



national association  
of primary care



# DOES THE PRIMARY CARE HOME MAKE A DIFFERENCE?

Understanding its impact

March 2017

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# FOREWORD

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Over the last 35 years I have had the privilege of witnessing health and social care teams who work alongside patients, carers and volunteers; change services for the better. The ever present challenge has been how to take what works well in one area and spread it quickly across the country and to make change stick. This report demonstrates that the Primary Care Home (PCH) programme supported by NHS England's New Care Models team is doing to just that.

Just over 12 months ago we set out with 15 PCH Rapid Test Sites. The programme has expanded significantly to a total of 92 Primary Care Homes across the country with more than 50 additional sites applying to come on board soon. This report provides insight into what elements of PCH are being successfully spread, what benefits are being realised and what conditions have helped to create spread.

Now is an opportune moment in the evolving landscape of the NHS to take stock of how new models of primary care might help deliver plans set out in the 44 STPs and in turn achieve the triple aim set out in the Five Year Forward View. The NAPC commissioned this report as a snapshot to understand the real impact of PCH so far; on local health economies, patient care and the people who deliver that care.

Often in our attempt to accelerate the translation of improvements from one area to another, we fall into the trap of holding back the very people who can deliver service change by starving them of the space, time and tools they need. We aim to provide helpful support but this can sometimes be received as stifling performance management which burns the vital oxygen needed for the continual evolution of local change.

A challenge for system leaders is to find the delicate balance between the necessary strategic top down vision and bottom up focus, knowledge and vital energy. How can we nurture and develop PCHs to provide the drive from the front line that will create a paradigm shift in the health and wellbeing of local health and social care economies? This report shows how, with a small amount of investment and following four core characteristics, PCHs have delivered substantial service improvements. These include reductions in A&E attendances and prescribing costs, whilst at the same time boosting staff recruitment and retention and most importantly having a positive impact on patient experience.

I commend this report to you if you are an STP leader, a commissioner or a front line professional and encourage you to join the debate and the growing number of sites which are working to deliver the PCH model of care locally. This report provides inspiration and confidence that, by working with four core characteristics and starting with a focus on your local population, you can make a real and much needed difference for the patient, the taxpayer and for hard pressed NHS and social care staff.



A handwritten signature in black ink, appearing to read 'John Pope'.

**John Pope CBE**  
**Chief Executive Officer NAPC**

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# 1 EXECUTIVE SUMMARY

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This report presents the key findings from an assessment of three Primary Care Home rapid test sites. These demonstrate that a wide range of financial and non-financial benefits can be released, with positive impacts at local and STP level.

## 1.1 Context

The NHS needs to change radically in order to meet the needs and expectations of people in the 21<sup>st</sup> century.

Sustainability and transformation plans (STPs) are proposals that set out the future shape of health and social care services in a defined geographical area. The STPs are tasked with addressing the “triple aim” - improved health and wellbeing, transformed quality of care delivery, and sustainable finances. To achieve this, existing services need to change and new models of care are called for.

A new model of primary care and broader primary care transformation is needed to achieve these aims. As it stands, primary care is cost effective, trusted by patients and performs an essential role in coordinating care for people outside of hospital. Because of this success, primary care will be expected to offer more capacity, to provide enhanced services, and to work with additional health partners in the future.

Historically, primary care transformation initiatives at scale have struggled to achieve the intended aims. There are a range of reasons why this has been the case – change has often been imposed upon providers, GPs have been asked to give up some (or all) of their sovereignty over their practices, and there has been insufficient support to drive through this change.

## 1.2 Primary Care Home

In response, the National Association of Primary Care (NAPC) has developed the Primary Care Home (PCH) model, based on four defining characteristics:

- Provision of care to a defined, registered population of between 30,000 and 50,000;
- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care inclusive of patients and the voluntary sector;
- A combined focus on personalisation of care with improvements in population health outcomes; and
- Aligned clinical and financial drivers through a unified, whole population budget with appropriate shared risks and rewards.

The PCH shares some of the features of the new multi-speciality community provider model though is flexible enough to be considered as a standalone unit or as a foundation for other at scale models of care.

The PCH model was formally launched at the NAPC annual conference in October 2015. After receiving 67 applications, 15 rapid test sites were selected in December 2015 to pilot the model. These sites are now putting the PCH model in to practice and making rapid progress in developing and rolling out plans to transform healthcare delivery for their local population. There are now a total of 92 sites as part of the NAPC’s Community of Practice with more than 50 additional sites applying to come on board soon. It is therefore timely to consider the benefits that the model can realise, and to explore the characteristics of the model that enable this change.

## 1.3 Summary of key findings

We worked with three rapid test sites - Beacon Medical Group (Plymouth), Thanet Health Community Interest Company (Thanet) and Larwood & Bawtry practices (South Yorkshire).

These sites have used the PCH model differently to address the priorities of their local populations. Our work focussed on identifying the initiatives they had undertaken as part of the PCH, and to analyse data to understand the impact of these initiatives. Wherever possible, these findings were validated with external data sources.

A summary of the most impactful findings from across these sites demonstrate the range of financial and non-financial benefits that PCH can drive. These findings also point to the PCH being a model through which STPs can work towards their broader goals in the form of the “triple aim”. This includes quantifiable financial benefits realised from reducing non-elective attendances, elective admissions and prescribing costs.

Rapid Test Site Benefits		
<b>A&amp;E Attendances</b>	▼	<b>£27k</b> of savings each year enabled by providing extended primary care access in Thanet
<b>A&amp;E Admissions</b>	▼	<b>£295k</b> of savings from reductions in A&E admissions driven by Thanet Health
<b>GP Referrals</b>	▼	<b>330</b> GP referrals to hospital avoided, a slowdown in the growth rate, demonstrated by Beacon Medical Group
<b>Prescribing</b>	▼	<b>£220k</b> of prescribing savings demonstrated by Larwood and Bawtry
<b>Staff Satisfaction</b>	▲	<b>67%</b> of staff surveyed felt that PCH had improved their job satisfaction across the three sites
<b>Utilisation</b>	▲	<b>78%</b> of staff felt PCH had decreased or not added to their workload across the three sites
<b>Staff Retention</b>	▲	<b>86%</b> of staff regarded Beacon Medical Group as a good employer
<b>Patient Experience</b>	▲	<b>82%</b> of staff felt that PCH had improved patient experience across the three sites
<b>GP Waiting Time</b>	▼	<b>6 day</b> reduction in the average time patients wait to see their GP at Beacon Medical Group

<b>Population Health</b>		<b>13% increase in flu vaccinations for patients with COPD registered with Beacon Medical Group</b>
<b>Length of Stay</b>		<b>8 day reduction for admitted care home residents registered with Beacon Medical Group</b>

### What makes the PCH work?

The findings indicate that implementing PCH ways of working can drive positive change in a relatively short period of time. This points to the fact that the defining characteristics of the PCH model make it a vehicle for change, and that it is a catalyst that enables faster progress to be made in addressing local primary care priorities.

Specifically, the following features are important enablers for the benefits observed:

- **PCH is developed, implemented and led by providers** – the people motivated and needed to make the change are those that are given the space, time and support to develop the plans.
- **Initiatives are selected, planned and implemented at a deliverable level** – The PCH quickly demonstrates that benefits can be achieved on the ground giving more confidence across the system.
- **PCH model fosters collaboration throughout the system** – introducing PCH and delivering benefits quickly provides an opportunity and incentive to bring together wider primary care as well as other partners.
- **PCH activates staff to become the drivers of positive change** – staff are bought into the PCH principles and are energised and excited about their futures. This translates into measurable impact in improved recruitment and retention rates and patient care.
- **An overarching organising vision combined with bottom-up self-organising providers teams can deliver local change and scaled change** – a clear model and enablers put in place by the NAPC have enabled rapid test sites to flourish by giving them the tools to make their own change.

### Recommendations for next steps

The findings presented in this report are exciting and warrant further exploration. There is a need to develop a broader evidence base. This would best be achieved through continuing to expand the PCH scheme and undertaking a cohort analysis. Developing a larger dataset with a light touch measurement framework would help provide more detailed insight to questions around the value for money of the PCH model, the causal link between initiatives and benefits, and the validity of extrapolating results to the national level. Repeating analysis over time could inform a view of the recurrence of benefits, the sustainability of gains and the impact on population health.

Expanding the scheme would be aided by providing existing and aspiring PCH pilots with tools including:

- A light touch measurement framework which focusses on collecting data that helps both to improve the running of the practice, whilst evidencing the impact of the PCH model.
- An activity tool that helps providers to understand their current workload and current case mix in order to forecast the future needs of their local population.
- An easy guide to inform the design and roll out of change programmes that is based on an accessible and clear approach, potentially based on a “scaled agile” framework.

- Over time the tools and experience of pilots could help towards codifying “what works” in PCH. This could underpin a high level framework for improvement that aspiring pilots and other primary care providers could use.

Future expansion must remain true to the four core characteristics of PCH as there is clear evidence that these give the model definition as a vehicle for change. Overlooking these may limit the ability of sites to unlock benefits for their local populations.

## 2 PRIMARY CARE TRANSFORMATION IS AN ESSENTIAL ENABLER FOR THE DELIVERY OF SUSTAINABILITY AND TRANSFORMATION PLANS

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The NHS Five Year Forward View recognises that the health and care system needs to change to meet the current and future requirements of patients. Primary care has a fundamental role to play in delivering this change.

### 2.1 Background and context

It is widely recognised that almost all parts of the health and social care system are under extraordinary pressure. Whilst we should celebrate the fact that people are living longer, much of this extended life is blighted by an increasing number of complex long term conditions, which is increasing the demand on our NHS. At the same time, gaps are appearing in the workforce and this further exacerbates the pressures. The models of care required for 21<sup>st</sup> century society may now need to be very different in order to provide for a changing need and expectation.

The case for change is clear. Incremental improvements will not deliver the scale of change needed to ensure sufficient, consistently high quality and financially sustainable capacity across the NHS. This is the right time to consider more radical steps in planning and delivering care <sup>1</sup>.

In response, NHS England (NHSE) has launched a national initiative for health and care commissioners and providers to come together as 44 areas to develop local proposals for better, more sustainable services for their populations. These Sustainability and Transformation plans (STPs) set out how local partners intend to work together to address the “triple aim” - improved health and wellbeing, transformed quality of care delivery, and sustainable finances - now and in coming years.

STPs provide an opportunity to develop a new model of care, with the aim of providing more services in the community, closer to peoples’ own homes. This will offer patients easier access, better experience, whilst being more affordable.

To make this model reality, it is essential that primary care is supported and resourced to become the resilient, sustainable foundation for coordinated care outside of hospital. This includes making best use of the funding earmarked for primary care as part of the General Practice Forward View.

From what we know of STPs, firm plans for and expectations from primary care transformation are still developing. This presents both a risk and an opportunity - that primary care may be asked to deliver too much in the future with insufficient support, whilst there is a window for GP leaders to influence the narrative and to inform and drive a realistic and exciting primary care future.

Based on an assessment of the relevant STPs, as well as the general understanding about what STPs require from primary care transformation, the following expectations have been articulated:

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<sup>1</sup> Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J., Thorby R and Lombardo S (2017), “Shifting the balance of care”. This timely report considers the evidence underpinning the prevailing NHS drive to shift care from hospital and into the community. This is a central tenet of most STPs. Rightly, it has been observed that initiatives to achieve this have had variable success, and that there are a wide range of challenges to overcome to get this right. The report recognises that “additional supporting facilities in the community, appropriate workforce and strong analytical capacity” are essential to succeed. Conversely, those initiatives that place additional responsibilities upon primary and community providers at a time when gaps are emerging in the workforce and when GP practices are closing are highly unlikely to deliver their aims.

- A percentage of cumulative savings necessary to close the anticipated financial gap are directly attributable to primary care transformation initiatives
- Other savings are indirectly attributed to primary care given that it is an essential enabler for new models of care.
- Input into the development of new GP-led models of integrated, out-of-hospital care <sup>2</sup>
- Input into the development of regional primary care strategies, to describe how best to implement the GP Forward View.

As such a renewed focus on primary care transformation is needed to achieve these aims and to deliver the “triple aim” in every STP, benefitting patients nationally.

## 2.2 Challenges

Though plans now exist for primary care transformation, so far these programmes have rarely delivered real change for patients on a large scale nor sustained impact for the system.

Primary care transformation has rightly been the focus of attention in many - if not all - of the STPs. However, at national level it has been identified as a weak spot in terms of the detail and clarity of these plans and the extent to which the primary care providers as a group, commissioners and other system providers share a vision for how primary care will contribute to the system of the future.

Primary care transformation at scale is a challenging endeavour and there are five clearly identifiable reasons for this.

### 2.2.1 Change has most often been imposed on primary care providers, rather than developed in partnership or stimulated from the bottom up

Clinicians tend to support best what they have helped to create. Imposing change can limit creative input from those closest to the front line, and constrains their empowerment and ownership of the change. The result of this may be to disengage providers from taking part in making that change stick. At the same time, commissioners can struggle to describe how the model would work in practice, and the impact that could be expected.

### 2.2.2 Models to deliver at scale can require providers to give up those aspects of primary care that they value the most

Models of care that require practices to formally come together in the form of super-partnerships, GP federations and other legal entities require providers to cede some (or all) autonomy. For many GPs, this represents a barrier to change that cannot comfortably be overcome, especially when combined with point one above.

### 2.2.3 Initiatives can be misaligned across the system. System plans often focus on methods to better distribute, rather than reduce demand

This may result in primary care being asked to support more and more complex, activity without commensurate adjustments in the model of care to incentivise behaviours across partners to deliver more joined-up support for patients. A deep understanding of the demand on a system is required before that demand can be shaped and managed through an improved and reformed approach.

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<sup>2</sup> Per the report by Ham C, Alderwick H, Dunn P, McKenna H. “Delivering sustainability and transformation plans”. King’s Fund, 2017, “All STPs set out proposals for redesigning primary care and community services and delivering more services outside of hospitals and in people’s homes... General practices are typically at the heart of these new care models, with GPs and primary care staff working more closely with other community and social care services. It is often expected that these new ways of working will reduce demand for hospital care”.

## 2.2.4 There is an appetite to show rapid returns, in a currency that is readily measurable and easily understood

Given the current pressure on the NHS, it is understandable that there is a focus on quick wins. However, this approach may adversely impact the appropriateness and sustainability of plans. Focussing narrowly on activities that reduce A&E attendances and non-elective hospital admissions (which can deliver system benefits in the short term) can overlook the intrinsic value of the primary care model – which values continuity and incremental gains (underpinning improved health outcomes likely observable over the long-term only). Transformative change in provision of care usually results from a well-managed set of sequential experiments with regular revisions and within a multi-year process.

## 2.2.5 Primary care transformation may be insufficiently supported

Much of the effort in developing new models of care is focussed on acute hospital services, which take up the majority of the healthcare spend. This can impact on the availability of financial and non-financial resources available to support primary care to change. As with all change initiatives, the risk of delivering the aims of reform significantly increases in proportion to the support provided (or lack of it). This support includes timely accurate data about patient flows and the ability to commit resources where they will be most efficiently and effectively utilised.

## 2.3 Primary Care Home presents a model to do things differently at a time of opportunity

The systemic pressures being experienced by primary care point to a need for a new model of primary care. This has opened up the opportunity to develop and trial new models and initiatives.

For the National Association of Primary Care (NAPC), primary care must continue to be defined as:

- The patients' first point of contact with the health and social care system
- Providing the majority of preventative and curative health needs, health promotion and care monitoring requirements
- A personalised approach rather than disease focused
- Comprehensive services delivered by multi-professional teams focussed on population health needs
- Co-ordinating the integration of care in partnership with patients and care providers.

The NAPC launched the primary care home (PCH) model to push this definition to its fullest extent as a complete care community, with an integrated multi-disciplinary workforce providing care closer to patients' homes. The model is based on four defining characteristics:

- **Provision of care to a defined, registered population of between 30,000 and 50,000.** This is population whose health outcomes can best be served by the optimum workforce size of 100-150 (using the evidence from a number of workforce and social anthropology models) in a way that truly integrates and effectively utilises local resources.
- **An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care inclusive of patients and the voluntary sector.** The PCH provides the environment and conditions for effective team working across different organisational forms to deliver the triple aims whilst also improving staff satisfaction.
- **A combined focus on personalisation of care with improvements in population health outcomes.** This means considering health and social needs and the social determinants of health of the population, emphasising proactive, preventative care for healthy and chronically ill people, including those who are not accessing care regularly.
- **Aligned clinical and financial drivers through a unified, whole population budget with appropriate shared risks and rewards.** The aim is for a PCH to have responsibility

for a whole population, 'fair share' budget formulated on the needs of the registered list of the constituent GP practices involved. The level of whole population funding should be dependent on the needs of the population and the scope of services that is agreed through local commissioning arrangements within the total resources that are available in a local health and social care economy.

The PCH embraces some of the characteristics of the multispecialty community provider model. It represents a suitable size to scale for local integrated provision, and can be the building block for other new care models operating at a larger scale, where provision across a larger population base is required. Indeed, in some areas multiple PCHs are working together to give greater scale.

The launch of the PCH is timely. The morale of staff across primary care is decreasing<sup>3</sup>. Fatigue from top down change has set in and staff are less able or willing to free up capacity to make plans to address the priorities they see around them. What is required now is a scalable model, that is easy to introduce, to unlock the creativity and energy of staff with the aim of making rapid improvements in the way that primary care is delivered.

## 2.4 This report sets out our findings from an assessment of three PCH rapid test sites

There is an understandable need that new models of care are considered cautiously and in context. This document considers the financial and non-financial benefits that the PCH model can deliver. Consideration is given to returns at practice level, as well as the impact of PCH in delivering the aims of STPs. Section 3 sets out the key findings from our assessment.

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<sup>3</sup> Findings from the Eighth National GP Worklife Survey by Policy Research Unit in Commissioning and the Healthcare System indicate that overall job satisfaction reported by GPs in 2015 was lower than in all surveys undertaken since 2001. The proportion of GPs expecting to leave the profession in the next 5 years had increased from 8.9% in 2012 to 13.1% in 2015 among GPs under 50 years old; and from 54.1% in 2012 to 60.9% in 2015 amongst GPs aged 50 and over

# 3 OUR ANALYSIS SHOWS THAT PCH RELEASES A RANGE OF BENEFITS

We worked with the three rapid test sites profiled in Appendix A collecting and analysing data to understand the impact that the PCH is having locally. Our methodology is described in Appendix B. Headline findings are set out in this section, with a description of the investment into initiatives that led to these outcomes.

## 3.1 Summary of findings from the rapid test sites

The PCH model is not prescriptive. There is no blueprint for what it should look like other than that it must be underpinned recognisably by the four characteristics. Its design is consistent with the aims and outcomes of the Five Year Forward View. The model presents the opportunity and catalyst for sites to develop and roll out a broad range of initiatives that are relevant to their local population needs and the workforce that serves them.

The three rapid test sites we considered are taking the four characteristics and applying them in practice focusing on initiatives that are a priority for them and their local populations.

In the dashboard below, we have set out the most impactful initiatives through PCH implementation across all three sites (as described in the right hand column). This can be used to understand how the PCH model can:

- (A) impact broadly on the work of the practice, the people that use it and the staff that support it; and
- (B) impact the system as described in numbers.

The assumptions used to quantify and validate these findings are set out in Appendix C.

Rapid Test Site Initiatives	
<b>PCH Investment</b>	<p>Each site received direct investment of <b>£40k</b> from the NAPC and NHSE in 16/17 to give site leads time to provide leadership to establish integrated working amongst localities and providers including, communication, relationship building, monthly meetings attended by health partners, clinicians and senior decision makers.</p> <p>Once set up, PCH teams were the vehicle through which test sites made decisions to evolve their model of care and to determine the best use of existing resources, for example by employing community pharmacists or reconfiguring urgent care teams.</p>

Rapid Test Site Benefits	
<b>A&amp;E Attendances</b>	
	<b>£27k</b> of savings each year enabled by providing extended primary care access in Thanet

<b>A&amp;E Admissions</b>	▼	<b>£295k</b> of savings from reductions in A&E admissions driven by Thanet Health
<b>GP Referrals</b>	▼	<b>330</b> GP referrals to hospital avoided given a slowdown in the growth rate demonstrated by Beacon Medical Group
<b>Prescribing</b>	▼	<b>£220k</b> of prescribing savings demonstrated by Larwood and Bawtry
<b>Staff Satisfaction</b>	▲	<b>67%</b> of staff surveyed felt that PCH had improved their job satisfaction across the three sites
<b>Utilisation</b>	▲	<b>78%</b> of staff felt PCH had decreased or not added to their workload across the three sites
<b>Staff Retention</b>	▲	<b>86%</b> of staff regarded Beacon Medical Group as a good employer
<b>Patient Experience</b>	▲	<b>82%</b> of staff felt that PCH had improved patient experience across the three sites
<b>GP Waiting Time</b>	▼	<b>6 day</b> reduction in the average time patients wait to see their GP
<b>Population Health</b>	▲	<b>13%</b> increase in flu vaccinations for patients with COPD registered with Beacon Medical Group
<b>Length of Stay</b>	▼	<b>8 day</b> reduction for admitted care home residents registered with Beacon Medical Group

### 3.2 Findings from Beacon Medical Group

The dashboard below sets out specific findings from observing the Beacon Medical Group rapid test site in Devon.

<b>Beacon Medical Group Initiatives</b>	
<b>PCH Implementation</b>	<b>£40k</b> for PCH setup and dedicated leadership time to establish integrated working amongst localities and providers, as well as communications support and relationship building.

<b>Enhanced Care Homes</b>	£67k for a full-time pharmacist and one GP providing one session a week to carry out ward rounds, medication changes and to review discharge summaries. This was funded by the CCG from the existing recruitment budget.
<b>Urgent Care Team</b>	Redesigned multidisciplinary Urgent Care Team based on revised rotas, a new triage model and clinic set-up. Two additional nurse practitioners recruited for the team, funded by the practice.
<b>Virtual Ward</b>	Virtual ward reconfigured to involve community health partners and the voluntary sector more actively. Increase in structure and frequency of meetings. More coherent care plans. No additional funding required.
<b>Flu Campaign</b>	Collaborative flu campaign with community pharmacy targeting people aged 16-64 and those with chronic conditions. No additional funding required.
<b>Other Initiatives</b>	Clinical input into dermatology, musculoskeletal and diabetes services pathways redesign.

## Beacon Medical Group Benefits

<b>A&amp;E Attendances</b>	▼	<b>£15k</b> – the growth rate in A&E attendances fell from 3% to 1%, resulting in an estimated 109 A&E attendances avoided. The growth rate in A&E attendances fell from 9% to 1% for patients over 60.
<b>A&amp;E Admissions</b>	▼	<b>£91k</b> – the growth rate in A&E admissions fell from 7% to 4%, resulting in an estimated 55 A&E admissions avoided. The growth rate in A&E admissions fell from 10% to zero for patients over 60.
<b>Prescribing</b>	▼	<b>£39k</b> – savings from 284 medication reviews for care home residents, leading to 194 medication changes.
<b>Referrals</b>	▼	<b>330</b> fewer GP referrals, resulting from a fall in the growth rate in referrals from 5% to 1%.
<b>GP Waiting Times</b>	▼	<b>6</b> day reduction in the average waiting time for a GP appointment - from 14 to 8 days.

<b>Staff Satisfaction</b>	▲	<p><b>87%</b> of staff enjoyed their job; compared to 61% in 2015.</p> <p><b>90%</b> of staff speak positively of the practice when speaking to patients or external colleagues, compared to 69% in 2015.</p>
<b>Staff Retention</b>	▲	<p><b>86%</b> of staff regarded the practice as a good employer, compared to 44% in 2015.</p> <p><b>59%</b> of staff felt that their team had enough staff to get the job done, compared to 15% in 2015.</p>
<b>Population Health</b>	▲	<p><b>13%</b> increase in flu vaccinations.</p>
<b>Length of Stay</b>	▼	<p><b>8 day</b> reduction in the average length of stay for care home residents admitted to hospital.</p>

### 3.3 Findings from Thanet Health Community Interest Company

The dashboard below sets out our findings from observing the Thanet Health rapid test site in Kent.

<b>Thanet Health Community Interest Company Initiatives</b>	
<b>PCH Implementation</b>	<p><b>£53k</b> of direct cost for implementing the PCH model in practice, covering integrated working amongst localities and providers, input into monthly meetings as well as ongoing clinical and non-clinical input. Funding provided from the NAPC and the CCG. Additional work undertaken as part of current roles.</p>
<b>Integrated Care Record</b>	<p><b>£100k</b> for integrated care record (EMIS) set-up and <b>£36k</b> for first year running costs, including licencing and training costs. Funding made available from existing facilities budget.</p>
<b>Acute Response Team</b>	<p><b>£115k</b> for Acute Response Team (ART) set-up, project management and clinical input to co-design new models of care. The ongoing additional annual running cost is approximately <b>£75k</b>, over and above the cost of running existing schemes, which covers additional GP input into the ART. Funding made available from existing budgets.</p>
<b>Pharmacist Pilot</b>	<p><b>£1.4k</b> for a pharmacist pilot that took place as part of Thanet PCH's Elderly Frail Pathway. The pharmacist was already employed as part of the CCG medicines management team and the investment cost is calculated from pharmacist and GP time input into the pilot scheme.</p>

## Thanet Health Community Interest Company Benefits

<b>A&amp;E Attendances</b>	▼	<b>£27k</b> expected annual savings from reduced A&E attendances enabled by Thanet's shared patient care record. Admissions avoided through cross practice working to deliver extended primary care access on Bank Holidays.
<b>A&amp;E Admissions</b>	▼	<b>£295k</b> approximate annual savings from a reduction of <b>14</b> A&E admissions a week following the roll out of the Acute Response Team.
<b>Prescribing</b>	▼	<b>£216k</b> of potential medicine review savings if the outcomes of the initial pharmacy pilot were replicable across the wider local care home population. The average medicine review saving per resident was <b>£165</b> .
<b>Staff Retention</b>	▼	<b>Zero</b> vacancies for community nurses, falling from 24 WTE since PCH commenced.
<b>Additional Savings</b>		Additional benefits linked to the introduction of a shared patient record (EMIS) are likely include reductions in A&E attendances and admissions out of hours, increases in primary care capacity and reduced waits for GP appointments.

### 3.4 Findings from Larwood and Bawtry

The dashboard below sets out our findings from observing the Larwood and Bawtry rapid test site in South Yorkshire.

## Larwood and Bawtry Initiatives

<b>PCH Implementation</b>	<b>£40k</b> to provide dedicated leadership, management time. Also covers costs for hosting a provider steering group, and learning and administrative support from a practice lead. Costs for governance, stakeholder engagement and other staff time dedicated to setting up and running as a PCH were found within existing budgets.
<b>Pharmacist</b>	<b>£34k</b> for an additional full-time pharmacist to carry out medicine reviews for care home residents and to act as a quality lead for prescribing. Partly funded by the practice and CCG.

<b>GPs</b>	<b>Three</b> additional GPs recruited. Plans for recruitment may have progressed if the practices were not a PCH pilot site (though PCH has served to attract candidates) and it is not considered part of the PCH investment budget.
<b>Community Advisor</b>	A community advisor working within the practice to provide patient guidance and navigation support to access other community services, funded by the voluntary sector.

## Larwood and Bawtry Benefits

<b>A&amp;E Admissions</b>		<b>£352k</b> of projected annual savings, accounting for forecasting risk and causality. The PCH pilot claimed savings of <b>£277k</b> resulting from an <b>8%</b> reduction in non-elective admissions over a seven month period.
<b>Prescribing</b>		<b>£229k</b> of projected annual prescribing savings, accounting for forecasting risk and causality. The PCH pilot claimed prescribing savings of <b>£169k</b> over a seven month period, a <b>5%</b> saving.
<b>Outpatients</b>		<b>£32k</b> projected annual rise in spending, due to growth in the number of outpatient appointments by 152 patients, a <b>3%</b> increase.
<b>Staff Satisfaction</b>		<b>87%</b> of staff felt that the PCH way of working had improved their job satisfaction.
<b>Staff Retention</b>		<b>3</b> new GPs recruited based on the appeal of PCH ways of working. The PCH pilot is actively recruiting additional staff based on confidence in the model, and report that recruitment is now easier.
<b>Patient Experience</b>		<b>93%</b> of staff felt that PCH had improved patient experience.
<b>Population Health</b>		<b>80%</b> of staff felt that PCH would help to improve population health and <b>93%</b> felt it would help to improve clinical outcomes.

### 3.5 Impact on the STP and the “triple aim”

The dashboards above present the demonstrable benefits that PCH rapid test sites are delivering. Our assessment primarily focussed on understanding the benefits released at the practice / pilot level. This

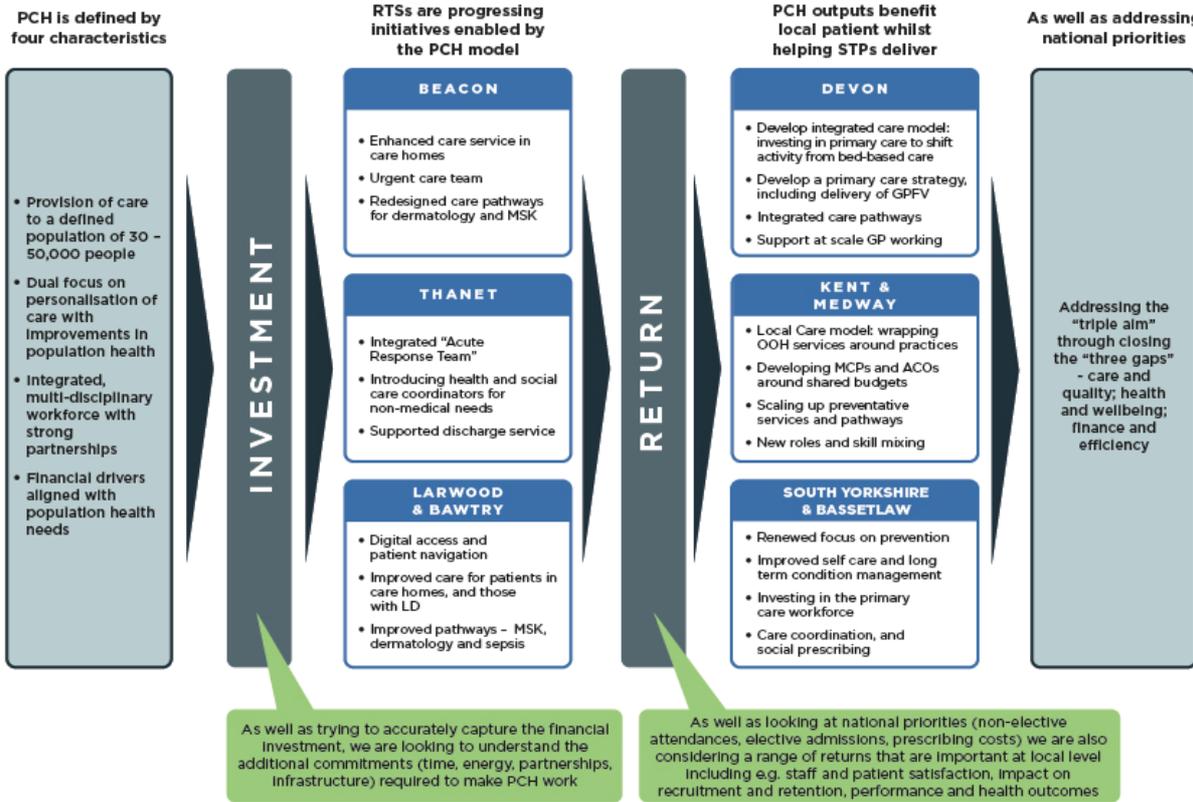
provides a local perspective (i.e. the benefits which people can readily experience themselves) and reflects the spirit of the PCH model in implementing change at the grassroots.

In addition, we looked more broadly at how the PCH model could impact the wider system. The logic model set out in Figure 1 should be read as a flowchart or process diagram from left to right. This shows the relationship and dependencies between:

- Resources that have been put into the PCH programme (i.e. the investment)
- The interventions, activities and processes that have been prioritised by the three rapid tests sites in scope
- The local outputs and outcomes (i.e. the returns) from these; covering those returns that have already happened, those that are happening, and those that are likely to happen
- The impact of these on local STPs
- The potential impact if extrapolated to the national level.

Research was coordinated to understand inputs and returns in line with this logic.

Figure 1: The approach to understanding the investment into and returns from PCH, including impact on regional and national priorities



Review of the relevant STPs indicates that the benefits observed could help the delivery of these plans. We recognise that STPs are tasked with addressing the "triple aim" and have set out stretch targets that cover these.

In many areas, though targets have been agreed, the incremental steps to achieving these are in varying degrees of development. The proposed means to achieve these savings (in terms of e.g. evolving the workforce, innovating the use of IT, equipment and estates) is also developing and though specific to the unique circumstances of each STP, share some common features.

The Kings Fund report that all STPs are developing new models of out-of-hospital care with the aim of managing patients in the best place, making optimal use of available resources. This is proposed as the key enabler towards closing the gap on the "triple aim".

We understood that these models reflect the characteristics of the PCH and heard how these had been incorporated into STP discussions. Implementing the PCH can unlock benefits we observed through this work. The enabling nature of the PCH model could act as a catalyst for collaboration and local problem solving which would close the gap further.

In the table below we have set out how these specific benefits could help STPs to achieve their aims.

<b>STP aim</b>	<b>How demonstrable benefits from the PCH rapid test sites work towards this aim</b>
<b>Improved health and wellbeing</b>	<ul style="list-style-type: none"> <li>• Additional focus on prevention, rather than on reactive medicine</li> <li>• Increase in vaccination rates</li> <li>• Greater practice input into residential and nursing homes, improving overall health for people living in these settings (e.g. through upskilling care home staff)</li> </ul>
<b>Transformed quality of care</b>	<ul style="list-style-type: none"> <li>• Better patient experience through more tailored support (based on population segmentation and care pathway redesign)</li> <li>• Faster access to primary care</li> <li>• Care provided closer to home – more convenient and less institutional</li> <li>• Availability of better, more joined up patient care data</li> </ul>
<b>Sustainable finances</b>	<ul style="list-style-type: none"> <li>• Helping to realise potential savings from providing care outside of hospital</li> <li>• More efficient primary care</li> <li>• More timely and appropriate interventions that reduce emergency attendances and admissions</li> <li>• Reduced prescribing costs arising from more appropriate medication plans</li> <li>• Using resources more appropriately, including new ways of working for existing staff and introducing new roles</li> </ul>

Additionally, workforce considerations are a major focus of all STPs. Initiatives to promote a happy, healthy and motivated workforce are essential to making plans a reality, sometimes referred to as a “fourth aim”, we observed that the PCH model could help STPs to achieve through:

- Engaging staff to own their futures
- A happier workforce with reduced sickness and increased retention
- More attractive in recruiting new staff
- Creating capacity and a platform for sharing and innovating
- New ways of working to address onerous workloads
- Opportunities for learning and development through multi-disciplinary working
- Fostering a sense of partnership and collaboration, rather than competition

In summary, though the timescales of this work have limited the opportunity to engage with STP teams, it is proposed that the impact of the PCH model in catalysing change would make delivery of the “triple aim” more likely. This could help the NHSE national team to reappraise risk scores for those footprints hosting a PCH site.

## 4 THE CHARACTERISTICS OF THE PCH ENABLE FASTER PROGRESS TO BE MADE IN ADDRESSING LOCAL PRIMARY CARE PRIORITIES

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The evidence we have seen points to the PCH acting as a catalyst for positive change and warrants more detailed consideration.

### 4.1 We have identified features that are important to enabling primary care transformation. These are aligned with the four characteristics that define the PCH model

The PCH may not be an outcome in of itself, nor a prescriptive model of care. The evidence we have observed points to the fact that the PCH puts in place the foundations for change to happen at a faster pace, and so should be considered as an enabler for primary care transformation.

The features of this approach address the shortcomings observable from previous initiatives by focussing on the following:

#### 4.1.1 The PCH is developed, implemented and led by providers

The PCH values the expertise, experience and relationships of providers as one of the most important drivers of primary care transformation. We observed how the PCH offered a platform for providers to become engaged and energised, whilst also making it more likely that changes made would be sustained.

*“Pilots in NHSE South SW appear to be delivering significant patient and practice benefits and pleased to see level of CCG support for rollout is growing”*

**Primary Care Project Lead,  
NHSE South (SW region)**

We heard how the PCH model presented support through a framework, time and space for providers to more actively consider their local primary care priorities. The PCH supported capacity to consider and analyse need, as a precursor for providers to developing plans for action.

The range of initiatives observed demonstrate how unique local needs can be addressed in a creative way. Providers are not bound to a particular way of doing things. Rather, the PCH liberates local leads from the narrow rules of day-to-day operating that can stifle primary care.

Going further, the PCH model does not get caught up in the “form versus function” debate that can constrain other change programmes. Sites can progress on the functions and service improvements they feel best meet the needs of their population rather than on the hard detail around contracts, legal form and programme management for example. We heard provider leads report a sense of pride in their ownership of their future, as well as their operating model.

This strategic autonomy was a powerful motivator for participants. Inviting rapid test sites into more formal collaborations and partnerships with other providers would have required GPs to give up some of the autonomy that they enjoy. Our conclusion is that this would, at best, limit the benefits demonstrated, whilst impacting on the delivery timelines.

### Examples we observed:

The sites we engaged all spoke positively about the time and “headroom” that the PCH had freed up to observe local needs, as a precursor to making actual changes that were relevant to them. Specific examples include:

**Beacon Medical Group:** time could be invested into identifying those patients most frequently making use of local A&E services. Against expectations, these patients were found to be adult women with low-level mental health conditions (anxiety, depression). In response, the practice has invited a psychiatrist to attend the practice on a weekly basis to provide a service for these patients, with the aim of meeting their needs more appropriately in a primary care setting, rather than through an emergency attendance.

**Thanet Health:** the PCH test site presented the opportunity to develop the collaborative infrastructure of the practices involved. This gave sight of ways to best pool funding and staff resource to respond to patient need. Providers agreed to pool funding from PMS premiums and previously commissioned Local Enhanced Service contracts, and community staff employed by a range of providers. The site is a much more effective coordinator of this multi-disciplinary Acute Response Team with GP input which is now making a significant impact on hospital attendances and admissions.

**Larwood and Bawtry:** the test site lead reported that their most significant achievement was the provider steering group introduced as part of their PCH plans. This brings people together to collaborate and innovate in the local system. We heard from attendees to this group how empowering and vital it was as a forum, which was acting as a vehicle for genuine change.

## 4.1.2 Initiatives are selected, planned and implemented at a deliverable level

There is much evidence which indicates that quality improvement initiatives typically take a minimum of two to three years to yield observable impact. Whilst we would naturally anticipate that the PCH would evidence some impact over these timescales (particularly health outcomes), our analysis demonstrated more immediate benefits.

Our conclusion is that the PCH provides a platform for making day-to-day changes, whilst also getting on with the effective running of a primary care business. Change initiatives typically require capacity and resourcing, which can often impact upon the day to day service provision. What we have observed is the model acting to underpin continuous incremental changes which sum up to material impact over the short and medium term.

Incremental change has engaged and energised pilot staff. Significant upfront investment of time and energy is not necessarily required, whilst sharing out priorities makes improvements everyone’s business.

Building the evidence base to see impact in response to efforts (i.e. quick wins) maintains momentum and enthuses people to explore further opportunities for improvement. It also opens up channels for practical conversations with other providers and commissioners around how best to contribute to the wider system.

The initial investment is at a good level to make a tangible difference. We heard from site leads that this had provided them with “headspace” and “opportunity to catch their breath” from the day to day functions of their practice. This had provided invaluable time to consider local priorities, and to think about what needed to be done.

*“The resources we needed were already there. Primary care home helped us use these in a different way, and provided leadership to unlock these”*

**GP, Larwood and Bawtry**

In turn, this can energise other primary care providers and partners, as well as CCGs and STP teams, by demonstrating that positive change can be made quickly. It can also show that the sum of those changes can make a huge difference.

Looking at scale from another perspective, we understood from the sites that the PCH model strikes the right balance between providers organising at a suitable level to lead and distribute resources around the system, whilst retaining focus on the relationships that give such value in primary care. This extends the scope of the primary care footprint and the opportunities around providing for the population, whilst remaining entirely personalised and focussed on the needs of individuals.

**Examples we observed:**

**Beacon Medical Group:** linking together datasets tracking patient journeys provided a compelling case that PCH initiatives were positively impacting the wider system. We observed how this evidence base excited local commissioners (who had previously been less aware of the potential of the PCH), and provided an opening for a practical conversation on taking the work of the test site even further.

**Thanet Health:** the commissioned pharmacist-led review of medication plans for over 70 people living in care homes identified a significant number of clinically unwarranted medications. Stopping these released an average saving of £165 per patient. This opens up the potential for a more wide-reaching initiative across the wider care home population in the area.

**Larwood and Bawtry:** the value of incremental improvement is cherished by the test site team. We heard how the PCH had introduced a mindset to critically appraise and challenge the work of the practice. This had triggered the development of plans to deliver aspect of CAMHS care locally as well as introducing physiotherapist input to the practice to improve MSK pathways.

**4.1.3 The PCH model fosters collaboration throughout the system**

Consistently, we heard that the PCH model created the opportunity to break down professional and organisational barriers to multi-disciplinary working. This was creating the richest and most diverse input to plans possible whilst also broadening the capacity and capability to deliver.

The model provides a platform for provider agnostic conversations about how best to deliver for the population and across the system. It is a platform using population segmentation as the organising principle for providing care.

Segmentation can inform a better understanding of the needs of the population. Following this, care can be targeted and refined to more directly address the needs of population cohorts with shared needs (e.g. frail older people). This is a basis for delivering better population-based health outcomes, through the most efficient use of system resources and community assets, to release the widest benefits.

*“I feel that working collaboratively as part of an integrated, multi-agency team we have been able to make a real difference to the patient experience and in many cases we have had a huge positive impact on patients’ lives. How do we know this? Because the patients have told us so”*

**Partnership Officer, Bassetlaw Community and Voluntary Service**

*“This has opened numerous doors and conversations with patients and partners across the wider system to develop opportunities for more joined up care”*

**GP, Beacon Medical Group**

The example of the Larwood and Bawtry provider steering group demonstrates this in practice. Bringing in system partners into areas which primary care has traditionally protected has opened up conversations and routes for action that were previously not available. In this case, the test site is in advanced discussions with the local authority about proposals to improve housing, as well as potentially taking on a council building for the purposes of setting up an integrated community wellbeing hub.

The providers we spoke to shared aspirations that the results demonstrated now could be used to draw together clinical and financial drivers in the longer term. Opening up conversations with commissioners and STP teams in the future around gain share arrangements could reward and incentivise even better system-wide care delivery in the future.

*“[The PCH] works very well to support learning across the organisations and working together”*

**General Manager, NHS Nottinghamshire Foundation Trust**

#### **Examples we observed:**

**Beacon Medical Group:** historically, flu vaccinations locally have been provided by community pharmacists. The remuneration model (i.e. per vaccination) has led to a sense of competition between pharmacists and GPs, which has limited collaboration and data sharing in this area. The PCH has reset this dynamic. In advance of flu season this year, more detailed planning between providers - starting from population segmentation - supported a 13% increase in vaccination rates. As well as improving population healthcare, the motivation is that improvements should support a case for future gain share that would align incentives to benefits patients, providers and commissioners alike.

**Thanet Health:** the PCH model has helped the practice involved in the test site to begin operating as a shadow integrated accountable care organisation. The PCH has provided energy and support to develop a shared strategy and governance arrangements, as well as an integrated patient care record. This has enabled the sharing of resources (such as the Acute Response Team) as well as joining up services (including extended access primary care).

**Larwood and Bawtry:** the test site has brought on board a full-time community advisor who helps patients with the wider determinants their health and wellbeing. Through the shared aims and relationship developed with local voluntary and community sector partners, this key role has been introduced at no cost to the practice; hence generating benefits far beyond the scope of the test site investment.

#### **4.1.4 The PCH activates staff to become the drivers of positive change**

Without the right workforce, primary care is certain to fall short of what is required of it. Conversations with site leads identified that primary care staff had fully embraced the principles of the PCH. There had been almost universal identification with the characteristics of the model, and the demonstrable impact on patients and clinicians alike had enthused primary care staff to commit additional time and energy to the test site. A significant part of this is a focus on the development of purposeful leadership as a style of practice across the workforce.

*“There's a real energy for change and new ideas can be implemented quickly”*

**GP, Larwood and Bawtry**

As part of this work, we invited test site staff to respond to a short survey to assess their satisfaction and belief in the PCH model. Results were overwhelmingly positive. Going further, test site leads were confident that this renewed energy (at a time when the morale of primary care providers is increasingly under pressure) was helping with recruitment and retention.

Applicants were attracted to working in a more creative, collaborative and solution-orientated way. Similarly, those nearing the end of their careers were excited about the work of the PCH and we had heard how people were deferring their retirement to remain close to the programme.

Whilst the rapid test sites demonstrated delivery of quantifiable, financial benefits, we consistently observed a very broad range of “softer” i.e. non-financial benefits released through rolling out the model. These could be overlooked as enablers. However, our conclusion is that these are necessary outcomes themselves; as these help release “harder” i.e. financial benefits as by-products.

Put simply, energising staff, fostering partnerships, changing behaviours and shifting a mindset of competition into one of collaboration lays the groundwork for unlocking benefits including reductions in A&E attendances, non-elective admissions, and reduced prescription costs.

*“There is a 'happy buzz' at our practice since PCH has started”*

**Practice pharmacist, Larwood and Bawtry**

*“Working in this way has made me want to defer my retirement”*

**District nurse, Larwood and Bawtry**

#### **Examples we observed:**

**Beacon Medical Group:** we observed that overall GP workload had reduced. This was simultaneously improving morale, whilst also freeing up clinicians to provide their expertise into further initiatives.

**Thanet Health:** the PCH model was a compelling factor in driving better recruitment and retention rates. Most notably, working in a different way had led to a reduction of over 20 WTE vacancies for community nurses (at a time when there is a widely recognised recruitment crisis for this role).

**Larwood and Bawtry:** the value of incremental improvement is cherished by the team. We heard how the PCH had introduced a mindset to critically appraise and challenge the work of the practice. This had triggered the development of plans to deliver aspects of CAMHS care locally; as well as introducing physiotherapist input to the practice to improve MSK pathways. At the same time, the PCH new way of working had been a significant contributing factor for three full time GPs (including two partners) deciding to join the practice.

#### **4.1.5 An overarching organising vision combined with bottom-up self-organising providers teams can deliver local change and scaled change**

The PCH model has been developed and refined over many years by the NAPC. This work has brought definition to the model, including its characteristics, and an understanding of how the model can address health priorities. Rapid test sites have benefited from this work and the support of the NAPC team.

As well as providing financial support to get these test sites off the ground, NAPC has used funding from NHSE to establish a central programme that supports sites through:

- Providing access to regional advisors with specialist knowledge in developing new care models and implementing change;
- Setting up a “community of practice” comprising aspiring PCH sites, to help support and influence the development of the model;
- Offering access to NAPC and PCH networking events to share ideas and learning;
- Offering access to learning and knowledge developed by new care models programme; and
- Commissioning this assessment in addition to the evaluation being undertaken by the Nuffield Trust to understand better the benefits of the PCH model, what makes it work, and how to extend its benefits in the future.

Sites reported that the clarity around the characteristics had shaped their approach to turn plans into action. They lend themselves to implementation in a scalable way that minimises barriers to progress.

We also understood that sites appreciated the role of the NAPC in supporting relationships between the sites, other providers and commissioners. Having an additional voice at the table helped to take a higher level view of the system and how best to organise care in a way that breaks free of traditional organisational boundaries.

**The features of the PCH that enable the benefits:**

- The PCH is developed, implemented and led by providers
- Initiatives are selected, planned and implemented at a deliverable level
- The PCH model fosters collaboration throughout the system
- The PCH activates staff to become the drivers of positive change
- An overarching organising vision, incorporating the four characteristics combined with bottom-up self-organising providers teams can deliver local and scaled change.

## 5 THERE ARE FOUR RECOMMENDATIONS THAT WOULD SUPPORT THE PCH COMMUNITY AND BUILD THE EVIDENCE BASE FURTHER

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There is a significant level of interest in new models of care, and appetite for exploring what models are doing, and how they are yielding returns. There are also some support needs for existing and aspirant PCHs. As such there is an understandable need to develop and refine a robust evidence base to support wider spread alongside a “toolkit” of support.

Our analysis demonstrates that the PCH model releases a wide range of benefits that have both local and system-wide impact. This resonates with the findings from the developing NHSE evaluation of the new care models programme, as well as the patient-centred medical home model in the US<sup>4</sup> and points to four main recommendations to support the next stage of this programme:

### 5.1 Plan the future PCH roll-out in a way that enables and harnesses the recognised success factors

The principles of the PCH model are already being put into practice across a total of 92 sites. We know there is great interest in the model and that more than 50 other practices across the country have expressed interest in taking part in developing and introducing their own PCH pilots.

Further expansion of the PCH scheme would be more likely to succeed based on the approach and tools set out in 5.2 below. However the impact of the model itself in delivering locally is dependent on the four key characteristics and the associated features as outlined in Section 4 of report.

Section 3 sets out the four characteristics of the PCH model that we understand are fundamental to it functioning as a catalyst for positive change. These should be held in mind in developing plans and tools to support expansion. Losing sight of these, limits the local potential of the PCH model.

Conversely, placing these at the heart of site plans should unlock a broad and multiplying range of benefits that will allow schemes to flourish.

### 5.2 Support PCH sites with business tools that aid evaluation and help them to run their business

Scaling up the PCH at pace would be no small feat. To support the programme and to provide the greatest prospects for success, a suite of tools could be developed for existing and aspiring PCH sites to use. Feedback we heard from current test sites indicate that there would be particular value in the following:

- A light touch measurement framework which focusses on collecting data that helps both to improve the running of the practice, whilst evidencing the impact of the PCH model. We propose that a simple cloud-based tool could be used to automatically capture data and generate reports.

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<sup>4</sup> A large scale, meta-analysis conducted over 4 years confirmed a return on investment in the range of 6 to 1. Consideration needs to be given to the respective starting point of US-based provider pilots which are typically more fragmented and less well established than UK primary care, including general practice. Reference: Nielsen, Marci, et al. "The patient-centered Medical Home's impact on cost and quality." *Annu Rev Evid* 2014 (2013): 2015.

- A demand and capacity tool that helps providers to understand their population, current workload and current case mix in order to forecast the future needs of their local population. This can inform plans to adapt e.g. in terms of future recruitment and developing new ways of working.
- An easy guide to inform the design and roll out of change programmes that is based on an accessible and clear approach. Our insight is that this could be based on a “scaled agile” framework which supports small scale, iterative cycles of change, which is harmonious with the dynamic and incremental nature of the PCH model.

### 5.3 Gather further evidence from more sites as the scheme expands

This report is based on an approach proportionate to the scale of the current PCH rollout, the current stage in the project lifecycle, and the time available to conduct the assessment. These characteristics present the following challenges which future work could address:

- Making comparisons across sites (given the difference in respective models of care and the initiatives prioritised)
- Identifying a causal link between initiatives and benefits
- Drawing conclusions around value for money
- Understanding the impact of extrapolating results to another population, including the national level
- Understanding the impact on population health outcomes

To address these limitations and build further the evidence base, we believe there is a need for a new evaluation approach, which would require an expansion of the PCH scheme. We have set out the necessary steps below.

More forensic analysis of individual PCH sites is unlikely to offer any further insight to address the challenges identified above. Instead we believe that the greatest value would be in scaling up the evidence base to understand better the broader relative impact of the PCH, as measured against a comparator population.

This would make the impact clearer and present a larger signal in the data. Supporting the launch of additional PCH sites would provide a larger population sample enabling us to answer additional questions such as:

- Does PCH return value for money and if so by how much?
- What variables and implementation styles drive benefits and by how much?
- Can these benefits can be extrapolated nationally?

To do this, it will first be necessary to select specific and measurable variables which are likely determinants of success. These will underpin comparison between sites. This report (and our insight) strongly suggests that local ownership and empowerment are a condition for success. Other variables that are likely to be important and, therefore could be considered, include the characteristics of sites (e.g. list size, GPs per population head), the initiatives implemented or redesigned, the direct investment into the scheme, and the level of support and leadership (e.g. weekly input by local lead).

A sufficiently large sample size is then needed to draw robust, statistically significant conclusions – both as aggregated cohorts of PCH sites vs non-PCH sites, but also to quantify the attribution and benefits of different implementation styles and initiatives.

A light touch measurement framework should be developed to collect data which tell the most insightful story about the relative value of the PCH. This framework should focus on collecting data that is useful for practice leads to manage their day-to-day service, and should not be onerous.

Ideally, PCH teams would assess their own progress using this framework, against a set of objective categories that are clear from the outset. This is a natural ingredient of the “top down” guidance and vision that needs to be created before the “bottom up” ownership of change can be driven.

Standardising the analysis makes it possible to display and share outcomes in the form of a functional dashboard or league table to engender a sense of transparency and healthy competition amongst PCH sites.

Going further, running this reporting cycle iteratively over time would help to answer questions about the broader impact of the model over the medium and long term, including:

- **Are benefits observed recurrent? If so, are they increasing or diminishing in nature?**
- **How can benefits be sustained?**
- **What impact does the PCH model have on population health outcomes?**

Future evaluation could also consider the potential merits of gain share, including what specific benefits should underpin it, the data required to evidence this, and the proportionate levels of returns based on outcomes.

## 5.4 Collect evidence on which initiatives drive greatest benefit for patients as part of a framework for improvement

Our insight is that the much of the success of the PCH rapid test sites is attributable to the vision and commitment of local leaders which is often observed with “early adopters”. At the same time, these sites are contributing to an understanding of what works, and lessons learned.

Future expansion of the PCH programme should capitalise on this knowledge. This must strike a balance between presenting a single template for success (recognising that the PCH is not a prescriptive model of care), and providing the opportunity for sites to develop their own solutions to the unique needs of their local populations (which is one of the aspects of the PCH scheme that participants most cherish).

Codifying what can work should be based on sharing emerging learning between sites. Feedback from test sites evidencing demonstrable improvements and savings can help other sites to develop their own initiatives. It can also help facilitate wider discussions and fuel new ways of working.

### **Recommendations that would support the PCH community and build the evidence base further:**

- Plan the future PCH rollout in a way that enables and harnesses the recognised success factors;
- Support PCH sites with business tools that aid evaluation and help them to run their businesses;
- Gather further evidence on impact from more sites as the schemes expands;
- Collect evidence on which initiatives drive greatest benefit for patients as part of a framework for improvement.

# APPENDICES

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# A PROFILES OF THE RAPID TEST SITES

In the section below detail is provided on the three rapid tests sites in scope of this report. These profiles are based on information from conversations with pilot leads, as well as from reviewing the relevant STPs:

## A.1 Beacon Medical Group, Devon

<b>Number of practices:</b>	4
<b>Population covered:</b>	32,500
<b>STP footprint:</b>	Devon
<b>Partner organisations:</b>	<ul style="list-style-type: none"> <li>• North, East and West Devon CCG</li> <li>• Plymouth Hospitals Trust</li> <li>• Plymouth Community Healthcare</li> <li>• Plymouth City Council</li> <li>• Devon Local Medical Committee (LMC)</li> <li>• Devon Local Pharmaceutical Committee (LPC)</li> <li>• South West Network for Pharmacy</li> <li>• Healthwatch</li> <li>• Patient Groups</li> </ul>
<b>Priority PCH initiatives:</b>	<p>Beacon Medical Group is focussed on delivering these PCH initiatives:</p> <ul style="list-style-type: none"> <li>• An enhanced care homes service</li> <li>• A multi-disciplinary urgent care team</li> <li>• Redesigned care pathways including for dermatological and musculoskeletal (MSK) conditions</li> </ul> <p>At the same time the site is working on a range of other activities including:</p> <ul style="list-style-type: none"> <li>• A virtual ward for at risk patients</li> <li>• A redesigned diabetes pathway</li> <li>• A dedicated psychiatrist-led primary care mental health service</li> <li>• Near patient testing (including CRP)</li> <li>• A collaborative flu immunisation campaign</li> </ul>
<b>STP primary care priorities:</b>	<p>Ensuring high quality, sustainable primary care services to form a significant component of a local integrated care model by:</p> <ul style="list-style-type: none"> <li>• Developing integrated primary care</li> </ul>

	<ul style="list-style-type: none"> <li>• Delivering the GP Forward View</li> <li>• Supporting primary care development to be fit for the future</li> </ul>
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## A.2 Thanet Health Community Interest Company, Kent

<b>Number of practices:</b>	18
<b>Population covered:</b>	47,550
<b>STP footprint:</b>	Kent and Medway
<b>Partner organisations:</b>	<ul style="list-style-type: none"> <li>• East Kent Hospitals University Foundation Trust</li> <li>• Kent Community Hospital Foundation Trust</li> <li>• Kent County Council</li> <li>• Kent and Medway Partnership Trust</li> <li>• Voluntary Sector Organisations, including Ageless Thanet</li> <li>• Kent Local Pharmaceutical Committee (LPC)</li> <li>• Kent Local Dental Committee (LDC)</li> <li>• Kent Local Ophthalmic Committee (LOC)</li> <li>• Thanet Hospice</li> <li>• South East Coast Ambulance Service</li> </ul>
<b>Priority PCH initiatives:</b>	<p>Thanet Health Community Interest Company is focussed on delivering these PCH initiatives:</p> <ul style="list-style-type: none"> <li>• Establishing four PCH models, working together as a shadow accountable care organisation covering all residents of Thanet</li> <li>• An integrated electronic patient record</li> <li>• An acute response team (ART) to safely manage unwell patients outside of hospital</li> </ul> <p>At the same time the site is working on a range of other activities including:</p> <ul style="list-style-type: none"> <li>• Health and social care coordinators to help with non-medical needs</li> <li>• A supported discharge service</li> <li>• Improving health literacy and self-management</li> <li>• Reviewing clinical and non-clinical processes to identify opportunities for improving productivity</li> </ul>
<b>STP primary care priorities:</b>	<p>Scaling up primary care into clusters and hub-based MCP models, including:</p> <ul style="list-style-type: none"> <li>• Bring integrated health and social care into the home</li> <li>• Provide a single point of access to secure any community and social care package</li> <li>• Care coordination, planning and management around GP practices and community service</li> </ul>

	<ul style="list-style-type: none"> <li>• Access to expert opinion without referral for outpatient appointment, including making use of GPs with a special interest (GPwSI) and advanced nurse and therapist roles</li> </ul>
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### A.3 Larwood and Bawtry, South Yorkshire

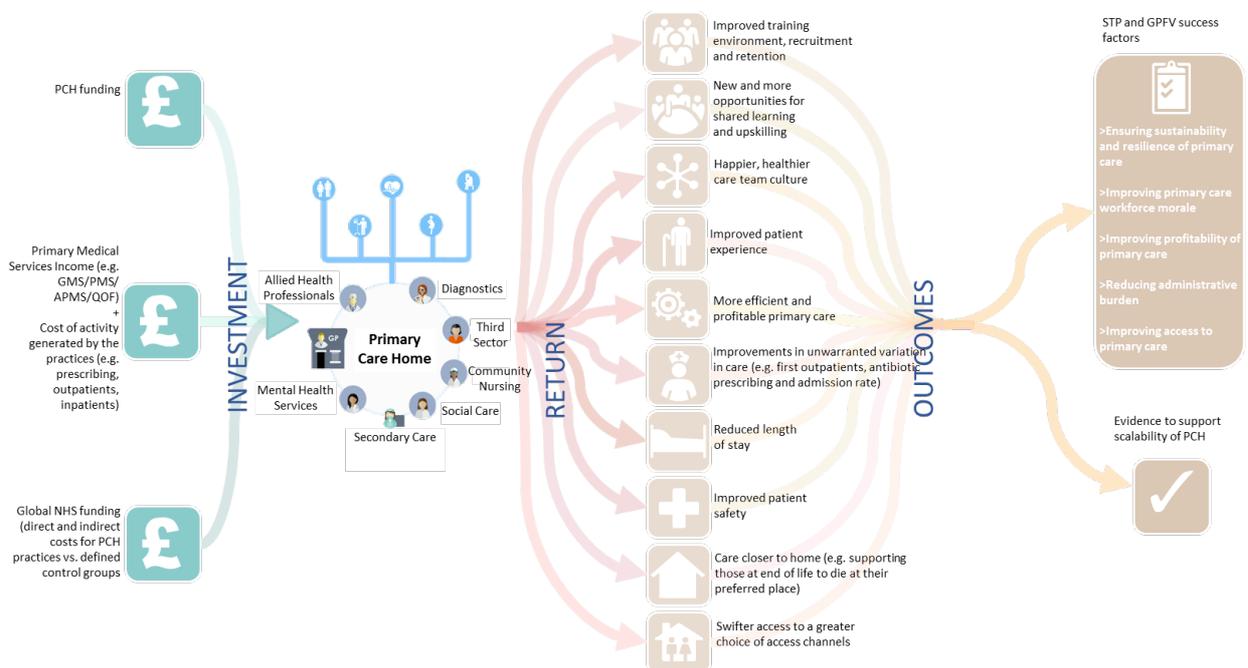
<b>Number of practices:</b>	2
<b>Population covered:</b>	30,450
<b>STP footprint:</b>	South Yorkshire and Bassetlaw
<b>Partner organisations:</b>	<ul style="list-style-type: none"> <li>• Bassetlaw CCG</li> <li>• Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust</li> <li>• Nottinghamshire Healthcare NHS Foundation Trust</li> <li>• Nottinghamshire County Council</li> <li>• Nottinghamshire Local Medical Committee (LMC)</li> <li>• Nottinghamshire Local Pharmaceutical Committee (LPC)</li> </ul>
<b>Priority PCH initiatives:</b>	<p>Larwood and Bawtry is focussed on delivering these PCH initiatives:</p> <ul style="list-style-type: none"> <li>• Improving care for patients in care homes and for patients with learning disabilities</li> <li>• A pharmacist-led prescribing pilot</li> <li>• Implementing a phone hub within the test site to improve call handling and care navigation</li> </ul> <p>At the same time the site is working on a range of other activities including:</p> <ul style="list-style-type: none"> <li>• Hosting Citizens Advice clinics run by local volunteers</li> <li>• Providing social care clinics to reduce waiting times for assessments</li> <li>• Improving access to wider support services, signposting to public health prevention services</li> <li>• Improving vaccination rates for vulnerable patients</li> <li>• Improving care pathways for MSK, dermatology, sepsis and palliative care planning</li> </ul>
<b>STP primary care priorities:</b>	<p>Reshaping primary and community-based care through:</p> <ul style="list-style-type: none"> <li>• Early detection and intervention</li> <li>• Urgent care intervention and treatment closer to home</li> <li>• Care coordination, including community based multi-professional teams, based around community hubs or GP surgeries</li> <li>• Improving self-care and the management of long term conditions.</li> </ul>

## B METHODOLOGY

This analysis is based on a methodology that was proportionate to the stage of the programme, and focussed on collecting the richest evidence base from three PCH site.

The diagram below describes the broad range of investment and benefits categories considered within this assessment.

Figure 2: Summary of indicative investments into and returns from the PCH



This work explores:

1. What benefits (in both financial and non-financial terms) can be demonstrated - or could be demonstrated given more time - from the PCH model; and
2. How PCH test sites could help the wider system in delivering against the aims as described within STPs

The work has been broken down into phases with specific aims and activities.

### Phase 1 – Mobilise

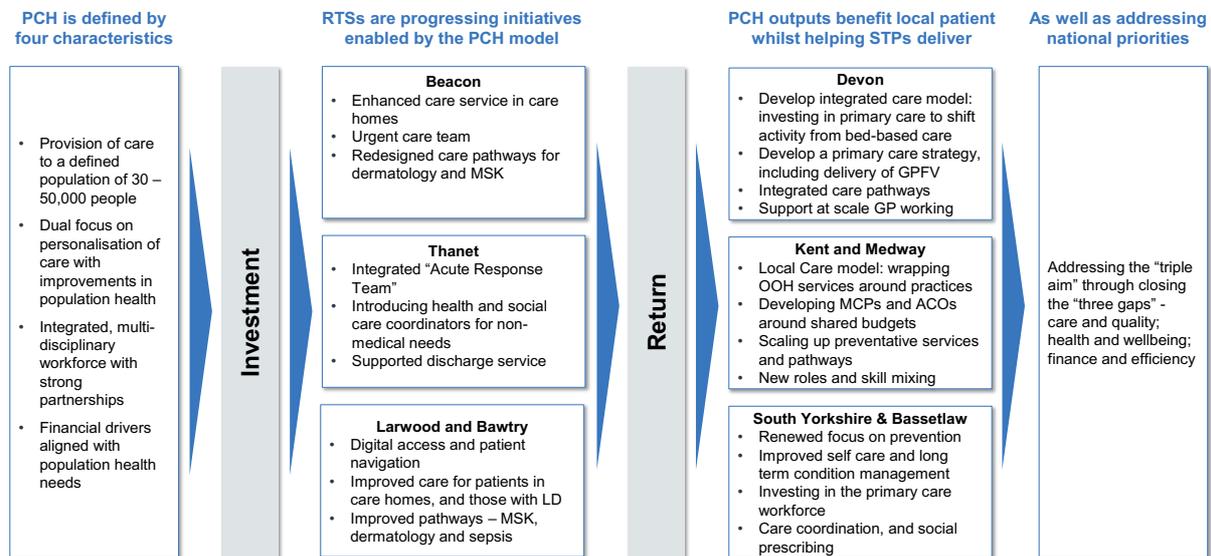
In this phase, initial contact was made with the rapid test sites in scope of the assessment. Additional and wider research helped inform an understanding of:

- The local primary care challenges for the rapid tests sites
- The primary care initiatives prioritised in response to these challenges
- The availability of relevant data demonstrating initial findings and a sense of the investment (financial and non-financial) to get these initiatives moving.

## Phase 2 – Develop the model

The logic model below provides an overview of the overall approach that was undertaken to develop this assessment:

Figure 3: Approach logic model



The logic model - read as a flowchart or process diagram from left to right – shows the relationship and dependencies between:

- Resources that have been put into the PCH programme (i.e. the investment)
- The interventions, activities and processes that have been prioritised by the three rapid test sites in scope and the changes that have occurred
- The local outputs and outcomes (i.e. benefits) from these; covering those that have already happened, those that are happening, and those that are likely to happen
- The impact of these on local STPs.

Activities were coordinated to develop the assessment in line with this logic:

- Ongoing conversations with the rapid test sites to understand their priority initiatives, and how these were distinct from core primary care activity
- Understanding the cost of undertaking these initiatives (separating out the additional cost on top of core primary care activity so as to avoid double counting)
- Collecting data (financial and non-financial) from the rapid test sites to populate the model as inputs for investment and benefits – recognising that gaps exist given that some initiatives are in the process of being implemented
- Agreeing with rapid test sites the extent to which returns could be justifiably attributed to activities enabled by PCH
- Reviewing the relevant STPs to understand the priorities for the wider health economy and how the rapid test sites fit within these plans.

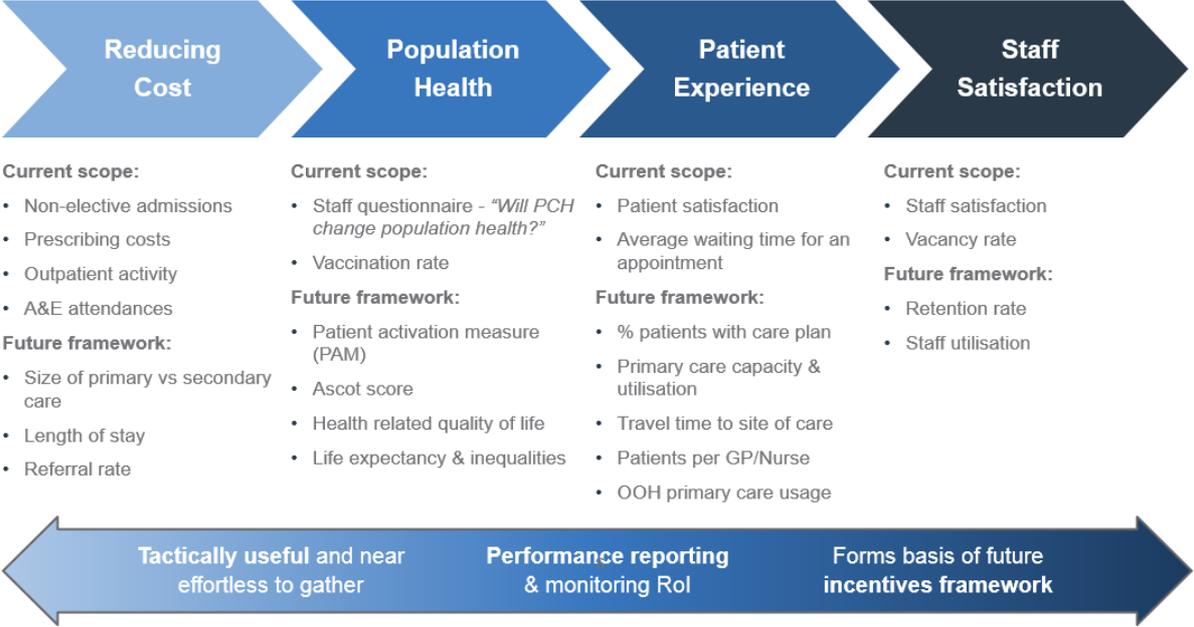
## Phase 3 - Report

Developing a report that sets out key findings from the assessment, and providing suggested next steps for continuing this work.

### Data and measurement framework

Figure 4 sets out the data sources and the metrics used to develop the assessment – as well as those which could be used in future evaluations and setting up a longer term benefits measurement framework. These cover the “triple aim” as well as staff satisfaction – which is widely considered to be a fundamental outcome itself given that it is an essential enabler for wider change and improvement.

Figure 4: Performance measurement metrics



This assessment is primarily based upon data provided by the rapid test sites. Additional data has been sourced to validate inputs and findings from the analysis to help build the strongest possible causal link between reported PCH investment and outcomes.

An analysis of data from neighbouring practices, CCG averages and historic trends enabled further validation of whether changes in metrics could be attributed to PCH. Careful consideration was also given to the timing of new initiatives and observed changes in performance metrics. Primary data has been collected as part of the staff questionnaire only.

The focus of this assessment has been on data that is robust and readily available, and those metrics which are easiest to track. A balance of outputs and outcomes have been used accordingly. Hard, quantitative and soft, qualitative measures have been considered. This approach has been used to inform the richest, most detailed picture of return on investment in the time available.

## C ASSUMPTIONS LOG

The assumptions we used to develop the model and to validate conclusions are described in this section.

### C.1 Global assumptions

The assumptions underpinning analysis of all three PCH sites are set out in the table below.

Global Assumptions
Episode costs have been sourced from NHS Reference Cost data for 13/14 and 14/15. Costs have been inflated based on historical growth to calculate indicative costs for 15/16. These assumptions have been cross referenced with multiple data sources and local studies to validate their accuracy.
<b>£1654</b> as the average cost of a non-elective admission
<b>£141</b> as the average cost of an A&E attendance
<b>£46</b> as the average cost of a GP appointment
<b>£139</b> as the average prescribing cost saving per patient from pharmacist-led medicine review
<b>£115</b> as the average cost of an outpatient appointment

### C.2 Beacon Medical Group

The assumptions underpinning analysis of the Beacon Medical Group PCH site are set out in the tables below.

A&E Attendances
Beacon Medical Group saw a <b>3%</b> growth in A&E attendances from (Apr – Dec) 2014 to 2015. This fell to <b>1%</b> from 2015 to 2016.
In total an estimated <b>109</b> A&E attendances were avoided, equivalent to a saving of <b>£15k</b> if the previous year's growth rate had continued over 2016. These savings assume an average A&E attendance cost of £141 per patient.

For GP registered patients over the age of 60 (i.e. those patients targeted by PCH initiatives taking place in Beacon), the reduction in A&E attendance growth was greater. From 2014 to 2015, the number of A&E attendances grew by **9%** for this population cohort. The growth rate fell to **1%** from 2015 to 2016.

Nationally, the growth rate in A&E attendances was **0.5%** from (Apr – Dec) 2014 to 2015 and grew to **4%** from 2015 to 2016. PCH may have lowered the A&E attendance growth rate in Beacon against national trends.

## A&E Admissions

Beacon Medical Group saw **7%** growth in non-elective admissions from (Apr – Dec) 2014 to 2015. This fell to **4%** from 2015 to 2016.

In total an estimated **55** non-elective admissions were avoided and a saving of **£91k** achieved during 2016. These savings assume an average A&E admission cost of £1654.

For GP registered patients over the age of 60 (i.e. those patients targeted by PCH initiatives taking place in Beacon Medical Group) the reduction in non-elective admissions growth was greater. From 2014 to 2015, non-elective admissions grew by **10%**, yet in 2015 to 2016 **no growth** in admissions occurred.

The national growth rate in non-elective admissions was **3%** from (Apr – Dec) 2014 to 2015 and continued at **3%** from 2015 to 2016. PCH may have reduced the A&E admission growth rate in Beacon Medical Group against national trends.

## Prescribing

**284** medication reviews for care home residents took place, leading to **194** medication changes, from Jul 16 to Dec 16.

Assuming an average medication review prescribing cost saving of £139 per resident, Beacon Medical Group has achieved savings of **£39k** per annum.

## Referrals

Hospital referrals grew by **5%** from (Apr – Nov) 2014 to 2015, and fell to **1%** from 2015 to 2016 (44 fewer referrals).

This approximates to **330** fewer referrals over the course of 2016, if the previous year's referral growth rate had been maintained.

Nationally, the referrals growth rate was **4%** from (Mar – Sept) 2014 to 2015 and **6%** from 2015 to 2016, which suggests Beacon Medical Group is bucking the national trend.

## Other

From Oct to Dec the **average length of stay for admitted care home residents** dropped from **12.7** days in 2015 to **5.1** days in 2016.

The **average waiting time for a GP appointment** fell from **14** days to **8** days (from 15th Aug 16 to 3rd Feb 17).

Beacon Medical Group saw a **5%** increase in **flu vaccinations** across all age groups and a **13%** increase in flu vaccinations for patients suffering from chronic respiratory illnesses, a notable hard to reach patient group.

## C.3 Thanet Health

The assumptions underpinning analysis of the Thanet Health PCH site are set out in the tables below.

A&E Attendances
Savings from reduced A&E attendances, facilitated by cross practice working during bank holidays enabled by Thanet's Integrated Care Record (EMIS). Reductions in A&E attendances from other Primary Care Home (PCH) initiatives were not considered.
<b>576</b> appointment slots were made available and <b>212</b> patients were seen in GP appointments slots over 16/17 Christmas bank holidays.
Assumed <b>50%</b> of patients seen would have presented at an A&E department if appointment slots had not been made available.
Based on these assumptions, cross practice working enabled by PCH and EMIS over this period led to a saving of <b>£10,019</b> .
Extrapolated over all banks holiday over a year, Thanet can expect to achieve a saving of <b>£27k</b> in A&E attendances alone.

A&E Admissions
Reductions in A&E admissions may be a result of work carried out by the Acute Response Team (ART), however a causal link is not clear. The majority of referrals to the ART are from A&E departments and GP practices.
A&E admissions fell by <b>155</b> admissions over a 10 week trial period from 14 <sup>th</sup> Nov 16 to 31 <sup>st</sup> Jan 17 or <b>15.5</b> admissions a week compared to the same period the previous year. Calculated from HCOOP dataset (Health Care for the Older Person).
A reduction in admissions was also observed using CCG data which reported an A&E admissions drop of <b>13.7</b> admissions a week over the period.
Thanet non-elective activity over the period is lower in 2016 than in the previous two years, suggesting the ART may have caused the change.
Thanet non-elective activity costs have remained stable while neighbouring CCG admission costs have grown over the period. The reduction in HCOOP activity bucks the trend of all East Kent CCGs over the last three years, further supporting Thanet's ART as the change agent.

Based on an average A&E admissions cost of £1654, the savings over the 10 week trial period were **£256k**.

Projected annual savings calculated as **£295k** by applying a discount factor of **25%**. A large discount factor has been applied to account for the short analysis period, seasonality and absence of a clear causal link that admissions reductions were a result of the ART.

Analysis carried out by the pilot site estimate 455 to 708 admissions avoided per annum, with estimated savings of **£281k** and **£437k** per annum.

## Prescribing

A pharmacist pilot took place as part of Thanet PCH's Elderly Frail Pathway.

The pilot reviewed **71** care home patients who were representative of Thanet's whole care home population.

**282** interventions were carried out and **163** medicines were stopped.

The pilot reported average medicine review savings of **£165.47** per resident and total savings of **£11,748**.

The total number of care home residents is estimated at **1500**.

Assuming a GP approval rate of **87%**, extrapolating pilot results over the whole care home population would suggest potential medicine review savings of **£216k**.

The pilot reportedly also released GP time. Annual savings would reduce as medicines management becomes more efficient, although as staff turnover, there is likely to be a recurrent need for training and education.

## C.4 Larwood and Bawtry

The assumptions underpinning analysis of the Larwood and Bawtry PCH site are set out in the tables below.

A&E Admissions
Reductions in A&E admissions may be a result of PCH however a causal link is unclear. Further work needed to establish to what extent any benefits can be attributed to PCH.
Site adopted a PCH model of care in Mar 16. Over the seven month period from May 16 to Nov 16 Larwood and Bawtry saw an <b>8%</b> reduction in A&E admissions compared to the same period the previous year. This equalled a reduction of <b>127</b> admissions.
The other practices in the CCG, not trialling a PCH care model, collectively saw only a <b>3%</b> reduction in A&E admissions, indicating that PCH may have had an impact on admission numbers.
Larwood and Bawtry accounted for only <b>32%</b> of CCG spend on A&E admissions in 2015, but were responsible for <b>57%</b> of CCG admissions savings achieved in 2016.
CCG stated A&E admission savings of <b>£277k</b> for the pilot site, at an average cost of <b>£2181</b> for each A&E admission, over the seven month period.
Projected annual savings calculated as <b>£352k</b> by applying a discount factor of <b>50%</b> and using the national average A&E admission cost of £1654. A discount factor has been applied to account for forecasting risk and the absence of a clear causal link that admissions reductions were a result of PCH.

Prescribing
Since adopting a PCH model of care, the pilot site have stated prescribing savings over a seven month period from May 16 to Nov 16 of <b>£169k</b> , over the same period the previous year.
This is equivalent to a <b>5%</b> decrease in prescribing costs, compared to a <b>2%</b> decrease in prescribing costs achieved by those practices in the CCG not implementing the PCH care model.
Larwood and Bawtry accounted for only <b>27%</b> of CCG spend on prescribing in 2015, yet were responsible for <b>54%</b> of CCG admissions savings achieved in 2016.
By applying a discount factor of <b>50%</b> to account for forecasting risk and causality, Larwood and Bawtry may be able to achieve prescribing savings of <b>£229k</b> per annum.

Reductions in non-elective admissions and prescribing costs have been achieved despite growth in the practice list by 500 patients from 14/15 to 15/16 and a budget reduction of £80k owing to a loss of the practice's PMS risk premium.

## Outpatients

Over the seven month period from May 16 to Nov 16 Larwood and Bawtry saw a **3% increase** in outpatient appointments compared to the same period the previous year. This equalled an increase of **152** appointments.

Outpatient appointment numbers for those practices in the CCG not trialling a PCH care model remained broadly static, indicating that PCH may have had led to an increase in outpatients. Further work is needed to understand fully the reasons behind this increase.

The CCG stated an outpatient cost increase of **£24k** for the pilot site, at an average cost of **£157** for each outpatient appointment.

Projected annual cost increase of **£32k** by applying a discount factor of **50%** to account for forecasting risk and causality.

Over the seven month period from May 16 to Nov 16, Larwood and Bawtry saw a **3% increase** in outpatient appointments compared to the same period the previous year. This equalled an increase of **152** appointments.

## Notes



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- 57 – Pharmacy members
- NPCN Network – 300 members on database, National Thought Leaders
- Nurses Voice Network – cohort of 6 senior nurses from across the country
- Innovation Network, Primary Care Navigators – 90 trainees from across pharmacy and general practice



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