



National Primary Care Network

Developing a successful Multispecialty Community Provider

Report



Report sponsored by



Introduction to the National Primary Care Network

The National Primary Care Network (NPCN) is a group of over 500 healthcare professionals from across primary care including GPs, nurses, dentists, optometrists and pharmacists. It holds a quarterly meeting for around 50 participants from which a report is produced. This is the latest in the series.

This year, the NPCN is delighted to receive the support of Microsoft.

This report by Closer Still Media reporter Ailsa Colquhoun is intended as a record of a daytime meeting held on 24th June 2015 at London ExCel during the annual Health + Care and Commissioning event organised by Closer Still Media. The theme of this meeting was 'Developing the components of a successful Multispecialty Community Provider' and it comprised a thought-provoking introduction to the topic provided by Dr James Kingsland OBE – the NPCN's Chair, and a presentation by Louise Watson, NHS England National MCP Programme Lead, New Models of Care team, who provided an update on NHS England's 'vanguard' sites. These are supporting the improvement and integration of services as part of NHS England's delivery of the Five Year Forward View.

During the meeting, participants divided themselves into discussion groups to discuss three specific aspects of the MCP model of care, and the results of these discussions are also presented in this report on pages 3-5. The discussion topics were:

- Risks and rewards of locally managed capitated budgets
- Integrated workforce modelling
- Developing population health outcomes.

CloserStill Media, the business media company which puts on Health + Care and Commissioning, the largest event for health and social care professionals, supports the NPCN financially but has no input in the NPCN's discussions.

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MCP: The challenge ahead

Opening the June 2015 NPCN meeting, NPCN chairman Dr James Kingsland challenged members to propose the outlines of a new service model that “builds on current primary care”, takes primary care “to a new level” and which can be implemented relatively quickly. To aid understanding, the meeting was encouraged to see the new model as a type of ‘primary care home’.

Dr Kingsland told members that the NHS in England was open to proposals that built on the vision for Multispecialty Community Providers already set out in its Five Year Forward View, and which are now being tested in the vanguard sites until April 2016. (An update on this work programme is provided by Louise Watson, NHS England national MCP programme lead, on page 5 of this report).

Dr Kingsland told members that several key elements should feature in the new models of primary care, notably, that there should be:

- a continuum of integrated, multidisciplinary care
- funding based on a registered population base, ideally of between 30,000-50,000
- features that can be replicated
- a balance of personalised care and local population health
- a robust evidence base that includes the views of individual service users
- a manageable scale that reduces risks associated with very small population groups.

He also suggested that when setting out proposals for NHS England, NPCN members should consider how internal market efficiencies might be achieved. Dr Kingsland continued: “If you don’t manage your estate, your consumables and your workforce, your ability to achieve efficiencies will be seriously compromised. We need to introduce the principles of business efficiency and leadership into the way we manage care. We need to act like a householder and behave responsibly; we can’t allow patients with low complex needs to attend A&E without consequences.”

The meeting heard that although a multidisciplinary workforce is important, to maintain a sense of ownership organisations need to manage staffing levels. Organisations of over 150 people often lose their innate ability to connect with people and there tends to be less sense of collegiate working, the meeting was told.

Dr Kingsland also stressed the importance of new care model teams having a vested interest in behavioural change. In other words, “we need healthcare professionals with ‘skin in the game’, he said.”

Challenging times

Summarising the challenge, Dr Kingsland told the meeting that there was a need to achieve a sea-change in GP thinking. Dr Kingsland said: “GPs are now far more focused on developing federations than getting involved in the commissioning process. We now need to focus attention on ‘make or buy’ decision-making, and to introduce some accountability for that decision-making.”

GP capacity workforce concerns

Handing the floor over to NPCN members, Dr Kingsland invited discussion and questions, and to encourage debate, he invited the meeting to discuss workforce remodelling. “If we are going to meet increasing population demand, we must think how we will involve specialist healthcare professionals, such as optometrists, dermatologists, etc. We also need to release the resources for commissioning-based transactions.” Angela Dempsey, from Enfield CCG, suggested that the army model of multidisciplinary care services could provide some insight into possible new NHS primary care service models.

NPCN members quickly suggested that GP workforce capacity is a major consideration in the debate about new models of care. It is estimated that between one third to 80% of GP consultations could be managed by a non-medical healthcare professional, and that if this demand is managed correctly, this could turn the current under-provision of GPs into an oversupply. "But before that can happen, questions need to be asked", said Georgina Craig, Director, Georgina Craig Associates. She said: "We need to ask: what needs to happen so that we don't need more GPs?"

David Paynton, RCGP National Clinical Lead, also pointed out: "We need to scrap the thinking of 'do we need more/fewer GPs?', and instead consider what right care actually looks like, and structure the workforce around that."

Agreeing with the general sentiments, Dr Howard Stoaite, Chair, NHS Bexley Clinical Commissioning Group, countered with an issue about GPs handing over the management of patients to a non-medical healthcare professional. He said that a key question to answer is: 'Which third do we give up?' He explained: "We all know the apparently trivial consultation that becomes more complicated as the patient gets up to leave the room. GPs have extensive training in risk management. My question is: 'Without a GP, how will you ensure that the patient still receives the right care?'"

Patient viewpoint

Providing the patient viewpoint, Mark Duman, Director, Monmouth Partners, urged any new model of care to put patients at the centre. He said: "Let me be the integrator of service, not the system. Include patients and carers in the workforce, and please look at me as part of the workforce."

The meeting was also urged to consider how patient contact might be organised, and who might be the first port of call. The phone, for example, can be used for 60% of acute consultations.

Delegates then widened the discussion to consider other barriers and opportunities for new models of care. Turning to inter-professional communication networks, Mukesh Lad, Pharmacist and Chairman – Pharmacy Northamptonshire, pointed out that lack of IT links is a real problem for the non-GP workforce and that there are important savings to be made if communications were improved. Echoing his sentiments, Rosemary Plum, Pharmacist, Chief Officer – Pharmacy Northamptonshire, said: "IT is a can of worms, it is a big problem."

Public health in development plans

The meeting was also reminded about the need to include public health promotion in the plans. Simon Poole, GPC, BMA, said: "Health information and education is a therapy in itself and this also needs investment. Leave out public health and social care and you are missing the whole point."

Liz Stafford, from Rowlands Pharmacy, also noted that by 2020 there will be a very well-developed healthy living pharmacy network. "All MCPs need to have pharmacy input," she said.

Introducing the topic of risk and reward in the new models of service provision – a topic that was discussed further in a subsequent break-out discussion (see page 7 for more information) - Simon Poole, GP, Chair Cambridgeshire LMC, noted that "rewards are not just financial". Dr Poole said: "GPs do not want more money but a better working environment. Money is not the only incentive."

What is a Multispecialty Community Provider?

The Multispecialty Community Provider vision is a horizontal integration of primary and community services, described in the Five Year Forward View as "a focal point for a far wider range of care needed by their registered patients. As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists,

psychologists, social workers, and other staff."

According to the 5YFV, this is a model that "will expand the leadership of primary care to include nurses, therapists and other community based professionals [who] in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers".

MCPs – current learning and future ambition

The NPCN meeting was delighted to welcome Louise Watson, NHS England national MCP programme lead to provide an update on the MCP vanguard programme in existence in England since March, 2015.

Of the 29 'vanguard' geographies, 14 are multispecialty community providers (MCPs) have been taking the lead on transforming care for patients in towns, cities and counties across England by focusing attention on moving specialist care out of hospitals into the community. The aim, says Ms Watson is to "address the care and quality gap" identified as present in current NHS England care models.

Looking back at the first few months of the vanguards' progress, Ms Watson says that the new models have demonstrated a potential to significantly challenge current organisational models, existing workforce structures, working cultures and even current commissioning/contracting models.

She told the NPCN meeting that NHS England has set out only the principles of the programme: clinical engagement; patient involvement and local ownership, with the benefit of national support.

She said that it was a decision for local communities – not NHS England – to determine the appropriate local model of care. "NHS England is less interested in operational form and more on the delivery of end to end patient care. vanguards are not governed by existing structures and processes and are free to ask the question 'What if... ' rather than 'What do we usually do?'

As a result there has been a "significant cultural change" as CCG models grapple with the ramifications of change for their

operations. She noted: "There are lots of questions currently being asked such as: 'What happens to the current CCG model of primary care?' 'How do locally-owned capitated budgets work on the ground?' and 'What payment systems are appropriate for these models?'

She said that after conducting vanguard site visits earlier this year, it was now becoming possible to define success:

- For the NHS this centres on a replicable model, where local nuances are understood and that there are metrics around patient experience and care.
- For patients, it is that health, care and support services are more accessible, more responsive and more effective and that experiences and outcomes are improved through more coordinated support and 24/7 access to information and advice.

She told the meeting that NHS England was currently supporting the 29 geographies with shared support and learning resources.

National support for vanguards



Mind the gap

Three proposed solutions will fill the gaps faced by the NHS in England

Health and Wellbeing gap –
Radical upgrade in prevention

Care and Quality gap –
New care models

Funding gap –
Efficiency and investment

Who are the vanguard 29?

The 29 vanguard 'geographies' comprise:

- 14** multispecialty community providers (MCPs) – moving specialist care out of hospitals into the community;
- 9** integrated primary and acute care systems (PACS) – joining up GP, hospital, community and mental health services, and;
- 6** models of enhanced health in care homes – offering older people better, joined up health, care and rehabilitation services.

What do MCP vanguards look like?

- Enhanced primary care service
- Specialist care in the community
- Integrated and multidisciplinary teams
- Offer personalised care as well as population health
- Function as information hubs
- Provide tools for self care
- Promote public health
- Use technology to support health management

NPCN members had a range of burning questions for Louise Watson. Here are the key questions and answers

Q What happens to secondary care if funding flows into primary care?

A The aim is to provide holistic care for the individual in the community. There is no intention to destabilise secondary care and the overall health economy.

Q Is risk stratification proving problematic?

A We are currently working with sites to embed risk stratification processes. In some proactive care management is routine, others are struggling and it is little more than a philosophy.

Q Is self care being effectively taken forward by the vanguards?

A There is huge enthusiasm for 'social movement', a mechanism through which the health service engages the local population in its health and engenders change within the community.

Q What sort of financial model are the vanguard sites adopting?

A There is continuing dialogue about how the vanguard service models will be financed. We are urging our vanguard sites not to think they can't do something. We want to see financial models that don't constrain choice; that is why vanguards have the flexibility to move beyond annual accounting. We want the vanguards to have a conversation with us about what they want to do, and how it might be achieved.

Q Are positive health outcomes being seen following the delegation of commissioning responsibility to local authorities?

A Some vanguards have very positive relationships with local authorities and others are finding this more difficult to achieve. Local authorities have their own funding constraints, which affects how they can align with health. Where working relationships are strong locally, the

locality sees strong and powerful outcomes

Q What is the level of pharmacy involvement in the vanguard sites?

A Six of the 29 vanguards have active pharmacy involvement. But there is a spectrum of involvement, from alliances with a pharmacy organisation to on-site pharmacist models. The community and clinical pharmacist roles are very different, and we need to have a conversation about this.

Q What sort of metrics are the vanguards using to measure success?

A We want the vanguards to develop metrics that capture not just satisfaction with a service, but the improvement in the service user's ability to manage their own healthcare.

Discussion group I report: Risks and rewards of locally managed capitated budgets

The aim of this group's discuss was to determine the key questions for the design of locally-managed capitated budget holders, and define the potential risks and rewards that they may face

Issues for consideration:

- should budgets be decided by affinity rather than geography?
- possibility of take-over by a bigger non NHS organisation
- complexity of commissioning network
- what else should be included? Tertiary/ specialised care, social care, dental care?

Risks

Governance and accountability:

- who holds the ring? Perhaps, health and wellbeing boards/strategic commissioners
- what are the performance indicators of effective population based care? (Budgetary or activity-based?)

Financial wellbeing:

- what happens if there is an overspend?

- what happens for patients requiring spaced out care if the money runs out?
- what is the impact of short term accounting periods?
- where are the efficiencies in transaction costs?

Patient outcomes:

- what is the contingency for expensive patients?
- how can equitable services be maintained?
- prevention and education: How are upstream outcomes be rewarded?

Staffing

- if technology reduces headcount, what is the impact on skill mix and service quality?

Rewards

- pay on outcomes, eg, hip ops – guarantee for outcomes for five years
- risk share associated with care pathway
- positive impact on total costs from reduced transaction costs
- potential for reinvestment of surplus
- improved professionalism and organisational development
- transparency and improved relationships with patients and communities equals growth public scrutiny and trust
- salaried GPs/staff: increased focus on clinical activities
- removal of perverse incentives that destabilise acute care

With special thanks to group facilitator Sam Sherrington

Discussion group 2 report: Integrated workforce modelling

The aim of this group's discussion was to re-orientate the first contact service to meet the needs of the population it serves. The following suggests the focus, structure and actions required to redesign the workforce to meet those needs.

Focus	Commissioning	Structure	Action
Policy	<p>Provide training for the whole workforce in situ in the home</p> <p>Rearrange funding across groups of staff and learners for fair allocation</p> <p>Base training on capability not professional silos</p>	<p>Support free movement of workforce professions across organisation and buildings</p>	<p>Liaise with HEE LETB to inform them what 'Home' would need.</p> <p>Build on MCP and vanguard and 10 point plan work</p>
Creating a supportive environment	<p>Focus on values and supporting/measuring safe and supportive culture that supports commitment to improvement and to community as well as value for money</p>	<p>Flexible working and working hours for flexible workforce, no more 9-5 idea.</p> <p>Include voluntary sector</p>	<p>Identify what has to stop and what has to start. Train professionals to stop doing the usual and known when it doesn't work, and start doing the unusual and unknown that does work.</p>
Develop community skills	<p>Focus on community health and well as personal health</p>	<p>Acknowledge workforce health too, including resilience and ongoing professional development – especially if we are going to start reporting on safety and changing professional identities</p>	<p>Explore community development models such as dementia friendly community and support for staff that supports disclosure, risk and change in professional identity – Balian etc?</p>
Developing patient skills	<p>Focus on self care as well as clinical care,</p>	<p>Public are our workforce – what is in place to educate and support the public?</p> <p>What is in place to support professionals to develop shared decision making that helps concordance?</p>	<p>What works for patient enablement?</p> <p>What works to address 'power issues' for professionals?</p>
Develop professional skills	<p>Generalist skills needed across the professions, not defined by the badge but by the persons; capability .</p> <p>Social prescribing as well as medical model</p>	<p>Link across 'homes' to others to support key specialist roles.</p> <p>Support staff and skills needed for 'outreach' to communities not reached by current model, from homeless, to commuter.</p>	<p>Challenge current structures that limit this eg nurses cannot sign sick / fit notes,</p> <p>Support more non medical prescribing programmes</p> <p>How to turn professional identity from expert to enabler</p>

Discussion group 3 report: Developing population health outcomes

The discussion group felt that changing the outcomes we measure to hold any new MCP or 'primary care home' to account was critical to their impact.

The group felt that the outcomes measured linked closely with and drove the risks that MCPs would take. Members commented:

"You can't detach outcomes from risk and size of the population. If the population is 50,000, you need outcome measures appropriate for that population size"

The group felt achieving outcomes needed to lead to reward; incentives needed to align across the whole system as well.

Group members commented: "The architecture needs to link outcomes to risk and reward"

A comparison could be drawn between the suggested framework and the way a company reports to the stock market. There would be two outcomes frameworks: one external and national that would act as a benchmark for 'big ticket outcomes' – and a second one that would be internal and about driving quality and improvement. This would be more flexible and tailored to the local situation.

Xhead: Principles of outcome measurement

The group did not want outcome measurement to become 'an industry' in

its own right' and it felt there was a danger of that happening. Instead there should be a focus on outcomes in a way that added value to the management process; a few simple measures that were evidence based. This included measures that are person centred and reflect what matters to people, families and front line teams.

Benchmarking was important too, with organisations able to compare themselves with others who faced similar challenges and cared for similar populations e.g. in terms of geography and levels of deprivation.

Holding all providers to account for a small number of meaningful shared outcomes was important to drive collaboration and joined up working. The group saw the MCP sharing responsibility for delivering some outcomes with others.

The national framework would include:

- Financial stability of the health economy (beyond MCP walls)
- Broad, community based, public health (clinical) that are measured over long time periods so MCPs have the 'chance to make a difference'

The local framework would include:

- 'Measures that encourage less medicine' and demedicalised care
- Measures of behaviour change – both front line clinicians and people, families – towards "what I can do for myself"
- Measures of "being in control"
- Wellbeing outcomes – both front line teams and people, families

The discussion raised further questions:

- How do we align with local authorities? They are in control of a lot of the things that impact on wellbeing
- How do we get better at educating people to take control of their health issues?
- Are we getting through to people?
- What is the impact of the 'Google effect'?

With special thanks to group facilitator Georgina Craig

Attendance list

With thanks to all those who attended

Suj Ahmed

Diabetes UK, Senior Healthcare Professional
Engagement Officer

Katherine Andrews

NAPC, Network Manager

Moira Auctherlonie

CEO, Family Doctors Association

Paul Batchelor

Consultant, Dental Public Health - Thames
Valley

Sue Blakeney

Clinical Advisor - College of Optometrists

Alastair Buxton

Head of NHS Services, Pharmaceutical Services
Negotiating Committee

Nav Chana

Chair, NAPC

Ailsa Colquhoun

Freelance journalist, editor and writer

Georgina Craig

Director, Georgina Craig Associates

Angela Dempsey

NHS Enfield CCG

Mark Duman

Director, Monmouth Partners

Brian Fisher

GP, PEC Chair,
NHS Alliance PPI Lead

Sasha Foley

Personal Assistance,
Dr James Kingsland & Waring Health Ltd

David Hewlett

Federation of Opticians (FODO)

Paul Hitchcock

Business Development Director, Academic
Health Science Network

Sally Gosling

Assistant Director, Chartered Society
of Physiotherapy

James Kingsland

GP, Chair NPCN, President NAPC

Mukesh Lad

Pharmacist, Chairman –
Pharmacy Northamptonshire

Steve Laitner

GP, NHS Herts Valleys CCG

Andrew Lawrence

Managing Director, Monmouth Partners

Marion Lynch

Dep, Medical Director, NHSE South Central

David Lyon

NHS Halton CCG

Kosta Manis

NHS Bexley CCG

Julia Manning

Chief Executive, 2020 Health Organisation

Andrew Nwosu

Regional Allied Health Professions Lead,

David Parkins

President, The College of Optometrists

David Paynton

National Clinical Lead - RCGP

Rosemary Plum

Pharmacist, Chief Officer – Pharmacy
Northamptonshire

Simon Poole

GP, Chair Cambridgeshire LMC

Gill Rogers

Director of General Practice Nursing /
Londonwide LMC's

Zoe Richmond

Optical Lead, Local Optical Committee Support
Unit

Harjit Sandhu

Head of policy, National Community Hearing
Association

Sam Sherrington

NHSE, Head of Stakeholder and Cultural
Transformation

Liz Stafford

Rowlands Pharmacy

Louise Stewart

Interim Senior LETC Lead/Workforce
Development Specialist

Howard Stoate

Chair, NHS Bexley Clinical
Commissioning Group

Key dates to save:



18-19 October 2015
NEC Birmingham



18-19 October 2015
NEC Birmingham



21-22 October 2015
NEC Birmingham



21-22 October 2015
NEC Birmingham



12-13 November 2015
Excel London



12-13 November 2015
Excel London



25-26 November 2015
NEC Birmingham



25-26 November 2015
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22-23 April 2016
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