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Future proofing General Practice
New Models of Care

Dr Nigel Watson
GP and CEO Wessex Local Medical Committee

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My various roles

- GP – Managing Partner
- Chief Executive – Wessex Local Medical Committee
- GPC – Rep for Hants and IoW
- Executive Board Member – Hants and IoW STP
- Board Member Health Education England – South
- Member National Advisory Committee – New Models of Care
- Board Member – Wessex Clinical Senate
- Board Member – Hampshire MCP
- Board Member for Local Delivery Boards (ACS)
  - SW Hants
  - SE Hants and Portsmouth
  - North Hampshire

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The NHS challenge

- Ageing population 
- More people with long term conditions 
- Workload and complexity 

- Recruitment and retention 
- Financial challenge 
- Patient expectation 

- New drugs and medical technologies 
- Lack of social care 

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The NHS Challenge

- Demographic and other drivers create an imperative to shift the balance of care from hospital to community.
- Transformation being undertaken at a time of rising demand and financial constraint.
- Out of hospital expected to deliver the ‘triple aim’ of:
  - improving population health
  - and the quality of patient care,
  - while reducing costs.
- Key element of many of the Sustainability and Transformation Plans (STPs) currently being developed across the country.

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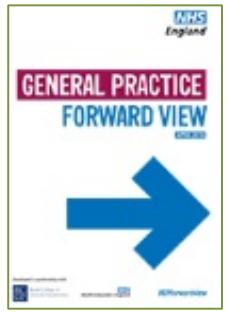
A sustainable and resilient general practice is central to the vision for the future NHS

The **Five Year Forward View** (5YFV) published in 2014. It sets out the role of integrated care

Two of these models are:

- **Multispecialty Community Providers (MCPs)**
- **Primary and Acute Care Systems (PACS)**



The **General Practice Forward View** (GPFV) published in April 2016. Acknowledges the significant difficulties in general practice sets out a package of investment to sustain and transform General Practice.

The GPFV describes the benefits that integrated, at scale working can bring to GPs and patients and ring fences funding for primary care transformation and care redesign.

Published March 2017 the **Next Steps on the Five Year Forward View** names primary care as one of the four priority areas for the NHS in England.

Supports GP surgeries to increasingly work together in networks or hubs delivering care to populations of around 30,000 to 50,000 people.

STPs, Accountable Care Systems, commissioners, local authorities and providers (including GPs) are collaborating to integrate services

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New Models of Care

- ## Multi Specialty Community Providers (MCPs)

Provides place-based population health by bringing primary and community based services together around the GP registered list. When this is contracted for it is a type of ACO.

- ## Primary and Acute Care System (PACS)

Care model to provide place-based population health based around the GP registered list which extends to services traditionally based in hospital. When this is contracted for it is a type of ACO.

- ## Sustainability and Transformation Plans (STP)

Partnership between NHS commissioners, NHS providers, GPs, local government and patient groups. oversee the delivery of – shared plans for improving system-wide quality, health and outcomes and efficiency. STPs are not statutory bodies. They are a collaboration of organisations and supplement, rather than replace, the accountabilities of individual organisations.

- ## Accountable Care Systems (ACS)

Commissioners and providers, in partnership with local authorities, take collective responsibility for system resources and the population's health, providing joined up, better coordinated care, and making faster improvements in priority areas. In return, they gain greater freedom and control over the operation of their local health system.

- ## Accountable Care Organisations (ACO)

Provider organisations that are given contractual responsibility for most or all of the health and care services for the local population and for associated resources.

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How does it all fit together?

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The challenge

- Over last few years hospital funding has increased by 10-12% and activity increased by 10%. (payment by results)
- General practice, community services, mental health – funding has not increased by the same amount as activity. (capitation based funding)
- PBR – is a perverse incentive to change.
- Hospitals funded at the expense of the rest of the health service

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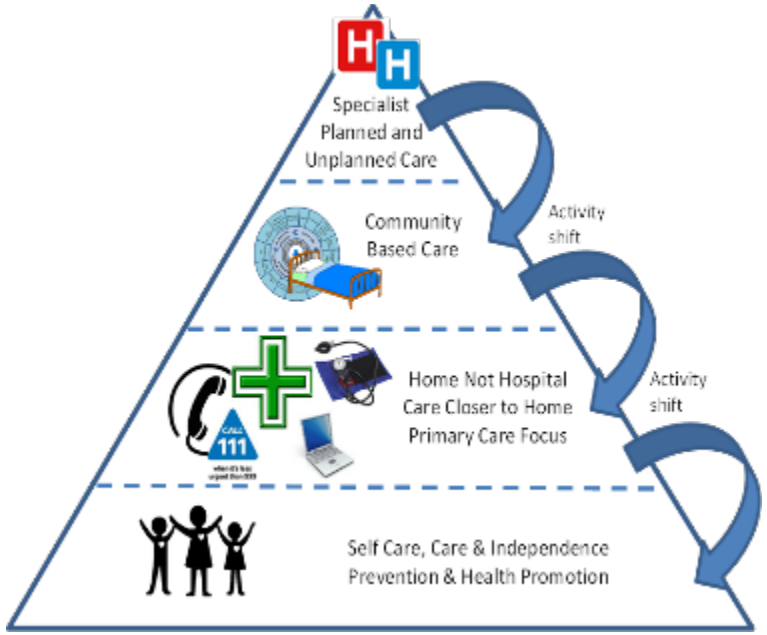
What is the future?

Our older population is expected to rise by 21% over the next 5 years

About half of our over 60s have multiple health and care needs

The number of people needing social care could quadruple in the next 20 years

Almost two thirds of all emergency hospital admissions in 2013/14 were for over 75s



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One View of the future

Current system of payment by activity for hospitals

and

capitation based contracts for general practice, community services and mental health replaced by:

- Population based budgets
- Outcome based commissioning
- Choice and competition replaced by provider partnerships

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General Practice

- 99% of population registered with a practice
- Gatekeeper role has been eroded but still important
- Life long medical record
- Cradle to grave care
- Holistic approach – specialist generalist
- Knowledge of the family and wider community
- Continuity of care – as a team
- Shown to be the most cost effective model
- The essential building block of the NHS

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Working at scale

- Maintain the practice – deliver what you can at this level
- Working at scale means practice collaborating and services provided at scale “backing into practices”.
- Can be super partnerships, networks or federations
- Working at populations of 30 - 50,000
- Look at the Primary Care Home model – a building block for New Models of Care

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One view of the future

- ***Urgent care service***

Urgent care team for the day cover the whole practice. Team includes GPs, NPs, community team, paramedics – with admin support. Could be a neighbourhood or locality.

- ***Long term conditions***

Focus on CVD, Diabetes, Resp and frailty – delivered to the practice population but integrated with specialist teams for diabetes, respiratory and frailty.

Diabetes – use practice record – team included specialist consultant, GPs,
trainees (specialist and GPs) specialist nurses, practice nurses.

- ***Family doctor service***

Work together in small groups focused on the holistic care of patients – supported by urgent care and the LTC services.

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Out of hospital care

- We need to be less reliant on hospital based care
- Hospital based care
  - Lacks holistic approach
  - Too specialist based lost the generalist approach
- General practice – specialist generalist
  - Workload
  - Capacity
  - Workforce
  - Resources

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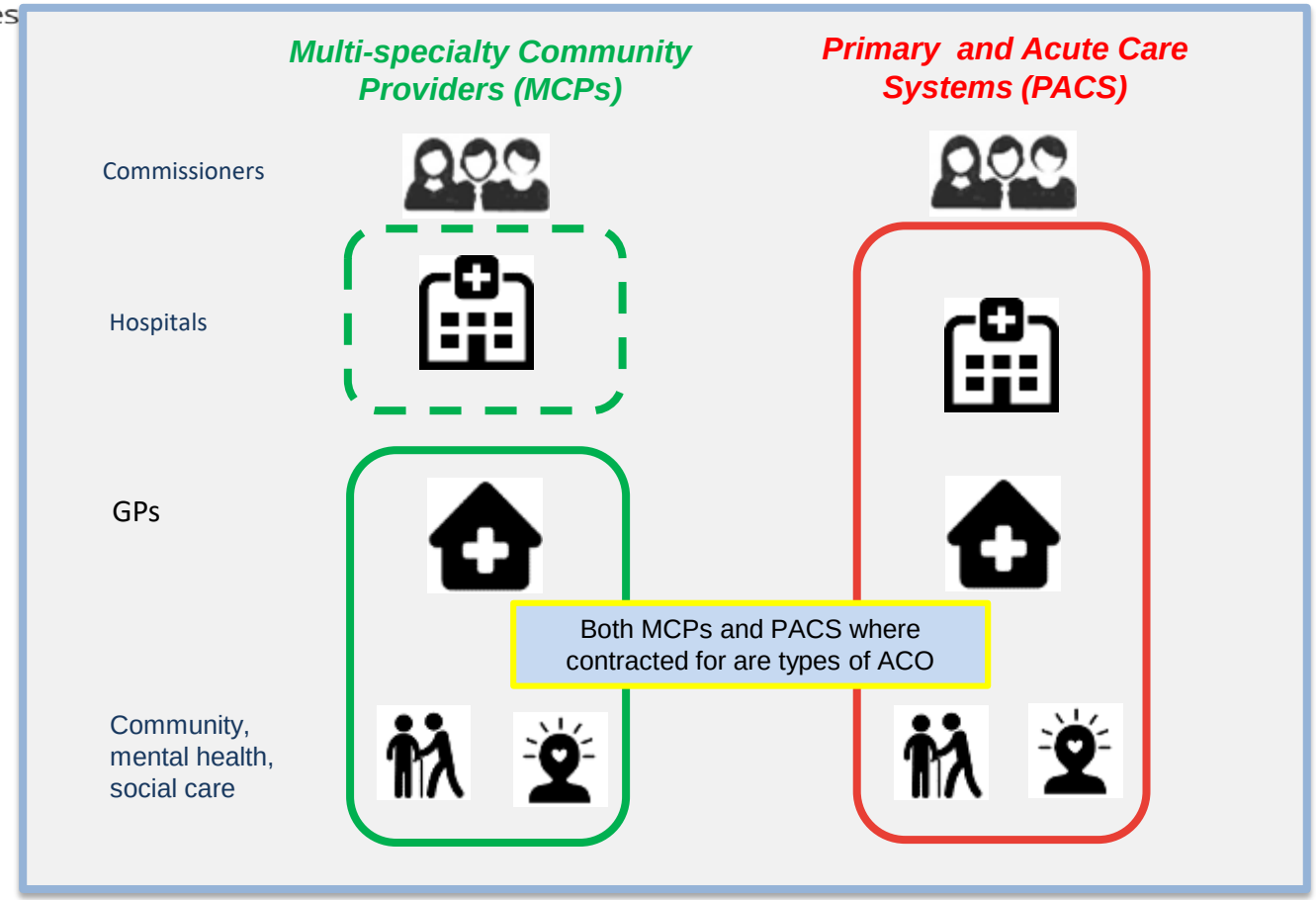
PACS and MCPS are both ACOs

MCPs
Provide place-based population health by bringing primary and community based services together around the GP registered list. This can include some outpatient and specialist services where appropriate.



PACS
Differ from MCPs in scope and scale. They also provide place-based population health based around the GP registered list but they extend to services traditionally based in hospital. This means they are likely to serve a bigger population.

All services in scope

Some services in scope

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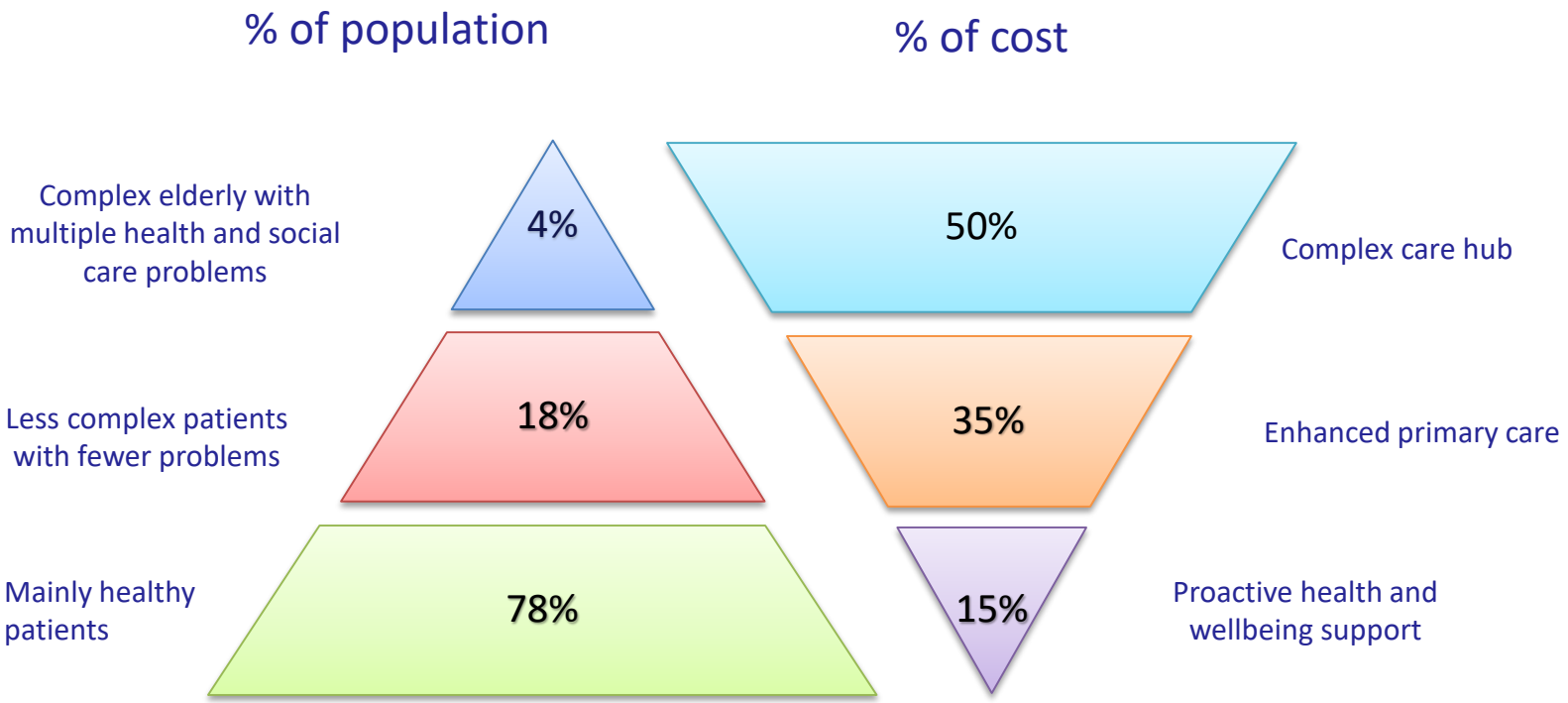
New Models of Care



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Hampshire MCP

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New Models of Care

- Natural community of 100,000 population
- 11 Practices
- Working in partnership with:
  - Community team
  - Local authority
  - Voluntary sector
  - CCG
  - Small hospital

- GP led but supported across organisations

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New Models of Care

- Wider primary care at scale
- Improved access – seven days a week (8am to 8pm)
- Extended primary care team
  - General practice
  - Community services
  - Social care
- Delayering specialist care
- Population focus




Workforce

Context

Government committed to training 5,000 more GPs – but GP training places remain unfilled.

Newly qualified GPs not going into general practice.

Older GPs retiring faster than they can be replaced.

Need to create capacity in general practice by using other clinicians.

Need to work across organisations

Develop a wider multi professional primary care team

Achievements

MSK extended scope practitioner working in a practice.

Mental Health worker replaced a GP in Gosport.

Pharmacists based in practices fully funded working with community and hospital pharmacists

Care Navigators working in all Practices.

GPs employed as frailty GPs.

Training posts taken out of hospital and now spend time doing Diabetes, Respiratory, pain clinic and community geriatrics.

Planned Impact 2016-18

Make general practice a better place to work.

Free up GP time. Add capacity.

Improve quality.

Benefit system by moving workforce into general practice.

Increase workforce in primary care.

GP Training

Context

GP Training is still to based on a hospital model of care.

Junior doctors are an important part of the hospital based workforce.

Need to expand the GP workforce and therefore need to train more GPs.

Need to provide more training places.

Changing the provision of care to be a more community focused model must be accompanied with a change in the Way GPs are trained.

Achievements

Agreement reached to work with community and hospital to create new posts that have a greater community focus.

Worked with Health Education England to create new community posts.

12 posts created – ST2 – 2 days in general practice 3 days working in community based Respiratory care, Diabetes, Frailty, Pain clinics.

Recruited practices and established the new posts

Positive choice for trainees

Positive feedback from those who have completed the rotations.

Planned Impact 2016-18

Expand the number of GPs in training.

Add capacity to the GP workforce.

Create new training places which will lead to new portfolio roles – for example new frailty service looking to recruit from the GPs who have had experience in frailty.

Change the view of specialities in terms of what can be achieved in the community.

Comment: Positive impact and being developed further.

MSK practitioner

Case for change

30% of GP contacts are MSK

High social burden for MSK pain, association with co-morbidities

Solution

Option to see MSK practitioner as the primary contact.

Expected outcomes:

Increase GP appt capacity

High patient satisfaction with new model of care

Attendances at A&E (type 3&4 MIU and walk-in) reduced by 3%

Increase in GP knowledge of MSK care options

Reduced primary care (GP) appts for specified MSK issues

Early Outcomes:

Access:

First contact for any MSK patient – 20 Minute appointments. Option to see either GP/PT

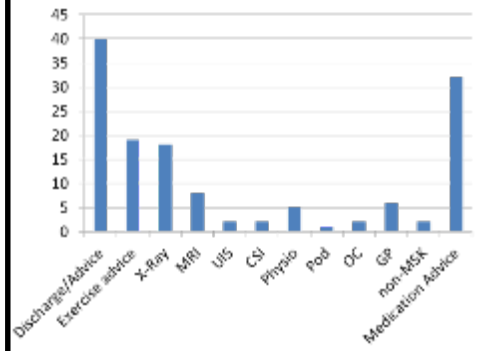
Now 4 clinics/ week , to 11 in locality

GP capacity:

44 GP contacts for MSK,

165 MSK–P contacts

Outcomes:



SWNF ROI

Weekly cost saving £12,878.47
Annual cost saving: £643,923
GP time saved per week 113. hours.
If time reinvested, GPs could spend 11.1 minutes per patient

Modelled outcomes:

Orthopaedic Choice Impact	Current	Proposed
Orthopaedic referrals from 1ry Care	3258	127
Physio referrals from 1ry care	5189	3814
Patients managed in 1ry Care	25283	29959

Next Steps

Replicate across vanguard

Expand service in New Forest with base at The Practice

Spread to include physio skills training and supervision, and cost modelling per practice.

HEE are supporting funding further development of the new care model in practice.

Comment: Model proven being copied around country, not been adopted by local health economy. Mismatch between commissioning plans and Vanguard.

Clinical Pharmacists

Context

30-50% of medicines are **not taken as intended**.

Half of patients aged 65-74, and 70% of those aged 75 and over, take at least three prescribed medicines.

1 in 20 prescription items in primary care has an **error** and **1 in 550 is serious**

60 million prescription items were **dispensed** in Wessex in 2016/17. This means that there were over **100,000 serious error**

£13m spend on medicines prescribed by the 7 practices in SW New Forest

Achievements

Medicine Management team have become part of practice team.

A Pharmacist placed in every practice.

Funding used to employ additional Pharmacists. Continued funding based on quality and savings.

Work commenced on poly pharmacy, LTCs, hospital discharge, drugs of limited value.

Sustainability plan agreed

CCG looking at a roll out to other areas

Planned Impact 2016-18

Reduce prescribing costs.

Improved care on discharge from hospital.

Liaise with community and hospital pharmacists.

Add capacity in general practice.

Reduce demands from Care Homes.

Rationalise high cost prescribing

Comment: Excellent model created by joint working between the CCG and Vanguard. Pharmacists can help to add capacity and sustain general practice but also make significant savings within the system

Extended Primary Care Team (EPCT)

Context

General Practice and Community Services work in isolation.

10% of work duplicated.

30% of patients could be seen by a difference health care professional.

Could include adult mental health and older peoples mental health.

Patient records not shared.

Communications fragmented

Action

- Creation of an EPCT by Oct 2016.
- Locality based team.
- Embedded in general practice.
- GP led with locality manager and Lead Nurses.
- To include mental health and older peoples mental health by April 2016.

Planned Impact 2016-18

- Creation of a Common Health Record.
- Reduced bureaucracy.
- Creation of wound care service.
- Specialist nursing – locality based for Diabetes and Respiratory .
- Integration of practice and community nursing.
- Locality based MSK service (Physiotherapy and Extended Scope Practitioner.

Comment: Integration with community team based around a defined population has been an aspiration of most Vanguards – despite much discussion and plan we have made little progress. Major problems in terms of working across organisations.

Primary Care Access Centre (PCAC)

Context

Create improved access to general practice.

Provide a service for a population of 70,000.

To help with sustainability of general practice needs to be integrated with local practices, OOHs.

Additional funding and workforce required.

Need to use a wide skill mix

Achievements

Provision of an 8am – 8pm service seven days a week.

Prime Minister Challenge Fund.

Opened Sept 2015.

Branch surgery of 7 practices.

Common health record.

GPs, Nurses, MSK specialist

Currently discussing merger with MIU

Planned Impact 2016-18

Reduced A/E attendance

Help general practice workload

Provision of general practice at scale

Merger with MIU

Locality based urgent care hub

Comment: Criteria changed to provision in evening and weekends – model evolved. Plan to develop services based on hub. These include urgent care, wound care, diabetes, reparatory, A/E streaming and training. GP provider company were a major contributor.

Common Health Record

Context

In our locality general practice, community staff, hospice and hospital all use different patient records, no ability to message within clinical records, separate care plans.

Duplication caused by inability to see when when people are visiting.

Patients often asked same question by different health care processionals – e.g. end of life care – preferred place of death.

Achievements

- Primary Care Access Centre uses TPP and EMIS so can access GP records.
- Community staff using TPP.
- Hospice to use Palliative Care Version of TPP.
- Worked on information Sharing Agreement, GP, Community, CCG, hospice, ICO. Records shared from 18.4.16.
- Common templates
- MIG commissioned

Planned Impact 2016-18

- Reduced duplication.
- Improved care for patients.
- Improved safety.
- Creation and sharing of care plans.
- Reduced need for referral letters.
- Hospital able to access GP records
- Single record for Long Term Conditions

Comment: Three practices have a shared record with community staff and local hospice but difficult to change messaging and working together to produce common templates, protocols etc.

Digital Technology

Context

The NHS struggling to cope with workload need to exploit technology.

Self help critical to reduce workload. E-Consultation have been shown to reduce workload by 10%

General practice operating at scale needs to be able to communicate more effectively.

Improved communication between general practice and hospital – could use Skype.

Achievements

Web-GP now being used by 5 out of 7 practices.

VOIP Telephone system in all 7 practices and PCAC.

Common Healthcare Record being created.

MIG – purchased.

DXS funded due to be implemented shortly.

Arden's Template installed 1st April 2016

Better Local Care Website

Planned Impact 2016-18

Patients better able to self care.

Reduced demand in general practice.

Greater efficiency with a Common Health Record.

Use Skype consultations as an alternative to face to face patient consultations.

Comment: The potential is huge but at present there is disparity between frontline clinicians, providers, commissioners and the IT leads.

Delayering specialist services

Context

Use diabetes as model.

£10bn spent on diabetes care, most on avoidable complications.

QoF – outlived benefits.

Focus on best outcomes

Prevalence increasing therefore need more capacity in general practice.

Move care from hospital to community, integrate with general practice.

Create a single record

Achievements

Established a task and finish group

Aim to risk stratify population focus on those with greatest impact.

Employ more HCAs to support practices.

Specialist teams to be practice based.

Agreed to create a single care plan.

Discussions about future of specialist nurses and practice nurses.

Planned Impact 2016-18

Improved care – focus on those that will gain most benefit. Targeted on:

- BP
- Cholesterol
- HBA1c

Reduce duplication between services.

Create a single care plan shared with patients.

New agreed locality model to be in place by end of 2017

Comment: Progress slow, very difficult to change the mindset of hospital based staff. Will only be achieved with a budget held by an MCP which includes some hospital based services such as diabetes, respiratory and care of the elderly for example.

Frailty

Context

New long term condition, often patients have 3 or more LTCs. Need to address frailty holistically

SW New Forest has high numbers of patients aged > 75 and > 85.

5% of local population aged > 85.

Frailty leads to increased demands on healthcare.

Can stratify into 3 groups:

- Mild
- Moderate
- Severe

Achievements

Task and Finish Group established.

Working with local authority to create web resources to help patients identify their level of frailty and list resources or self help groups.

Model agreed to support patients in their own home that is based on a natural community of care.

Model commissioned – started in June 2017 will be fully established by October 2017.

Planned Impact 2016-18

Reduced hospital admissions

Improved quality of care for older patients.

Reduce demand on general practice.

Improved quality of life for older patients

Comment: Excellent example of commissioners and providers working together to design a service that will help general practice.

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What difference does it make?

Problems

- Culture
- Workload
- Recruitment and retention
- General practice status
- Competition
- Premises
- Organisational barriers
- Barriers to change
- Can’t do

Solutions

- Noticing radical change in culture
- Focus of all streams of work
- Changing – better place to work
- Leading, enhanced
- Replaced with partnership work
- Lease, ownership, different use
- Less of a problem
- Being removed
- New ideas

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What next?
The New Models of Care

- Created a strong partnership
  - Practice
  - GP provider company
  - Community provider
  - Hospital

- Now need a joint venture
  - Accountable Care Organisations

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Accountable Care Systems (ACSs)

Groups of:

- Commissioners
- Providers
  - Hospitals
  - Community providers
  - General practice

and

- Local Authorities

that take collective responsibility for managing resources, quality improvement and population health.

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Accountable Care System

1. **Shared decision-making**, supported by an effective collective governance structure.

2. Organisations **acting and behaving as though they are one single system**, even though in law they are a number of distinct entities with distinct duties.

3. Collective management of the financial resources for the ACS's defined population though a **system financial control total** that covers the income/expenditure of NHS commissioners and NHS providers

4. A system partnership that has **clear plans** –and the **capacity and capability** to execute those plans

5. '**Horizontal integration**' of providers whether virtually or through actual merger or joint management and '**vertical integration**' with GP practices formed into primary care networks

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Accountable Care Organisation

An ACO needs either directly to encompass general practice:

- *through sub-contracting with GP practices*

or

- *employing primary care staff (or a mix of the two)*

or

- *there needs to be a very strong integration agreement between the ACO and local GPs.*

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Accountable Care Organisation

- Commissioners entering into an **outcomes-based contract** with a single provider.
- A longer contract length.
- The provider organisation taking on **activities traditionally carried out by commissioner.**
- A **single, integrated budget** (potentially with risk/ gain share with other providers)

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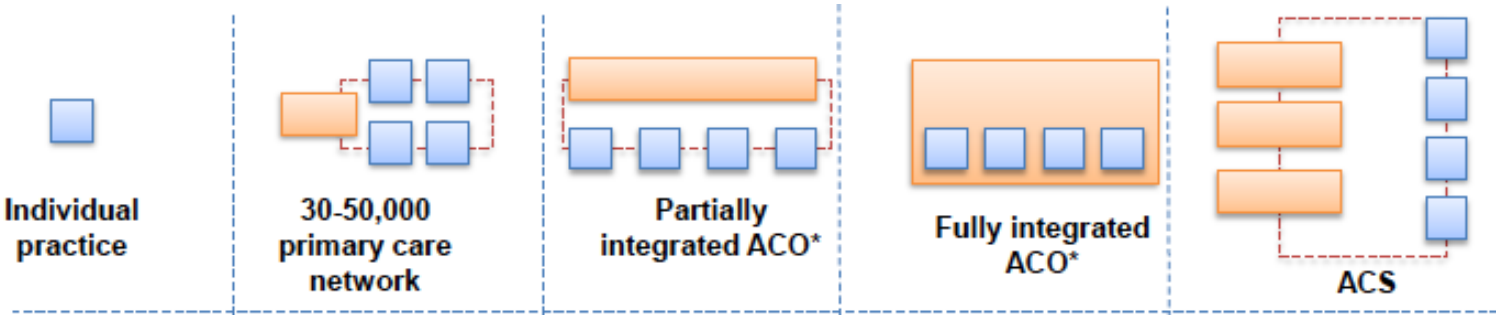
What could an ACS or ACO look like?



- Capitated contract
- QoF

- Retains contract
- QoF - may share
- Integrated with community services
- Incentive at network level
- Engaged with ACS but not part of an ACO

- Retains contract
- QoF - may share
- ACO has population budget
- Incentives at ACO level but could include practices and primary care networks

- Practice employed by ACO
- Employed contract for GPs
- Premises and employer risk removed
- Indemnity covered

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Where are we know?

- Aligned with STP
- Need a legal entity to hold a population budget
- Create a joint venture
- Move planning and implementation to provider partnership
- Radical change to current contracting and commissioning
- Define role of acute services
- Will the system allow this to happen?

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What benefits could there be to GPs?

- Greater influence and control over the local health and care system including **control over the allocation of financial and human resources** in the community
- Work in a care model built by GPs that allows GPs to have a **work/life balance** which will in turn **increase recruitment and retention**
- Make helping those with complex problems **easier** by offering a greater access to a broader, more in-depth range of services in primary care settings
- True multidisciplinary working that **reduces hand offs to general practice** from other clinicians and professionals
- Wider career opportunities for GPs that allow **portfolio careers**

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What is happening now?

Practice

- Registered list
  - Vital building block for the NHS
  - Need to have a locality focus
- ACOs
  - Virtual, Partially or Fully Integrated
  - GPs as part of the Board
- GPFV
  - Pharmacists, Mental Health Workers
  - More GPs
  - Integrated community teams

System

- April 2019 – new contract
  - Community services
  - Some hospital services
  - Primary care
- Hub – supporting practices
  - Urgent care
  - Children's services
  - Primary Care Home
  - Extended Opening
  - Wound Care
- At scale working
  - Practices – mergers
  - Federations

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Summary

- Clinically led transformation
- Out of hospital care provided at scale
- General practice at the core and leading
- Sustainable general practice – new roles
- Reform urgent care and management of long term conditions
- Wrapping services around the patient – build on registered list
- Increasing capacity at level of the practice
- End silo working and organisational barriers
- Change culture – single teams
- Work force – skill mix
- Population based focus with capitation based funding

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Let’s grasp the opportunities and talk up general practice

rather than preach doom and gloom!

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Any Questions