	Business Case	Project Stage **Define**

Project Name	2C GP Practice Remodelling	**Date**	09.11.20
Project Reference No.	HSCP.20.049	**Governance Programme Board(s)/ IJB**	Executive Programme Board / IJB
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1. Summary of Project

This project seeks to remodel the six 2C General Practices in Aberdeen City to provide a sustainable model of service delivery that is person centred, takes cognisance of the learning and serviced delivery changes from the COVID pandemic, is high quality, affordable, and in line with the new GMS contract, the Primary Care Improvement Plan and the Partnership's Strategic Plan.

2. Background

3.1. In Primary Care, there are several different kinds of contract that a GP practice can have, which are outlined below:

	Explanation	Managed By	Aberdeen City #
17J	A 'Section 17J' or 'GMS' (General Medical Services) practice is one that has a standard, nationally negotiated contract.	GP Partners	17
17C	A 'Section 17C' practice (formerly known as 'Personal Medical Services' or 'PMS' practice) is one that has a locally negotiated agreement, enabling, for example, flexible provision of services in accordance with specific local circumstances.	GP Partners	5
2C	In general terms, this is most likely to mean that the practice is run by the NHS Board.	ACHSCP / NHSG	6

3. Business Need

2.1 Project rationale

The challenges faced by health and social care systems due to increasingly trying financial and epidemiological factors contributing to increasing demand are well documented. These include (but are not limited to):

1) Population increases (the figure below predicts an increasing population in Aberdeen City over the next 30 years, meaning there will be more people needing to be cared for)

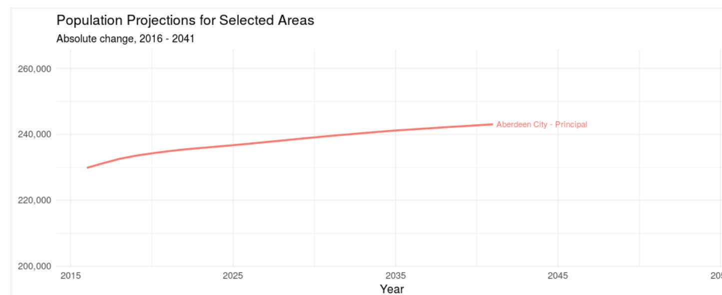
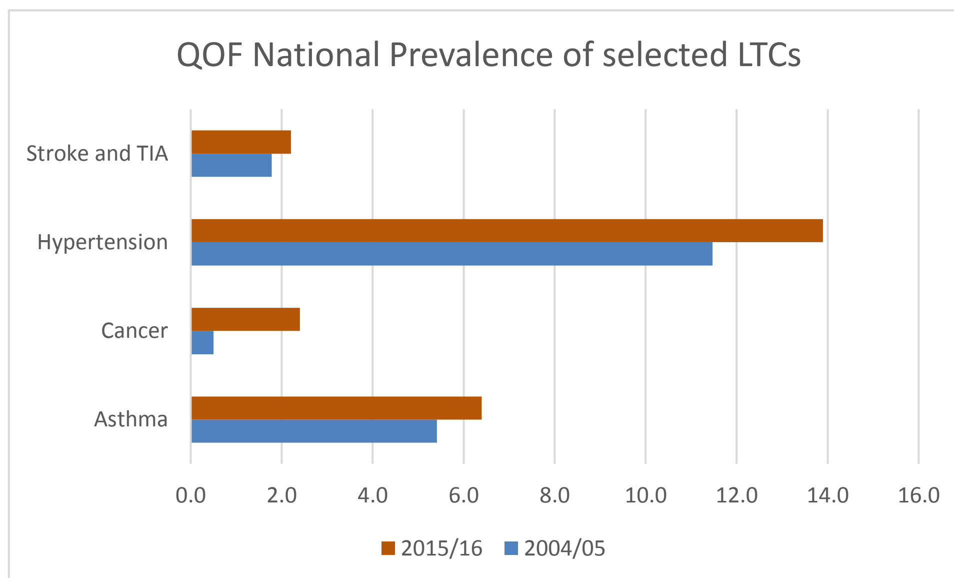


Figure 1. Aberdeen City Population Projections (Source: ISD)

2) Complexity (the figure below demonstrates the national rise in incidence of long-term conditions, meaning people are living with more complex needs, thus requiring more complex care)



3) Workforce Such challenges are exacerbated in General Practice, where most people interact with health and social care services in the first instance. Moreover, the

proportion of GPs between the ages of 55 – 64 leaving General Practice doubled from 2005 – 2014[1], resulting in a reduced workforce to undertake the required interventions. Locally, a declining number of GPs are evident.

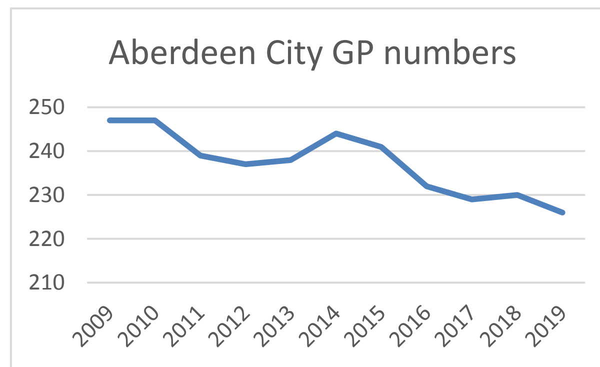


Figure 1. Aberdeen City GP numbers. Source: ISD

4) Sustainability: increasing demand; complexity and workforce challenges are resulting in increasing unsustainability across Aberdeen City, as evidenced in the 2019 Practice Sustainability Study (summary below)

High risk	>70
Medium Risk	50-70
Low risk	<50

Practice	Score 2019	Score 2017	Locality
REDACTED	135	61	Central
REDACTED	118	63	Central
2C Practice	113	69	Central
2C Practice	108	83	South
REDACTED	106	70	Central
2C Practice	90	52	South
2C Practice	88	75	North
REDACTED	87	75	North
REDACTED	86	77	North
2C Practice	85	67	North
REDACTED	85		Central
REDACTED	84		Central
REDACTED	83	57	Central
REDACTED	78	36	South
REDACTED	78	81	North
REDACTED	74	84	North
REDACTED	72	78	Central
REDACTED	71		South
REDACTED	70	66	South
REDACTED	70	38	North
REDACTED	64	76	Central
REDACTED	57	55	Central
REDACTED	53	77	Central
REDACTED	49		South
REDACTED	49	66	North
REDACTED	45	45	South
2C Practice	32	71	Central
REDACTED	29	50	Central

[1] Baird, B. et al. (2016). Understanding pressures in general practice. The King's Fund, London.

A key objective for this project is to support delivery of ACHSCP's strategic direction for primary care, as set out in documents such as the most recent General Medical Services contract[2] and Primary Care Improvement Plan. These highlight opportunities to transform how General Practice is delivered, emphasising that more of the same will not adequately address the aforementioned challenges.

2C Practice in Aberdeen City

In Aberdeen City, there are six 2C General Practices managed by ACHSCP and NHS Grampian, with a legal responsibility to provide a General Medical Service to these specific practice populations. The key characteristics of these practices are detailed below:

Table 1. Characteristics of the 2C Practices in Aberdeen City

2C Practice	Practice Postcode	Locality	SIMD Quintile	Practice Population	% Practice Population >65 years	GP Staff Hours per week	GP Staff Hours per week per 100 patients
Camphill	AB15 9EP	South	5	1854	15%	92	5.0
Carden	AB10 1UT	Central	5	8867	17%	244	2.8
Marywell	AB11 6FD	Central	2	226	0%	24	10.6
OAMP	AB24 3NG	North	5	11011	2.2%	213	1.9
Torry	AB11 8ER	South	4	6842	9.7%	40	0.6
Whinhill	AB11 7XH	Central	5	7026	13.8%	153	2.2

Aberdeen City has a higher proportion of 2C practices, some of which have remained 2C for a long period of time (21% of our total GP practices, compared with 4% nationally). This is different to other HSCP areas, where the 2C model is deployed to ensure continued provision of medical services to a population when an existing practice becomes unsustainable.

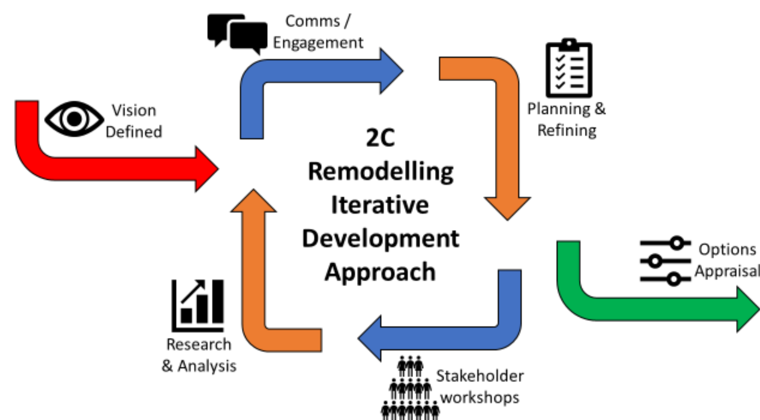
The funding context delineated in the medium term financial framework (available here) resulted in a revision of the Leadership Team's objectives on 7th January 2020 to address this; one of which being the focus of this paper (objective to "*A redesign of 2c practices to*

[2] Scottish Government. (2018). The 2018 general medical services contract in Scotland. Scottish Government, Edinburgh.

deliver a sustainable service based on patient profile, population needs assessment and available resource”). This was agreed by the IJB in March 2020.

2.2 Development to date

The options presented in Section 4 to deliver this project have been developed using a multi-stage, iterative approach (visual provided below). There were numerous components within this process that occurred in a cyclical nature (though it is important to realise that these are not necessarily sequential and often occurred frequently until the necessary outcome was achieved). A key stage in development was the inclusion of an internal proposal from 2C Practice staff following the initial stakeholder workshops.



<u>Comms / Engagement</u>

Ensuring that the appropriate stakeholders are engaged with at the appropriate times using the appropriate methods during the development phase was a priority. This included (but was not limited to):

- Regular contact with 2C Practice Staff (such as email; Microsoft Teams and some face-to-face meetings within Practices and briefings before and after workshops)
- Colleagues from HR, Trade Unions and GP Sub / LMC (to ensure awareness of the process and to highlight any unintended consequences / further considerations to be aware of)

<u>Planning & Refining</u>

The options presented in Section 4 are the result of three stakeholder workshops held with 2C Practice Staff, and an additional internal proposal received after these workshops. An outline structure for each of these workshops were developed and refined by a project team and members of the 2C remodelling panel, this was evaluated and altered accordingly following discussions and outputs of subsequent workshops, in addition to ongoing research and analytical work. Workshops had representation from the 2C Practices and other stakeholders of interest, such as HR, Trade Unions and GP Sub / LMC.

<u>Stakeholder workshops</u>

The purpose and function of each workshop were:

Workshop 1	Workshop 2	Workshop 3
The first workshop presented the rationale for change; gathering perspectives on immediate and short-term improvements and gathering concerns about the process of change.	The second workshop reviewed and addressed immediate and short-term improvements and initial concerns, followed by assessing advantages and disadvantages of longer-term models.	The final workshop presented revised models based on 2C Practice Staff feedback and included a Q&A with Leadership Team representatives from the Partnership so staff could directly ask any outstanding queries they had.

Workshops were recorded and circulated to all 2C Practice Staff in the instances that some would be unable to attend.

Research & Analysis

Data collection and analysis has underpinned the process. Examples of this include:

- Desktop research to understand innovative models of General Practice implemented elsewhere, along with understanding the key principles required to implement an effective General Practice service that will be sustainable to meet the demands of the future
- Developing and distributing data collection methods to shape the future direction of the process (such as inviting 2C Practice staff to share their own innovative ideas for different ways of working and ranking the options provided by colleagues). Note – the preferences of the 2C Practice staff have been integrated into the scoring process in Section 4.1[3].

This approach, combined with the lived experience of those working in General Practice, allow a triangulated process that minimises bias. The culmination of these workshops were the identification of short-term improvements that can be implemented regardless of the outcome of this business case.

Short Term Improvements

During the first workshop, 2C Practice staff were invited to put forward ideas suggestions for improvements that could be made in the short-term, regardless of what option was put forward in this business case. Thematic analysis of this feedback indicated three key areas that were suggested to be progressed:

[3] It should be acknowledged that some 2C Practice Staff chose to abstain from voting. The two main reasons for this was the length of the development process (deemed too short) and the information provided on each of the options (deemed not specific enough).

Short-term Theme	Descriptor	Example feedback from 2C Practice Staff
Flexible workforce	The ability to utilise different staff to cross-cover with other Practices	"*Alignment of medical staff to days that practice has heaviest workload*".
Streamlined systems and processes	Standardising the use of electronic systems and different working processes across all Practices	"*Need to think about access to clinical systems … any possibility of amalgamating some / all of them?"*
Shared use of resources	Understanding how as a collective, Practices can support each other.	"*It would be helpful to have a grouping with another 2C Practice so that we could support each other*".

Whilst the preferred option described below is ongoing, these themes and the options offered up by staff during the workshops will be explored further to understand initiatives that can be mobilised in the short and medium term to improve efficiencies in service delivery.

4. Objectives

1. Ensure the chosen option can be achieved with limited adverse impact on staff / patients
2. Ensure service continuity whilst remodelling
3. Develop a future-proofed model that will mitigate against the increasing epidemiological and recruitment challenges
4. Develop a future-proofed model that will mitigate against the increasing financial challenges
5. Facilitates the implementation of shared resources, cross-practice working and supporting resilience (as per the Scottish GP contract 2018)
6. Has a direct link to the ACHSCP Strategic Plan

5. Options Appraisal

Option 1 – Do Nothing / Do Minimum	
Description	Continue the status quo of the six 2C General Practices functioning as individual General Practices.
Expected Costs	There are no additional costs associated with the implementation of this option, however existing budget pressures would not be addressed (for example locum use) and this option would not mitigate against increasing demand placing resulting in increasing financial pressure.
Risks Specific to this Option	There is a risk that this option will not prepare 2C General Practices for the future and current epidemiological, financial and workforce challenges highlighted previously, resulting in increasing unsustainability and a service which is not fit for purpose. **IJB Strategic Risk Register:** this option does not help the Partnership mitigate against any of the risks as identified in the Strategic Risk Register (see appendix 3).
Advantages & Disadvantages	Advantages • Causes minimal disruption to staff • Requires minimal resources to implement Disadvantages • Will require ongoing and increased Primary Care team support for the operational delivery of six, separate 2C Practices. • No benefit in terms of sustainability either for the 2C practices or the city as a whole. • Not aligned to the 2018 General Medical Contract in Scotland; will not achieve potential benefits of independent model. • Unlikely to enable the Partnership to utilise our assets to meet demand and service delivery in a flexible and efficient way. • Does not meet patients' needs for an increased demand on services in an innovative and future-proofed manner.

	• Unlikely to result in positive financial gain.
Other Points	

Option 2 – Partial Merger of 2C Practices	
Description	Some of the 2C General Practices would join to become a larger Practice.
Expected Costs	• Not fully identifiable currently, dependant on specific configuration. • Potential costs include any refurbishment or adaptations required for possible co-location following merger. • Potential savings include reduced locum costs and possible reduction in estates footprint.
Risks Specific to this Option	Risk that this minimal change will not prepare 2C General Practices for the future and current epidemiological, financial and workforce challenges highlighted previously **IJB Strategic Risk Register:** This option has limited, mainly neutral, impact on the Partnerships' ability to mitigate against risks in its Strategic Risk Register (see appendix 3)
Advantages & Disadvantages	Advantages • Causes minimal disruption to staff. • Likely to result in some limited economies of scale and scope from operating as larger Practices (such as shared use of resources). • Provides additional support for smaller practices • Partial creation of a more flexible workforce to meet increased patient needs • Most preferred option from the preference vote from 2C Practice Staff group (see appendix 2) Disadvantages • Will require ongoing Primary Care team support for the operational delivery of remaining 2C Practices. • Limited benefit in terms of sustainability either for the 2C practices or the city as a whole. • Not aligned to the 2018 General Medical Contract in Scotland; will not achieve potential benefits of independent model.

	• Unlikely to enable the Partnership to utilise our assets to meet demand and service delivery in a flexible and efficient way. • Does not meet patients' needs for an increased demand on services in an innovative and future-proofed manner. • Limited financial gain.

Option 3 – Full Merger of 2C Practices	
Please note that this option includes detail of an internal proposal received from 2C Practice Staff on 05.11.2020. The proposal (option 3b) was independently submitted to the project team and reflected the previous option of "Full Merger of 2C Practices" (option 3a). The analysis here summarises and adds additional consideration to the proposal, however the full, unedited proposal can be found at appendix 1	
Description	This option would see an organisational merger of all the 2C practices, however they would continue to operate from existing premises. The proposal includes details of the overall structure and organisation; clinical process; workforce; shared management and administration; teaching and training; and qualities improvement This proposal has been co-designed by staff from 2c practices and they would plan to continue to work in this way. Additionally they would create a patient representation group to participate in this process of co-design.
Expected Costs	Cost reductions: • Reduced locums spend due to increased cross-cover of pooled workforce • Proposal highlighted possibility of new income streams: from enhanced services contracts, training and teaching, improved processes around non-GMS work, extended hours.
Risks Specific to this Option	• The greatest risk from any service re-modelling would be loss of staff. This proposal specifically addresses this risk by ensuring ongoing staff co-design and retention of existing teams. • There is a risk of non-delivery of the service model • There is a risk that not all 2C Practices are as "bought-into" the proposed model resulting in resistance to

	change. ACHSCP has received complaints/concerns from 1 practice who would like to be withdrawn from the process. There is a risk that practices who have endorsed this approach may not continue to endorse this post-decision making. • There is a risk that this will not result in positive financial gain **IJB Strategic Risk Register:** This option has limited, mainly neutral, impact on the Partnerships' ability to mitigate against risks in its Strategic Risk Register (see appendix 3)
Advantages & Disadvantages	• Whilst initially this option (3a) was not the most preferred option from 2C practice staff, as indicated by the vote, the revised version (3b) has been a co-designed proposal from 2C Staff provides greatest opportunity for staff engagement and endorsement, reducing risk of resignation. • Reduced likelihood of any significant adverse effects upon staff or patients during any transition period to an independent contractor • Reduced impact on service continuity during the remodelling process. • This would provide a cost-effective modern well-coordinated primary care service that would be resilient to future pressures and demands. • In the longer term, this would not preclude other possible models of ownership or service configuration such as 17c arrangements, should ACHSCP/NHSG choose to revisit this issue in the future. **Disadvantages** • Will not realise the benefits of the independent (17J or 17c) model, in line with the new GMS contract, though does not preclude this as an option for the future. • Does not provide opportunity for other practices to improve their sustainability through procurement process • Does not increase capacity of the Primary Care Support Team to provide further support or to work preventatively with other practices that may require support in the future. • Proposal does not consider relocation or co-location of practices, stating practices will remain in own premises,

	therefore does not maximise use of existing assets (though recognises this could be progressed in future) • Limited internal redesign may not achieve significant changes required or within timescales • The detail outlined in the proposal describes a service model which could also be delivered by another of the options included in this business case, rather than a whole system approach which best mitigates the risks in the Strategic Plan.
Other Points	The willingness of the practises to collaborate will, if required, allow for some changes in the use of existing assets within the context of wider NHSG plans for the city. The proposal states that "*practices will also look at the feasibility of a Social Enterprise Model as a possible means to deliver this service model*". By retaining and improving the 2c model this proposal would increase the diversity of possible models that might provide effective solutions in the future for the problems facing primary care. However, this does not preclude a future change by NHSG to a different model of ownership, e.g. to 17c or 17j independent provider status.

Option 4 – Partial Merger and Partial Procurement Process	
Description	Some of the 2C Practices merge together to create a larger Practice, whilst ACHSCP undertakes a procurement process for the remaining Practices.
Expected Costs	Not fully identifiable at this time, dependant on specific configuration.
Risks Specific to this Option	Risk of staff turnover through dissatisfaction of the procurement process. This would be mitigated by a robust communication and engagement strategy and implementing a flexible workforce model to ensure that Practices cross-cover staffing absences as required. Additionally, business continuity planning has been undertaken by the Lead for Primary Care with neighbouring practices. **IJB Strategic Risk Register:** This option some potential to have a positive impact on most key risks as outlined in the Partnerships' Strategic Risk Register, though may have a

	negative impact on risk 6 (reputational damage) (see appendix 3)
Advantages & Disadvantages	Advantages • Allows ACHSCP to focus resources on a smaller number of 2C Practices deemed in more 'need' which is in line with the intentions of the 2C model nationally. • Allows elements of the internal 2C proposal to be implemented, whilst attaining some of the benefits associated with the 17J/17C independent model for others. • Opportunity for financial savings through potentially no longer having responsibility overspend for some practices. • Increased development to create a more flexible workforce to meet patient needs • Patient needs are partially met for an increased demand on services in an innovative and future-proofed manner • Increased likelihood that the Partnership can utilise the assets to meet demand and service delivery in a flexible and efficient way • Partially facilitates the implementation of shared resources, cross-practice working and supporting resilience (as per the Scottish GP Contract 2018) Disadvantages • Possibility that business cases submitted during the procurement process are not acceptable and as such, time is wasted during the process • Partial procurement process does not allow the Partnership to see all potential models of innovation and change from interested parties • Risk of staff turnover through dissatisfaction of the procurement process • Only partially facilitates the implementation of shared resources, cross-practice working and supporting resilience (as per the Scottish GP Contract 2018)

Option 5 – Procurement Process for all 2C Practices (individually, in groups or as a whole)	
Description	A procurement process is undertaken for all 2C practices as separate lots to determine whether other independent Practices would be suitable to take them on.
Expected Costs	Not fully identifiable at this time, dependant on specific configuration.
Risks Specific to this Option	• There is a risk of increased staff turnover through dissatisfaction of the procurement process. This would be mitigated by implementing a flexible workforce model to ensure that Practices cross-cover staffing absences as required, as well as undertaking robust business continuity planning alongside independent contractors. Additionally, business continuity planning has been undertaken by the Lead for Primary Care with neighbouring practices. • There is a risk of legal challenge regarding the outcomes of the procurement process. **IJB Strategic Risk Register:** This option some potential to have a positive impact on most key risks as outlined in the Partnerships' Strategic Risk Register, though may have a negative impact on risk 6 (reputational damage) (see appendix 3)
Advantages & Disadvantages	Advantages • Likely to produce business cases or solutions with higher levels of innovation which may be more likely to address pressures in the system. Encourages the widest range of possible options so does not limit the solution. • Provides opportunity to increase stability /sustainability of the independent contractors and the wider primary care system, as well as the 2C practice, reducing the risk of market failure as identified in risk 1 of the Strategic Risk Register • Option releases the biggest financial savings through potentially no longer having financial responsibility for

	any Practices and consequently any overspend on budgets. • Aligned with the current direction of the 2018 General Medical Contract in Scotland • Enables the Partnership to see if our assets can be utilised to meet demand and service delivery in a flexible and efficient way • Meet patient needs for an increased demand on services in an innovative and future-proofed way Disadvantages • Least favoured by the 2C practice staff as indicated by the 2C practice staff vote (see appendix 2); • Risk of staff turnover through dissatisfaction of the remodelling and procurement process; • Possibility that business cases submitted during the procurement process are not acceptable and as such, time is wasted during the process;

5.1 Scoring of Options Against Objectives

Use the table below to score options against the objectives to create a shortlist of options to be considered. 3a demonstrates the original scoring of a full merger option. Option 3b demonstrates the revised scoring of the full merger option *following* receipt of the internal 2C proposal.

OBJECTIVE	1	2	3a	3b	4	5
1.Ensure the chosen option can be achieved with limited adverse impact on staff / patients	0	2	1	3	1	1
2.Ensure service continuity whilst remodelling	2	2	2	2	1	1
3.Develop a future-proofed model that will mitigate against the increasing epidemiological and recruitment challenges	-1	0	1	1	2	2
4.Develop a future-proofed model that will mitigate against the increasing financial challenges	-1	0	1	1	2	3
5.Facilitates the implementation of shared resources, cross-practice working and supporting resilience (as per the Scottish GP contract 2018)	-1	0	2	2	1	3
6.Has a direct link to the ACHSCP Strategic Plan	-1	0	0	2	1	2
TOTALS	-2	4	7	11	8	12
RANKING	6th	5th	4th	2nd	3rd	1st

Scoring
Fully Delivers = 3
Mostly Delivers = 2
Delivers to a Limited Extent = 1
Does not Deliver = 0
Will have a negative impact on objective = -1

5.2 Recommendation

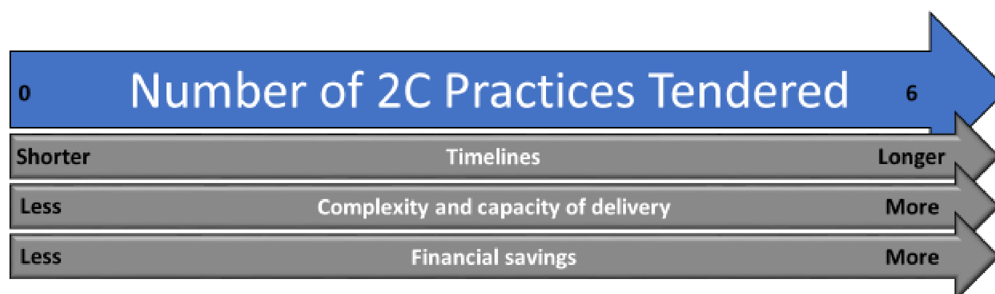
It is recommended that Option 5 (Procurement Process for all 2C Practices) is progressed as the highest scoring option outlined above. This would see a procurement process commence with an invitation by suitably qualified parties to express an interest in assuming responsibility for some / all of the six 2C General Practices in Aberdeen City. Whilst the process is underway, work can begin to implement short-term improvements as highlighted by 2C Practice Staff during the workshops.

Option 3b also scored strongly in the options appraisal. The *difference* in scoring between the initial full merger option and the 2C practice proposal was largely due to factors in the proposed service model which could also be achieved through a procurement process. However, option 5 aligns more closely to the strategic plan and provides additional benefits with more potential to deliver transformational change of primary car services in line with this strategic direction. Furthermore, option 5 provides the opportunity to mitigate against the broadest range of risks within the Strategic Risk Register (such as market or financial failure – see appendix 3).

6. Scope

Procurement Process

As aforementioned, the Procurement process will invite initial expressions of interest, from suitably qualified parties*, for the provision of Primary Medical Services through a General Medical Services contract in Aberdeen City. (*interested parties require to comply with the relevant terms of the National Health Service (Scotland) Act 1978, as amended, including & specifically Section 17L). Such a preferred option cannot have a clear blueprint developed before the process has been undertaken as there is no way of predicting what business cases will be submitted. The visual below highlights some of the complexities associated with such an approach:



However, there are numerous key considerations that are evident from the outset:

Procurement Strategy

The procurement strategy outlines key considerations as to how the procurement process should be undertaken. This includes determining the route to market and consideration of “lots”. In this case, it is recommended that each practice is considered a separate lot to maximise the number of potential applicants and to provide the maximum number of configurations for consideration in a business case.

Evaluation

Development of robust evaluation criteria will be essential in ensuring the suitability of business cases. One critical criterion will be ensuring that the procurement process does not result in increasing health inequalities. For example, assurance will have to be provided to guarantee that services would not be removed from areas of multiple deprivation where the needs of such populations are higher. Such business cases that cannot provide these assurances will not be considered given the Partnership’s commitment to reducing health inequalities and ensuring equitable provision for citizens across the City.

Note – given the numerous outcomes that there could be within this process, the costs outlined in Section 7 assume that all Practices are tendered, which includes all aspects of the service (such as staff and buildings). A full breakdown of costings has been developed and are available on request.

Evaluation criteria
Once business cases are received, the business case selection for interview award criteria is initially applied to all applicants. Interviews will be awarded on the basis of the business case submission/s which demonstrate a high level of scoring and feasibility, taking into consideration local context / conditions and other relevant factors. Selection panel members will use the evaluation criteria, together with the scoring guide, to assess overall viability to move to interview or not.

Contract award criteria
The contract will be awarded based on the submission/s which demonstrate a high level of scoring and feasibility, taking into consideration local context / conditions and other relevant factors. Please note that an applicant’s proposal consists of the submitted Business Case, the oral presentation and answers to panel member’s questions. Selection panel members will use an evaluation criteria, together with the scoring guide, to assess overall viability.

Given the context of ACHSCP being required to intervene and provide services for three other independent practices in the past 24 months, particular consideration must be given to the sustainability of business cases and alleviating the risk of Practices collapsing and requiring the Partnership to assume control of them again.

Note – ACHSCP are under no obligation to accept any tenders. This allows the opportunity to see what is out there.

This also acts as a potential bridge between Option 4 within the Options Appraisal (partial merger + partial procurement process) that could be explored later should the outcome of the procurement process not be as anticipated.

6.1 Out of Scope

(List any notable exclusion, those areas that may be viewed as associated with the project or the affected business area but which are excluded from the scope of the project.)

In the case of a procurement process, to enable practices to put forward innovative business cases for tender and merger, no practice will be deemed ‘out of scope’.

6.2 Project Dependencies

Project dependencies include (but are not limited to):

- Other disciplines that are co-located within General Practice (such as Substance Misuse, Podiatry and Link Practitioners) that may be impacted by any changes. This could be mitigated with a statement of intent for the services potentially impacted within the procurement process.
- The 2018 General Medical Services (GMS) Contract In Scotland and the Memorandum of Understanding (MoU) – ‘GMS contract implementation in the context of Primary Care Service Redesign’

7. Benefits

7.1 Citizen Benefits

Benefit	Measures	Source	Baseline	Expected Benefit	Expected Date	Measure Frequency
Improved access to services	Number of NearMe Consultations	Vision / EMIS	@ contract award	Patients more satisfied with care provision	Accrued impact over time	Monthly
	Number of E-Consult consultations	Vision / EMIS	@ contract award			
Receipt of more appropriate care	Increased number of consultations conducted by multi-disciplinary professionals	Vision / EMIS	@ contract award	Patients receive the right care from the right person		

7.2 Staff Benefits

Benefit	Measures	Source	Baseline	Expected Benefit	Expected Date	Measure Frequency
Improved resilience	Recruitment of additional professional roles	HR	@ contract award	Developing the General Practice model will enhance the experience for staff working within it	Accrued impact over time	Monthly
	Sickness / absence rates					

7.3 Resources Benefits (financial) – indicate whether these benefits are cashable or non-cashable

Benefit	Measures	Source	Capital or Revenue?	Baseline (£'000)	Saving (£'000)	Expected Date	Measure Frequency
Reduced financial pressure on ACHSCP	Cost of 2C model	Finance	Both	£5,254,724	£518,405 (assuming all Practices are successfully awarded)	August 2021	Baseline @ 3 months post award

8. Costs

8.1 Post- Project Revenue Expenditure & Income (Business as Usual)											
(£'000)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Staffing Resources	4980										
Add cost items under each heading											
Non Staffing Resources	794										
	5774										
Revenue Receipts and Grants	(5255)										
Sub-Total	**518**										

9. Equalities Impact Assessment
An equalities impact assessment will be undertaken on the submitted business cases once the details are known.

10. Key Risks	
Description	**Mitigation**
2C Practice staff do not want the remodelling process to occur and have said a proportion will resign. This point is emphasised by the preferred option for full procurement process is the 'least preferred' option from 2C Practice Staff	Ensure an effective comms / engagement plan is in place. Practice staff have already engaged in numerous workshops and discussions to date.
There is a risk of 2C Practice Staff resignation because of the remodelling process, impacting on service delivery.	Business continuity planning for ensuring continued service delivery
There is a risk of reputational damage to the Partnership. Patients may be displeased at no longer attending 'their practice'. There may also be a wider perception that the Partnership are 'selling off' Practices, thus resulting in reputational damage	Develop and implement effective comms and engagement plans. Ensure those contractors submitting business cases are required to state how they will mitigate this should they be successful and awarded their contract.
There is a risk that no business cases are received through the procurement process	Ensure appropriate time and awareness raising of procurement process are implemented to maximise potential interest; open procurement process with individual lots to maximise possibilities. Deliver workshop on 'How to develop and submit a Tender'. Contingency: alternative to develop next highest scoring option from the business case if no proposals received.
Successful bidder for the contract is not able to accomplish the transition from 2C model to independent model and responsibility for the patients reverts to ACHSCP	Ensure robust criteria are developed by which to measure applications. ACHSP Primary Care Team – to work closely with those parties that have been awarded a tender to identify risks and support for success

11. Time

11.1 Time Constraints & Aspirations

Whilst the procurement process is underway, other potential solutions that were considered (such as the merger of some / all of the 2C General Practices) will be unable to progress as this will alter the terms of the procurement process. However, the key principles outlined in Section 5 (flexible workforce; streamlined systems and processes; and shared use of resources) can be commenced.

Full details on the proposed timelines are included in the procurement strategy and will be published alongside the procurement documents.

11.2 Key Milestones

Description	Target Date
Preferred option agreed	**01 December 2020**
Procurement Process go-live *Extended timescales for submission of proposals; evaluation; interview stages; and stand-still*	**25 January 2020**
Contract Award close / decision	**17 May 2021**
Full handover of tendered Practices (if successful)	**July- August 2021** *(dependent on number and details in transition plan)*

12. Governance

The governance structure is visible below.

The roles within the project team are described below. NB: This team are supported by a steering group of wider stakeholders, including colleagues from HR; Trade Unions and the LMC.

Role	Name

Project Lead	Lorraine McKenna
Business Change Managers	Emma King; Steve McMaster
Programme Manager / Research Lead	Calum Leask / Sarah Gibbon
Project Manager	Chris Smillie
Organisational Development Facilitator	Fiona Nairn
Clinical Lead / Independent Practice Rep	Alasdair Jamieson

13. Resources

Task	Responsible Service/Team	Start Date	End Date
Effective delivery of transformational change Lead the tender process	Transformation team Primary Care Team NHSG Procurement Team	Oct 20 Ongoing Nov 20	Aug 21 Ongoing May 21
Intimate knowledge and expertise of Primary Care operations	Primary Care team Local Medical Council (LMC)	Ongoing	Ongoing
Knowledge of organisational change policy and procedures	HR / Trade Unions	Oct 20	Aug 21

14. Stakeholders

CONSULT	**COLLABORATE**
Finance General Public Independent General Practices Capital Team LMC Modes of communication Briefings; Face-to-face meetings (both in person and virtual)	2C General Practice Staff 2C Remodelling Project Team Organisational Development LMC Modes of communication Project team meetings; Workshops; Informal catch ups
INFORM	**INVOLVE**
IJB ACHSCP Colleagues PCIP Project Team LMC Modes of communication Briefings; Presentations	Trade Unions HR Clinical Leads LMC Modes of communication Briefings; Workshops

15. Assumptions

- Costings assume that the full tender is successful and all 2C Practices are taken on by independent Practices
- Preferred option assumes that there suitably qualified parties open to assuming responsibility of some / all of the current 2C Practices

16. Constraints

Document any known pressures, limits or restrictions associated with the project.

- There may be pressures to maintain service delivery should staff turnover be evident during the process
- If no appropriate tenders, full redesign may be restricted by long-term building and leasing options already in existence

17. ICT Hardware, Software or Network infrastructure		
Description of change to Hardware, Software or Network Infrastructure	**EA Approval Required?**	**Date Approval Received**
Scale up of NearMe	No	n/a
Scale up of E-Consult	No	n/a

18. Support Services Consulted

Service	Name	Sections Checked / Contributed	Their Comments	Date
Finance	G Parkin	Costings	Costing inputted.	04/09/20
Procurement	Jennifer Yeoman Peter Obosi	Tender details	Inputted	07/09/20
Assistant Clinical Director	Alasdair Jamieson	All	Inputted	07/09/20
LMC	Emma Houghton	Process and eligibility of GMS provision & Change	Inputted	07/09/20
2C General Practice Staff	NA	Workshop process Internal proposal	Additional proposal included	06/11/20
Information Governance	A Bell	Information Governance Implications	Assessments required a future point in the project	06/11/20
Governance Legal Team	J. Anderson	Entire Business Case	Inputted into the business case	20/11/20

19. Document Revision History

Version	Reason	By	Date
1.0	Initial creation	L McKenna	28/08/20

1.1	Further development	C Leask	31/08/20
1.2	Financial costings	G Parkin	04/09/20
1.3	Consultation document with project team; Trade Union and Clinical Leads	C Leask	04/09/20
1.4	Further input from project team	E King L McKenna	07/09/20
1.5	Comments integrated from Executive Programme Board	C Leask	14/09/20
1.6	Further iteration of comments from project team	C Leask	17/09/20
1.7	Updated following IJB Pre-Agenda meeting	S Gibbon	29/09/2020
1.8	Inclusion of 2C Practice Proposal and scoring	S. Gibbon	06/11/2020
1.9	Update following IJB Pre Agenda	S. Gibbon	17/11/2020
2.0	IJB Final Report Deadline	S. Gibbon	24/11/2020

Appendix 1

Option 3b	
Description	**Merger of 2c Practices** **Overall structure and organisation** **All practices would continue to operate from existing premises, although a permanent location for the homeless practice needs to be identified in the city centre. There would be significant integration and modernisation of services and enhanced workforce cross-cover as detailed below.** This would allow practices to retain their individual practice identities but financially they would constitute a single entity, increasing overall security and providing opportunities for working across practices and harmonising working practices. In the longer term, this would not preclude other possible models of ownership or service configuration such as 17c arrangements, should NHSG choose to revisit this issue in the future. The practices are also cognisant of the need to consider how all assets and premises are utilised to achieve the overall objectives of NHSG and would welcome being involved in future consultation and planning around this. This proposal has been co-designed by staff from all 2c practices and we would plan to continue to work in this way. Additionally we would create a patient representation group to participate in this process of co-design. **Clinical** **Our overall philosophy is *to provide person-centred, holistic care that is easily accessible with long-term relationships and continuity of care for patients where this is important; co-ordinating care for those patients who need this whilst grounding everything in local knowledge and a commitment to the local area.*** The 2c practices have a higher-than-average proportion of patients with complex needs and patients from vulnerable groups such as those with learning disabilities, alcohol and substance dependence, homelessness and multiple exclusions, as well as practices serving patients in areas of concentrated socio-economic deprivation. It is well-known that these groups require continuity of care, which would be guaranteed by our proposal. We already utilise innovative patient access and management systems such as eConsult, virtual wards and digital sign-posting as well as remote consultations, and we would plan to further develop and integrate these systems. However, equity of access requires that we also continue to provide more traditional routes of access for those patients who need these. Our teams already include a range of allied health professionals who effectively manage many patient needs, and we would plan a further extension of this provision. Improved Multi-Disciplinary Team (MDT) working and Advance Care Planning (ACP) are essential to effectively manage patients with complex needs. The significantly larger patient population and clinician group resulting from the merger would ensure efficient and effective use of the precious time resource of relevant specialists and allied health and social care colleagues.

This in turn would ensure their ongoing participation and would be facilitated by IT resources that already exist in practices. Staff from secondary and social care and Housing could thereby be more efficiently aligned to the 2c practices, e.g. care manager, support workers, link worker, psychological practitioner, paediatrician, geriatrician, adult and old age psychiatrists.
We would share clinical expertise across practices, e.g. minor surgery, sexual health, pessaries, diabetes, joint injections. Aside from providing care to patients closer to home and more quickly, this would reduce pressure on secondary care and provide additional income streams for the practices. It would also provide attractive career options and training opportunities.
We would create shared protocols and systems across practices, including standardisation of chronic disease management using successful systems already in place in practices. There would also be standardisation of consulting room layout. Collectively these changes would ensure ease of cross-working by staff between practices and would improve patient safety.
Instead of individual clinicians taking responsibility for specific clinical areas in their own practice, they could do so across a number of practices, further enabling quality improvement work, and freeing up more clinical time.
The combined effect of these changes and the enhanced MDT structure would also allow for improvements in QI processes including medicines rationalisation which would enable improvements in patient safety, reduce adverse events, and would reduce prescribing costs.
In order to anticipate and plan for future service needs, we would liaise closely with AHSCP's health intelligence data analysts.
We would improve door-to-door transport to care by utilising and where necessary creating voluntary resources within localities. We would invest in enhanced Link Worker functions and additional mentoring & wellbeing roles to support lifestyle change, including third sector and voluntary providers. We would utilise pooled resources and expertise in health literacy and patient education interventions. We would extend the House of Care model of chronic disease management across all practices as standard to optimise patient participation in the own care.

Workforce

In order to minimise and even eliminate locum use we would introduce contractual agreements across all staff groups to provide cover across all practices for planned and unplanned leave. This would require a small amount of additional permanent sessions across all areas (clinical and administrative), but would be vastly exceeded by savings in locum costs and improved staff welfare and resilience as well as improved patient safety.
We would realise the potential for incorporating shift type patterns with extended opening hours, e.g. '8 till 8', or even Saturday mornings. This would provide access to additional funding for extended hours and has proven to be a popular pattern of working for some staff.
Overall, a larger and more secure workforce will attract and retain staff, especially with increased opportunities for training and broader clinical experience.

Management and administration

A larger administrative team would enable sharing tasks such as summarising or coding, which also creates further opportunities for quality improvement and standardisation.
We would share management resource as required, e.g. leading for the whole group, rather than just for an individual practice, in a particular area (e.g. implementing quality improvement projects, HR issues, website maintenance, streamlining processes, training etc).
Working across practices in admin/secretarial areas, could be carried out for multiple practices at one location, or by a team working across practices.
In order to allow realisation of all income available from non GMS activities, we would propose the devolution of a small amount of financial and budgetary function to the practices themselves. Additionally some limited Human Resources function could also be helpfully devolved, all to be conducted within NHSG processes with appropriate oversight and governance. This would allow for some degree of budgetary responsibility and allow quick responsiveness to the needs of succession planning so as to avoid gaps in service provision which can rapidly erode staff wellbeing and lead to sickness absences and the use of expensive locums in a small workforce where patient demand is continuous and cannot otherwise be displaced, except to secondary and emergency care.

Teaching and training

Teaching and training of existing staff and also of undergraduate (UG) and postgraduate (PG) trainees are considered an essential element of a high-quality service, and are known to improve standards, increase job satisfaction, maximise future recruitment and long-term succession planning. They are also important additional streams of income and can augment the available workforce.
Administration and rotas for teaching could be done in one location with one (or more) clinicians taking the lead; teaching sessions could easily be undertaken across practices via technology such as Teams. By sharing UG and PG teaching and training across practices (e.g. one tutor delivering tutorial to four trainees), we would automatically increase the possible breadth of clinical experience for trainees and students. It would additionally reduce the time commitment for individual tutors and increase their availability for clinical work.
Likewise, there would be improved joint-educational opportunities for staff.
It would allow the further development of ties between the practices and the universities in Aberdeen and also with NHS Education Scotland.

Quality Improvement

There would be a quality improvement programme for all the practices, including coaching, training and collaboration.
Wider participation in MDT across practices would also enable more QI work and interfacing / vertical integration and service alignment with secondary care and with social care.
The cross-practice clinical oversight structure would also fit more easily within a clear explicit QI framework.
Significant Event Analysis could also be undertaken across practices, as appropriate, to optimise systems learning.

Expected Costs	Cost reductions: Reduced locums spend. Improved vertical (with secondary care) and horizontal (with rest of primary care) integration enabling more rational and effective use of limited resources. Enhanced MDT working reduces impacts on secondary care and emergency and unscheduled care by improved anticipatory planning and continuity of care. QI work across practices with a focus on prescribing will enhance rational prescribing and help reduce the medicines budget. Increased specialist elective services delivered in primary care such as minor surgery reduce costs in secondary care. New income streams: from enhanced services contracts, training and teaching, improved processes around non-GMS work, extended hours.
Risks Specific to this Option	The greatest risk from any service re-modelling would be loss of staff. This proposal specifically addresses this risk by ensuring ongoing staff co-design and retention of existing teams.
Advantages & Disadvantages	The changes overall would provide a stable resilient workforce further enabling retention and recruitment. The ongoing co-design process will ensure improved staff empowerment. We would not anticipate any significant adverse effects upon staff or patients nor any loss of service continuity during the remodelling process. It would help deliver primary care for the city within the limits of the medium term financial framework. This would provide a cost-effective modern well-coordinated primary care service that would be resilient to future pressures and demands. This model of care is outcome and patient-focused model rather than staff-focused. We anticipate that the service improvements facilitated by this proposal would increase the number of patients reporting a positive experience of GP services and also of care that they would rate as excellent or good. The proposal can be seen to link directly to the AHSCP Strategic Plan 2019-2022 across all relevant areas.
Other Points	The willingness of the practises to collaborate will, if required, allow for some changes in the use of existing assets within the context of wider NHSG plans for the city. The practices will also look at the feasibility of a Social Enterprise Model as a possible means to deliver this service model. By retaining and improving the 2c model this proposal would increase the diversity of possible models that might provide effective solutions in the future for the problems facing primary care. However, this does not preclude a

	future change by NHSG to a different model of ownership, e.g. to 17c or 17j independent provider status.

Appendix 2

Options Voted on	**1st Preference**	**2nd Preference**	**3rd Preference**	**4th Preference**
Full Merger	5	24	10	9
Full Tender	1	2	13	38
Partial Merger	47	20	11	5
Partial Merger & Partial Tender	6	13	25	7

Appendix 3 Analysis of the options against the IJB's Strategic Risk Register.

This is presented to provide further context to the options outlined above, and it not yet fully reflected in the Strategic Risk Register. Following the IJB decision, the risk register will be updated to reflect the preferred way forward.

Risk	Option						Notes
	1	2	3a	3b	4	5	
1 *Market capacity*	Negative Impact	Neutral Impact *Limited impact?*	Neutral Impact	Neutral Impact	Positive Impact	Positive impact	Procurement process (options 4 & 5) is the only way of providing opportunities to stimulate the market; increase sustainability across the system and promote innovation across general medical services.
2 *Financial failure*	Negative Impact	Neutral Impact	Neutral Impact	Neutral	Positive Impact	Positive impact	Options 2, 3a & 3b are assessed as neutral as whilst they may deliver some operational savings, risk of overspend lies with the IJB Options 4 & 5 removes/partially removes the risk of overspend therefore has a positive impact
3	NA – hosted services						Not a hosted service
4	NA – Partner organisations functions i.e. governance; performance						Does not relate to these functions
5 *Performance standards*	Negative Impact	Positive Impact	Positive Impact	Positive Impact	Positive Impact	Positive Impact	All options would seek to further improve services and meet performance standards and outcomes, except Option 1 which retains the status quo
6 *Reputational damage*	Negative Impact	Neutral Impact	Neutral Impact	Neutral Impact	Negative Impact	Negative Impact	Option 1 would have a negative impact on reputation (inaction) Options 2, 3a and 3b would have a neutral impact as internal process Options 4 & 5 have reputational risks associated with the procurement process
7 *Deliver transformation*	Negative Impact	Neutral Impact	Neutral Impact	Neutral Impact	Neutral Impact	Positive Impact	Option 1 does not support delivery of transformation Options 2, 3a, 3b and 4 limit opportunities for delivery of transformation Option 5 encourages innovation and has the potential for the widest range of possible solutions
8	NA – locality working						
9 *Redesign from transitional models*	Negative Impact	Neutral Impact	Neutral Impact	Neutral Impact	Positive Impact	Positive Impact	Option 1 does not support Option 2, 3a and 3b limits to redesign internally Options 4 & 5 provide opportunity to redesign internally and externally
10 *Brexit*	NA						