NAPC ANNUAL CONFERENCE 2018

at Best Practice

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Primary care homes making an impact

Speakers: Professor James Kingsland OBE, President, NAPC, Dr Steve Kell OBE, GP Partner and Lead, Larwood and Bawtry Primary Care Home, Dr Philip Wallek, GP and Lead, Lewes Primary Care Home and Dr Stewart Smith, GP and Lead, St Austell Healthcare Primary Care Home

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Primary care homes making an impact

Professor James Kingsland OBE, President and
National PCH Clinical Director, NAPC

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NHS reform

- The Five Year Forward View – focussed investment on headspace and tools for change
- New models of Care – PCH demonstrated spread
- Adapting to the environment/organisation memory is important
- A Long Term Plan - 10 years of sustained investment and focus of primary care
- How can we ensure health systems reform succeeds?

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How to create sustainable system change

- Altering cultural persistence
  - Creating the right environment in which change can flourish
  - Align behaviours to ensure adoption
  - Consistent sets of values – co-production
  - The art of “control” by letting go – subsidiarity with freedom to create to move from status quo and centralism
- Leadership is key
  - Ensuring distributed leadership
  - Overcoming real/perceived challenges of delegation
  - Enchant and Enfranchise those who do the work
- Tools to do the job at the front line
  - Data analytics to inform decision making
  - Meaningful metrics
  - ‘*Devolved*’ responsibility for resources (not necessarily full accountability)

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The hard work of health care delivery reform

- Transformation – multiple small scale redesigns over long periods of time
- Carry out a series of experiments, keep testing and prepare for feedback and mid course correction and revision
- Operational change should then emerge rather than be planned
- No-one gets it right first time
- Ultimately progressive change is a well managed set of sequential experiments

Health care reform

- No ideal set of circumstances
- A component change in a complex system often reveals interdependencies not formally recognised
- In adaptive problems, leadership is about mobilising and engaging people with ‘the problem’ – clinician buy-in to reforms is crucial
- Staff morale is the greatest financial risk for the NHS
- Hostile local conditions or inadequate support must be managed
- Can’t redesign the workforce without redesigning the work
- Reform is a multiyear process of often exhausting work

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Key elements for success

- Development of local clinical leaders and teams. Leadership becomes a style of practice
- Standardise repeatable processes for change and improvement
- Need support (but not control) of senior leadership team
- Skilled project management to operationalise
- Senior management should protect staff from firefighting and facilitate clinician and their patients to control the system
- A deep understanding of the paradox of form and function, reform and restructuring, rhetoric and reality
- Partnership. Care reform cannot be sustained without payment and institutional reform.

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New Care Model Style - Primary Care Programme

- The primary care home
- A complete clinical community
- Size really does matter
- Learning from success – budgetary responsibility
- One system, one budget - to provide care to a defined population

The primary care home

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What it is

- An opportunity to really transform first contact care
- A shift to focus on primary care provision
- An attempt to involve a ‘complete care community’ in the decisions to provide or commission care in daily practice
- A drive to improve efficiency in the deployment of NHS resource usage through a fully integrated system of care

The Primary Care Home

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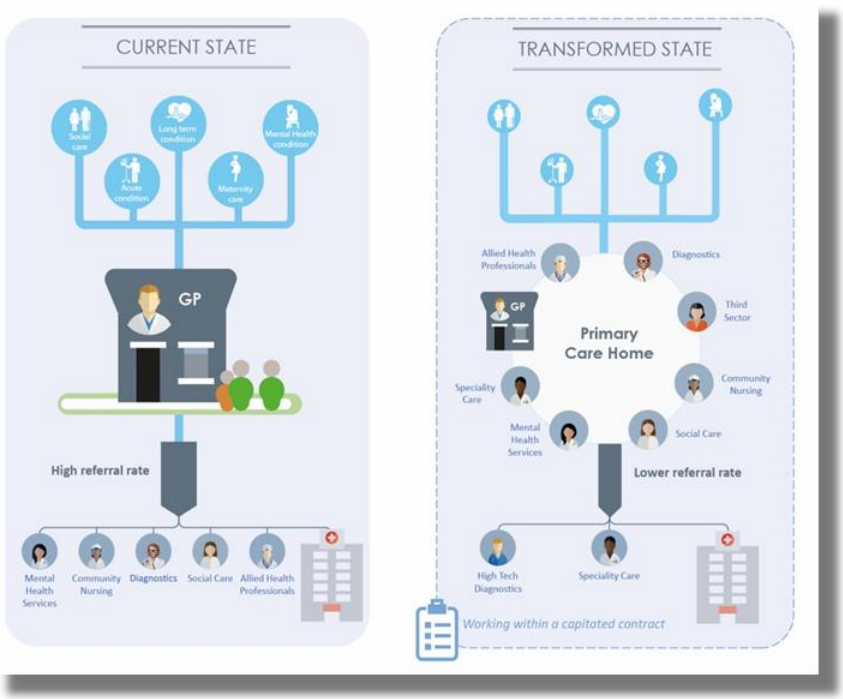
What it is not

- A return to any previous reform of the internal market (albeit incorporating a strong organisational memory)
- An NHS management reorganisation or requirement for new legislation or regulations
- A sub-set of NHSE or a CCG
- Locality commissioning or general practice at scale
- A focus on general practice profitability or new income streams
- A new idea

Core characteristics: primary care home

1. Whole population health management. A combined focus on personalisation of care with improvements in population health planning, provision and outcomes
2. A multi-disciplinary workforce based on the needs of a defined local population with an emphasis on the integration of primary, community, secondary, mental health, social care and third sector
3. Financial and clinical drivers aligned with the health needs of the whole population. Improving outcomes through value based interventions
4. Focus on care to a defined registered population size of 30,000 – 50,000 people



The right size to **scale** and the right size to **care**

Retention, return to practice, re-energising and meeting patient need

- "If you land this - I am deferring my retirement"

  General Practitioner - Newcastle

- "If we are able to do this, I am returning to practice"

  General Practitioner - Nottingham

- "You know…I read this and it made me feel young again"

  Practice Manager – Liverpool

- "For the first time, in a long time, I feel really valued"

  District Nurse – PCH Rapid Test Site

- "I've lived in the same house for 50 years. Being able to access one of these would make me move"

  Chair - National Patient Representative Body

Founding principles of a PCH – the quintessential quintet

- Enhancing person-centred care. Focusing care on the needs of the person rather than the needs of the service and ensuring shared decision-making and self-care is inherent in the delivery of care to an individual.
- Enriching the experience of an individual in a care system with heightened satisfaction particularly in relation to good access and short waiting times.
- Improving population health through registered lists of people, thereby gaining a better understanding of the local need of that population. Screening, early detection and prevention of disease becomes a defining principle of care provision.
- Reducing costs and strengthening the deployment of care resources by an alignment between care decision-making and the financial consequences. This means that the care teams that do the work take responsibility for a whole population budget for that registered community.
- Improving the working life of the health, social and managerial professionals delivering the care, with better workforce planning and team development.

Future of NHS commissioning

- Evolve and devolve
- Demand and Divvy – ‘is over’
  - *No more block contracts*
  - *Pay for actual activity*
  - *Referrer defines the service requirement through referrals*
- Current model is unsustainable
- Uncontrolled / unchallenged activity must cease
- Release resource tied up with other providers
- Without referrer responsibility the risk is greater, engagement is the key – ‘smash’ organisational boundaries
- This is 15 years old

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Larwood and Bawtry PCH

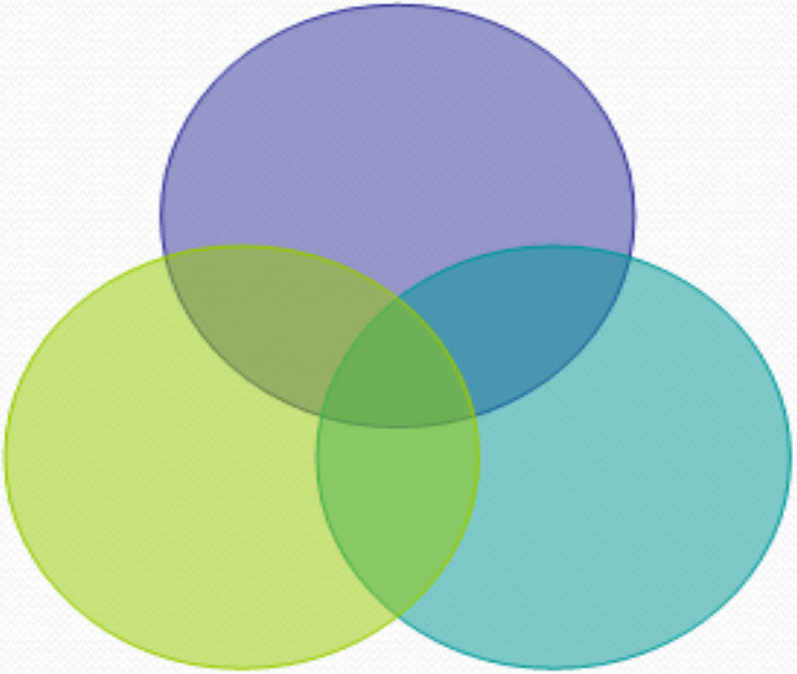
Dr Steve Kell OBE, GP Partner and Lead, Larwood and Bawtry Primary Care Home

Building a Team

- No one was going to do it for us.
- 30-50,000 patient size helped
- Rebuild the PHCT – but better..
- Reduce workload, share care.

Our Local Aims

Staff Support and Wellbeing



Better Patient Outcomes

Efficient Ways of Working

Monthly Provider Board:

- Larwood and Bawtry GPs
- Local Health Partnerships (Community services)
- Voluntary Sector
- Notts Healthcare Trust (Mental health)
- Doncaster and Bassetlaw NHS FT
- Bassetlaw CCG
- Social Care and Employment
- Bassetlaw District Council/Housing
- IAPT

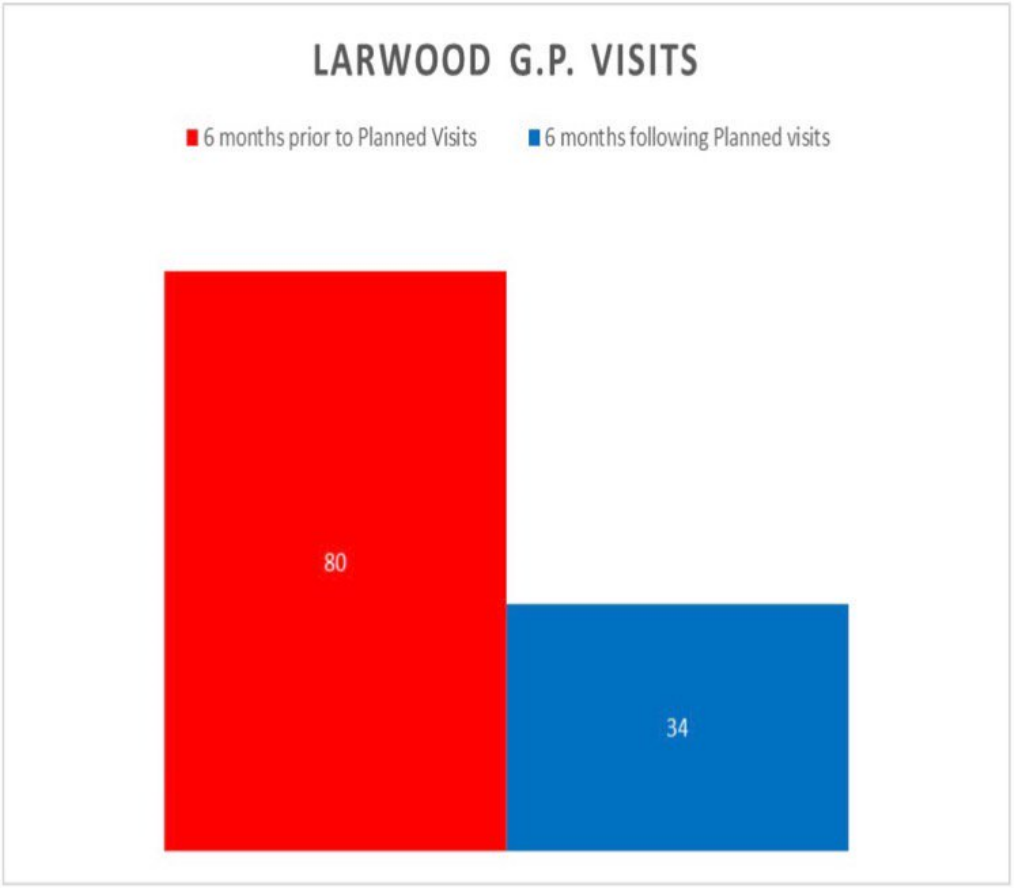
Results

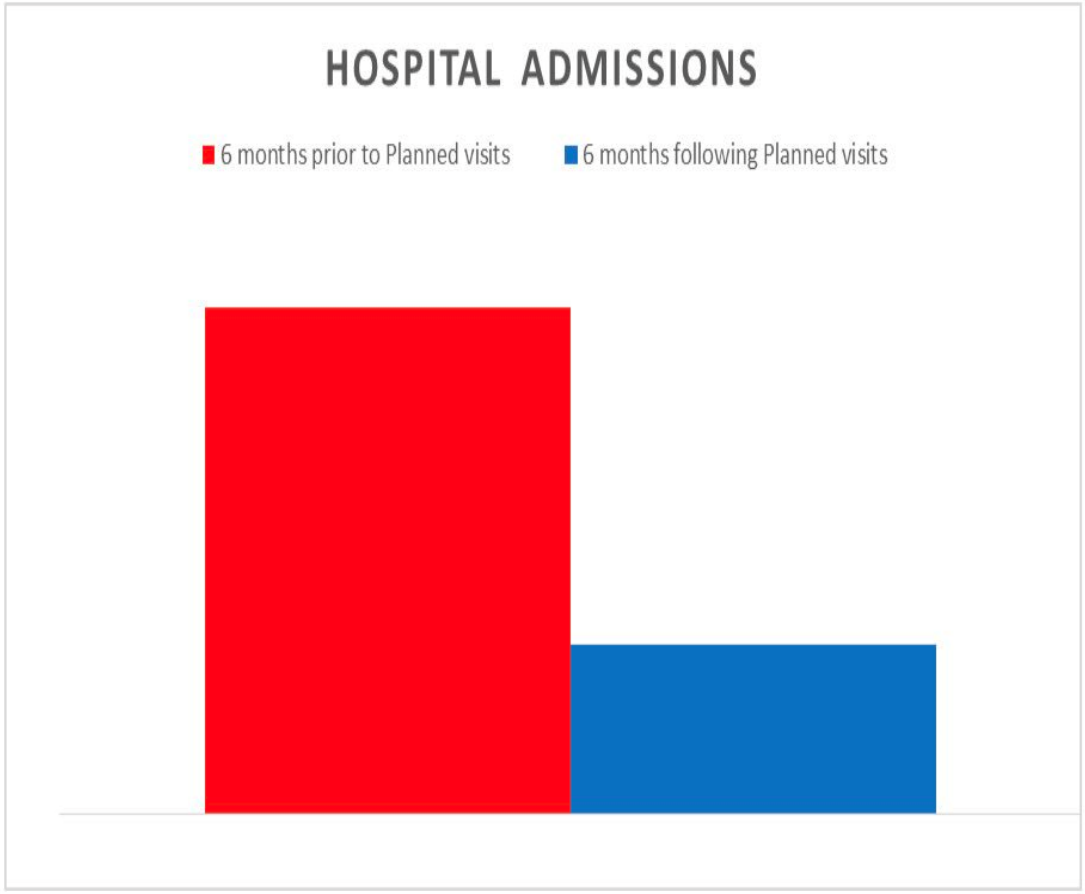
Staff Satisfaction	**82% of staff felt that PCH had improved their job satisfaction. The vacancy rate has risen as the practice now feels confident to hire. Hiring was frozen prior to PCH.**
Staff Retention	3 new GP partners recruited based on appeal of PCH ways of working. Pilot site feel confident to go out and hire again after a recruitment freeze.
Patient Experience	91% of staff felt that PCH had improved patient experience.
Population Health	73% of staff felt that PCH would help to improve population health and 91% felt it would help to improve clinical outcomes.

Emergency Admissions

- Despite list size increase:
- 7.8% reduction over 2 years
- Plus 50% reduction in rapid response referrals

Care Homes


LARWOOD G.P. VISITS
6 months prior to Planned Visits
6 months following Planned visits
80
34



Graph A: (Graph shows 67% reduction in hospital admissions in the two time periods)

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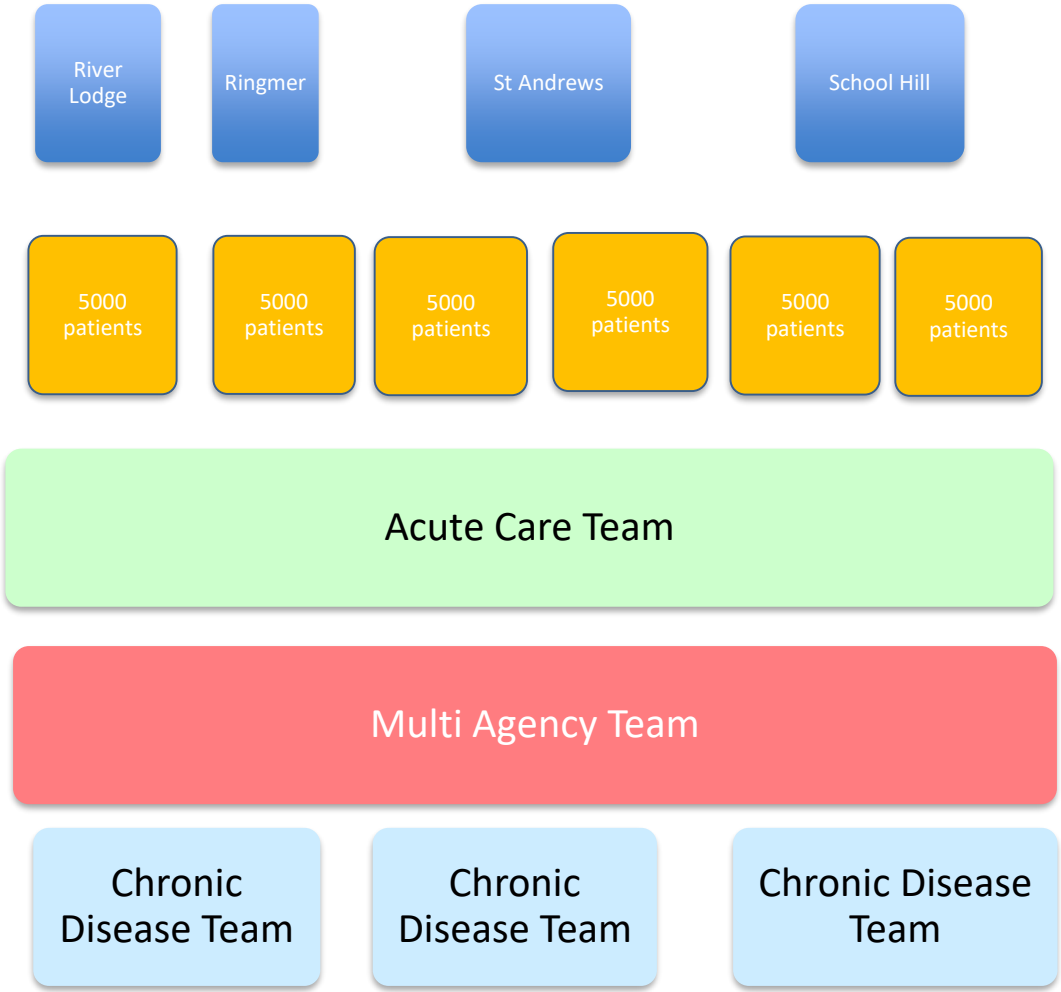
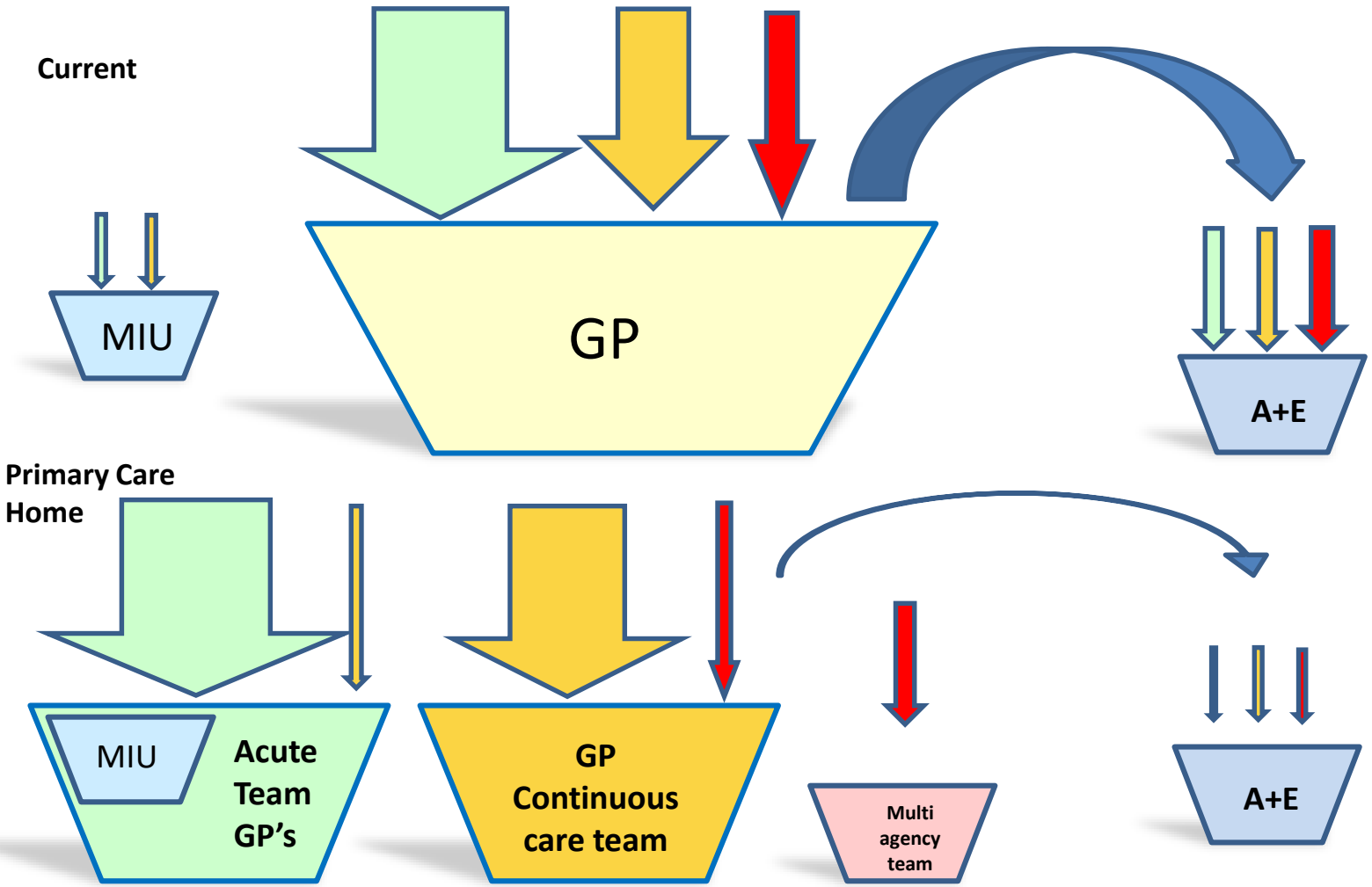
Lewes Primary Care - fit for the next 70 years of the NHS

Dr Philip Wallek, GP and Lead, Lewes Primary Care Home

Reorganising The Practices



Urgent Treatment Centre



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St Austell Healthcare PCH - impact

Dr Stewart Smith, GP and Lead, St Austell Healthcare Primary Care Home

St Austell PCH Priorities

- Creating a sustainable work force and improving working lives.
- Integration with Health and social care stake holders
- Community integration

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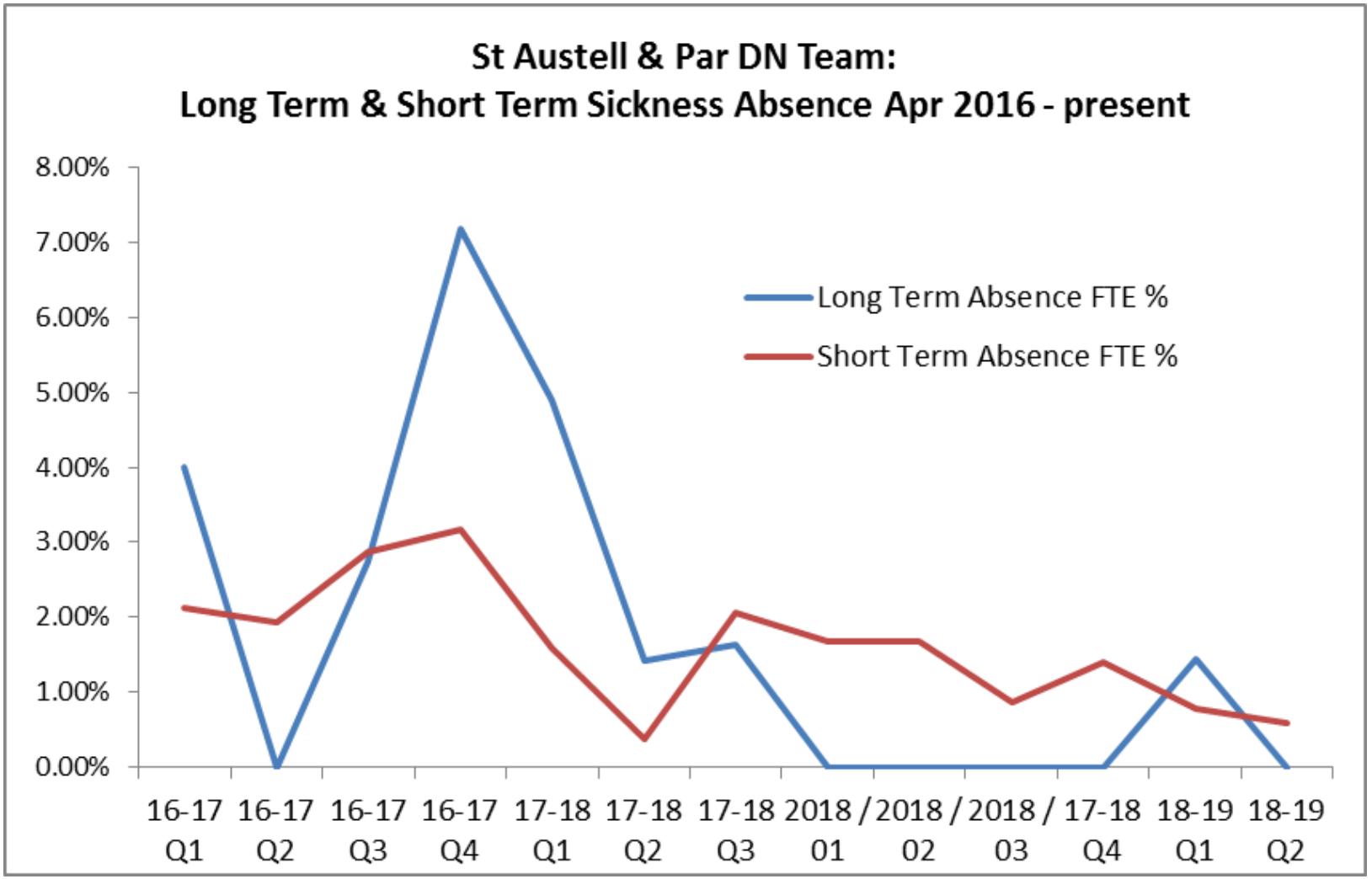
Reduction in both types of sickness absence but most notably long term:



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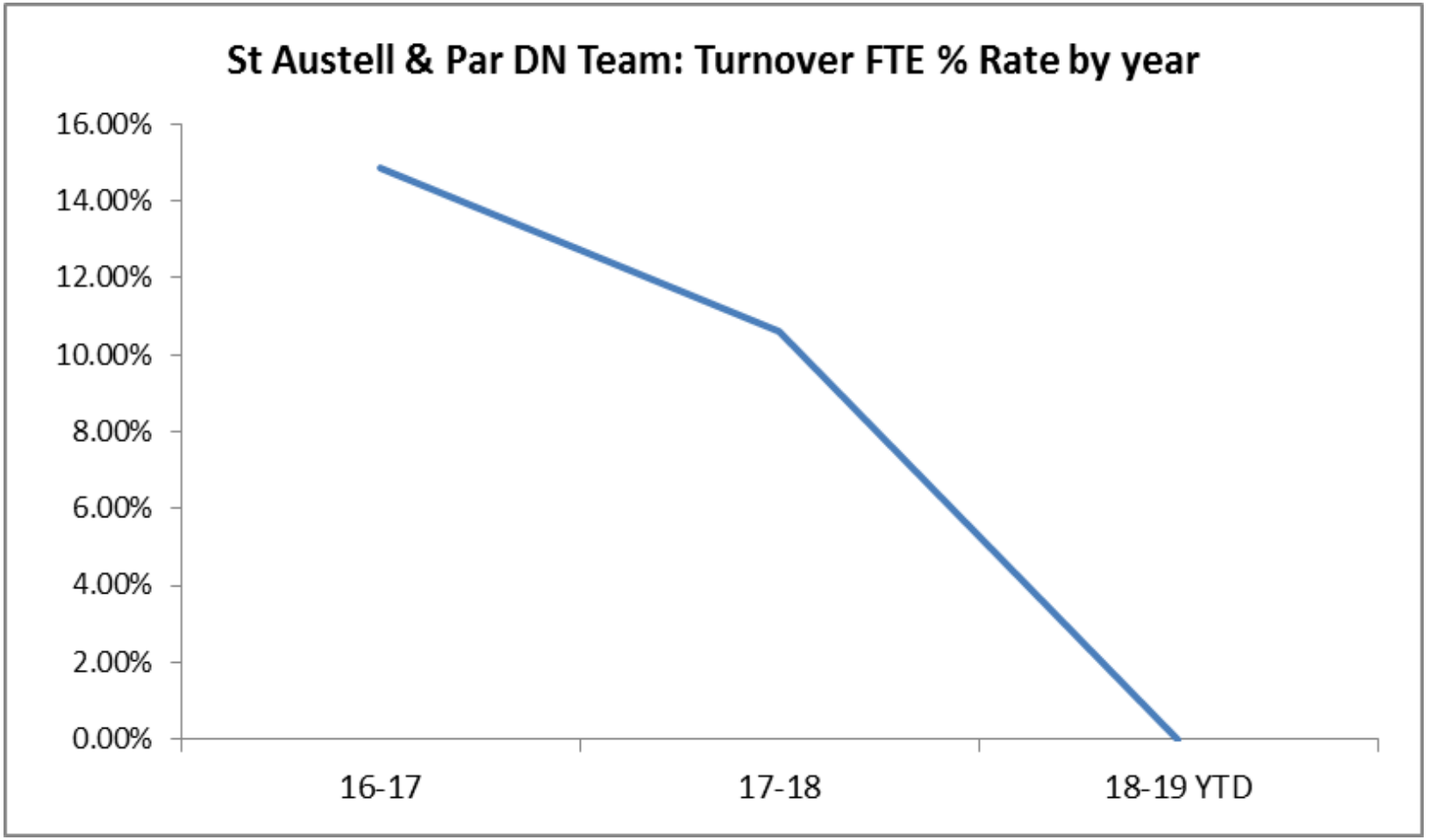
Marked reduction in turnover over last 30 months:



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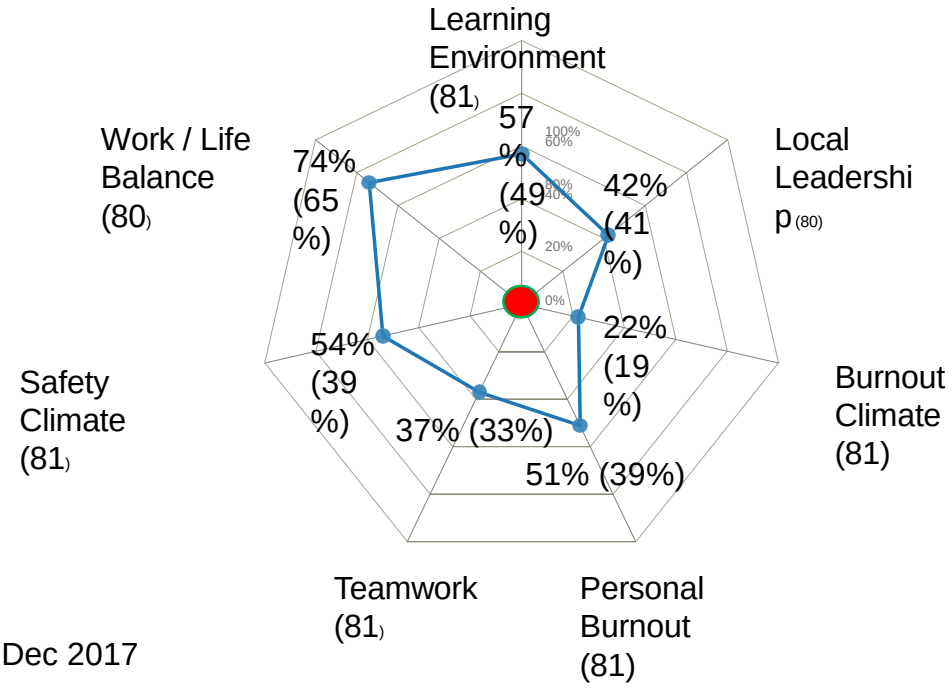
St Austell Healthcare
Improvement in All Culture Domains



Source Data: Dec 2017
Institution: St Austell Healthcare Work Setting(s): All Work Settings Position(s): All Positions

SAFE & RELIABLE Healthcare

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Other PCH Impact

- 40 % reduction in appointment utilisation at 6 months in social prescribing group (>500 appointments saved every 6 months)
- Statistically significant weight loss in SP group
- 87% SP patients showing improved well-being scores
- 30% Reduction in Home Visits
- Reduced prescribing spend (3 years in a row).

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