# this year's model

**The five-year forward view sets out two models for breaking down the primary/secondary care boundary. Seamus Ward finds out what it could mean and the steps NHS organisations are taking in this direction**

General practice is the hub of the NHS. GPs act as gatekeepers, referring patients for tests or more specialist care where necessary, and deal with 90% of all patient contacts. However, the role of the GP is changing. Coalition government reforms have given them more commissioning responsibility through clinical commissioning groups and these duties are set to expand. NHS England favours giving them a greater say in the commissioning of specialised services and, should the *Five-year forward view* (FYFV) recommendations be adopted, GPs could become the main players in new provider organisations.

As well as examining the future funding needs of the NHS, the FYFV also looks to flesh out the consensus around the need for transformation in the way healthcare is delivered.

The approach is simple. NHS England and other national organisations will examine and categorise health communities and develop transformational models suited to the circumstances in each category. They will then work with the health communities to consider whether to adopt the model they believe is best suited to local circumstances. The FYFV insists this does not mean 'let a thousand flowers bloom'; areas should choose from a list of approved models. Nor does it mean the end of the status quo; GPs will be able to provide services as they do now.

To kick off the process, the document sets out two possible models for the interface between primary and acute care: multispecialty community providers (MCPs) and primary and acute care systems (PACS).

King's Fund senior research fellow Rachael Addicott says the principles behind the two models are sound. But she adds: 'These more formal ways of working are quite a leap from where they are now.

'The position varies across the country, with some providers ready to work together, whereas others will have no or a poor relationship and are a long way from being able to do it.'

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While PACS look toward vertical integration, MCPs build on the recent changes in general practice that have seen GPs and other primary care clinicians become involved in commissioning patient services.

The FYFV also says primary care could offer a greater range of services, enable new ways of delivering care – harnessing digital technologies, new skills and roles – and offer more convenience for patients. But to do this, groups of practices (federations and networks) or even large single practices will be allowed to form MCPs.

MCPs would be based on a registered list of patients and could employ specialists, including consultant physicians and geriatricians, to work alongside community colleagues. Most outpatient and ambulatory care would be shifted out of hospital, though MCPs could also take over community hospitals, allowing them to expand diagnostic and day treatment services such as dialysis and chemotherapy.

## MCP approach

With the right credentials, MCP GPs and specialists could admit patients directly to hospital. And MCPs could manage a delegated budget for the care of their registered list. This could include health and care pooled budgets. Nuffield Trust chief executive Nigel Edwards says: 'We have already seen many federations or super partnerships emerging and one of the first things they have tended to do is to centralise their back offices. They also tend to employ more senior, experienced managers,' he says.

'Once they have centralised the back office, the next step is to reduce the variation and increase standardisation in practices across the group. Then they start taking in community nursing and other services.'

As the FYFV acknowledges, some proto-MCPs are emerging, including the integrated care pioneer in Greenwich, south London.

Greenwich Co-ordinated Care (GCC) has been providing integrated community health and social care since 2011 and was selected for pioneer status in 2013. The pilot focuses on the most complex patients with more than three long-term conditions who are at high risk of being admitted to hospital. These patients have a named professional who co-ordinates their care plan.

GCC says that, since 2011, it has reduced admissions by about 100 a year, despite an ageing population. In the process, it has moved from the highest rate of emergency admissions in the country in 2004 to the ninth best. Care home admissions have fallen by 35%. There have been savings in health services, which have been reinvested in more community care. And social care spending is down by £900,000.

The Vitality Partnership in Birmingham is also close to the MCP model. Managing director Sarb Basi says the partnership was formed in 2008 by forward-thinking GP practices that recognised the current structure was not sustainable. 'We felt the whole nature of general practice needed to change to create an integrated care organisation based on the foundations of the general practice registered population,' he says. 'We have been on that journey for four or five years.'

Vitality serves more than 65,000 patients across 13 sites, and a number of further mergers are on the cards. The partnership allows the practices to deliver a wider range of services, including dermatology and rheumatology. It has a digital X-ray facility and is examining the expansion of its out-of-hours service.

It employs a range of specialists, including GP and nurse specialists, GPs with special interest and advanced nurse practitioners. It also subcontracts consultants on a sessional basis from the local acute trust. In particular, these consultants are used to supervise the work of the GP and nurse specialists. These specialist services are funded through CCG-commissioned community contracts and enhanced services payments.

'We have a good relationship with local consultants and we see this as a partnership model going forward,' says Mr Basi. 'We don't see ourselves as in competition and we are looking to develop integrated care pathways to provide more seamless services.'

Vitality has re-engineered the non-clinical side of its operation, streamlining its back-office functions, but Mr Basi says it is moving to phase two in its organisational development. It is part of the first wave of the prime minister's challenge pilots to improve access, developing a single clinical contact centre with phone triage and a more interactive website. 'This will allow patients to contact us seven days a week. If they decide in the middle of the night they need a consultation, they can request one online and that will be picked up in the morning.'

**"Emergency admissions and delayed discharges are going up and we don't have sufficient capacity, so it's inevitable that we will seek to take control of more of the patient pathway"**
Suzanne Tracey

## Vertical integration through PACS

The second model, PACS, promotes vertical integration. Single organisations will be allowed to provide NHS list-based GP and hospital services, together with mental health and community care.

The momentum for the formation of PACS could originate in several ways. For example, acute trusts will be allowed to open their own GP practice in deprived urban communities where GPs are under strain and recruitment is proving difficult. In these cases, the FYFV says, foundation trusts' accumulated surpluses would kick-start a new generation of primary care, although safeguards will be necessary to ensure they do not become a feeder for traditional hospital care.

MCPs could mature and take over their main district general hospital as the next stage in their evolution. And, at their most radical, the FYFV says PACS could be accountable for the whole health needs of their registered population, funded by a delegated capitated budget. This model would be similar to the accountable care organisations emerging in the US, Spain and other countries.

Finance directors contacted by *Healthcare Finance* say many trusts will be interested in the vertical integration of PACS. And those that have already looked at setting up primary care practices – or making formal arrangements with existing practices – say it is vital to speak to GP federations or large practices before making a move.

Royal Devon and Exeter NHS Foundation Trust (RDE) director of finance and business development Suzanne Tracey says the trust's interest in integration is driven by the quest for a sustainable model of patient care. Vertical integration would allow trusts greater control over demand by extending its reach into primary care – for example, to run preventative programmes.

'If we don't get involved in the integration agenda, we are not going to be viable going forward,' she says. 'Emergency admissions and delayed discharges are going up and we don't have sufficient capacity, so it's inevitable that we will seek to take control of more of the patient pathway.'

Integration makes sense financially and from the point of view of the patient, who will receive better joined-up care. 'I don't think it is just foundations that will be thinking of integration, but we are perhaps slightly better placed to take it forward,' says Ms Tracey. 'We are used to operating in a different sector and probably have the wherewithal in terms of capacity and better financial headroom.'

In the first instance, the opportunity to integrate has been provided by the reprocurement of transforming community services (TCS) in Devon. The trust has been chosen as the preferred supplier for the eastern sector of the county.

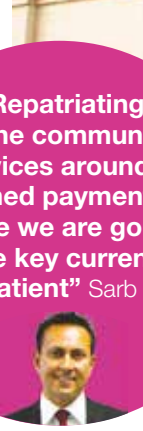
'From our point of view, it's a great first step to becoming an accountable care organisation,' says Ms Tracey. 'The pathway would be: acute to combined trust, to PACS and potentially PACS/ACO. Given the financial challenge, taking on a role outside the four walls of the hospital will help support our commissioners managing risk, particularly financial risk, and some of the delivery risk. If the NHS nationally was looking for a pioneer for PACS, we hope that we would be considered as a pilot site.'

The trust is thinking about the models of care and has a pilot scheme with social care in the Exeter area. 'We realised it could only happen if we pooled health and social care resources. In effect, there is one lead provider, likely to be the RDE, focusing on the health and wellbeing agenda.'

Vitality's Mr Basi does not support acute trusts setting up their own GP services. 'We want a stable and strong high-quality acute hospital on our patch – it's important to us and our population. We want to work in partnership so they continue to do what they are good at and we can focus on what we are good at. It will deliver a better deal for patients.'

Vitality's strategy is also to build an accountable care-style organisation. 'We have started to engage nationally around co-commissioning and holding capitated budgets. It is fair to say as part of our strategy we intend to build an accountable care organisation-type model. That's why we need these budgets – to deliver as much care as we possibly can and contract with acute care specialists for the remainder of that care. I think this is a model that will emerge over the next few years.'

**"Repatriating all the community services around a defined payment is where we are going. But the key currency is the patient"** Sarb Basi



He argues that Vitality shows elements of horizontal and vertical integration. 'Potentially it is a national model, where people could work with us or follow us.'

The Nuffield Trust's Mr Edwards warns that vertical integration is not easy. 'The hospital side is even more challenging. It takes some time for hospitals to learn how to work with primary care. US experience shows it's not that easy. It's better for them to look for joint ventures rather than go into direct competition.

'Experience shows it's quite difficult to get people to shift lists, unless you are working with GPs who are retiring. Also, as a hospital, do you want to be in competition with the people who are your commissioners? A joint venture or collaborative approach might be best. But people need to learn to trust each other. That cannot be short circuited.'

The FYFV recognises there is work to do on funding and other areas. Mr Edwards believes both capitated budgets and year-of-care payments could be used to fund the new models.

Vitality's view on funding is linked to its expansion plans. Mr Basi says it plans to continue to expand by adding more member practices, potentially covering the whole of Birmingham – 250,000 people. The aim is to improve access where it is poor and boost community resources and infrastructure. As well as community nursing and therapy, Vitality could also seek to incorporate dentistry, pharmacy and optometry.

'Repatriating all the community services around a defined payment is where we are going. But the key currency is the patient,' he adds. 'The contracting environment is fragmenting and we would like to move to a model of a simple capitated budget delivering an integrated package to our population with set outcomes. That's where commissioners need to be more innovative and forward-thinking in terms of how they contract and commission.'




Ms Tracey says that NEW Devon Clinical Commissioning Group has been exploring alternative funding models to support pathway working and has a focus on outcomes-based commissioning. 'It has talked about two main options – payments based on capitation and a pathway tariff,' she says.

It could use both, depending on the type of service. 'For example, it could be a capitation tariff for frail and elderly people to take account of their mortality and co-morbidities, alongside a pathway tariff for, say, a hip replacement.' She adds that, with a lot of work still to do, it could take 18 months to two years to begin operating such a system locally.

## Funding is key

King's Fund senior research fellow Ms Addicott says decisions over funding could determine the success of the initiative. 'If you want to see transformation and integration it needs to be reinforced in the way money flows around the system. It must be pooled or capitated to some extent to ensure providers are working to the same incentives.'

There is also a question over whether integrated care with more services delivered out of hospital will cost less. 'The model most closely resembles what patients might want and gives providers the opportunity to deliver more co-ordinated care,' says Ms Addicott. 'But there are questions over whether it is more cost-effective. A more robust evidence base is needed to show it is a more cost-effective way of delivering care.'

British Medical Association GP committee deputy chair Richard Vautrey is circumspect about the new models. 'There is no one perfect model for this and one size does not fit all. The same applies to hospitals taking over GP practices. This may be the only possible option for some practices struggling to remain viable – such as a small number of remote, rural GP practices, but there is little evidence that this is needed or necessary for most of the country and could make matters worse for patients rather than improve services.'

However, the FYFV gives the NHS the opportunity to introduce integrated care, Ms Addicott says. 'The stars are aligned in support of these approaches and CCGs are increasingly interested in designing new provider models.'

With the FYFV behind it, the conditions in favour of – and the expectations for – transformational change have never been as good.