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National Primary Care Network

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New Models of Care

Report

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Welcome

Samantha Jones Appeals to the NPCN for Answers on How to Make the New Models of Care Work

Samantha Jones, NHS England's Director of New Models of Care, has called on the National Primary Care Network to support her and the programme to implement the new models of care that underpin the Forward View.

Addressing an NPCN meeting in London last week, Samantha, just four weeks in post, admitted 'feeling a range of emotions ' as she read through 269 expressions of interest to become Vanguard sites. The most promising contenders for a slice of the £200 million transformation fund were invited to present their plans to a workshop with a range of stakeholders including local government, patient and clinical representatives. As part of these workshops, participants were asked to give their views through a voting system " X factor style".

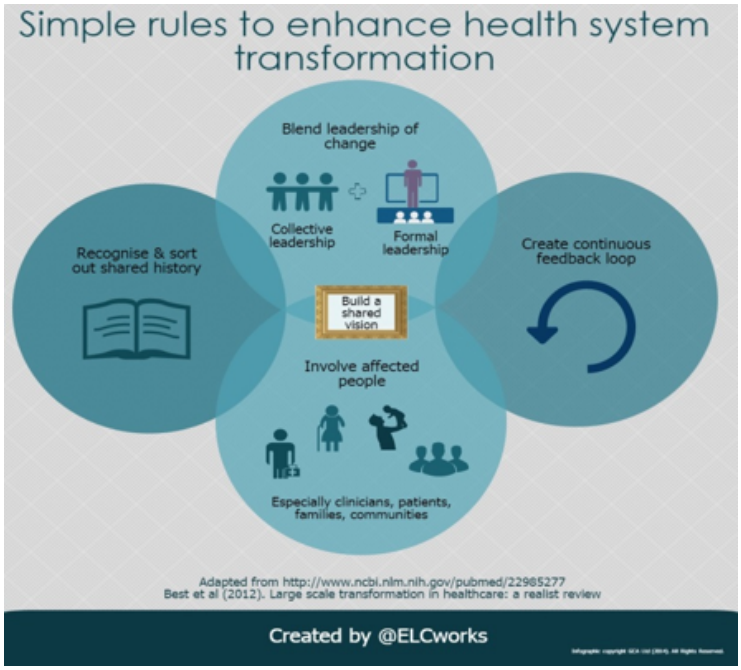
Once appointed, the Vanguards will undergo real-time evaluation and must turn around replicable models of care by the end of 2015/16, said Samantha, who was head-hunted from her role as chief executive at West Hertfordshire Hospitals Trust. However, NPCN (England) Chair Dr James Kingsland and other members warned against overreliance on the Vanguard programme to deliver the new care models fearing the process risked stifling innovation elsewhere in health and social care.

HOW TO MAKE THE NEW CARE MODELS WORK - IDEAS AND INSPIRATION FROM MEMBERS OF THE NPCN

In response to Samantha's appeal for support in making the new care models work, NPCN members who attended last week's meeting have produced some heart-felt suggestions.

1. Communities of people, families and front line teams already know how to improve health and wellbeing outcomes. In fact, they are the only ones who can improve them. We need to build the seven models of care based on deep insight into peoples' lived experiences and what is already working well. Few health economies have invested in really understanding what matters. Fewer still seek to improve the experience of frontline teams. By focusing more on relationships and less on systems and process, communities will accelerate their progress and get it right first time.

Georgina Craig, National Programme Manager, Experience Led Commissioning Georgina Craig Associates



2. The 5YFV provides a way of thinking about what we need to do, collectively, to ensure health and care are provided to communities according to their need by working together with shared values and aligned ambition. Community pharmacy has a central role: providing insight, expertise and capacity to make new delivery models work, and spreading benefits across the whole population, not only those within vanguard sites. This is achieved when LPCs/LPNs are fully involved in local plans and when Pharmacy Voice, representing well over 90% of the owners of community pharmacy, contributes to the national leadership of health and care transformation.

Deirdre Doogan, Policy & Communications Team, Pharmacy Voice

3. The 5YFV provides an opportunity for whole-system engagement and integration. There are many examples and pockets of good practice and these need to be spread at scale to achieve the efficiencies and transformation required to improve the health of the population. Vanguard (and other) sites should engage at the outset with LPC/ LPNs to align local and national pharmacy leadership to ensure that new delivery models are fit for purpose. This will require transformational resource to allow all clinicians, health and social care professionals to have the space to communicate

Liz Stafford, Rowlands Pharmacy

4. Modernisation of health care is essential but the proposed vanguard selection produces a tension between the support of a few elite and losing the enthusiasm of those who despite all the challenges of the health economy still put themselves forward. Most innovators require permissions, guidance and support to enact changes not large allocations of resource.

There are a wealth of veterans whose expertise and corporate knowledge can be harnessed to spread lessons that emerge, manage changes to deal with risk aversion and nurture leaders of the future. Organisations such as NAPC are in a unique position to help support early adopters, provide a holding space for leadership networks and promote a vision based on population health outcomes.
Dr Ian Greaves, Senior Partner Gnosall surgery

5. Optometrists are well placed to become part of an integrated network of clinically led care and manage patients with long term or minor conditions outside the hospital, safely and effectively. There are already examples of this around the UK.

Optometrists have clinical expertise, well-equipped premises and are easily accessible. Patients can be seen closer to home and more quickly than if referred to hospital. This means that optometrists can make a significant contribution to a new model of care, where a clinically led community eye care team places the patient at its centre.
Dr Susan Blakeney, Clinical Adviser, College of Optometrists

6. At the core of any model is influence over clinical behaviour to improve quality and minimise waste. Most of the solutions lie within the hearts and minds of our frontline clinical/care staff. The perfect model of care does not exist, and we need to create the capacity to piece together all the learning from other systems. The commitment, encouragement and resilience of the people who wish to progress this is our greatest asset and some of our answers may not appear so obviously to begin with. Whilst exemplars can be good motivators we need to guard against losing great ideas in the noise of a top down process such as the Vanguard bid.
Dr Gordon Sinclair, Chair, NHS Leeds West Clinical Commissioning Group

7. We need our new care organisations to be agile, enterprising and focussed on 'running and innovating the business' versus 'satisfying NHSE and regulators'. We do need assurance, so please ensure this is based 100% on routinely available, publicly accessible quantitative and qualitative data. Please do not tie-up managers and clinicians in monitoring meetings and feeding data upwards to regulators and NHSE. Assurance must be seamlessly 'designed in' (quality assurance) versus 'layered on top' (quality control). Let's make best use of ideas from cutting-edge management research on quality assurance.
Dr Jagdeesh Singh Dhaliwal, Deputy Director of postgraduate programmes, Keele Medical School

8. The 5YFV cannot possibly meet growing demand, deliver new models of care and live within potentially available resources without re-thinking the networks of care that operate outside hospital – particularly in primary and community care. During the gestation of the 5YFV the three non-medical Primary Care professions worked hard to produce responses to Calls to Action for eye health, pharmacy and dentistry.

It is to be hoped that the 'vanguard sites' will be encouraged to engage with their local community professional and patients' networks – particularly LPNs - to deliver the 5YFV goals. Without them the vanguards cannot succeed
David Hewlett, Optical Confederation, Federation of Opticians

9. Despite not having a separate 'Call To Action', the NHS community hearing service is a key part of primary care and essential to patients' well-being, independence, quality of life and remaining out of hospital. Unaddressed sensory impairment impacts on loneliness, isolation, depression and cognitive decline and tackling it must be a priority given the ageing population, limits on resources and the need to keep people out of hospital. Delivering adult hearing care in the community at scale should thus be an equal priority both in the 'vanguard sites' and across the NHS in developing networks of primary care outside hospital.
Harjit Sandhu, National Community Hearing Association

10. The Royal College of Speech and Language Therapists supports the clear vision as detailed in this plan and we wish to be part of the solution to the many challenges facing the NHS. As a profession we are used to working in an integrated fashion with a broad range of agencies and welcome the opportunity of reducing barriers to such approaches. We recognise the importance of outcome measurement and have adopted a common approach. Our contribution to addressing health inequalities by addressing the poor communication skills of children from some communities, which places them at disadvantages in education and employment, is key to the initiative. Transforming our role by adopting broader strategies and approaches with older people living in the community and sharing our skills in facilitating communication with other professionals in order that we've become part of a more flexible workforce is being addressed.
Pam Enderby, Professor Emeritus, University of Sheffield

11. Take care that the Vanguards do not become the key focus of the New Models of Care. This could serve the purpose of alienating and disengaging everyone else, which would not be the intention.

Change at pace needs the application of rigorous and robust quality improvement methodologies in order to understand what works well and not so well.

It will be interesting to understand how this will dovetail with the Shape of Caring review due to be published March 2015. Higher Education Institutes will benefit from understanding how they can best support the adoption and spread of New Models of Care.
Rhian Last, Clinical Lead at Education For Health, Warwick

12. There is a need to create and hold a 'space' for innovative change.

A collaborative partnership with such a high-level of innovative practice requires high-quality, full time facilitation; at the very least in its early formative stage. Historically this has not been a natural capability for most organisations working within health and care, nor is it usually considered a full-time role.

However, it will be important to ensure that this role of 'holding the space' is built into the process as a primary role for one of the partners.
Paul Hitchcock, Business Development Director, Kent Surrey Sussex Academic Health Science Network

13. Multidisciplinary approach is key.
Prevention needs to be explicit.
We need a dialogue about place as well as people.
We need to make sure that the needs of children and young people are understood and new services meet their needs - historically we have built services for adults and tried to make CYP fit.
Professor Viv Bennett: Director of Nursing at Public Health england. Immediate past Deputy Chief Nursing Officer

14. It is important that, once vanguard sites are chosen, support is provided to ensure that all local professionals are included in shaping the new models of care. Local leadership for some professional groups may not be fully developed but this should not put at risk the positive opportunity there is to utilise the whole workforce.

Pharmacy has an increasing role in supporting health and wellbeing and this should be accelerated in the vanguard sites (and others). This will only be possible by supporting local pharmacy leadership to be part of planning from the very start.
Robbie Turner, Chief Executive Officer, Community Pharmacy West Yorkshire

15. The 5YFV allows us to focus on dissolving traditional boundaries and develop integrated networks of care co-ordinated around the patient. This should allow better use of the available workforce.

As we heard in the responses to NHS England's Calls to Action, optical practices, pharmacies and dental surgeries can play a key role in helping GPs deliver out of hospital care at the heart of communities. We hope that this will be embedded in the new models of care programme and the vanguard sites.

LOCSU will contribute to the national and local leadership of the programme as part of our support for LOCs and LEHNs.
Zoe Richmond, Optical Lead, Local Optical Committee Support Unit

16. Authors of NHS Five Year Forward View are dominantly of hospital background, making hospitals the hare in the marathon ahead. To win, Primary Care (General Practice, Community Pharmacist, Dentists, Optometrists) needs:

- Allies: PATIENTS, Carers, District Nurses, Social Services, Public Health, Charities, Councils, Private Sector in an all-inclusive corporate partnership.
- Implement existing successful models of community care, providing high quality – low cost service – this is currently suppressed by hospitals' vested interests.
- CCGs to lead by using Primary Care budgets to DELIVER the NHS Five Year Forward View, leaving the hare sorrowfully mulling over, "Why the tortoise, NPCN, always wins!"

Dr Kosta Manis, Bexley CCG Clinical Lead

17. We need to be very clear in developing new models of care of the "value" to a population. Value of such outcomes should be built around outcomes that matter to people - those encompassing health and wellbeing and not just around the more easy to measure biomedical outcomes.

Primary care is a solution as it enables the paradox of population focus and person centred care to be neatly addressed. Moving away from activity based funding systems to capitated systems for a population is key as is transforming the workforce so that the focus is on inter-professional approaches to delivering excellent care.
Dr Nav Chana, NAPC Chairman

18. Include a measure of continuity of care in the New Models of Care solutions. Research estimates 1% increase in continuity of care over a year can save £20,000 per GP practice. Service design which includes continuity can substantially reduce costs from hospital admission.

Quality healthcare depends on the quality of relationships between patients and professionals. General practice at its best is about delivering continuity of care which benefits patients, carers, practitioners and the wider NHS. Longitudinal relationship healthcare matters to patients, especially those with multiple long-term conditions.
Moira Auchterlonie, Chief Executive Officer, Family Doctor Association

19. New Models of Care presents an opportunity to maximise the contribution that pharmacy can make to prevention, early detection and delivery of patient care. There is untapped clinical capability, capacity and accessibility in the workforce.

Also a clinical and financial imperative to address the suboptimal use of medicines with 17% of hospital admissions in over 65s due to problems with medicines and up to 50% of people not taking medicines as intended by prescribers.

Integration of pharmacists with GPs and all health and social care professionals could provide better joined up care across pathways. New incentives are needed to make this happen at a local level.
Liz Butterfield, Pharmacy consultant, Royal Pharmaceutical Society.

20. Don't forget that 'primary care home' concept is what needs to be developed, around the GP patient list size – with wrap around services contributing to the first contact practitioner model- right person first time. We need to address the wider determinants of wellbeing with a shift from patient health to population wellbeing. Primary care professionals, in the privileged roles, should be encouraged to participate in building social capital and contribute to corporate responsibility. Give Primary Care the opportunity to embrace this agenda by supporting innovation over and above Multispecialty Community Providers, don't let the commissioners get sucked into subsidising Social Care with Primary Care development being the casualty of this type of behaviour.
Dr Raian Sheikh, GP Board Member, Mansfield & Ashfield CCG

21. Stalin had five year plans and he had Gulags for his dissenters! The care model needs to be what the patients and public want and need, not what the organisations supply. The model of medicine needs to modernise and get back to what the NHS was set up to do. It was meant to keep people well enough to work to pay taxes to fund the service. Prevention has never been invested in as the returns are too long in coming. The Health and Wellbeing Boards can assess and invest in the determinants of health. When determining change remember WAMO applies (worried about missing out!). Every organisation has business models based on growth but with fixed budget there have to be losers and this needs managing.
Dr Joe McGilligan, LGA Health and Wellbeing Champion

Here are the key messages from Samantha Jones' slides presented at the NPCN Meeting 24 February 2015

What we are trying to achieve

There are three key elements to the New Models of Care programme

1 **Dissolving traditional barriers**	• A need to manage systems of care not just organisations • Integrated services around the patient giving the patient greater control • Addressing pre-existing barriers to change
2 **Co-designing local services**	• Harnessing the 'renewable energy' of communities • Targeted prevention initiatives • Investment and flexibilities to support implementation of new care models • Active patient involvement
3 **Applying learnings across the health system**	• Promote peer learning with similar areas • Fast learning from best practice examples • Applying innovations and learnings across the system

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What does success look like?

A range of new care models that are locally delivered across the country and can be replicated across the system

1 **New care models**	• A need to manage systems of care not just organisations • Integrated services around the patient giving the patient greater control in their care
2 **Locally delivered**	• A focus on meeting local population health needs • Support from a diverse range of active delivery partners, local commissioners and communities • Active patient involvement
3 **National replicability**	• Fast learning from best practice examples that can be applied to other areas across the country • Applying innovations and learnings across the system

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Last Words

Dr James Kingsland OBE

Dr James Kingsland OBE
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What has been will be again, what has been done will be done again; there is nothing new under the sun.
Ecclesiastes 1:9

If we believe this Old Testament counsel, then history often merely repeats itself. It has all been done before. Nothing may now be truly new?

Maybe we need to learn from Marie Antoinette, the Dauphine of France, guillotined by French Revolutionaries in 1793, who is credited with saying, 'There is nothing new except what has been forgotten'.

In July 2000, Professor Sir Liam Donaldson, then the Chief Medical Officer, published a report, appositely entitled "An Organisation With a Memory", highlighting the importance of patient safety, which led to the establishment of the National Patient Safety Agency. But a decade on, the 2010 Francis Report into the care scandal at the Mid-Staffordshire NHS Foundation Trust was treading exactly the same ground. We´re evidently not learning from experience. Indeed, does the NHS have a corporate memory?

Yes, we need to do things differently in the future, but we must learn from the past. Sometimes we need to look back to understand the future. Change is inevitable and generally expected and welcomed when engendered from a stable foundation, with a strong evidence base for change and a clear vision for a brighter future. The deep personal commitment of the health and managerial professionals serving the NHS is born from purpose and service and motivated by care reform, not continual re-structuring of the NHS.

The practical advice from the NPCN in this short report gives an overview of how clinical thinking needs to be incorporated into any new models of service delivery.

In July 2000 at the launch of the NHS 10 year Plan, the then Secretary of State for Health, Alan Milburn, advised that the NHS was 'drinking at the last chance saloon'.

The Five Year Forward View has now got to get it right on the delivery of new models of care or this time we really may not have another attempt to rejuvenate the NHS.

Dr James Kingsland OBE

Chair, National Primary Care Network (England)
President, National Association of Primary Care (UK)

Key dates to save:

Pharmacy Show

18-19 October 2015
NEC Birmingham

TRADE DAYS
TIME TO DO BUSINESS
Mobility • Living Aids • Assistive Technology

18-19 October 2015
NEC Birmingham

Best Practice

21-22 October 2015
NEC Birmingham

Best Practice in Nursing

21-22 October 2015
NEC Birmingham

PATIENT FIRST
PREVENTING HARM IMPROVING CARE

12-13 November 2015
Excel London

ACUTE & GENERAL MEDICINE

12-13 November 2015
Excel London

dentistry show
for all that dentistry demands

17-18 April 2015
NEC Birmingham

THE Clinical Pharmacy CONGRESS

24-25 April 2015
Excel London

HEALTH CARE 2015

24-25 June 2015
Excel London

COMMISSIONING

24-25 June 2015
Excel London

Occupational Therapy Show

25-26 November 2015
NEC Birmingham

THERAPY EXPO

25-26 November 2015
NEC Birmingham

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