



The Primary Care Home

Report



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Introduction to the 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 and CloserStill Media.

This report by CloserStill Media reporter Francesca Robinson is intended as a record of a daytime meeting held on 1 October 2015 at Chandos House, 2 Queen Anne Street, London, W1G 9LQ. The theme of this meeting was The Primary Care Home. It comprised an introduction to the topic by Dr James Kingsland, NPCN Chair, and a discussion by delegates about the practicalities of implementing the model with the aim of identifying the risks and challenges that need to be overcome before the anticipated launch date of 1 April 2016.

During the meeting delegates divided themselves into discussion groups to discuss four specific aspects of the Primary Care Home:

- Integrated care records
- Involving people and commissioners so that everyone is motivated to change
- Social and secondary care integration
- Workforce planning

CloserStill media, the business media company which puts on health plus care and commissioning, the largest event for health and social care professionals, supports the NPCN financially but has no input in the NPCN ends discussions.

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Contents

- 2 Introduction to the Primary Care Network
- 3 The Complete Community: Delivering first contact care more collaboratively
- 6 Discussion Groups:
 - Integrated care records
 - Involving people and commissioners so that everyone is motivated to change
 - Social and secondary care integration
 - Workforce planning
- 8 Conclusions and Next Steps
- 9 Attendance List



The Primary Care Home

The National Association of Primary Care (NAPC) 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.

The key elements of the PCH 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.
- Multidisciplinary 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 of between 30,000 and 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.



The complete clinical community: Delivering first contact care more collaboratively

Opening the October meeting, Dr James Kingsland, Chair NPCN and President NAPC, explained that the Primary Care Home (PCH) concept developed by the NAPC had been approved by NHS England for national implementation as part of the Five Year Forward View. There had already been 15 CCG areas expressing interest for a rapid test phase implementation programme and the purpose of the meeting was to tease out any risks and challenges that might need to be resolved before the first PCHs went live, which could be as early as April 2016.

“We want to make absolutely certain that the Primary Care Home concept is able to deliver the outcomes that we are expecting from the cultural shift that a PCH promotes, and deliver solutions for the challenges that the NHS is currently facing,” said Dr Kingsland.

He explained that when they were designing the PCH model a systematic review had been carried out of the previous policy that had been used to manage the internal market to date and the lessons learned as to why previous reforms, introduced since the internal market was created in 1990, had failed. They had also looked at the factors which empowered health and care workers, around ownership of an agenda that could promote behavioural and cultural change, and previous policy success in achieving multi-disciplinary working.

The evidence from early internal market reforms such as fundholding, total purchasing and multi-funds had been analysed; aspects on the Primary Care Act of 1997 and the advent of Personal Medical Services, through to what made GPs work differently in Primary Care Groups, the predecessors of Primary Care Trusts. PMS Plus (personal medical services incorporating hospital and community services budgets) had been reviewed and what that meant for collaborating on combined budgets to deliver extended services outside of hospital; practice based commissioning which involved larger groups taking on extended indicative budgets to promote a

more accountable way of deploying NHS resources.

“We wanted to have a strong evidence base behind us rather than just individual or collective opinion which sometimes may seem like a good idea but all too often has been tried before. We wanted to define how a balance between personalised care and population health could be achieved using the registered list. The Primary Care Home is about building from the registered list which has served the NHS so well but it is not general practitioner-centric; it recognises that you access the NHS by registering with general practice. The organisation should be more ambitious in its delivery of first contact care and patients should expect more from their registration,” said Dr Kingsland.

The PCH concept means that patients on a registered list could access, through first contact care, an extended primary care team including GPs, practice and community nurses, mental health services, diagnostics plus a whole range of other health, social care and third sector personnel. An entire episode of care would be able to be completed within an accountable care organisation through “make or buy” decisions. The organisation would be able to strategically plan for its local population’s health needs and would be able to finish more episodes of care from within the PCH, only buying high-tech hospital based care when it was appropriate and necessary.

Dr Kingsland said the evidence behind

how people worked collectively indicated that the ideal number of staff in a PCH would be around 150. “The idea is that you will be working with a team that you are on first name terms with and know each other personally as well as professionally. But at the same time you are big enough to be able to take a strategic view of your population’s health need within a registered organisation. You will have the tools to do the job to change behaviours, have accurate data that flows from when the patient is first referred and extended budgetary control. This size of organisation also ensures that you do not lose personalisation.”

Most importantly, the evidence shows that the ideal population served to deliver the PCH concept is between 30,000 and 50,000 people.

There would need to be local ownership of each PCH and there would need to be a capitated budget that would be devolved from the CCG. The law requires that the CCG remains accountable so there currently is no way of passing on legal accountability. Some contractual mechanism would need to be introduced to ensure that the devolved budget was held to account.

The process would be a collective approach between the CCG and the provider organisation. For example, PCHs could be formed from established super practices, current practice groups wanting to work together collectively, or federations which had already been formed.

"We expect the idea of the Primary Care Home will receive a mixed response from the NHS. Nobody is saying this is a panacea and we are not expecting it to be a solution for all the issues that need to be solved, but we do think it is a critical solution for moving care out-of-hospital, creating new types of accountability for alignment of clinical decisions and resource deployment, all of which were core themes of the White Paper which introduced the Health and Social Care Act 2012.

"We think we can deliver the Primary Care Home without having to create new structures because the idea is the existing estate will be used within a type of campus. This campus will be a collective of people working together through affinity, rather than a completely perfect geographic fit. Practices with registered lists will be working together with other primary care contractors and community services for example, to build diagnostic services and extend opening hours to deal with urgent care issues," said Dr Kingsland.

Georgina Craig, Director, Georgina Craig Associates, said the PCH would not work unless it was supported by a different style of commissioning with an outcomes based approach. "The way I would describe it is that commissioners would need to understand what matters, what needs to be measured and what will be different from what we measure at the moment. They need to set the outcomes for the accountable care organisation and then get out of the way."

Professor David Colin Thome, former

National Clinical Director for Primary Care at the Department of Health and now an independent health care consultant, said currently the NHS was set up so that providers did everything and commissioners enabled good providers by holding them to account without trying to drive micro-policy in. He warned that some commissioners might want to operate in a controlling mode, as they had done in the past with practice based commissioning, and this stifled innovation. "Unless the primary care home is a social movement from the bottom up it will just become another bureaucratic approach. And that won't get us as far as we would like," he said.

Liz Butterfield, a pharmacist, said: "I'm interested to know how much the local population might shape the Primary Care Home and what level of influence is envisaged for local people. Probably in most areas people aren't one hundred percent happy with the way primary care is organised at the moment so they could make some suggestions about what their priorities might be and what priorities they might have for a change. I wonder how much their ideas might shape the early sites."

Dr Kingsland said: "I see that as being absolutely critical. The whole point about the "no decision about me without me" concept was to try and have the population we serve understanding a lot more about the services they receive, the issues around decision-making and constraints on resources. So the very

core of this is that the population served has got to be inherently involved in the development of the Primary Care Home. In each area the local population will be different and there will be workforce planning around those local needs.

Dr Nav Chana, Chair NAPC and a board member of NHS England's New Care Models team, said planning the workforce needs around the joint strategic needs assessment of the local population was a very important element of the PCH model. "Simon Steven's (NHS England Chief Executive) challenge to us was - can you demonstrate that you can deliver an integrated workforce in its broadest possible sense that is responsive to the needs of the population?"

Paul Hitchcock, Business Development Director, Kent Surrey Sussex Academic Health Science Network, said he would like to see primary care homes developed in areas of the country where whole new towns were being built, such as around the Ebbsfleet International Station in Kent, where primary care services would need to be established from scratch.

Dr Chana said the current 15 expressions of interest were not exclusive and he hoped that there would be a whole raft of new PCH initiatives. "Our job is to start from somewhere with the rapid test phase. It does need CCG alignment and without that it isn't going to happen. But I want to get the message across that these 15 expressions of interest are not an exclusive number, the Primary Care Home could happen anywhere."

GP: North East of England:

"If you land this I'm deferring my retirement"

GP in the Midlands:

"I'll increase my time back in practice if we can do this"

Practice manager in the north-west:

"It made me feel young again"

Discussion Groups

The meeting was divided into four discussion groups to flesh out the practicalities of implementing the Primary Care Home model and specifically to identify the risks and challenges to be overcome.

Group 1: Integrated care records

The key issues:

- How far do we take integrated care records, what are we going to integrate and what does that all need to look like?
- The medical record: how does the general practice medical record interoperate with other care settings, and what does that look like in terms of the medical record of the future and how do people navigate in order to get the right information at the right time?
- When patients hold their own records what does that look like in the future and how do patients take accountability for their own information and sharing that information?
- We need to incentivise the system and hold it to account in terms of being more efficient and effective and sharing information. What does that look like and how might remote consultations or electronic consultations change models of care?

Challenges:

- We need to have a vibrant supply market. General practice is currently held to account by two sets of IT suppliers. We need to get away from that and have IT systems of choice, open interfaces, open standards, and some principles and rules about how we share information.
- We currently have legacy structures and contracts. How do we accelerate away from that to achieve interoperability and more flexibility?
- How do we encourage primary care contractors such as dentists, optometrists, pharmacists and private providers, to invest in technology when they might wonder "what's in it for me, I don't need this information"? How do these other primary care contractors fit in to the paper-free NHS at point of care by 2020?
- How are we going to encourage everybody to sign up to standardised, integrated care records where everybody is doing things differently? What is NHS England's role in creating an interoperability solution where we can all share information at the point of need?

- The supply market: Currently technology is commissioned separately from services yet technology is absolutely integral to service delivery. Future commissioning needs to make technology part of a service's specification.
- Remote access to clinical systems is important and needs to be part of our future strategy.

With special thanks to group facilitator Tracey Grainger

Group 2: Involving people and commissioners so that everyone is motivated to change

Key issues:

- It is absolutely critical that patients are involved in shaping the development of the PCH and have a real sense of ownership of it. The PCH model is likely to be different in each health economy and it needs to have governance and accountability structures which ensure that it is very responsive to the local community.
- The PCH concept needs to be sold to CCGs as a way of getting GPs engaged and involved. If we can show how excited GPs are about this it could be a really strong selling point for CCGs.
- Vested interests must be recognised and the PCH needs to earn its autonomy and prove that it is trustworthy.
- We need to recognise that everybody has got a personal agenda and that's why current systems are not working. We have to ensure that this model is about more than any one of us. We need to focus on the fact that this is about improving things for patients and it's not, for example, about growing the power of general practice or getting more control over money.
- Money is the currency that makes everybody get into their little silos and say - you're not having any of mine. How do we start the process of building a PCH and getting everybody signed up and responding to what matters to patients? Getting patients involved will help to prevent people getting stuck in their silos.

- We need to change the outcomes that are measured so that we focus on wellbeing and what matters to people and families.
- We need to have clarity of purpose so that we are really clear about why we are doing this, what good looks like and what the outcomes are that we want to achieve.
- The PCH needs to be a bottom-up organisation owned by people and communities and a whole range of providers, not just general practice and it needs to be really good at involving people.

The Challenges:

- Changing mindsets and in particular changing professional mindsets and getting people out of their bunkers and aligned with a new focus on people and working with people.
- Can you involve people as citizen taxpayers who can be non-partisan in their thinking?
- Can we talk about this in the language of normal people as opposed to the language of NHS speak?

With special thanks to group facilitator Georgina Craig

Group 3: Social and secondary care integration

Key issues:

- We need to identify both the blocks and the enablers which make the relationships and culture work to support innovation in general, and the PCH in particular, to be successful.
- The blocks and enablers won't necessarily be written down in a document but they need to be in the back of our minds when we try to influence people. They will help us to avoid being shot down.
- Integration is not about organisations or specific services but it should be about the way that things happen around a patient.
- We need to ensure that we engage with local government and in particular those involved with public health and adult social care.
- How do we enable individuals to do things differently? How do we encourage the organisations we work for and interact with to permit individuals to do things differently?
- We must ensure we have a shared language so that we all understand each other. For example we need to ensure that our social care colleagues are not baffled when we use words to specifically describe health care and that healthcare professionals understand what we mean when we talk about issues such as the social determinants of health.
- We must make sure that we are inclusive and that we have a healthy model of collaboration and partnership. We must avoid going back to adversarial models where people feel blocked out and

disengaged by a top down model rather than having a shared direction.

- If we are being inclusive and we are thinking about messaging, communication and language, then the message from our local politicians and local government is as critical as the message we are giving. This is because they are often speaking directly to those for whom health and care services really matter. So how we communicate and educate all of the population is critical to this model succeeding.

With special thanks to group facilitator Paul Hitchcock

Group 4: Workforce planning

Key issues:

- Contractors who work outside the PCH campus: The PCH is an NHS entity, no new structure is being created but it involves using existing estates and suppliers to work more collectively in one organisation, defined as a "campus" where the patient accesses first contact care. This raises questions about the services supplied by primary care contractors such as optometry, pharmacy and dentistry, which do not have registered lists, who will operate outside the PCH campus and are funded differently. Do we need to pull these contractor services into the campus? What are the issues around mapping patient flow, first contact care and ensuring the patient sees the right person at the right time? What are the issues for patient choice?
- Geography: There are issues around making sure the PCH is a multispecialty organisation in terms of health and social care and the third sector, while retaining an affinity with the registered list. There are also the local authority boundaries to think about as well as the health boundaries.
- Training and education: The PCH will create opportunities for multidisciplinary training, education and learning. We need to look at budgets to support this potential development which is something we've always aspired to.
- Workforce planning: How do we develop a multidisciplinary workforce around the registered population? There is evidence to show that up to 60 per cent of patient contacts with a GP could be better dealt with by other practitioners. Maybe we do not need an extra 5,000 GPs – if we can get the workforce modelling right we may be able to solve some of the current primary care workforce issues.
- Transient populations: How do we make sure that people are not excluded or falling between the gaps of the registered population and that we have a fair registration process?

With special thanks to group facilitator Dr James Kingsland

Conclusions and Next Steps

Dr James Kingsland said the four discussion groups at the meeting had raised a number of issues that still needed to be resolved but had not found any major gaps or issues which would prevent the Primary Care Home model going live.

He explained that NHS England Chief Executive Simon Stevens had given the go ahead for the Primary Care Home model to be included in the Five Year Forward View. The current 15 expressions of interest in a rapid testing phase are not exclusive and the Primary Care Home could happen anywhere.

We have lit the blue touch paper on the debate around the Primary Care Home model as a vehicle for accelerating the speed of the changes outlined in the Five Year Forward View.

We hope there will be an alignment where commissioners say this is the right thing for their area and there are providers ready to go with it. A rapid testing process will then be launched and the expectation is the Primary Care Home model will go live on 1 April 2016.

“When it goes live I think we will see an incremental process to budgetary management by an accountable care type of organisation making decisions. Patient flows may begin to change and contracts may be thought about differently with secondary care providers. CCG contracts for next year are currently being placed about now, so it may feel that the first Primary Care Homes will operate from 1 April in shadow form with indicative budgets. It is likely there will then be an incremental process of them taking accountability for real budgets over that first year with the ability to go fully live from 1 April 2017.

“From November until April the NAPC will be involved in discussions with NHS England about what sort of support is going to be required. There is also likely to be some support from the NHS Confederation. The resource issues should be clearly identified by 1 April,” said Dr Kingsland.

Attendance list

With thanks to all those who attended

Dan Alton

Leadership Fellow, Health Education
Thames Valley

Katherine Andrews

Project Manager, NAPC

Paul Batchelor

Consultant, Dental Public Health,
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Alan Beasley

Chief Finance Officer, High Weald Lewes
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Natalie Beswetherick

Director of Practice, Chartered Society of
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Primary Care Lead, High Weald Lewes Havens
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Ann Blackmore

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and Dispensing) Opticians (FODO), Optical
Confederation

Liz Butterfield

Pharmacist, Board Member Royal
Pharmaceutical Society

Alastair Buxton

Director of NHS Services, Pharmaceutical
Services Negotiating Committee

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Chair, NAPC

Professor David Colin-Thome

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Notes

A series of horizontal dotted lines for writing notes.

CloserStill events include:



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