a new integrated community model. This model will be developed using a system wide population health management approach that secures collaborative and integrated ways of working through new, GP led models of care, based around General Practice.

2. Recommendations

The Governing Body is asked to:

Consider the proposed approach to developing the integrated model of care and to approve the proposed application of the Locality Transformation Funds (LTS) in support of that approach.

3. Background

The GP Forward View (GPFV) outlines a requirement for CCGs to carve out £3.00 per head of population (non-recurrent) from within their baseline allocation in 2017 to 2019 to create a "Primary Care Transformation Fund".

The investment can be spread across two years and is expected to stimulate the development of at scale providers for improved access, implementation of the 10

high impact actions to free up GP time and ultimately to secure sustainable general practice.
The Locality Transformation Scheme sets out how the BNSSG CCGs will apply these investments in support of developing the integrated model of community care in BNSSG.

Local context for developing the integrated community model of care is the BNSSG Sustainability and Transformation Plan (STP) which has set out a high level ambition for more care to be delivered in future within an integrated model of care, reducing reliance on acute care and bringing the system into balance.

The cornerstone of the STP model is of General Practice working at scale. The BNSSG CCGs' Primary Care Strategy also describes a vision for a resilient and thriving primary care sector and a future model of care in which groups of practices collaborate with other community provider organisations to provide integrated care and services for a defined population and geography.

The BNSSG CCGs are clear that to effect the scale of change required, such models need to be led and developed at a scale that both maximises the most effective use of resource to deliver the required outcomes and makes it possible for providers jointly to develop workable systems of care. The CCGs expect this to be at a locality level, representing populations of at least 100 000.

The transition from where we are today to a GP-led integrated community model of care by 2020/21 will require support to develop strong local GP leadership and joint working with other providers.

The CCGs wish to enable this work through a Locality Transformation Scheme (LTS), utilising the £3/head of population over 2 years that CCGs are required to carve out from within their baseline allocation and aligning the Improved Access Fund of £6/head of weighted population.

4. Financial/resource implications

These are set out in the body of the paper.

5. Legal implications

There are no legal implications arising from this proposal.

6. Risks/mitigations

The risks and potential mitigations are set out in the body of the proposal.

7. Implications for health inequalities

Development of locality models and plans will be subject to equalities impact assessments.

8. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

As above.

9. Consultation and Communication including Public Involvement

The development of the locality model and implementation plans will ensure appropriate and proportionate involvement and engagement of patients and the public.

10. Appendices

Appendix 1: Proposal to establish a Locality Transformation Scheme in support of the implementation a new integrated community model in BNSSG

Proposal to establish a Locality Transformation Scheme in support of the implementation a new integrated community model in BNSSG

1 Purpose

The purpose of this paper is to set out, for approval, a BNSSG framework for implementing a new integrated community model. This model will be developed using a system wide population health management approach that secures collaborative and integrated ways of working through new, GP led models of care, based around General Practice.

Specifically:

- **To outline the longer term commissioning approach to developing an integrated community model of care in line with national requirements and the local STP vision**
- **To describe the development of locality vehicles: groups of GP practices working together with clear governance and leadership**
- **To describe how this will facilitate the development of provider alliances to support collaborative working across the system**
- **To be clear as to how the CCGs will align available GPFV and other system investments to strengthen GP locality leadership in support**

2 Context

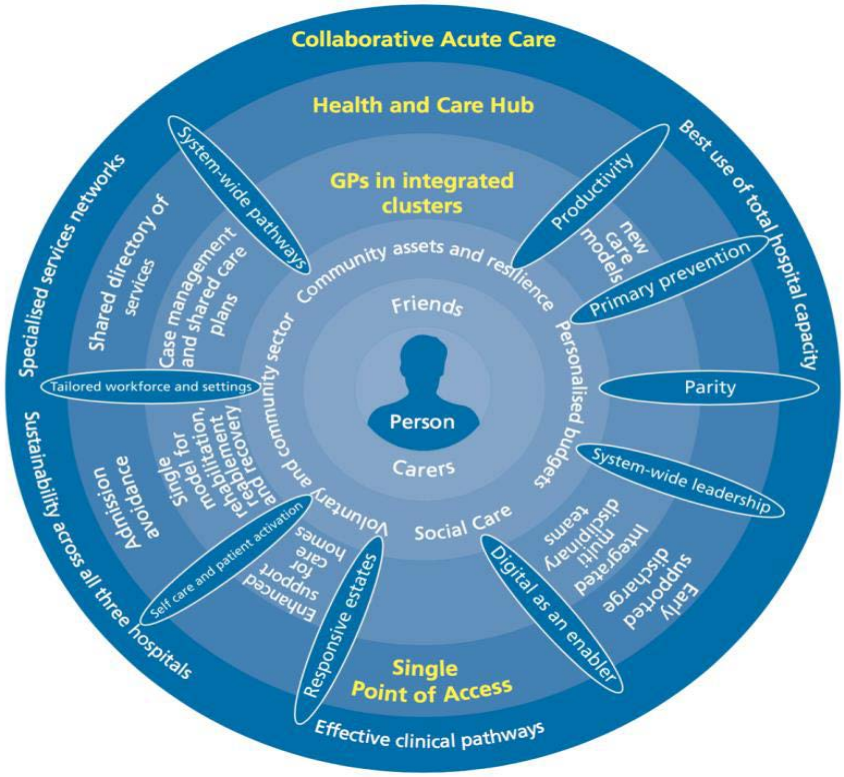
BNSSG CCGs have recently come together to develop a joint commissioning approach. The ambitions for commissioning in BNSSG are:

- To deliver high quality healthcare to our population based on local need
- To be excellent commissioners who lead the system across BNSSG
- To make the best use of our resources across BNSSG and live within our means
- To grow out of hospital care and support people to be well and independent in their communities

2.1 BNSSG STP vision and primary care strategy

Local context for developing the integrated community care model is the BNSSG STP which has set out a high level ambition for more care to be delivered in future within an integrated model of care, reducing reliance on acute care and bringing the system into balance.

Figure 1 STP model of care



The cornerstone of the STP model is of General Practice and General Practice working at scale. The BNSSG CCGs' Primary Care Strategy also describes a vision for a resilient and thriving primary care sector and a future model of care in which groups of practices collaborate with other community provider organisations to provide integrated care and services for a defined population and geography. Figure 2 below.

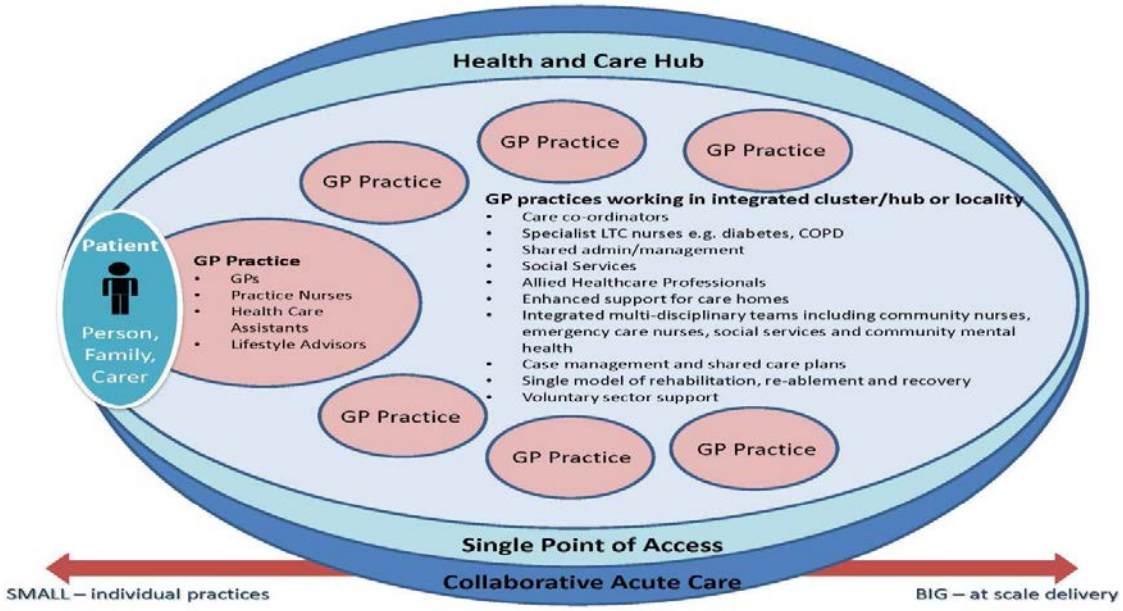


Figure 2 Primary Care Strategy model of care

2.2 Where we are now

Previously there has been work across BNSSG to establish more integrated ways of working and models of care, including:

- Strong multi- disciplinary cluster working in South Gloucestershire including the model of support to care homes and those who are frail
- Work on the North Somerset Sustainability Plan – setting out an integrated population based approach to place based transformation
- Locality clinical leadership in Bristol, including shared delivery of the Bristol Primary Care Agreement (BPCAg) which incentivised cluster and locality working
- Primary Care Home in South Bristol: developing new ways of working with community services
- Learning from the BNSSG wide provision of improved access in primary care facilitated by 2 years of the Prime Minister's Challenge Fund, coordinated by the BNSSG GP provider organisation, One Care Consortium (now Ltd) and delivered at a cluster level
- Development of a single EMIS platform, including sharing of care records in and out of hours
- Funding allocated to One Care Ltd to develop shared telephony
- Work on resilience plans at a GP practice cluster level based on a BNSSG wide stocktake, commissioned jointly by CCGs and NHSE and delivered by One Care and the Primary Care Foundation, of primary care demand and capacity
- Development of clinical models of care at individual CCGs and increasingly BNSSG level for key conditions

2.3 GP Forward View

NHSE and the CCGs have jointly led BNSSG wide delivery of the GP Forward View commitments and investments. As BNSSG CCGs take on this work in 2017/18 and have responsibility for designing the schemes, such as improved access, there is an opportunity to ensure that investments in General Practice are aligned in support of the integrated community model of care, as part of an overall strategic approach.

The GPFV sets out the national commitments to strengthen General Practice, supporting firstly a more resilient, sustainable core General Practice and secondly the care design and at scale working to deliver transformed primary care as part of a more integrated model. GPFV investment and support runs across workforce, workload, practice infrastructure and care redesign.

Whilst there is a clear link between resilience and longer term sustainability and integration, this paper is focussed on investment that can facilitate GP leadership within new models of care and the transformation of General Practice as part of the larger integrated model of care.

Resilience, sustainability and core General Practice support and investment

There is a separate piece of work underway to specify the ongoing BNSSG approach to delivering the national GPFV resilience programme, including the future deployment of change managers to work directly with practices on their resilience

plans, which in some instances may involve closer working or even merger with other practices.

Fundamental to this work is the development of a richer skill mix and new ways of working within General Practice. General Practice itself has led much of this work but this is also being supported in a number of other ways. Money has already been given to practices with which they can access training for care navigators. There have also been successful bids to secure clinical pharmacists in practices and smaller pieces of work commissioned by NHSE through One Care Ltd around recruitment and retention. The CCG has now recruited to a workforce post to develop further the workforce strategy.

There is some specific ETTF (Estates and Technology Transformation Fund) investment targeted at resilience but in the main this funding has been targeted at longer term transformation.

Transformation support

As part of the STP vision, CCGs are expected to have a clear, articulated vision of the care redesign[1] that will deliver transformed services. This should include details of the changes to be made to redesign services for improved outcomes.

CCGs are expected to carve out a total of £3 per head as a one-off non recurrent investment commencing in 2017/8, for practice transformational support. This is specifically aimed at [2]stimulating development of at scale providers for improved access, implementation of the 10 high impact actions to free up GP time and securing sustainability of general practice. This investment has been committed but not yet spent across BNSSG.

Improved Access

BNSSG General Practice, through One Care Consortium, originally developed improved access services as part of the national pilot scheme (Prime Ministers Challenge Fund). As a result, £6/ head of population (weighted) is now available to commission improved access. This requires commissioners to ensure that everyone has access to GP services, including sufficient routine and same day appointments at evenings and weekends to meet *locally determined demand,* alongside effective access to other primary care and general practice services such as urgent care services.[3]

This must be done in a way that meets national requirements for extended hours appointments (**Appendix 1)** but has also an aim of promoting transformation, integration and support to the wider system.

The total investment available from the Transformation and Improved Access Funds by locality and CCG is outlined in **Appendix 2.**

[1] NHS Operational Planning and Contracting Guidance for 2017-19 Annex ^ General Practice Forward View planning requirements 1.3

[2] NHS Operational Planning and Contracting Guidance for 2017-19 Annex ^ General Practice Forward View planning requirements 1.2.1

[3] As above 1.3.1

Estates and Technology Transformation Funding

BNSSG has obtained funding for a number of digital infrastructure projects in support of new models of care and new ways of working, including bids as follows:

- Document Sharing (Connecting Care) - £603k
- Personal Health Record (Connecting Care) - £1.025 million
- Radiography image sharing with GPs (Connecting Care) - £235k
- Electronic Palliative Care Coordination System (link to Connecting Care) - £530k
- One Domain for GP Practices - £759k
- OneCare telephony platform. - £2.5 million

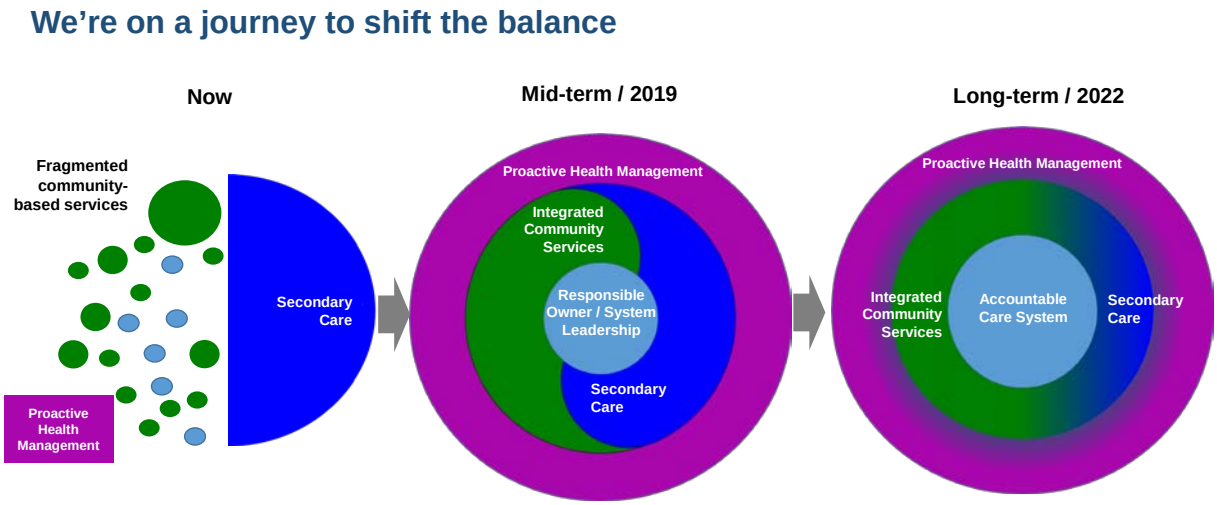
These projects will also actively support development of an integrated community model of care.

Investment has also been secured via the STP in support of developing closer working with the third sector (Building Health Partnerships) and by the Community Education Providers Network (CEPN) to provide education and training for clinical pharmacists, paramedics, general practice nurses and health care assistants as well as organisational development monies to support cluster multi-disciplinary team (MDT) working.

3 The integrated model

The BNSSG health and care system is currently on a journey: from a more fragmented and dis-jointed out-of-hospital provider environment, with insufficient focus on proactive health management, to a model where the out-of-hospital system and the secondary care system are more in-balance and working together in a more integrated and cohesive way, with strong central leadership and a focus on proactive health management across the entire system. This is illustrated in Figure 3 below

Figure 3



1

The immediate focus is on the creation of an organised, coordinated and effective out-of-hospital provider environment that is seen as the main conduit for meeting a person's health and care needs. This new out-of-hospital environment sees primary care, out of hours, community services, mental health, the ambulance service, the local authority and the third sector working much more collaboratively around a single, person centred care plan.

In the longer term, a more integrated model which supports an integrated, accountable care system is envisaged but the priority now is to bring together the currently fragmented community model, including general practice.

Different levels of collaboration will emerge across the out-of-hospital system. For example, certain services will be provided at a local GP Practice level, while for other services it will make more sense to provide them at cluster (30-50 000 population) /locality (100 000 population) level or at the next level up i.e. across multiple clusters/localities (referred to in the STP as supra-clusters) and across BNSSG.

3.1 Proposed principles for development

Collaboration is already taking place across the system in a number of areas. In North Somerset, this collaborative approach is starting to be formalised, providing a test bed for a BNSSG approach both to developing the collaboration but also to establishing a locality vision for implementation of a BNSSG integrated community model.

Building on the work done as part of the North Somerset Sustainability Plan, the following principles will be applied to commissioning and developing the integrated community model of care. It should:

- Be commissioned at a scale that maximises the most effective use of resources to deliver the required outcomes and to enable providers to develop workable systems of care - suggested to be at least 100k population
- Be driven by a systematic and evidence based assessment of population and patient need
- Make best use of existing resources (e.g. money, workforce, estates) to deliver required population outcomes
- Balance care between out-of-hospital care and secondary care to deliver the best outcome for patients within the resources available and ensuring funds follow the patient
- Promote proactive care and health management**,** keeping more people safe and well at home, encouraging independence and supporting them to take an active role in managing their own care.
- Integrate mental, emotional and physical wellbeing at all levels
- Integrate provision in and out of hours and across 7 days/week
- Enable full involvement and integration of social care, the independent sector, community and the third sector, recognising their unique contribution and expertise
- Enable innovation in developing the workforce to work in new ways and in new roles
- Maximise the use of technology and encourage and respond to patient and public digital literacy
- Focus initially on the few priority areas in each locality where change potentially has greatest impact for people and for resources

Within the STP there are several elements described as part of the integrated community model, which have tended to remain constant throughout various iterations and are as follows:

- GP practices working at scale (clusters or supra clusters)
- Supported self-care and social prescribing
- Integrated Multi-Disciplinary Teams (at practice, cluster and “supra-cluster” level), including care home support
- Integrated hubs including diagnostics and support for the most complex and acutely ill patients that do not require acute hospital care
- Early Supported Discharge, rehabilitation and reablement services
- Admission avoidance services including urgent assessment and rapid response

- Single Point of Access
- Supported by system wide agreed clinical pathways for key conditions or cohorts

Many of these services are currently provided within BNSSG but in a fragmented way, not always to a consistent level and often without the care coordination, shared care planning, trusted assessment and other shared processes and collaborative working specified within the BNSSG STP model for MDT working.

Work has also been done in the STP to define more closely cluster based MDT working component of the model. This has recommended a model of care based on GP practices who then work at scale, as part of an integrated, multi-disciplinary team sharing resources and capabilities to provide care at the appropriate level according to the needs of the individual. The model states that "general practice will offer a wider skill mix of clinicians and non-clinicians to support the GP to deliver services. GP practice staff will work with cluster colleagues to provide holistic care with care" It is also envisaged that some care is provided at "supra cluster" level for those services better delivered at a larger scale.[4]

The levels of care suggested within this model need to be tested against the commissioning context including population need and available resource (money, estates, workforce etc.)

In response to the STP design work, the BNSSG CCGs now need to use commissioner resources effectively to support and direct the implementation of this model.

It is clear that to effect the scale of change required, such models, need to be led and developed at a scale that both maximises the most effective use of resource to deliver the required outcomes and makes it possible for providers jointly to develop workable systems of care. The proposal is that should be at a locality level, representing populations of at least 100 000.

GP leadership is critical to the success of the model. GP leadership for the rest of the out of hospital system should enable the provision of higher acuity services in the community and rebalance service delivery between the out of hospital and with the acute sector by enabling people to stay in or quickly returning them to their normal place of residence.

Figure 4 below shows how this might work. In this model, most services are aligned directly to localities but with an intermediate or "supra cluster" element working across localities and the whole model is supported by integrated technology at scale (digital, telephony etc). There are only 3 localities shown here but there are likely to be 6 or 7 within BNSSG.

- 3 in Bristol
- 2 in North Somerset
- 1 or 2 in South Gloucestershire

[4] BNSSG Integrated Care Model (Cluster Based Multi-Disciplinary Team-Working)

Locality hubs are not assumed in this high level model to relate to any particular location, are yet to be defined and may differ in focus based on the commissioner context including specifically the key patient cohorts requiring this level of response in each area.

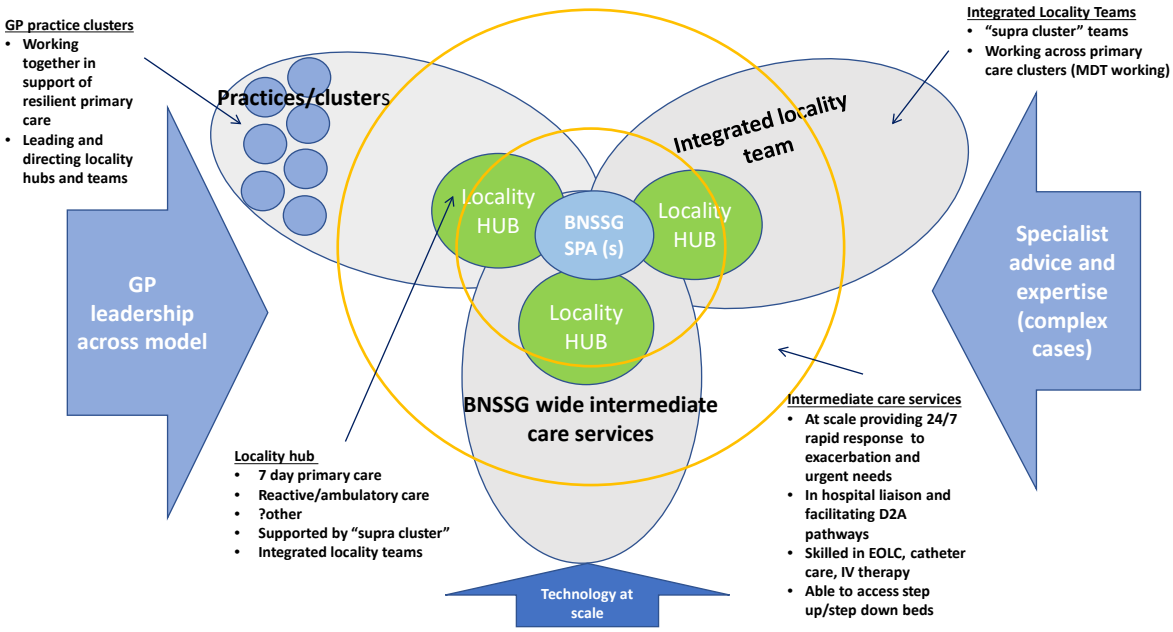


Figure 4

4 Delivering the change

Moving rapidly to the implementation of a BNSSG cohesive, integrated community model at a local level will require commissioners working collaboratively with providers in a phased approach.

This includes:

1. Supporting the development of GP leadership across the model
2. Aligning GPFV investments to support GP practices to work at scale with other providers
3. Working with providers to put together coherent business cases for their locality which can define delivery of the BNSSG strategy and model of care, within the resources available, for example: the key priorities for that locality; what care might be best delivered by a locality hub arrangement; location of any hub; how the role of General Practice can be expanded across the model in that locality
4. Fostering a collaborative provider environment that supports integrated provision of services centred around the individual, up to and including the establishment of a full Provider Alliance
5. Defining more closely the outcomes and any specific delivery requirements to be delivered by the providers involved in the integrated community model.

The CCGs will collaborate with providers in order to begin delivery of new models of care in 2017/18 and the first critical phase is to use GPFV investment, as intended, in support of this way of working.

4.1 GP leadership and locality transformation scheme (LTS)

The transition from where we are today to a GP-led integrated community model of care by 2020/21 will require strong local GP leadership, the resilience and sustainability of primary care and transforming primary care delivery through closer integration with other providers.

Enabling General Practice to lead in the design of this and also to engage in conversations with community providers is vital. General Practice needs the resource and headspace to consider how they will go about this. Building relationships and trust within a strong framework has been shown to gain the best results.[5]

The proposal is to enable this work through a Locality Transformation Scheme (LTS), utilising the £3/head of population over 2 years that CCGs are required to carve out from within their baseline allocation and aligning the Improved Access funding of £6/head of weighted population.

The scheme will support the establishment of "Locality Vehicles": an arrangement that allows commissioners to have a commissioning relationship with a GP Provider led, geographically based entity at a scale that supports best use of resources to deliver the required outcomes and enabling GPs to be strong partners in the design and delivery of the BNSSG integrated model of community care at a locality level.

4.1.1 Improved Access

Locality working also provides an opportunity to build on the experience of clusters locally in providing improved access requirements. **Appendix 1.** These are currently delivered via a contract with One Care Ltd. Improved access funding at £6/head of weighted population is intended to support general practice to provide greater access outside of non-core hours as per the national requirements.

The scheme allows for the current Improved Access contract to be devolved through localities from 1st April 2018. Commissioners will work closely with Localities and One Care Ltd to support the transition; including ensuring lessons are learned from the current model of provision.

Improved Access funding was also originally aimed at:

"testing innovative ways of increasing access and delivering wider transformational change in general practice. The fund will also support GPs to play an even stronger role at the heart of more integrated out-of-hospital services that delivers better health outcomes, more personalised care, and excellent patient experience." [6]

[5] The Kings Fund Commissioning and contracting for integrated Care Rachel Addicott November 2014

[6] NHSE Improving Access to General Practice: Innovation Showcase series. Effective Leadership. July 2015

The Transformation Scheme will enable practices to take on delivery of improved access at locality level and to consider how all available resources in the wider provider landscape might best be focussed to support it.

Nationally, Improved Access pilots have looked at a variety of elements that may meet specific population needs in an area, such as:

- The needs of a particular cohort - families with young children, deprived populations, those in care homes, populations who find it hard to access[7] services
- Extended weekday hours and urgent care at scale to support switching to longer appointments for those requiring more continuity of care based on an understanding of the need and preferences in an area
- Hub working, using estate and local resources efficiently including integrated working with out of hours services
- More systematic use of digital access e.g. skype, eConsult, remote access

4.2 Benefits of the scheme

The suggested benefits of these GPFV investments being spent in this way are:

- General Practice has support to develop leadership at a level that enables them to drive the required changes to community and other out of hospital services
- General Practice will be represented at significant meetings at a level likely to result in significant transformational change
- The scheme will facilitate developing the relationships, shared understanding of the issues and joint working arrangements required to make the model work
- The combination of a BNSSG wide consistent approach to the model and a locality population focus will drive confidence in the model across the system
- GP leadership can be secured as required across the whole model and, as a result, provide more flexible opportunities for the workforce
- Services can be designed that are more tailored to local needs and capacity
- Improved access investment can be stabilised, going to localities on a quarterly basis and enabling longer term planning of services
- Delivering the additional hours requirement at locality level, potentially in an integrated way with other providers including out of hours, should support capacity for delivery of other appointment types e.g. longer appointments to ensure continuity of care for those patients who need it
- Services can be designed that promote more integrated working as a locality with local community services including enabling joint approaches to workforce, estates etc.
- Duplication between out of hours and in hours General Practice can be prevented and integration promoted

[7] NHSE Improving access for all: reducing inequalities in access to general practice services 27 July 2017

- GP led localities can design the interface between NHS111 clinical hub and the GP appointments
- Digital elements of the model, including as part of Improved Access can be delivered collaboratively enabling at scale solutions

4.3 Scheme requirements

Please see **Appendix 3** for the details of the scheme, shared with General Practice.

The LTS has 3 main requirements phased over 2017/18 and 2018/19 financial years.

1 By 31st December 2017
£0.50 released up front to support delivery of the requirements for this phase.

GP Practices together to establish a Locality Vehicle to work at scale and with other relevant providers. This should include a business plan to provide the phase 1 requirements of the Improved Access scheme to be delivered from **1st April 2018**

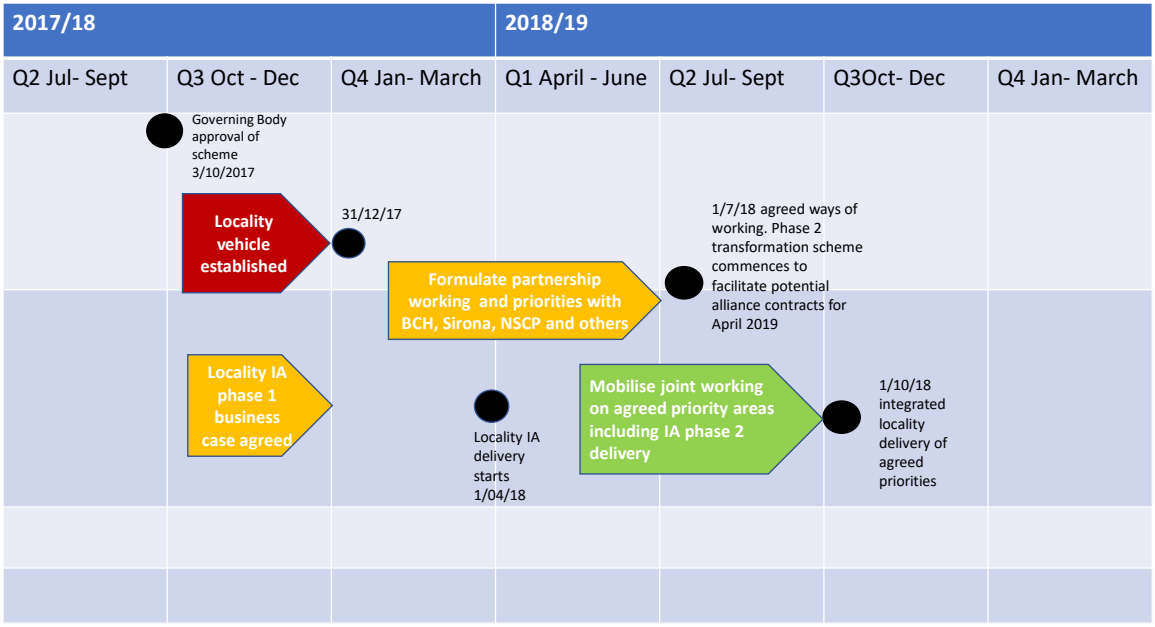
2 From January 2018 to 30th June 2018
£1.00 for this phase with £0.50 released on development of a plan detailing how locality GP practices and the community services provider will work together and £0.50 released on delivery of the other elements of this phase.

Locality providers to work in partnership with the community providers in each area to develop further the integrated community model of care. As a minimum, this should include developing the business plan to deliver improved access Phase 2 requirements. Work may also include other providers such as mental health, social care, VCSE and acute providers dependent on the emerging locality priorities and the current level of development in each locality.

3 **From 1st July 2018 to 31st March 2019**
A further £1.50 will be released for the remainder of 2018/19 for the continuation of this scheme based on evaluation of effectiveness and the development of next step milestones.

See the locality transformation scheme and Improved Access high level timeline below.

Locality transformation scheme timeline (including Improved Access)



It is proposed that Locality Vehicles will in future become the vehicles through which the CCG will direct all such investments.

Specific work to identify the current level and scope of enhanced services, some of which is targeted at supporting integrated working, is currently underway linked to work on delegated commissioning.

4.3 Commissioner support

As outlined above, localities will be able to use the Locality Transformation Scheme to source support. However, the commissioners will be key partners in the process.

In addition to investing in the development of locality vehicles and GP provider leadership, the commissioners will support providers by setting out the commissioner context and drivers in each locality for further development of the community integrated model of care.

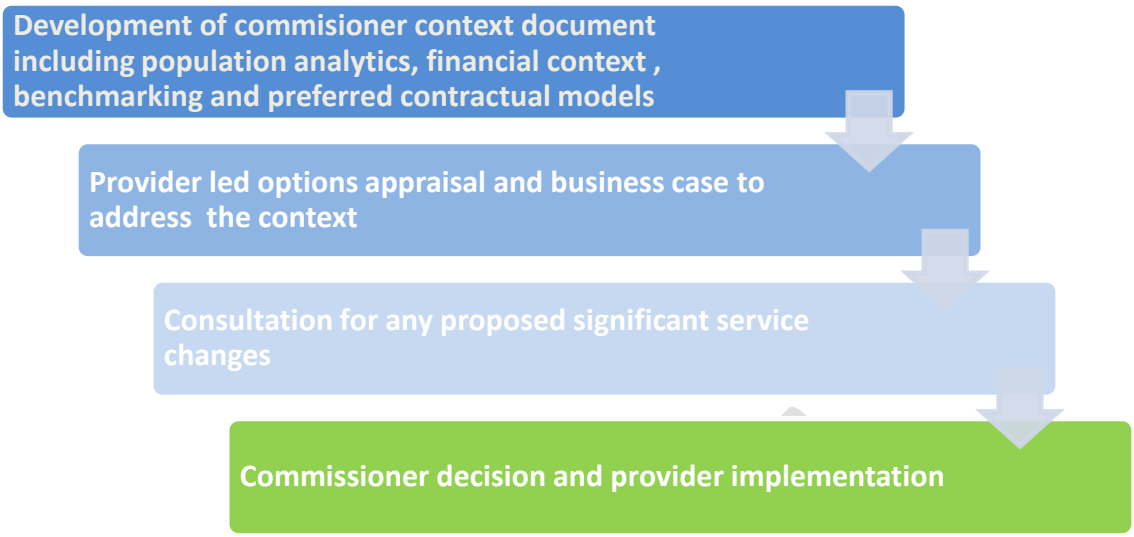
These contextual drivers include:

1 Local population need
2 The available financial resources for a given population now and into the future to make the model sustainable
3 An assessment of the current provider landscape and what needs to change and how
4 Benchmarked current outcomes for populations and any future required outcomes that are known,
5 The developing, longer term BNSSG commissioner vision in support of delivery including:

a. Further defining specific elements of the model and, with the BNSSG system, defining BNSSG clinical models of care for specific disease populations or groups (e.g. frailty, diabetes, mental health etc.)
b. Use of new collaborative and contractual models, levers and incentives in support of the integrated community model of care

6 Local priorities – whilst there is a consistent BNSSG approach as part of the STP and the BNSSG primary care strategy, more local population needs and services will impact the local delivery model of services

As locality vehicles develop and start joint working on key priorities, BNSSG CCGs will employ a consistent approach to commissioning and supporting development of the services that meet the local vision. This approach is being tested as part of the North Somerset Sustainability Plan and is followed within the commissioning context document. The key stages are set out below.



In summary, BNSSG CCGs will provide the following:

- Practical support to localities, specifically business support and intelligence and practice development support
- Clinical and managerial commissioning leadership and support including securing any GPFV national programme support available such as GP leadership development support.
- A clear BNSSSG design framework
- Clarity of process and decision making
- A locality commissioner context, including:
    - Population need and outcomes analysis
    - Financial analysis and benchmarking
    - Supply side analysis
    - Estates analysis and strategy
- Resilience support including change managers
- Strategic support in aligning community and other provider contracts as required (and gap analysis)
- Alignment of strategic programmes of work around estates, digital and workforce in support
- Close working with One Care Ltd to ensure alignment of the NHSE commissioned, ETTF funded telephony project and EMIS developments
- Public engagement and consultation support

4.4 New ways of working between providers

In the longer term, to move to local integrated care models that wrap around natural communities will require new ways of working between providers. These may range from a high-level Memorandum of Understanding agreement between providers, with a similar arrangement bringing in commissioners, all the way to the development of an Accountable Care System. **Appendix 4**.

However organised, CCGs wish to incentivise development of provider alliances noting that over time these will facilitate an outcomes based contractual agreement using a capitated payment model.

A range of contractual models are in use and being developed in the UK. The Kings Fund [8]suggested at the outset of this work that the three core aims of contract development for integrated care are:

- To hold providers to account for outcomes
- To hold providers to account for streamlining the delivery of patient care across gaps between service providers
- To shift the flow of money between providers.

The Kings Fund document notes that the challenge of establishing new contractual approaches should not be underestimated and can take a number of years to develop. The lessons highlighted are:

- It is essential to continually engage and communicate with providers, patients and the wider community to define the problem and identify appropriate solutions
- It will be important to develop transactional and relational approaches
- Payment mechanisms and incentives will need to be aligned across providers
- Providers will need to develop appropriate governance and organisational models (as providers will start to take on more accountability and risk)

The STP will be developing this longer term approach operating within a single system control total and moving to development of an Accountable Care System approach. The development of locality vehicles and the Locality Transformation Scheme is only the start of the development of new ways of working with providers to support integration but begins to address some of the above issues with a particular focus on leadership and collaboration in the out of hospital environment in the first place, where there is a clear and urgent need to promote a more cohesive provider environment.

[8] The King's Fund Commissioning and contracting for integrated care Rachel Addicott November 2014

5 Risks and mitigations

These are potential risks identified in delivering this approach – not in delivering new integrated community model of care

Risk/Concern	Mitigation
Speed and readiness for change • GP practices • CCG support	CCG resources need to be aligned rapidly to support but with a prioritised approach reflecting readiness of localities
The approach requires strong engagement with community providers and with GP practices. Community contracts are all in very different places and more or less aligned to the proposed direction of travel	Rapid work will need to be done to understand gaps and any key issues and develop relevant contract variations ahead of time
Willingness and capacity of all GP practices to take part	This will be the only route for this and future similar funds. Localities will be responsible for working across any gaps if practices do not take part
BI capacity and capability e.g. lack of a BNSSG population risk stratification tool	A standardised approach to be developed. A solution to risk stratification is required.
Weighted population allocation of the Improved Access funds may not sufficiently address access issues for more challenged practices with more challenging populations and so an opportunity missed if total amount goes to practices	CCGs could choose to top slice the amount to address any inequalities between localities if the issue is considered significant but this is probably better dealt with in the future iteration of improved access as part of a more outcome based approach
Opportunities to develop digital solutions at scale including developing BNSSG wide standardised data may be lost if localities do not choose to work with One Care Ltd in these areas.	The improved access business plans should be required to demonstrate value for money and integration with the overall system
Larger providers e.g. AWP may not have locality focus as a priority which may frustrate locality plans	Contract variations will need to be considered for providers other than community providers
Provider and commissioner savings programmes including Local Authority plans may be counter to longer term locality plans	Control centre plans should be reviewed in the context of the scheme
STP work focussed very closely on cluster based working including attracting CEPN funds in support and has built up a wide engagement and enthusiasm amongst those involved for proceeding which this proposal might be seen to ignore	CCGs leadership of the relevant aspects of the STP and assurance that design work done to date is being taken into account is being put into place

One Care Ltd has been established by practices to provide services at scale and be the provider voice and the establishment of locality vehicles may be seen as ignoring the stated wishes of BNSSG practices	The localities will be free to work with One Care Ltd and One care has already been alerted to the change in approach at a high level and recognise the direction of travel
BPCAg and similar schemes in other CCGs to facilitate elements of integrated working may be ending and there will be an assumption by practices that funding for these continues. The transformation scheme is one off funding and not equal in value to these pre-existing schemes so should not be seen as a substitute or replacement	The enhanced services including BPCAg will be reviewed separately as part of the work on delegated commissioning

6 Next steps

- The Locality Transformation Scheme (LTS) has already been discussed in detail and supported by the clinical leadership teams in the BNSSG CCGs
- The LTS has been shared in outline at meetings with the CCG GP Practice membership

Next steps are:

- Communication and discussion of the details of the LTS with practices and other stakeholders
- Formal Governing Body approval of approach and of the scheme
- Review of community contracts to assess the need for any significant contract variations (NB providers notified that a specification would be available by the end of October).

7 Appendices

1.1 Improved Access requirements
1.2 Release of Scheme funds
1.3 Scheme details
1.4 Progress to accountable care systems

Appendix 1.1

Improved Access Requirements[9]

In order to be eligible for additional recurrent funding, CCGs will need to commission and demonstrate the following:

Timing of appointments:

- commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day;
- commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs;
- provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week; and
- appointments can be provided on a hub basis with practices working at scale.

Capacity:

- commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population.

Measurement:

- ensure usage of a nationally commissioned new tool to be introduced during 2017/18 to automatically measure appointment activity by all participating practices, both in-hours and in extended hours. This will enable improvements in matching capacity to times of high demand.

Advertising and ease of access:

- ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity into the community, so that it is clear to patients how they can access these appointments and associated service;

- ensure ease of access for patients including:
  - all practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services
  - patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.

[9] NHS Operational Planning and Contracting Guidance for 2017-18. Annex 6 - General Practice Forward View planning requirements

Digital:

- use of digital approaches to support new models of care in general practice.

Inequalities:

- issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve in place.

Effective access to wider whole system services:

- Effective connection to other system services enabling patients to receive the right care from the right professional, including access from and to other primary care and general practice services such as urgent care services.

Appendix 1.2

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

Release of LTS Funds

Establish locality vehicle to work at scale including: • Clear governance, leadership etc • Plan for delivery of Improved Access (IA) at locality level from 1/4/18	31/12/2017	£0.50	Released up front to support delivery of key requirements
Joint working arrangements agreed with community providers IA phase 2 plan and plans for other joint priorities agreed	30/6/2018	£1.00	£0.50 on agreement £0.50 on agreement
Further implementation based on evaluation of effectiveness	1/7/2018 to 31/3/2019	£1.50	

Appendix 1.3

INFORMATION FOR GP PRACTICES

BNSSG Locality transformation scheme (LTS) for primary care collaboration

The GPFV outlines a requirement for CCGs to carve out £3.00 per head of population (non-recurrent) from within their baseline allocation to create a "Primary Care Transformation Fund".

The investment can be spread across two years and is expected to stimulate the development of at scale providers for improved access, implementation of the 10 high impact actions to free up GP time and ultimately to secure sustainable general practice.

Nationally £6/head of weighted population is made available to BNSSG CCGs for commissioning Improved Access. Currently, provision is secured via a contract with One Care Ltd, following their delivery (as One Care Consortium) of the Prime Minister's Challenge Fund

The Locality Transformation Scheme sets out how the BNSSG CCGs will apply these investments in support of developing the integrated model of community care in BNSSG.

1 Background and future direction.

Local context for developing the integrated community care model is the BNSSG STP which has set out a high level ambition for more care to be delivered in future within an integrated model of care, reducing reliance on acute care and bringing the system into balance.

The cornerstone of the STP model is of General Practice working at scale. The BNSSG CCGs' Primary Care Strategy also describes a vision for a resilient and thriving primary care sector and a future model of care in which groups of practices collaborate with other community provider organisations to provide integrated care and services for a defined population and geography. Figure 1 below.

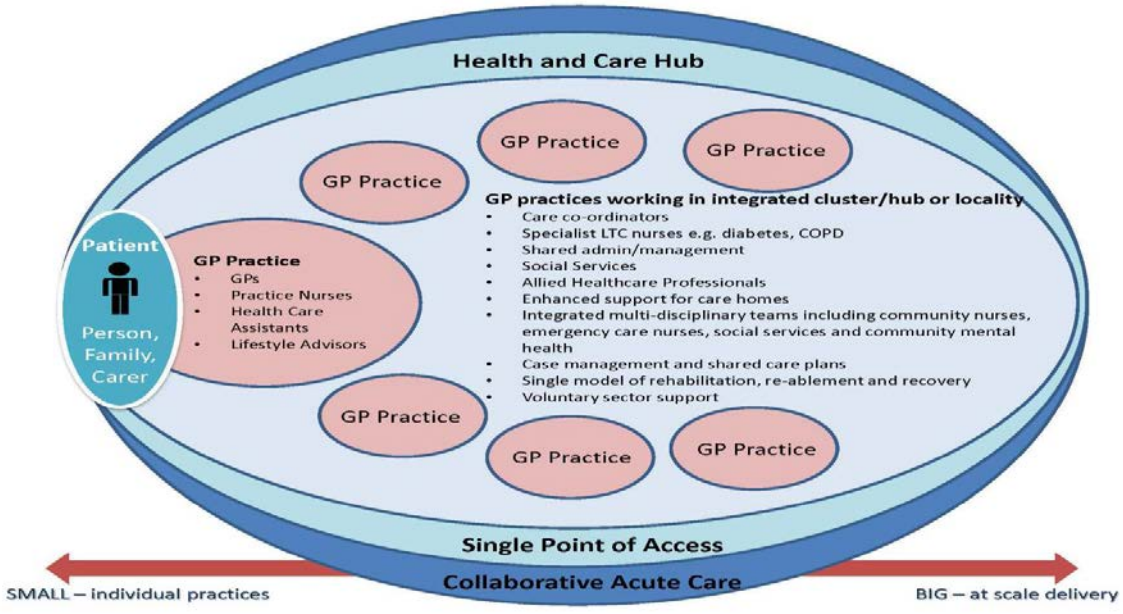
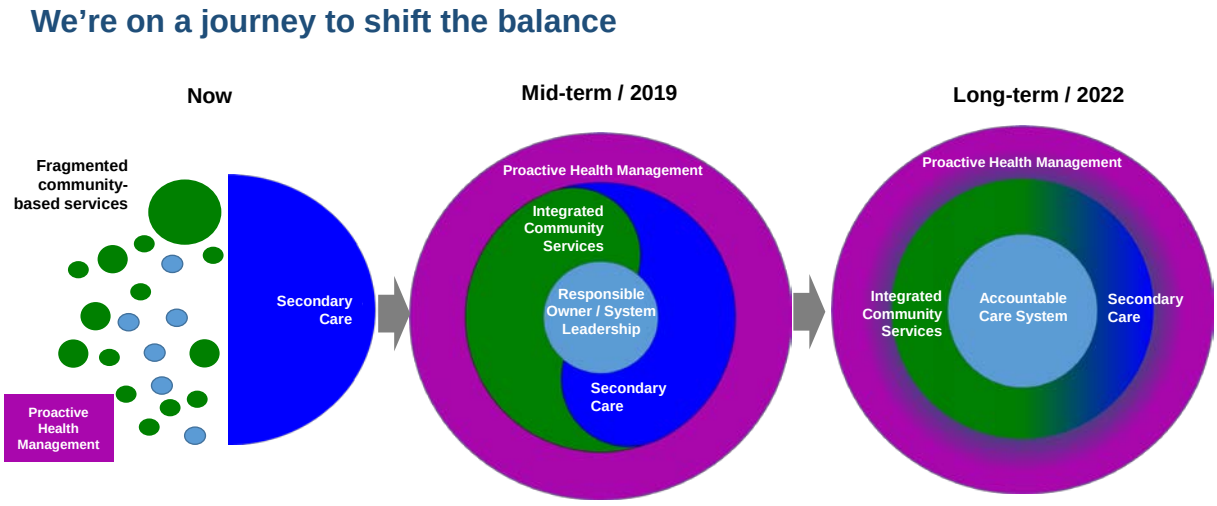


Figure 1 Primary Care Strategy model of care

The BNSSG health and care system is currently on a journey: from a more fragmented and dis-jointed out-of-hospital provider environment, with insufficient focus on proactive health management, to a model where the out-of-hospital system and the secondary care system are more in-balance and working together in a more integrated and cohesive way, with strong central leadership and a focus on proactive health management across the entire system. This is illustrated in Figure 2 below

Figure 2



The immediate focus is on the creation of an organised, coordinated and effective out-of-hospital provider environment that is seen as the main conduit for meeting a person's health and care needs. This new out-of-hospital environment sees primary care, out of hours, community services, mental health, the ambulance service, the Local Authority and the third sector working much more collaboratively around a single, person centred care plan.

In the longer term, a more integrated model which supports an integrated, accountable care system is envisaged but the priority now is to bring together the currently fragmented community model, including general practice.

Different levels of collaboration will emerge across the out-of-hospital system. For example, certain services will be provided at a local GP Practice level, while for other services it will make more sense to provide them at cluster (30-50 000 population) /locality (100 000 population) level or at the next level up i.e. across multiple clusters/localities (referred to in the STP as supra-clusters) and across BNSSG.

Within the STP there are other elements described as part of the integrated community model, as follows:

- GP practices working at scale (clusters or supra clusters)
- Supported self-care and social prescribing

- Integrated Multi-Disciplinary Teams (at practice, cluster and "supra-cluster" level), including care home support
- Integrated hubs including diagnostics and support for the most complex and acutely ill patients that do not require acute hospital care
- Early Supported Discharge, rehabilitation and reablement services
- Admission avoidance services including urgent assessment and rapid response
- Single Point of Access
- Supported by system wide agreed clinical pathways for key conditions

In response to the STP design work, the BNSSG CCGs now need to use commissioner resources effectively to support and direct the implementation of this model.

2 The integrated community model of care

The BNSSG CCGs are clear that to effect the scale of change required, such models, need to be led and developed at a scale that both maximises the most effective use of resource to deliver the required outcomes and makes it possible for providers jointly to develop workable systems of care. The CCGs expect this to be at a locality level, representing populations of at least 100 000.

GP leadership is critical to the success of the model. GP leadership for the rest of the out of hospital system should enable the provision of higher acuity services in the community and rebalance service delivery between the out of hospital and the acute sector by enabling people to stay in or quickly returning them to their normal place of residence.

Figure 3 below shows how this might work. In this model, most services are aligned directly to localities but with an intermediate or "supra cluster" element working across localities and the whole model supported by integrated technology at scale (digital, telephony etc.). There are only 3 localities shown here but there are likely to be 6 or 7 within BNSSG.

The transition from where we are today to a GP-led integrated community model of care by 2020/21 will require support to develop strong local GP leadership and joint working with other providers.

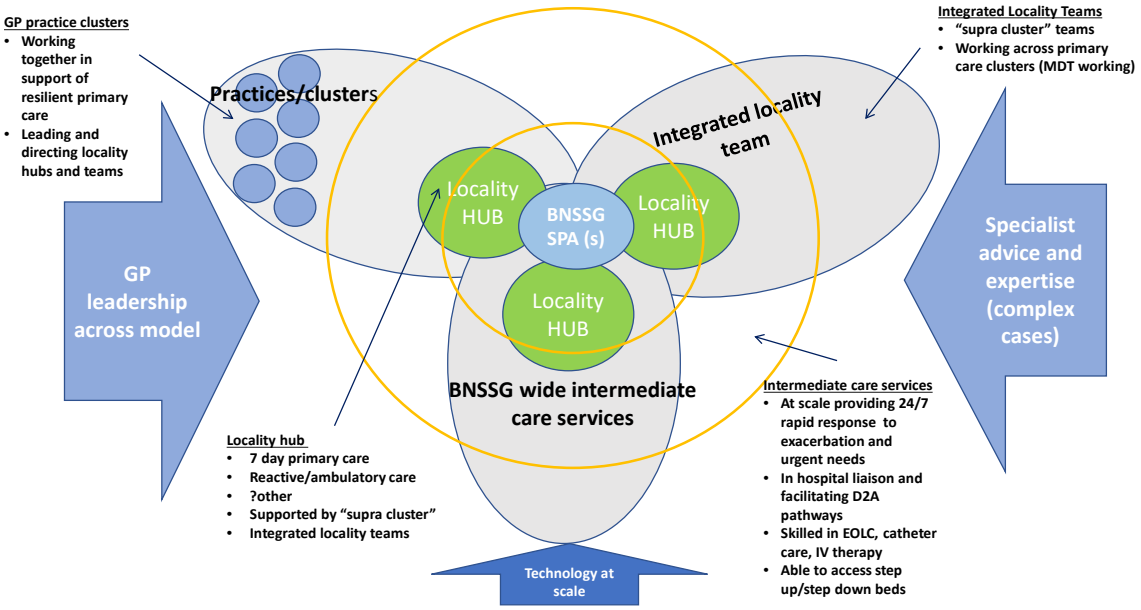


Figure 3

3 Locality Transformation Scheme

The CCGs wish to enable this work through a Locality Transformation Scheme (LTS), utilising the £3/head of population over 2 years that CCGs are required to carve out from within their baseline allocation and aligning the Improved Access funding of £6/head of weighted population.

The scheme will support the establishment of "Locality Vehicles": an arrangement that allows commissioners to have a commissioning relationship with a GP Provider led, geographically based entity at a scale that supports best use of resources to deliver the required outcomes and enables GPs to be strong partners in the design and delivery of the BNSSG integrated model of community care at a locality level.

The suggested benefits of this approach are:

- General Practice has support to develop leadership at a level that enables them to drive the required changes to community and other out of hospital services
- General Practice will be represented at significant meetings at a level likely to result in significant transformational change
- The scheme will facilitate developing the relationships, shared understanding of the issues and joint working arrangements required to make the model work
- The combination of a BNSSG wide consistent approach to the model and a locality population focus will drive confidence in the model across the system
- GP leadership can be secured as required across the whole model and, as a result, provide more flexible opportunities for the workforce
- Services can be designed that are more tailored to local needs and capacity
- Improved access investment can be stabilised, going to localities on a quarterly basis and enabling longer term planning of services

- Delivering the additional hours requirement at locality level, potentially in an integrated way with other providers including out of hours, should support capacity for delivery of other appointment types e.g. longer appointments to ensure continuity of care for those patients who need it
- Services can be designed that promote more integrated working as a locality with local community services including enabling joint approaches to workforce, estates etc.
- Duplication between out of hours and in hours General Practice can be prevented and integration promoted
- GP led localities can design the interface between NHS111 clinical hub and the GP appointments
- Digital elements of the model, including as part of Improved Access can be delivered collaboratively enabling at scale solutions

4 Scheme requirements

The LTS has 3 main requirements phased over 2017/18 and 2018/19 financial years.

1 By 31st December 2017
£0.50 released up front to support delivery of the requirements for this phase.

GP Practices together to establish a Locality Vehicle to work at scale and with other relevant providers. This should include a business plan to provide the phase 1 requirements of the Improved Access scheme to be delivered from **1st April 2018**

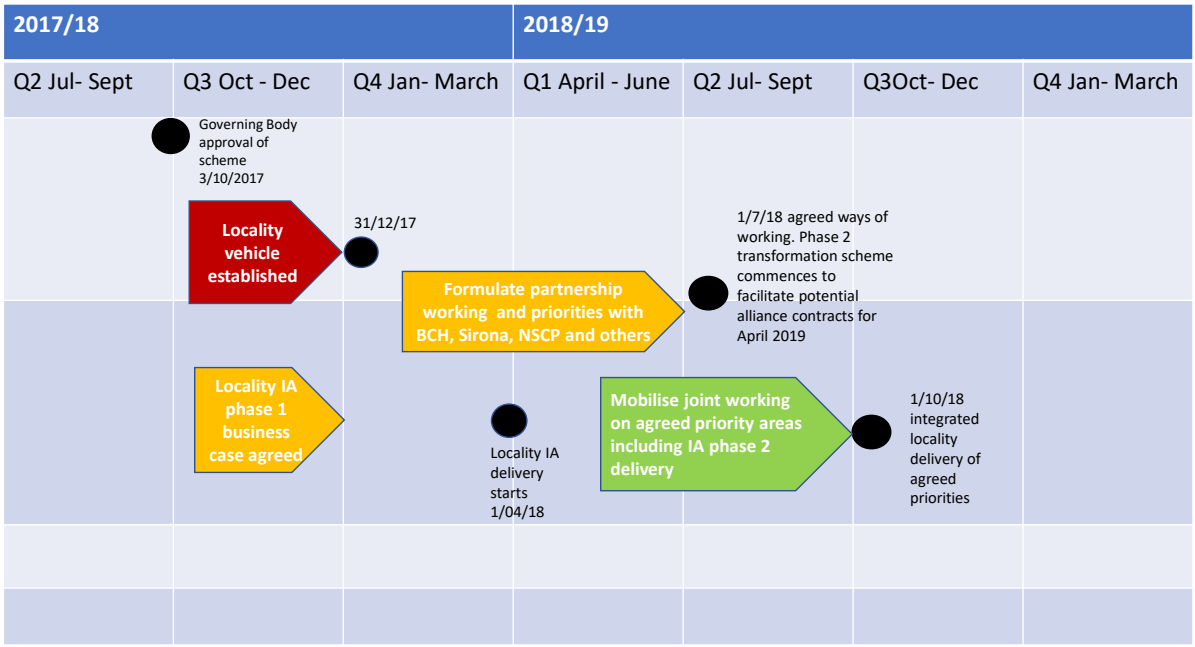
3 From January 2018 to 30th June 2018
£1.00 for this phase with £0.50 released on development of a plan detailing how locality GP practices and the community services provider will work together and £0.50 released on delivery of the other elements of this phase.

Locality providers to work in partnership with the community providers in each area to develop further the integrated community model of care. As a minimum, this should include developing the business plan to deliver improved access Phase 2 requirements. Work may also include other providers such as mental health, social care, VCSE and acute providers dependent on the emerging locality priorities and the current level of development in each locality.

4 **From 1st July 2018 to 31st March 2019**
A further £1.50 will be released for the remainder of 2018/19 for the continuation of this scheme based on evaluation of effectiveness and the development of next step milestones.

See the locality transformation scheme and Improved Access high level timeline below.

Locality transformation scheme timeline (including Improved Access)



5 Scheme requirements in detail

5.1 Locality vehicles

Practices and clusters will work together to agree a provider "Locality Vehicle". This vehicle will establish a single unified voice for the locality better enabling practices to work and make decisions together and for their views to be more effectively shared with providers to develop integrated models of care at this level. This vehicle can be informal such as an inter-practice agreement or a formal legal entity but will require:

- An agreed locality governance structure that sets out:
  - How locality lead GPs and representatives will be selected
  - How member practices will be consulted and engaged
  - How decisions will be made and ratified
- Identification of consistent locality representatives to participate in, for example, the development of integrated services, joint management boards and relevant STP forums, ensuring primary care involvement in the design of the future health and care system.
- Locality representatives capable of engaging members and mandated effectively to represent their views and interests from a provider perspective, to the wider health economy.
- A business plan for providing improved access at a locality level from 1st April 2018.

The minimum for Phase 1 Improved Access will be delivery of the national requirements, set out in **Appendix 1.** Locality Vehicles should cover at least 100 000 population to enable transformation funds to be deployed at a scale sufficiently effective to deliver the proposed integrated community model of care in a way that is sustainable.

Other arrangements for primary care at scale

The establishment of Locality Vehicles does not preclude practices from working as part of One Care Ltd, established to give General Practice a voice across BNSSG. The CCGs recognise that there may be benefits of working at this level to facilitate the development of an integrated model at Locality level.

Clusters and Primary Care Home

There has already been progress made at a cluster level across BNSSG in developing MDT and other innovative ways of working, including the Primary Care Home and the South Gloucestershire MDT cluster working and the STP sets out an expectation of the availability of MDT care coordination at a GP Practice and at cluster level. Localities may also choose to retain cluster level working, especially where this is already delivering clear benefits in terms of practice resilience.

Localities will identify and agree the role of any sub locality groups within the area and it will be the responsibility of the Locality Vehicle to manage its relationship with the sub localities, agree how any locality services are to be delivered and how their views will be represented.

The Locality Vehicle will be the primary vehicle for GP practice providers engaging with commissioners and other providers for those relevant services delivered by the locality, including those related to operation of the Improved Access Scheme, the application of any transformation funds and delivery of services operated at scale.

5.2 Joint working with community and other providers

Working with the relevant community services provider, the Locality will agree how community and GP services will work together to ensure the best use of both community provider and General Practice resources. The commissioner will require the Locality to work with the community providers to:

- Establish how Locality GP practices and the community services provider will work together and document this in a joint plan
- Agree arrangements for how GP practices and community providers may be able jointly to support challenging areas such as home visiting and care home support or other operational priorities in the locality
- Set out how the locality will work with community providers jointly to develop the locality operating model
- Agree a plan for delivery of Improved Access Phase 2 **from 1/7/28**

5.3 Development of business case for access to final tranche of transformation funding

Working with the support of the CCG and provider partners Locality Vehicles will build a business case to develop services using further transformation and improved access funding in the remainder of 2018/19 and beyond.

5.4 Improved access

Improved access funds – expected to be £6/head will be released to localities on a quarterly basis, from 1st April 2018, to ensure a stable funding stream for localities to embed this work. This will be dependent on localities satisfying the contract requirements that will be set out in response to the locality improved access plans.

The requirements of the scheme and Improved Access are set out in more detail below in the checklist and FAQ.

6 Finance

The summary of the release of funds to localities is set out below.

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

Release of LTS Funds

Establish locality vehicle to work at scale including: • Clear governance, leadership etc • Plan for delivery of Improved Access (IA) at locality level from 1/4/18	31/12/2017	£0.50	Released up front to support delivery of key requirements
Joint working arrangements agreed with community providers IA phase 2 plan and plans for other joint priorities agreed	30/6/2018	£1.00	£0.50 on agreement £0.50 on agreement
Further implementation based on evaluation of effectiveness	1/7/2018 to 31/3/2019	£1.50	

7 Support available

Localities will be free to use the funds to source expertise for developing their agreed provider vehicle and to meet any other enabling costs, providing the requirements of the scheme are met.

The CCGs will provide the relevant managerial and analytical expertise where required by localities in support of this scheme. The CCGs will also define in good time, the specific requirements for Improved Access phase 2. CCG support will include:

- Practical support to localities specifically business support and intelligence and primary care development
- Clinical and managerial commissioning leadership and support including securing any further GPFV national programme support
- A clear BNSSSG design framework
- Clarity of process and decision making
- A locality commissioner context, including:
    - Population need and outcomes analysis

    - Financial analysis and benchmarking
    - Supply side analysis
    - Estates analysis and strategy
- Resilience support including change managers
- Strategic support in aligning community and other provider contracts as required (and gap analysis)
- Alignment of strategic programmes of work around estates, digital and workforce in support
- Close working with One Care Ltd to ensure alignment of the NHSE commissioned, ETTF funded telephony project and EMIS developments
- Public engagement and consultation support as required

Improved Access Requirements[10]

In order to be eligible for additional recurrent funding, CCGs will need to commission and demonstrate the following:

Timing of appointments:

- commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day;
- commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs;
- provide robust evidence, based on utilisation rates, for the proposed disposition of services throughout the week; and
- appointments can be provided on a hub basis with practices working at scale.

Capacity:

- commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population.

Measurement:

- ensure usage of a nationally commissioned new tool to be introduced during 2017/18 to automatically measure appointment activity by all participating practices, both in-hours and in extended hours. This will enable improvements in matching capacity to times of high demand.

Advertising and ease of access:

- ensure services are advertised to patients, including notification on practice websites, notices in local urgent care services and publicity into the community, so that it is clear to patients how they can access these appointments and associated service;
- ensure ease of access for patients including:
  - all practice receptionists able to direct patients to the service and offer appointments to extended hours service on the same basis as appointments to non-extended hours services
  - patients should be offered a choice of evening or weekend appointments on an equal footing to core hours appointments.

Digital:

- use of digital approaches to support new models of care in general practice.

Inequalities:

- issues of inequalities in patients' experience of accessing general practice identified by local evidence and actions to resolve in place.

[10] NHS Operational Planning and Contracting Guidance for 2017-18. Annex 6 - General Practice Forward View planning requirements

Effective access to wider whole system services:

- Effective connection to other system services enabling patients to receive the right care from the right professional, including access from and to other primary care and general practice services such as urgent care services.

Locality Transformation Scheme with Improved Access: checklist

1 Locality vehicle established 31/12/2017

£0.50 per head of population released up front in support to meet the conditions below

1.1 Establish the Locality Vehicle as either a formal entity (e.g. a Federation) or an informal partnership, underpinned by an inter-practice agreement

1.2 Agree processes for selecting lead representatives and holding representatives to account on an on-going basis

1.3 Nominate lead locality representatives and any deputies

1.4 Agree process for engagement and consultation with practices

1.5 Establish rules for how locality decisions will be made and ratified

1.6 Define any sub localities and how their relationship with the main Locality Vehicle will work

1.7 Agree a plan for delivery of Improved Access to start **on 1/4/18**

2 Joint working with community providers

£1.00 for this phase with £0.50 released on development of a plan detailing how locality GP practices and the community services provider will work together and £0.50 released on delivery of the other elements of this phase.

2.1 Establish how Locality GP practices and the community services provider will work together and document this in a joint plan

2.2 Agree arrangements for how GP practices and community providers may be able jointly to support challenging areas such as home visiting and care home support or other operational priorities in the locality

2.3 Set out how the locality will work with community providers jointly to develop the locality operating model and identified priorities

2.4 Agree a plan for delivery of Improved Access Phase 2 **from 1/7/28**

Further transformation funding

Work with the CCGs and provider partners to develop a business case for further development of locality provision based on evaluation of effectiveness of this approach

£1.50 released on receipt of the business case

NB from 1st April 2018, the Improved Access funds will be released to Locality Providers on a quarterly basis provided the requirements set out above are met and the Locality delivers against the Improved Access requirements set out in Phase 1 and in Phase 2

Locality Transformation Scheme (LTS): FAQ

This document provides answers to some of the most common questions around the development of a new scheme to develop GP Localities with the capabilities to work at scale.

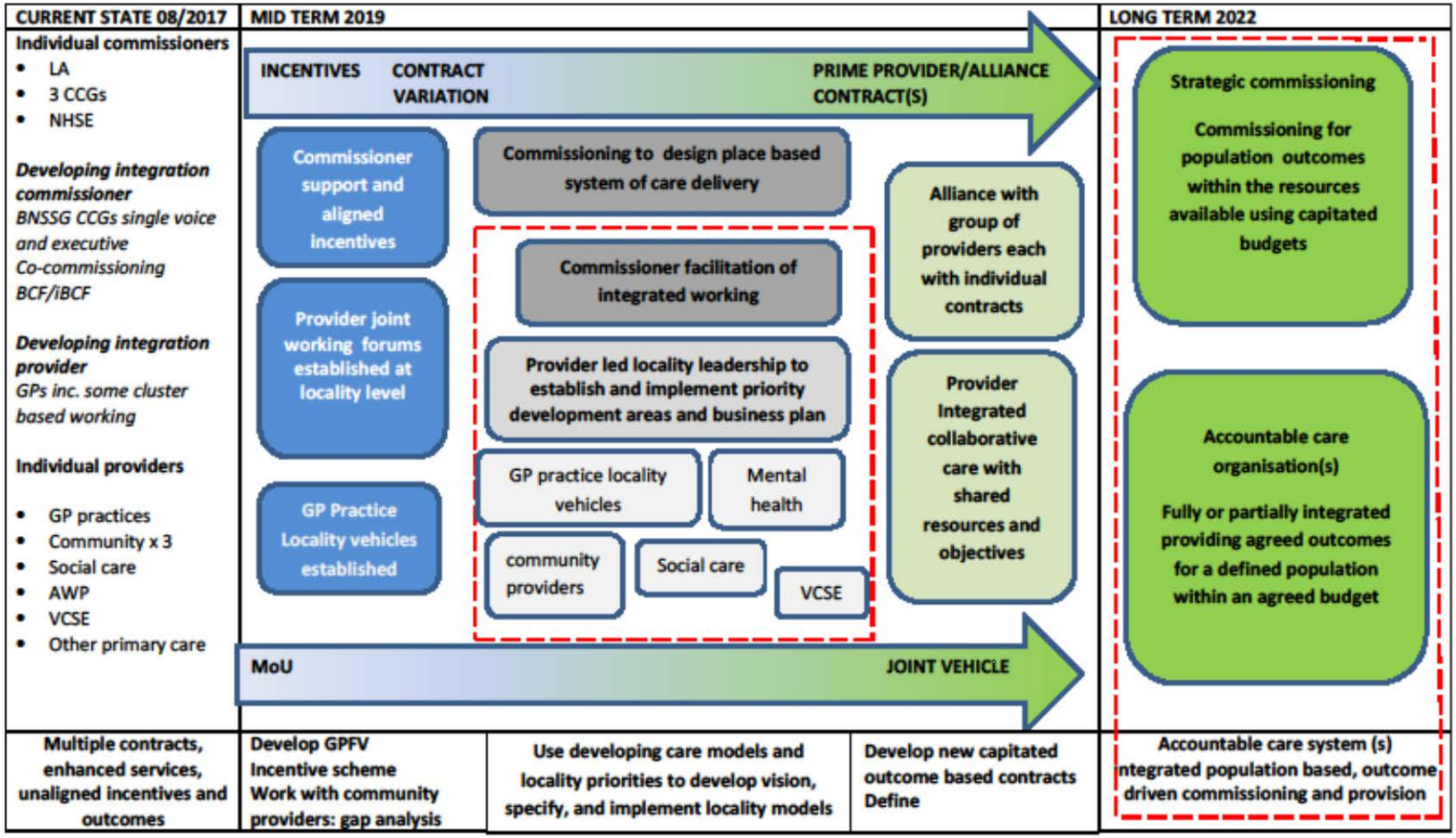
NB This will be developed further as implementation of the scheme progresses

Key Questions

1	**Do practices have to federate or form a new type of business vehicle**
	No. Localities are free to design the vehicle as they see fit. Some Localities may choose a formal federation, others may choose an informal partnership, underpinned by a Memorandum of Understanding or inter practice agreement. Any vehicle is acceptable as long as there are defined structures for leadership and set processes for how all practices are engaged and decisions made.
2	**Do practices have to contribute financially to set up of this vehicle**
	No. The transformation funding under the LTS is designed to support practices with the development of their vehicle. Practices are free to make additional contributions if they wish but at their own discretion
3	**Can funding through the LTS be used to source external support or expertise e.g. business management or legal advice**
	Yes. The Locality is free to use transformation funds to purchase expertise to support the development of their vehicle and to meet any other enabling costs, providing the requirements of the scheme are met for which the Locality Vehicle will be accountable.
4	**Can practices opt out of being a part of a Locality Vehicle?**
	Yes. Practices can opt out of a Locality Vehicle. However, it is likely that future transformation funds and newly commissioned services will be awarded on a Locality basis. In these circumstances funding will be provided to the Locality to deliver services on behalf of the whole population. The Locality may then agree an arrangement with the opted out practice(s) to provide an equivalent level of service, or may decide to provide the service at scale and offer it to the population of the opted out practice. This will be at the sole discretion of the Locality.
5	**Can localities use an existing vehicle as the basis for meeting the requirements of the LTS**
	Yes. Localities are free to use a pre-existing vehicle as long as the requirements of the LTS are met.
6	**Isn't this the role of One Care?**
	The models of care will need to be shaped to meet locality priorities. Provided the conditions are met, localities may choose to secure support from One Care where BNSSG wide working may bring clear benefits for patients, General Practice and for the wider system

7	**Why can't existing GP CCG leads carry out this role?**
	The CCGs represent the local population and member practices as commissioners and are responsible for sourcing the highest quality services for local people within the resources available. The CCG cannot represent Localities and Practices as providers.
8	**How will Localities develop joint working with community providers?**
	Integrated working with community providers is developed to a greater or lesser degree across BNSSG with some very good existing examples of joint working. The Locality will need to define joint working in partnership with community providers in each area. The CCGs will provide support and guidance as required.
9	**How do sub localities work and does the Locality have to have them?**
	Establishing sub localities – most commonly known as clusters in BNSSG is an option available to the Locality Vehicle at their discretion. The Locality Vehicle will be responsible for managing internal arrangements with the sub-locality. A Locality Vehicle may choose to have no sub localities at all.
10	**How will lead GP representatives be identified? Can Localities also nominate deputies?**
	This process is for Locality Vehicles to design and agree upon. Localities may choose to nominate deputy representatives but any deputies will be expected to be fully briefed and able to make decisions on behalf of the locality. Where deputies are nominated they should be consistent to ensure proper continuity of discussion and decision making in the groups in which they participate.
11	**What is the likely time commitment required for GP representatives?**
	The CCG will provide a schedule of key strategic forums where strong Locality representation is required. Lead representatives will also need to allow time to engage their member practices and provider partners outside these forums.
12	**How will the Locality Vehicle make, approve and ratify decisions?**
	It is for the Locality to define how decision making processes work. However, the locality's representative must be able to make decisions on behalf of member practices and represent their views when interfacing with other senior system leaders, providers and the CCGs.
13	**How will the development of the business case(s) for Improved Access work**
	The CCGs will set out clearly any requirements over and above the attached national requirements in good time, including reporting and monitoring requirements. It is envisaged that the first phased of delivery from 1st April 2018 will be to deliver as a minimum an integrated Locality approach that provides the required hours and access at a locality level.
14	**What support will Locality Vehicles have from the CCGs**
	The CCGs will work collaboratively with localities to ensure they are successful. They will ensure clear, timely information and support. However, when it comes to developing and implementing more detailed plans there may be priority

	localities to which more significant resource will be allocated in the first instance. Examples might be where there is a significant estates issue requiring more urgent resolution.
15	**How will business cases be agreed**
	The CCGs will provide a standard format for the business case and provide managerial and analytical support to the development of proposals where this is requested. The CCGs will set out transparent criteria for the agreement of business cases in advance. Its s expected that business cases will comply with any relevant technical guidance and will be expected to set out tangible quality and efficiency benefits for the wider system.
16	**How will the localities know the CCGs' requirements for an integrated a model of care**
	The model is developing, based on design work being done across the system. The outline BNSSG approach is set out in the details of the scheme above and any further guidance or requirements e.g. in support of a particular clinical pathway will be made clear as they become available.
17	**If the practice already provides hours outside of core hours but not in the evenings or weekends because it suits patients will they now have to stop to fulfil Improved Access requirements?**
	No. Localities should fulfil the national requirements but also continue to ensure the local flexibility to suit their patients' needs


CURRENT STATE 08/2017
MID TERM 2019
LONG TERM 2022
Individual commissioners
LA
3 CCGs
NHSE
Developing integration commissioner
BNSSG CCGs single voice and executive
Co-commissioning
BCF/iBCF
Developing integration provider
GPs inc. some cluster based working
Individual providers
GP practices
Community x 3
Social care
AWP
VCSE
Other primary care
INCENTIVES
CONTRACT VARIATION
PRIME PROVIDER/ALLIANCE CONTRACT(S)
Commissioner support and aligned incentives
Provider joint working forums established at locality level
GP Practice Locality vehicles established
Commissioning to design place based system of care delivery
Commissioner facilitation of integrated working
Provider led locality leadership to establish and implement priority development areas and business plan
GP practice locality vehicles
Mental health
community providers
Social care
VCSE
Alliance with group of providers each with individual contracts
Provider Integrated collaborative care with shared resources and objectives
MoU
JOINT VEHICLE
Strategic commissioning
Commissioning for population outcomes within the resources available using capitated budgets
Accountable care organisation(s)
Fully or partially integrated providing agreed outcomes for a defined population within an agreed budget
Multiple contracts, enhanced services, unaligned incentives and outcomes
Develop GPFV Incentive scheme
Work with community providers: gap analysis
Use developing care models and locality priorities to develop vision, specify, and implement locality models
Develop new capitated outcome based contracts
Define
Accountable care system (s) integrated population based, outcome driven commissioning and provision