The Primary Care Home

The complete clinical community meeting the Health & Social Care needs of a registered population through a multispecialty community provider model

national association of primary care

Background

- There has been a specific ambition to provide more 'out of hospital care' for UK citizens since the publication of the Government's White Paper for health in January 2006[1]. This precept still applies.

- International evidence recognises that any health care system benefits from improved utilisation of resources, better patient experience and lower hospitalisation rates when there is a strong system of primary care[2]. The recent Commonwealth Fund report of June 2014[3] identified the UK National Health Service as the best performing amongst the 11 *OECD* countries assessed. However, despite this endorsement, an urgent case for change was identified for improving healthy lives and outcomes for patients.

- The benefits of integrated care and multi-disciplinary team working to provide comprehensive and personalised care to individuals and populations are well recognised. However it has been difficult to demonstrate sustainable community based models within the NHS with measurable impact.

- The Accountable Care Organisation (ACO) model from The United States of America[4] has been gaining interest and awareness as a possible vehicle for providing more out of hospital care within the NHS. In part, this is because current (activity based) payment mechanisms are not adequately incentivising a system to drive improvements in the quality of care provided to certain population groups. An additional benefit of this mode is that it is outcome focused and that the management of a capitated budget is contingent on outcomes.

- Characteristic features of the ACO model include a strong focus on primary care[5], close partnership and collaboration between primary and secondary care organisations, and a range of blended payment mechanisms that include significant capitated element as well as penalties for the provision of care of poor quality.

- The Five Year Forward View, published by NHS England in October 2014[6], has identified several potential new models of care for the future delivery of National Health Services in England. The concept of the 'Primary Care Home' (see below) is consistent with the principles of one of these models and previous experience from 'total purchasing pilots' in the late 1990s offers a number of lessons for future design.

- Pilots, when given maximal autonomy to make commissioning decisions, are likely to make the greatest achievements with regard to both their own and wider service area priorities[7]. The greatest influence on practitioner behaviour occurs when there is alignment between clinical decision-making and financial responsibility[8] (this is likely to be the case for both primary and secondary care clinicians). This was the founding principle of the Health and Social Care Act 2012. Administration and transaction costs can be alleviated through a focus on the use of information technology, defining a limited number of meaningful outcomes, and encouraging the 'making' rather than the 'purchasing' of services.

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The Primary Care Home

The National Association of Primary Care (UK) has, over the last 20 years, helped describe and develop the concept of the 'Primary Care Home' (PCH) as a future core delivery mechanism for health and social care services in the NHS. The key elements of the PCH should be central to the design of the multispecialty community provider (MCP) model cited in the Five Year Forward View.
This document now refers to the PCH as the preferred MCP model. The key elements of this MCP are:

- The provision of care to a registered population.
- A recognition that unregistered citizens will need care provision in the geographic area covered by the PCH.
- Balancing the provision of personalised care, responsive to the need of an individual, with population health planning and provision.
- Sensitive workforce planning, consistent with the need of the registered population.
- Multi-disciplinary clinical and social care team service delivery.
- Purposeful rather than positional leadership within the organisation, with clinical leadership being a style of practice.
- Dismantling of historical organisational boundaries, working collectively through networked arrangements within modernised community healthcare premises, with access to diagnostics on site and a fully integrated IT system.
- Focusing efforts on the 'make or buy' decisions within care provision through the accountability of independently managing a capitated budget for the registered population.
- A strong affinity between participating practices and community services, which are not necessarily geographically co-positioned but would be normally sited within the boundaries of one CCG.
- An optimal population size served by the PCH which would be not less than 30,000, but normally not more than 50,000 people.
- Recognises that waiting and access to NHS care remains the public's top concern and provides urgent, same day and pre-bookable appointments for the registered population. This is consistent with the concept of 'the never full practice'[9] and aspirations of the Prime Minister's Challenge Fund.

The PCH does incorporate the successful features of the ACO model, with particular focus on a unified budget, single integrated workforce and an uncomplicated consolidated range of outcome measures.

The alignment of clinical and financial drivers is essential to ensure a collective approach to risks and rewards. This also establishes an emphasis on productivity consistent with the recent review of operational productivity in the NHS by Lord Carter and the inherent business efficiency established within primary care contractor services.

Developing an integrated multi-professional workforce

- The PCH model enables primary care, community health and social care professionals to work in partnership with hospital-based specialists. A detailed understanding of the needs of the registered population (and therefore the expected volume and type of workload) will enable the creation of the right team at the outset who can then strengthen their efforts on maximising efficiency in the deployment of care resources and specifically in the 'make or buy' decisions with their patients.

- This approach facilitates a commitment by 'responsible' clinicians to align clinical and financial accountability for delivering agreed outcomes as well as building a culture of collaboration and the integrated working practice which is required to make this model work.

- With specialists involved in a more community focused service, the PCH offers the ability for these clinicians, currently working exclusively in hospital, to provide care closer to (or within) a patient's home; particularly those with a responsibility for long term conditions, rehabilitation and reablement, and surgeons who particularly specialise in 'office based' procedures.

- The workforce model must allow for opportunities to design and develop the roles of nursing, pharmacy, allied health professionals and other members of the wider health and social care team. This will allow general practitioners to focus their skills on undifferentiated problems (and organise the disorder often found in first presentations) and specialists on patients with more complex needs.

- Where staff are salaried or on sub-contracted arrangements, an equity stake or incentives payments will be needed to foster an inclusive approach to the delivery of high standards of responsive care.

- Building the culture to operationalise this model and empower the PCH team will require the rapid development of the existing workforce and the transition of clinical teams into new ways of inter-professional working. In the short term, investment will be required for change management support, coaching and clinical supervision. Any available workforce transformation funding should be identified to support such an approach. In the medium term, additional training for later PCH cohorts might be required. Cross-skilling amongst team members will improve efficiency and collaboration.

- Developing the future workforce must also be seen as a key priority for longer term planning, so that staff in training have the opportunity to learn in these settings, whilst contributing to the delivery of service outcomes with appropriate educational governance. Significant opportunities lie within postgraduate medical specialty training to achieve this. Training curricula for certain professional groups may need revision to enable a stronger focus on the wider, more generalist range of skills required to excel in integrated working.

- Health Education England funding, via Local Education and Training Boards (LETBs), for undergraduate medical, pre-registration nursing and postgraduate medical tariff could be used to incentivise and shift training from hospital environments to PCH settings. The PCH would need to be able to influence their LETB in relation to workforce needs in a similar way as large acute providers currently do.

- There are emerging examples from the community education provider networks (CEPNs) in London and in Kent, Surrey and Sussex, as well as from other parts of the country, which help to describe how this could be done in order to secure the supply of the workforce needed in the future.

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- Ensuring the right workforce and skill mix required for the PCH will need a systematic analysis of the registered population's health and wellbeing needs. This should address the skills, experience and quality of individuals required to meet the objective of completing a majority of episodes of care within the PCH.

- There must be a balance between national approaches to workforce planning, which tend to be supply driven, with a more locally sensitive approach for the PCH model in order to enable the design and delivery of a workforce more suitable for local population needs. Recent evidence suggests that there may be limitations to the traditional approaches to workforce planning[10]. Alternative approaches based on population need and a more sophisticated demand projection will have to be considered in order to ensure the workforce model is fit for purpose and is sustainable[11 12].

- Further essential aspects for workforce planning for the PCH model are:

  - Establishing the out of hospital need for the registered population and segmenting the workforce required against the strategic priorities of health improvement. An operational workforce plan will need to be established for the immediate 12 months from commencement.

  - An environmental scan to review existing supply and data about workforce availability and identifying gaps in service.

  - Profiling the current workforce against current and rising demand and an assessment of supply availability.

  - An evaluation of the demand and supply factors for the transition of the current to future workforce.

  - Succession planning in consideration of the pending retirement of a considerable proportion of the current NHS clinical staff over the next 5 years.

  - An assessment of future workforce supply and their development for sustainable provision and creating a clear plan for the organisation's need in consideration of the known and emerging trends in healthcare demand. This should not be less than for the following 3 years.

  - Determining appropriate actions to manage risk and identify mitigation strategies against a targeted future.

Business Vehicle for a Clinical Partnership

- Provisions in the NHS Act (Primary Care) 1997 may allow for the creation of the form and functions of the PCH. This primary legislation allowed flexibility and new freedoms for service provision to meet local needs. Personal Medical Services Plus retains NHS Body status and resides firmly within the NHS family with retained pension benefits, but works under Part 1 regulations of the NHS Act 1977. These provisions could allow for the development of the multispecialty workforce model, which could include the employment or partnership with hospital specialists.

- The PCH needs to have clearly defined incentives to promote inter-operational working and a collective approach in the provision of care to the registered population. Inclusivity within the workforce is essential for the delivery of the PCH.

- The nature of a model for 'clinical partnership' in which GPs and specialists (and possibly other health, social care and managerial professionals) could be equity 'shareholders' will be determined by the population size and the needs of the population covered. The PCH must allow for all willing and appropriate provider participants to have the opportunity for an equity stake in the organisation.

- A recent consultation with an expert clinical and managerial group within NAPC's network has identified that many experienced colleagues would be willing to enter into a partnership model through the creation of a legal entity in which stakeholders are jointly incentivised. The concept has also been favourably received by the NAPC's National Primary Care Network, demonstrating an appetite within the service to develop and implement this model[13].

- Another approach might be through a 'medical chambers' type arrangement with shared equity whilst retaining existing contractual arrangements. Further alternatives might include the formation of a company in which the clinicians become Directors (e.g. a community interest company or a not for profit company limited by guarantee). Any such company should work under the principles of a social enterprise.

- The type of partnership model will depend on the degree of the risk and reward that individual clinicians are willing to take, the scope for existing contractual arrangements which may be folded into the capitated budget and the likely minimum duration of such an agreement. This should not be less than five years, consistent with a political cycle, but ideally be for 10 years with defined review periods and the facility for break clauses in any agreement.

- NHS England will need to identify initial set up costs and management support for the establishment of a PCH. A recurring management allowance will need to be identified within the capitated budget to ensure business readiness and ongoing stability of the organisation.

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Population based capitated budgets

- The PCH requires a population-based capitated 'real' budget formulated on the registered lists of the constituent practices involved, with the level of capitated funding dependent on the need of the population and the scope of responsibilities within the contract (which might include primary care funding).

- The PCH is based around an optimal population size of 30,000 - 50,000 patients. Evidence from GP fundholding in the 1990s demonstrated optimal configuration included mental health and community services for such provision that is responsive to the needs of a population at this level. Further evidence from the Kings Fund cites population coverage in the range of 25,000 to 100,000 people is needed to enable federations and networks to function effectively[14].

- At this population level and given the need to demonstrate population health outcomes, practices within the PCH must have a strong affinity, with a requisite motivation to succeed even if they are not geographically aligned.

- The transition to a full risk model may entail layering the budget that the PCH takes responsibility for in stages, ultimately culminating in a responsibility for a full capitated sum per patient. Services would include:

    Elective care
    Urgent and emergency care
    Prescribing
    Community services
    Mental health
    Primary care
    Maternity and children's' services
    A range of inpatient services

The Primary Care Home Estate

- It is not envisaged that the PCH will necessarily need any new buildings or facilities other than those already available in the community for this out of hospital care facility. However the approach to estate development must be assessed in association with the needs of local communities and with a guiding principle of maximal value in relation to any new investment.

- The PCH concept espouses a campus approach with better management of current estates and networked arrangements of estates and facilities, which are responsive to the health and wellbeing needs of the population served.

- The PCH campus will be inclusive of the existing general practice premises, community services facilities and any other existing NHS or social care premises deemed appropriate to be involved in this development.

- Where existing Primary and community health care estates are poor, existing planned developments and methodologies to understand the optimal usage and location of out of hospital care provision will need to be reviewed and incorporated.

- Improved utilisation of technology within the PCH will be required for activating patients, transactional activities and the delivery of remote care.

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Outcome Metrics

- A key benefit of the PCH model is to achieve enhanced value in the utilisation of a capitated budget focused on improvements in population health outcomes.

- This will require a degree of patient segmentation to enable a better understanding of the outcomes that matter to patients. This should include quality outcome metrics based on:

    - Improving patient activation
    - Improving the capacity to self care
    - Improving wellness scores
    - Achieving individual health and wellbeing goals

- A number of quality process metrics need to be specifically designed relating to;

    - Access and availability of services
    - Responsiveness and efficiency
    - Clinical quality and effectiveness
    - Patient feedback metrics demonstrating improved experience and satisfaction

- In addition, a number of outcomes in relation to resource utilisation will need to be agreed. These may include:

    - Management of variation in the patient admission process
    - Management of variation in patient discharge thereby reducing lengths of stay
    - Removing the need for outpatient attendances, increasing clinical management in the right care setting
    - Application of a systematic approach to care of people with long term conditions leading to lower referral rates to hospital Improvement of access to key diagnostic tests to enable more completed episodes of care within the PCH
    - Commission (buy) day case surgery as the norm for elective surgery
    - Increase the range and reliability of therapeutic interventions through an on-site 'care bundle' approach.
    - Improve patient access by reducing the number of queues in the system and optimising patient flows
    - Optimising early discharge of patients admitted by PCH clinicians collaborating with acute care specialists
    - Improve and extend roles and responsibilities within the PCH in line with efficient 'care bundles' to attract and retain an effective workforce
    - Optimise therapeutics to reduce prescribing costs

- Locally sensitive measurements of care outcomes will also be necessary to demonstrate the personalised care services that are core to the functioning of a PCH.

- Current outcome metrics, particularly in relation to general practice performance may need to be discontinued in preference for PCH outcome metrics. This is to focus on outcomes that matter to people receiving the service, educe bureaucracy and prevent duplication of effort.[15]

Governance and managing risk

- The chosen organisational form of the PCH would direct the governance arrangement, and it is expected initially the commissioner would be NHS England. However the commissioner may change over time.

- A clear understanding will need to be developed, at individual constituent practice level, as to how and why practices consume resources and then how this may be refined. Risk pooling may be required between PCHs to reduce the problem of variability in demand on this type of care service.

- Tolerance levels for individual patient costs may need to be negotiated and a 'risk premium' developed with NHS England. This means that there might be a maximum cost levied against the PCH budget for any registered individual's care which is commissioned from external acute or scheduled services. The risk premium would then be used for costs over the maximum agreed. The aim would be to reduce the financial impact in relation to the variation in high cost patients.

- Safeguards must be in place, in relation to the registration of patients, to ensure that the value or cost of an individual to a PCH never becomes a perverse incentive to any constituent practice in the decision about accepting a person onto their list.

- A number of alternative mitigating financial risk sharing arrangements might exist ranging from shared risks with NHSE (with agreed exclusions e.g. high cost patients, specified low volume/high cost procedures and expensive drugs) to the acceptance of full risk with appropriate insurance arrangements or possibly partnering with commercial organisations.

- The interface between PCH delivery and budgetary management and working with specialised services will need to be consistent with those current arrangements between CCGs and the Area Teams of NHS England.

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Proposal

The NAPC will provide the support and evidence of current best practice, utilising its network resources and corporate memory, to refine the design of the PCH and workforce model described in conjunction with the New Care Model Team, subject to the acceptance of this paper.

This model, if to be rapidly deployed, will need the specific support of the Chief Executive's office of NHS England with rapid financial modelling, access to transformation funding and progressing to implementation in appropriate Vanguard/other trial sites before the end of 2015.

Next steps and timeline

- 2nd June 2015 – The final draft of this proposal was submitted to the New Care Model Team (NCMT)
- 24th June 2015 – An expert group was assembled to discuss the workforce and financial model in more detail with representatives of the NCMT
- 30th June 2015 – Final paper completed in association with an expert reference group and NCMT and submitted to NHSE Chief Executive Office in early July 2015
- On-going informal and confidential testing and refining of the proposal with primary, secondary and social carers was carried out in July 2015
- 25th August 2015 – Meeting with NCMT to update the proposal and identify potential test sites
- 16th September 2015 – Meeting with NHSE CEO to confirm implementation programme and test sites
- Establish the lists of test sites (with wide geographical spread) and hold national meeting October 2015
- Potential to publish/announce implementation programme at the NAPC Annual Conference, Best Practice 2015 21-22 October 2015
- November 2015 to March 2016 – Primary Care Home test sites preparation and developmental programme
- 1st April 2016 – PCH test sites go live

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