System impacts of primary care networks

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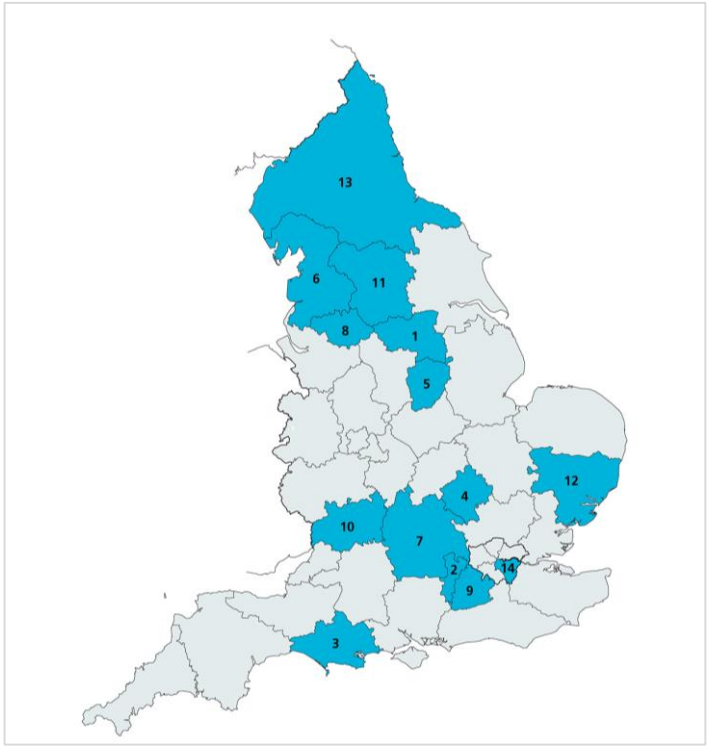
Systems working together to become more integrated

- Since 2016, health and care organisations have been working together in every part of England in sustainability and transformation partnerships (STPs).
- Local councils, care homes and different parts of the NHS – hospitals, family doctors, mental health teams and others – are working together more closely than ever before. In partnerships covering every part of England, they have begun to coordinate services better, spend more on keeping people healthy and out of hospital, and agree shared priorities for the future
- In ICSs, more formally organised STPs, NHS organisations take collective responsibility for managing shared resources and using them to improve quality of care and health outcomes for local residents, working closely with local councils and others in the community.
- The first of these systems were confirmed in 2018, with more announced in June this year. They now serve one in three people in England (21 million).
- Each has shown that its partners all share a common vision to improve health and care, backed up by robust operational and financial plans, and proposals for collective leadership and accountability.



Transformation from:

• Silo working	→	Co-ordinated
• Equal	→	Equitable
• Therapeutic	→	Preventative
• Reactive	→	Proactive
• Paternalistic	→	Engaging
• System centred	→	Person centred
• Blind	→	Value driven

The role of primary care networks (PCNs) within an integrated care system

A primary care network consists of **groups of general practices working together with a range of local providers**, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations.

Networks would normally be **based around natural local communities typically serving populations of at least 30,000 and not tending to exceed 50,000**. They should be small enough to maintain the traditional strengths of general practice but at the same time large enough to provide resilience and support the development of integrated teams.

99 per cent coverage (nearly 1,300 networks made up of around 7,000 GP practices) from 1st July.

PCNs are the foundation for integrated care systems

- Preventing ill health and tackling health inequalities
- Supporting the workforce
- Maximising opportunities presented by data and technology
- Making most effective use of NHS resources

Characteristics of a good PCN

Infrastructure

- Defined population
  - Between 30,000 and 50,000
- Clear understanding of population health needs
  - Build from what we know about patients and the population through use of population health management data
  - Evaluation supported by evidence of changes in population health outcomes
- Integrated delivery of care
  - Integration across primary, secondary care and community care - place based commissioning
  - Seamless care delivered through partnership working, collaboration and cooperation
  - Ability to work across multiple organisations and professions
- Personalised care
  - Enabling more choice for people based on what matters to them , their needs and their preferences
  - Supporting people to stay well for longer and involving them in decisions when their health changes
  - Making the most of the expertise, capacity and potential of people, families and communities
- Aligned drivers for change
  - Clinical and financial

Factors for success

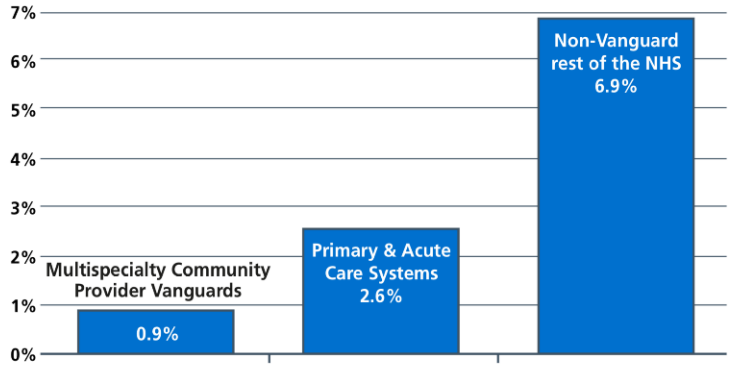
- Clear and shared vision and belief
- Strong leadership
- Support built around the Clinical Director
- Trusted relationships
- Strong ability to communicate and engage
- Committed teams working across organisations and professional disciplines
- Time to plan, time to do, time to think about what to do/what has been done and time to bring about sustainable change

Primary care networks build on past work

Long history of GP collaboration

90% practices self-identified as ‘networks’ last year

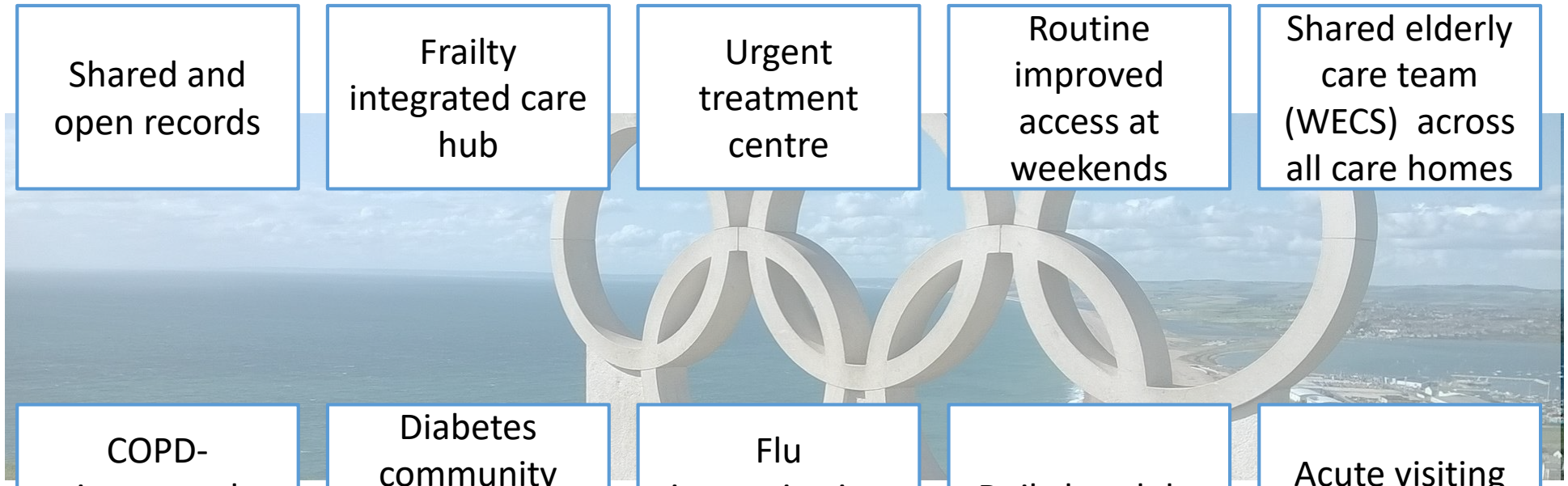
Figure 1: Growth in emergency admissions per capita 2014/15 to 2017/18: MCP and PACS Vanguards vs. the rest of the NHS.



Note: The MCP and PACS combined emergency growth rate is 1.6% which is statistically significantly lower than the rest of the NHS with 95% CI (the upper limit for a significant value is 3.1%).

Source: NHS England analysis of Secondary Uses Service (SUS) data.

New care models: examples of joint working



- Shared and open records
- Frailty integrated care hub
- Urgent treatment centre
- Routine improved access at weekends
- Shared elderly care team (WECS) across all care homes
- COPD- integrated locality team
- Diabetes community model – MDT and tech
- Flu immunisation programme
- Daily leg clubs
- Acute visiting service, 5/7 .

https://www.youtube.com/watch?v=Y9hYaD201rI

Maturity depends on:

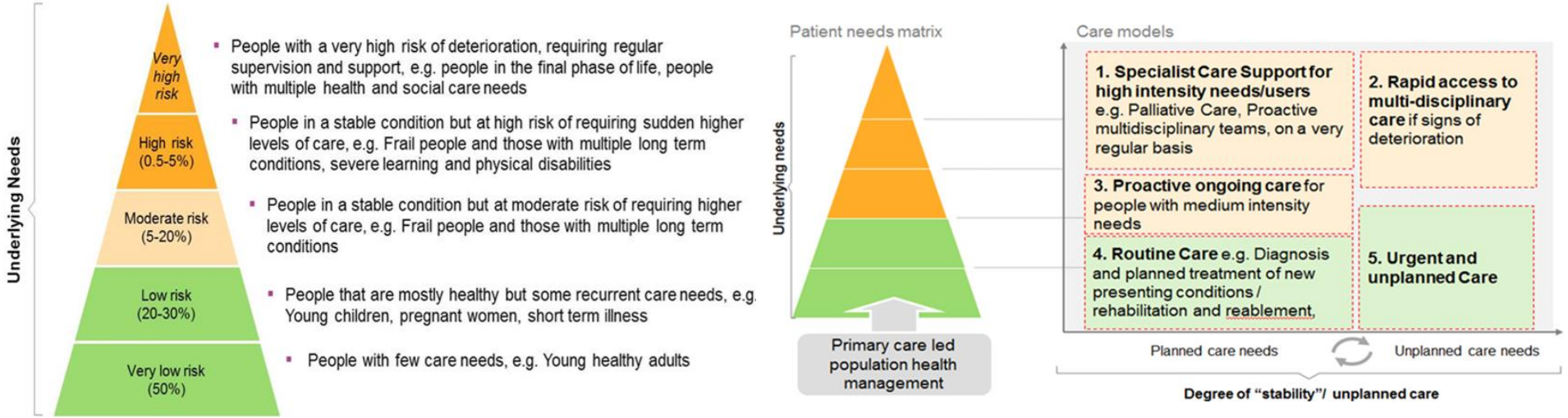
- Leadership, planning and Partnerships
- Population health management and use of data
- Integrating care
- Use of resources
- Development of people and partnerships

- Time
- Investment
- System leadership and support

Dorset Context and case study

- The Clinical Services Review (CSR) was carried out in 2014
- Co-produced Integrated Community and Primary Care Services (ICPCS) model was presented and agreed
- A 5 year £18m investment plan was agreed as part of the CSR; first tranche funding of £6.5m approved by Dorset ICS
- Community model is based on bringing services together to respond to the stratified local population needs

ICPCS Models of Care



ICPCS Models of Care : Year One Investment

•Year One investment focused on three areas:

1. Specialist care and rapid response for complex patients, including stranded patients
    - Integrated teams (MDTs) – nursing/therapy (Community Hubs) with Social Care input
    - Health and Social Care Coordination
    - Enhanced Pharmacy and in-reach in Care Homes

2. Proactive ongoing care for people with medium intensity needs (LTC management)
    - Coordination of care and support for people with Diabetes and Respiratory conditions
    - Polypharmacy reviews & meds optimisation

3. Domiciliary care for very complex patients
    - Community Support Workers supporting people at home linked to MDTs

General Practice Forward View

- ICPCS built on earlier investment in General Practice
- GPFV Recognised historic under-investment in general practice
- Practice level investment but also locality focus from development perspective – Working at Scale
- Focus on ensuring sustainable General Practice with additional investment support for:
  - Resilience
  - Workload management - Time to Care; back office process management
  - Workforce - GP retention & recruitment; Nursing Action Plan
  - Care redesign/improving patient care and access - On-line consultation/triage; Improved Access to General Practice (IAGP) initiative
  - Infrastructure & Estates

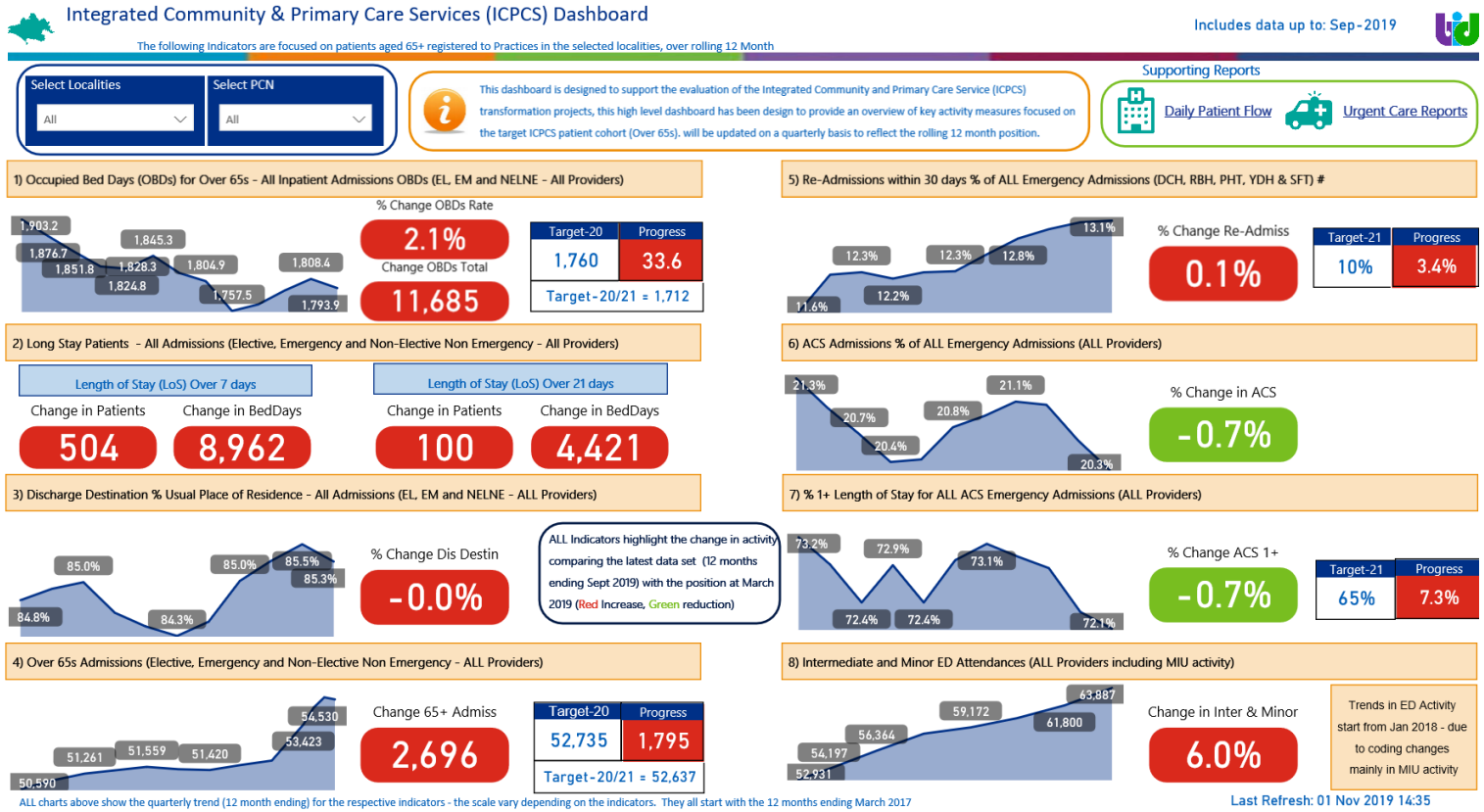
Primary Care Networks 2019

- Established 1 July – 18 Networks; 80 practices (two <30k / eleven 30-50K / five >50K popn)
- Majority aligned to Dorset Localities, so building on what has already been put in place
- GP Contract investment – PCN development/workforce
- Other investment has been aligned to PCNs and populations and considered in relation to to ICPCS models of care and investment:
  - quality improvement (prevention and Long Term Condition management)
  - improved access (over and above IUC service investment)
  - Population health management programme
  - PCN maturity

Measuring Impact

- Challenge to fully measure impact across all system partners – Acutes/Community/General Practice
- GPFV transformation – decreased administrative workload/signposting support/GP retention and improved access
- Shift to PCNs - development of an assurance framework currently underway, which will be linked to ICPCS indicators
- ICPCS investment – Agreed set of metrics by Dorset ICS partners to determine impact (ICPCS Dashboard). Further work in progress to better understand impact and measure – introducing Statistical Process Control (SPC) methodology and linking to UEC dashboard
- Also stocktake across localities to try to identify critical success factors of models of care tied to impact and benefit for whole system, which can then inform future investment strategy

ICPCS Dashboard – Performance Metrics



ICPCS Dashboard Progress

•Whilst the overall progress isn't where we hoped it would be, there are areas showing a sustained improvement against the dashboard. North Bournemouth PCN has shown a sustained improvement in more than three areas.

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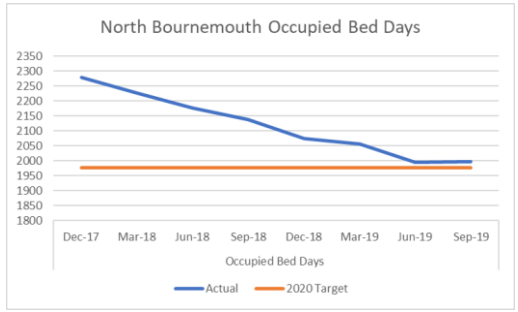
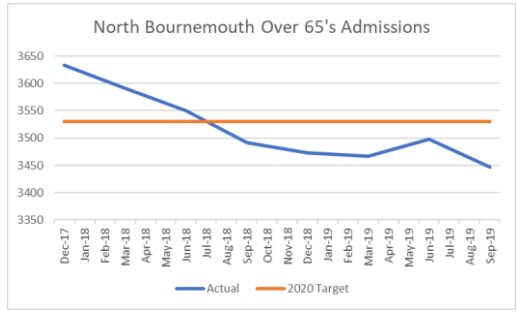
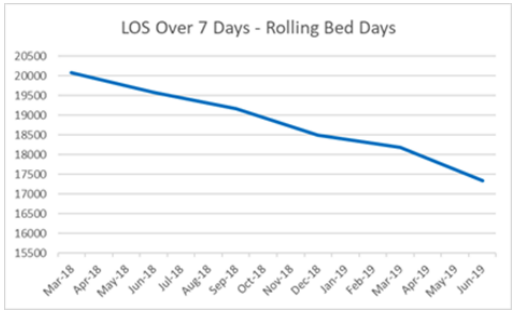
•An ICPCS stocktake was carried out to identify the critical success factors of our model of care and future investment plans to scale up. The Model of Care in North Bournemouth is being scaled across two other PCN's in Bournemouth.







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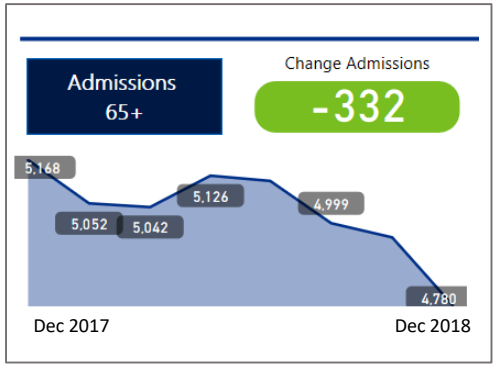
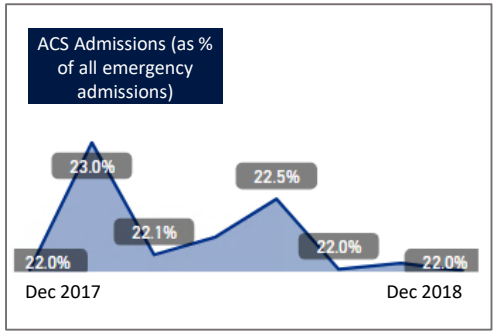
Making a system level impact

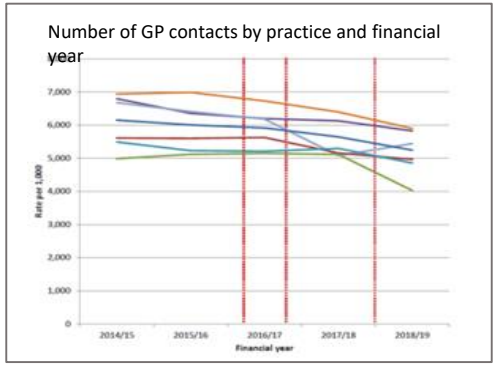




Reduction in all admissions types (EL, EM, NELNE*) for all age groups, most notably for the over 65s

Reduction in ACS Admissions volumes as % of Emergency Admissions

Significant **reduction in Occupied Bed Days** (OBDs) in Over 65s since March 2017

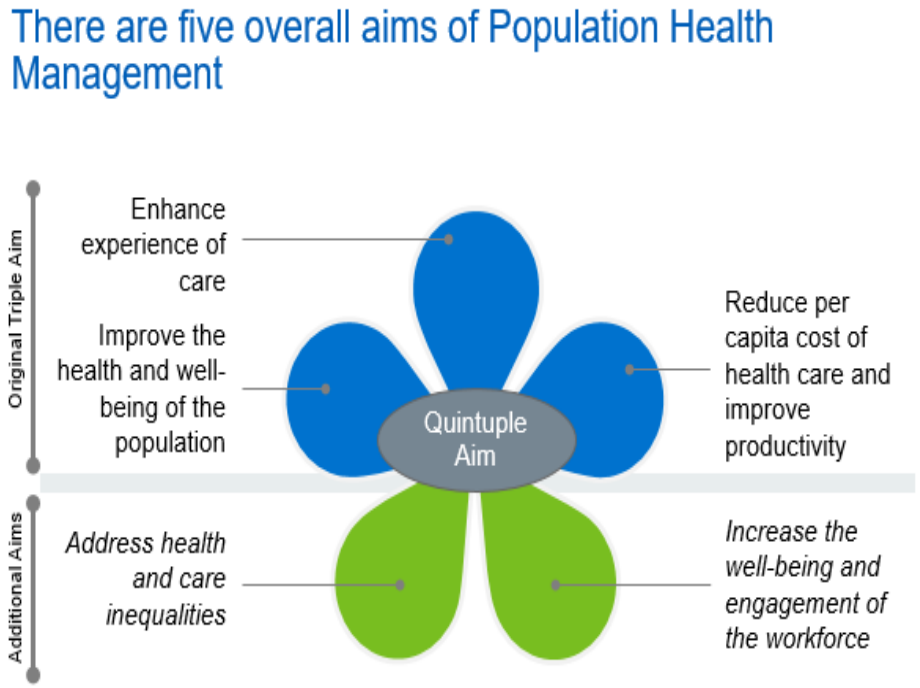


While the **number of GP contacts has been falling** for all practices year on year

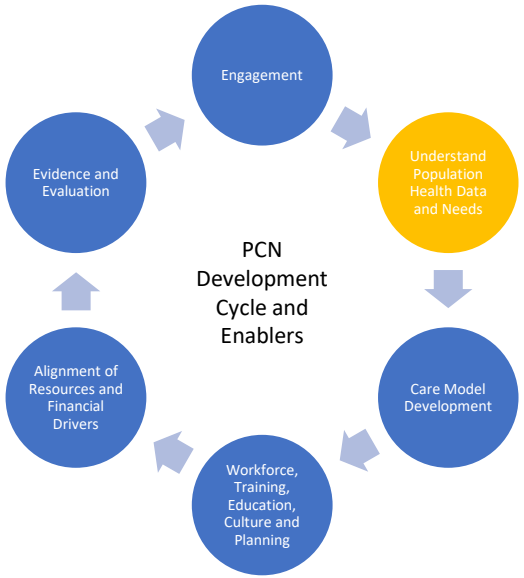
**Elective, Emergency and non-elective non Emergency*

Population health management approach

- Risk stratified approach for case finding
- Targeting unmet need, and gaps in care
- Reduction in variation
- Quality improvement cycles to improve care
- Linked with workforce development
- Use across frailty and approach to LTC
- Preventative approach possible , case finding
- Personalise health care approach



What Population Health Management means to Dorset



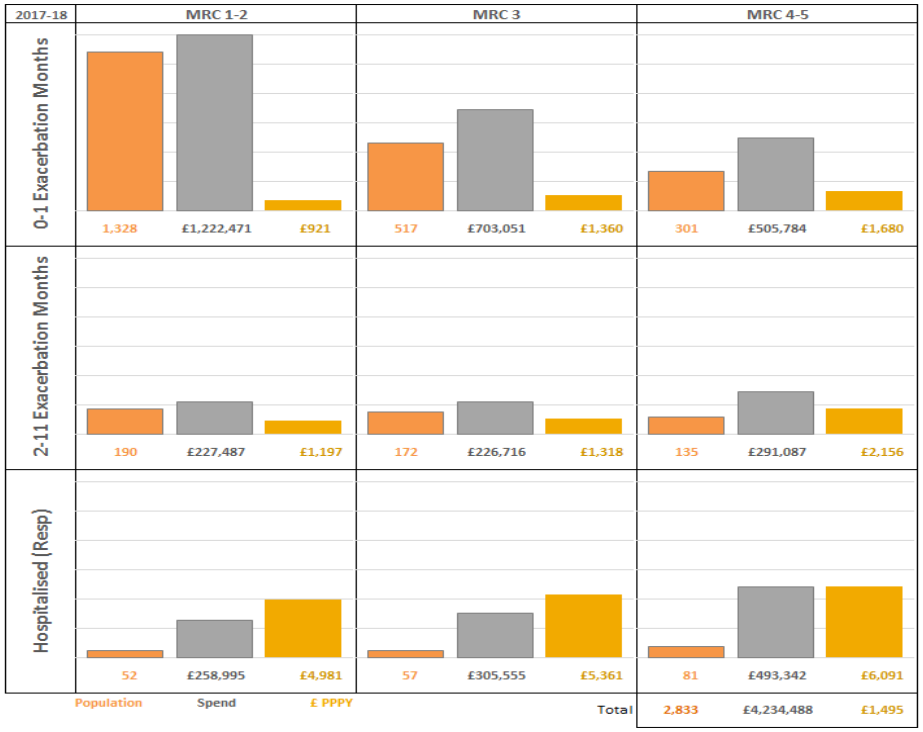
- Establishment of local PCNs across Dorset will be a critical building block for a wider, regional population health approach
- As the PCNs mature will start to partner with other organisations, e.g. local authority, voluntary sector, mental health (e.g. to enable design of ICS)
- An iterative cycle of activity with critical enablers that drive the cycle
- **Population health data is a key enabler** to not only understand population health but also inform strategy and measure success

Primary Care Networks (PCNs) are critical building block for a wider, regional population health approach

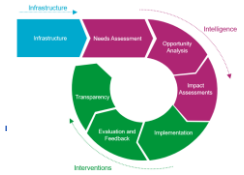
Dorset PHA – Weymouth & Portland Segment Matrix

- Population & Finance by Segment

MyCOPD HCA ed HCA f up SABA Group Consultation (GC)	Pulmonary Rehab PN fu LABA/LAMA GC	Pulmonary Rehab PN fu LABA/LAMA Annual spiro AOT assess LVRS?
MyCOPD HCA ed PN fu LABA/ICS or LABA/LAMA Annual spiro	Pulmonary Rehab PN fu Triple Annual spiro	Pulmonary Rehab PN fu Triple Annual spiro AOT assess LVRS?
Pulmonary Rehab PN fu LABA/ICS or LABA/LAMA Annual spiro	Pulmonary Rehab Spec fu/carousel Triple LTabs/roflu Annual spiro	Pulmonary Rehab Spec fu/carousel Triple LTabs/roflu Annual spiro AOT assess LVRS?



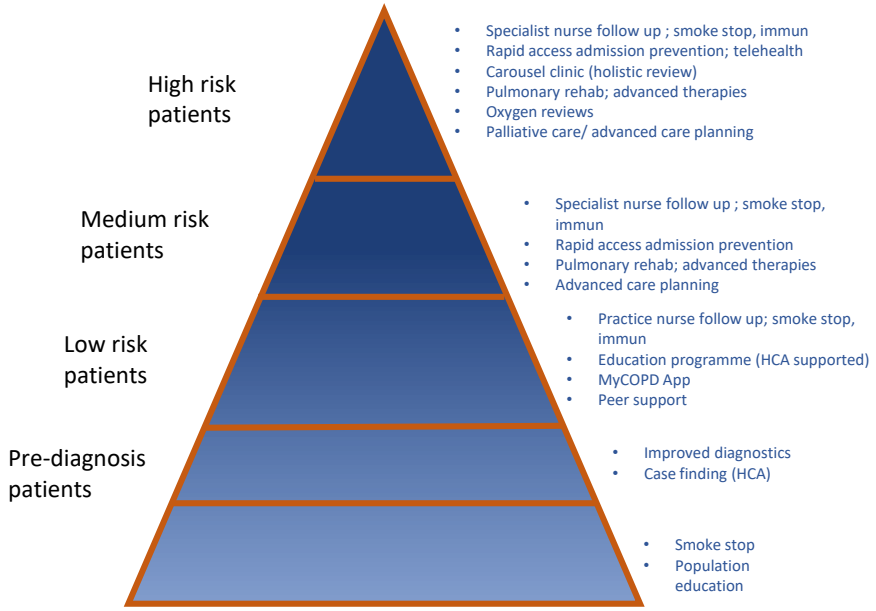
N.B This does not include 536 patients who have a diagnosis of COPD but no recorded MRC score.



PHM – Weymouth & Portland

Integrated Respiratory Care Model

- Improve the care of respiratory patients across the population
- Improve diagnosis of respiratory disease
- Prevent need for secondary care inpatient and outpatient care
- Provide more cost effective care
- Provide care that is more seamless with a better patient experience – bridging primary, community and secondary and across comorbidities

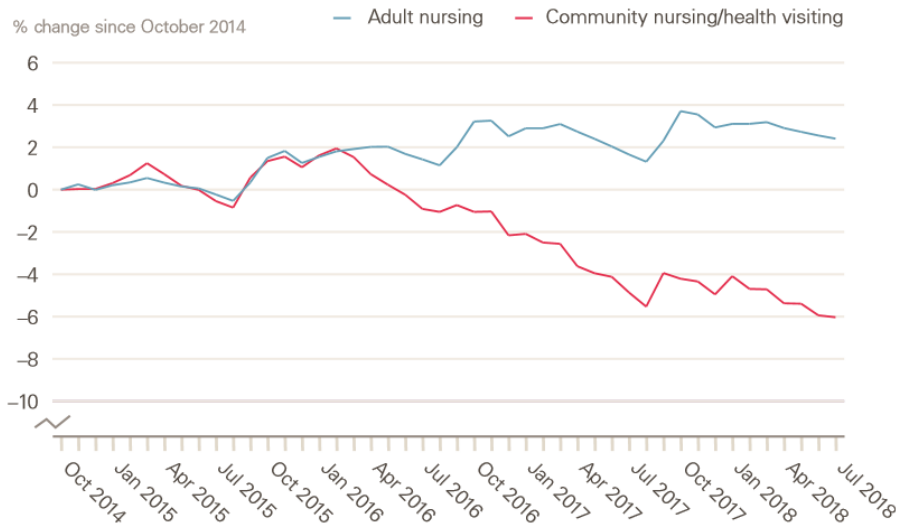


ICPCS Summary from Models of Care Stocktake

- **Specialist care and rapid response for complex patients, including stranded patients**
  - Health and Social Care Co-ordinator: Identified as a key role and enabler to offering alternative or more appropriate solutions.
  - Acute Frailty Response Teams: Visiting function – sees patients earlier in the day, frees up GP's to see more complex patients with benefits to all partners across the system
- **Proactive ongoing care for people with medium intensity needs (LTC management)**
  - The development of the model of care for LTC reviews for diabetes and COPD needs to further evolve and embed
- **Domiciliary care for very complex patients**
  - Community Support Worker: Bridging care and providing End of Life care at home have made a real difference. Part of Frailty teams that provide domiciliary care to support keeping people out of hospital or supporting discharge.
- **General**
  - Allowing a service to mature. True benefits of the models are felt when embedded and developed

Community and Primary Care Workforce

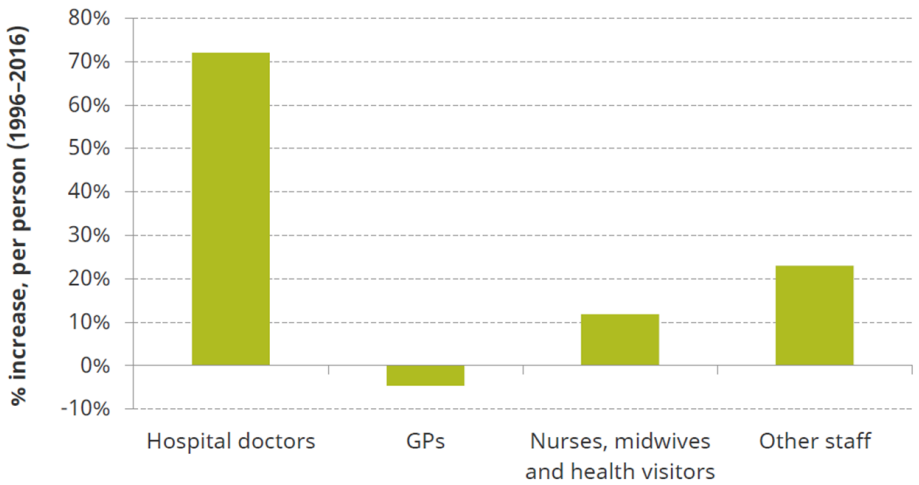
- Change in adult hospital nursing and community nursing/health visiting in the NHS in England (HCHS), October 2014 to July 2018



Community and Primary Care Workforce

- Investment into primary and community services recognises the decreasing workforce pattern over time and therefore the ‘low base’ on which we are building on

Figure 2.8. Changes in size of different NHS staff groups per population, 1996 to 2016



Workforce

- PCNs have also access to additional roles supported via the GP Network DES, which will support delivery of seven service specifications being introduced over the next two years (Personalisation/Meds Optimisation/Anticipatory Care Planning/Enhanced Health in Care Homes/Cancer Diagnosis/CVD Prevention and Diagnosis and Tackling Neighbourhood Inequalities)

- Allocation per PCN:
  - ***2019/20***: Social Prescriber / Clinical Pharmacists (transferred from national scheme)
  - ***2020/21***: Physician Associate / First Contact Physiotherapist
  - ***2021/22***: Paramedic

- Risk associated to both PCN and ICPCS investment is shift from other parts of system, either within organisations from core to new services, or from Acute Hospitals to PCN and Community Services

Future Investment Plans

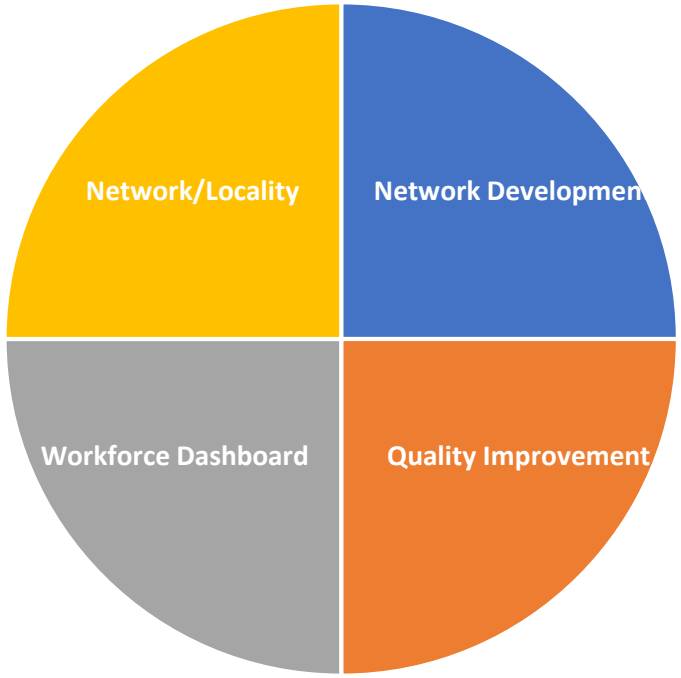
- From 2021/2022 and onwards we would continue to assess impact of new models of care and scale up as appropriate depending upon need and demand

- Focus on ***Proactive Ongoing Care for People with Medium Intensity Needs – LTC Management***

- Reducing variation in Long Term Condition management as we align this work to:
  - population health management using risk stratification tools to support targeted and personalised care approaches;
  - Prevention at scale initiatives
  - Anticipatory care and support planning
  - Mental Health programme

Clinical Commissioning Local Improvement Plan (CCLIP)

- The CCLIP is an incentivising specification which is worth £2,077,798 in total, funding which is split across the 18 PCNs.
- Four elements of the CCLIP



Thank you for listening

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