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NPCN
National Primary Care Network

Improving accountability in the provision of new models of care

Winter Review Report
March 2017

Introduction

The National Primary Care Network (NPCN), hosted and supported by the National Association of Primary Care (NAPC), is a group of over 500 healthcare professionals from across primary care including GPs, nurses, dentists, optometrists, allied health professionals and pharmacists.

The network holds a quarterly meeting for around 50 participants from which a report is produced. This is the latest in the series.

This meeting focused on population budgets and new metrics for new models of care particularly in relation to the Primary Care Home.

Presentations were given by:

Ed Smith CBE, Chairman, NHS Improvement
Dr Anant Jani, Executive Director, Value Based Healthcare
Dr James Kingsland OBE, NAPC President, led a debate about accountable care organisations (ACOs) and their translation into the NHS.

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Foreword

Dr James Kingsland OBE, President, NAPC

I am delighted to introduce the next report in the series of meetings of National Primary Care Network (NPCN), managed by the National Association of Primary Care.

The narrative style of our report attempts to convey the character of the meetings and the open inclusive debate that is so important to this network. Hopefully, in the following pages we have captured the energy and enthusiasm of the participants and speakers, as well as the important debates stimulated by the meeting.

This meeting was focused on testing ideas within what is currently being described in England as accountable care systems. There are many facets to accountable care, but this report concentrated on whole population budgets and metrics that may be used in the new care models that are prioritising primary care provision.

There was also a debate about what is known of accountable care organisations as created in the United States that are now being translated across the Atlantic into our healthcare system.

I am grateful to Ed Smith, Chair of NHS Improvement, and Dr Anant Jani, Executive Director, Better Value Healthcare, and all colleagues from a wide range of disciplines who were involved in helping develop this report.

Population budgets

Ed Smith CBE, Chairman, NHS Improvement

Population budgets start from the premise that the patient populations determine what services are needed and how those services are to be delivered, explained Mr Smith. They move money to the accountable provider group enabling them to focus on improving outcomes. This is achieved by ensuring there is a focus on developing a culture of shared leadership and purpose – make sure the "enemy" is outside, not inside the system.

Care must focus on the patient population's needs and required outcomes with a service delivery approach.

"Then we move away from something that is not just about contracting, to a system and culture that works around partnerships with true symbiotic relationships and money flowing through the system driven by delivery of care in a shared purpose," said Mr Smith. Fundamental enablers of this new system are linked data, transactional capabilities, the right workforce - both skills and capacity - and outcome-based evaluation rather than excessive short-term targets.

"We need to lower the barriers and focus on care, improving outcomes, a culture of being together rather than competing and then deal with the really, really difficult issues such as making sure we have an adequate flow of data across the UK health system and the workforce skills and maximising their efforts for the benefit of our public."

Population budgets – the win-wins

Whole population budgets support person-centred coordinated care. This addresses current problems with the payment system, which reinforces existing organisational boundaries, misaligns incentives and distributes risk unevenly.

When whole population budgets are linked to improved outcomes for individuals, it results in better accountability, better focus on need and alignment of spend across the system rather than in their individual components.

Making the system work and building strong relationships will be key to success. New models of care focusing on population health will focus on the needs of the whole population, not individual organisations, and will bring local partners together to build a shared understanding of patients' needs and system challenges. This will then enable improvements to be designed across pathways not just within them.

Population budgets will help to resolve long-standing problems, which individual organisations cannot solve in isolation and this will realise shared benefits. Developing a population budget must start with building relationships across organisational boundaries. "It will take time and it won't always be easy," said Mr Smith.

Dr James Kingsland, NAPC President, said the Primary Care Home model was constructed around registered lists and population budgets. The NAPC had built in some organisational memory into Primary Care Homes to act as a reminder of why things hadn't worked in the past.

Importantly behaviour and culture change was needed amongst staff. The biggest financial risk to the NHS was the loss of staff morale and lack of staff engagement. The Primary Care Home model worked by bolstering professional teams who were

involved in shared decision making on how population-based budgets were deployed.

The challenges of a population with complex needs:

- People with multiple conditions and complex needs comprise 4% of population but consume 50% of healthcare costs
- People with fewer conditions and less complex needs comprise 18% of the budget and consume 35% of healthcare costs
- Mainly healthy people comprise 78% of the population and consume only 15% of healthcare costs

Meeting these challenges must include better management of chronic conditions closer to home through:

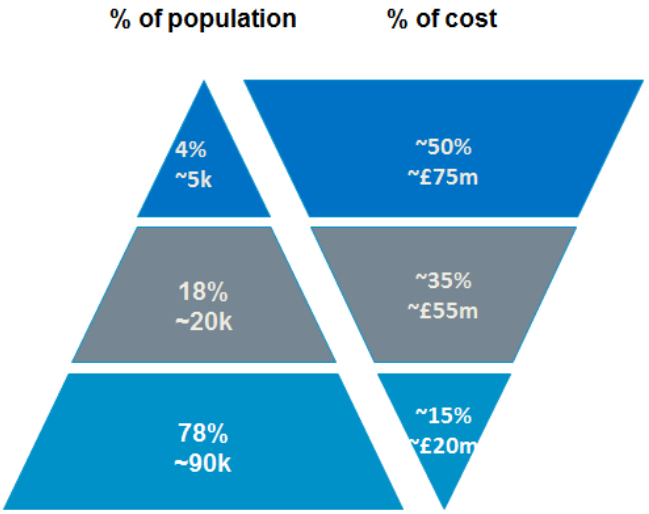
- Focus on self-care
- Greater emphasis on prevention
- Expanded primary care to support this
- Economies of scale
- Networks that standardise care and share knowledge and experience
- Concentration of expertise and facilities to raise quality
- Integration of care around the individual
- More 'expert' generalists and multi-disciplinary working
- Integration of the management of physical and mental health

Primary care has to be involved in the process/planning, and even to push for better strategies, to enhance primary and community care to help people manage long-term conditions.

New care models provide care for whole populations, integrating care around peoples' needs:

- Multispecialty community providers (MCPs) aim to provide out-of-hospital care, operating across healthcare, social care and wider wellbeing services to meet a local population's health and care needs

- Primary and Acute Care Systems (PACS) are whole-system care models that aim to join up primary, hospital, community, mental health and social care.



Discussion – A whole system approach to providing care

Ed Smith CBE, Chairman, NHS Improvement

Ed Smith started the discussion by saying that he was passionate about joined up systems and the whole systems approach to providing health and care.

He described the NHS as an aggregated but compartmentalised system where the problem was too often seen as inside the system rather than outside. The real problems, he explained, are factors such as increasing levels of obesity, diabetes and mental health disorders and rising numbers of frail and elderly people.

Compartmentalisation and change resistance block the flow that would come from a more connected system. He wanted to see more joined up systems between organisations such as NHS England, NHS Improvement and the Care Quality Commission. Sustainability and Transformation Plans (STPs) are intended to get local people in the same room, reintroduce them to each other and encourage them to find solutions that fit around their actual population.

The payment system also needs to change by moving away from “paying for widgets” and the mentality of wanting people to pass through turnstiles in secondary care. “We need to collectively change all that,” he said.

Looking to the future

Mr Smith said it would be impossible to achieve fully all the Five Year Forward View’s ambitions by 2020. The document set out the direction of travel but it was now important to plan what the healthcare system would look like in 2025 and 2030, taking a long-term view.

“You can do this because you've got 80 per cent of the ingredients which we know about today. We know largely what's happening to health, to the population and broadly what's happening to medical devices and the impacts that digitisation are likely to lead to. The future narrative will need to involve a fundamental redefinition of what goes on outside the walls of the hospital as currently defined.”

Speaking about the type of workforce skills that will be needed for the future, Mr Smith said there was a need to make better use of the new breed of nursing associates and skilled pharmacists, for example, and to redefine the medical curriculum in universities because by 2030 artificial intelligence may have developed to such an extent that many aspects of the role of the clinician will be fundamentally different.

He said people must think about how primary care, pharmacy and mental health services can be redesigned along with how the estate needs to be reconfigured at both ends of the system - primary care and residential and home care.

“At the moment, we have got displacement activity which is driving vast amounts of the healthcare demand to the front door of the acute provider. If that displacement activity continues, all you will do is bust the system and then what happens? There will be demands for more money for hospital activity and then you simply reinforce the continuation of the status quo, which is the wrong thing to do.”

Graham Phillips, Director of Manor Pharmacy Group, said that in his experience as a pharmacist, he had been excluded from any dialogue with STPs so he had no opportunity to influence and shape the system.

He was also disappointed that, while the Five Year Forward View had set out proposals for preventive health, local government had withdrawn funding for public health since the document was published and the Government was destroying the network of community pharmacies.

“I'm about to close two branches as a direct result of the funding cuts which will just push more people towards GPs and A&E departments,” he said.

Another delegate said the STP in Peterborough did not mention primary care at all and, in a recent talk about transformation, Lord Carter failed to mention primary care or general practice as part of the solution. “It was all very much acute trust focused – 90 per cent of the activity happens in the community with 11 per cent of the budget. It's the voices that represent the acute trusts who generally dictate policy,” he complained.

Dr Steve Laitner, GP, said the NHS indulged in too much navel gazing and was spectacularly bad at customer service. “When I talk about the customer to my GP colleagues, I get berated about using the word customer.”

Mr Smith said ‘customer centricity’ was the lifeblood of any organisation. “For example the best people in the great retailers that I have come across tip up at random stores unannounced and talk to their customers and staff and are intimately engaged with the customer experience. We, in the NHS, are not sufficiently and consistently like that and we have to ask ourselves why. We employ 1.4 million people who work in the NHS because it is a vocation rather than a job - those people should be embraced for their knowledge of what can be improved and what can be changed for the better.”

Too much regulation

Another attendee argued that the NHS inhibits successful organisations from taking over less successful organisations because of markets, competition and regulation, which prevented change at speed and scale.

Mr Smith responded: “My team in NHS Improvement is working to drive improvement, not simply regulation. You can only drive innate improvement with a freer system that talks with itself.
“Poor management and poor leadership takes a rules-based approach and suffocates the instincts and the behaviours of the people in their organisation. If you reverse the flow of dominating by rules funnily enough you then get the oxygenation, instincts and behaviours that produce better results. In the NHS, we seem to have hollowed out trust for people to instinctively do the right thing.”

He said the late Steve Jobs, former Chief Executive of Apple, used to say that he hired really smart people not so that he could tell them what to do, but so that they could tell him what to do. “We have got the reverse situation in the NHS. You need to allow the engagement of people on the ground who know best in order to allow the system to breathe and work. The NHS system has been run too tightly and has been too structured.”

Innovation must be shared

One delegate said: “We know there are lots of pockets of innovation and lots of good ideas out there and a lot of things that are being repeated again and again. Why can't we get to the point of sharing and industrialising across the NHS the things that work?”

Mr Smith said: “This is because, in the NHS, we have not got enough of a mindset that we can beg, borrow and steal from each other, because that is how you get rapid innovation. You learn from your neighbour and you improve upon it.”

Another attendee asked: “Who is going to lead the new vision of the NHS in 2030, who is going to help us to march forward?”

Mr Smith replied: “The time of heroic single person leadership has actually gone. The best thing that the leadership system can do now is get out of the way. So, my answer to you is, if I had my way, I would create a load of mutuals and create a fundamentally different governing structure driven by clinicians who are prepared to step up and sweep away quite a swathe of regulation and allow innovation and change to happen.

“If you want a vibrant health and care system that survives for the next hundred years and beyond we have got to start doing that because the current model doesn't work and will work less well in a digitally-rich world.”

Dr James Kingsland concluded:
“The take home message from this discussion is that primary care already innovates and knows how to change patient care. Within the Primary Care Home programme, we want to encourage that innovation and change in culture.

“Fundamentally though, we want to take that learning and share it nationwide, starting with neighbouring sites.

“The first wave of Community of Practice for the PCH programme has just launched and we are hopeful this community will be covering 20% of the population of England by late spring 2017.

“This gives the opportunity for change to large portions of the country, the difference this model makes to the NHS could be huge.”

New metrics for new care

Dr Anant Jani, Executive Director, Better Value Healthcare

Better Value Healthcare Ltd (BVHC) is an Oxford-based company set up by Sir Muir Gray to promote the practice of value-based healthcare for individuals and organisations in the healthcare sector.

Dr Jani began his presentation by outlining the problems and challenges in healthcare that need to be tackled. These include issues of patient harm, unwarranted variation in outcomes, inequity, failure to prevent preventable diseases, waste of finite resources both financial and human, increasing need and demand driven by an ageing demographic, increasing population and decreasing or stagnant resources.

Quality and Safety
He went on to consider issues of quality and safety in healthcare. These are essential but they do not in themselves guarantee high value healthcare if the wrong intervention is used, the wrong patient gets the intervention or the intervention is given at the wrong time. For example, you could have the best surgeon in the world do a tonsillectomy on a child, the surgery goes perfectly, the child recovers well and there are no complications. But, if the child did not need the surgery in the first place, even though the procedure has been done to a high standard and has been done very safely and efficiently, it would end up being of low value.

Better Value Healthcare identifies value at three levels:

Personal value: meeting the needs and expectations of patients to whom we are accountable. The needs and expectations of patients are to consistently get the best clinical outcomes they possibly can. In addition, you must meet the subjective needs of the individual. So how do you meet those needs and expectations if you have a consultation lasting only six to 10 minutes?

You need to ensure that you have a meaningful discussion with two-way dialogue and ensure that the patient can articulate what their needs and expectations are, otherwise they will go away dissatisfied.

Dr Jani cited the example of an orthopaedic surgeon who, during a consultation with a woman with terrible knee pain, found out that the only reason she wanted a knee replacement was so that she could bend her knee while she was gardening. When he told her that, if she had the operation, she would never be able to bend her knee in the same way again, she declined the operation because her gardening hobby was so important to her. She ended up being prescribed analgesics and anti-inflammatories. “This is the nuance of listening to patient’s needs and expectations,” said Dr Jani.

Technical value: the basic definition is the outcomes delivered by an intervention and the resources needed to deliver those outcomes. The interventions also need to be technically efficient and cost effective but it is important to note that these two characteristics are necessary but not sufficient to ensure they are high value because technically efficient and cost effective interventions offered to patients who do not need them will be of low value.

Allocative value: allocating resources to the maximum value for your population’s needs. Resources include money, time (clinician as well as patient time), use of space and consumable resources. Dr Jani said it can be tricky allocating the resources the population needs in an equitable way.

"It's an uncomfortable conversation that we have to have because not everybody is going to get what they want. People can pay a premium for their healthcare and this then generates two tiers of care and that probably has to be done carefully to ensure that there isn't that much inequity in the population."

Delivering triple value healthcare involves:

- Working with all the stakeholders in the healthcare system. This means breaking down silos and ensuring that patients are included as stakeholders.

- Focusing on outcomes from multiple perspectives. An ideal outcome for different stakeholders will be different. So you must have an open a dialogue with your stakeholders to refine what the outcomes will be and ensure the aggregate list of outcome metrics meets the key concerns of the stakeholders.

Siloed healthcare
The current NHS healthcare system has jurisdictions (e.g. CCGs), institutions (e.g. hospitals) and professions and regulators working together within a healthcare archipelago comprising general practice, mental health and community and hospital services in a 'weird chunky way' which crystallizes them into silos. The one common factor for all these stakeholders is population healthcare. The payers, providers and patients traverse these healthcare silos.

- The only normalisable factor across all of healthcare are the patients and their clinical conditions – this is true at different times (for example, 50 years ago there were patients with asthma and 50 years from now there will be patients with asthma) and geographies (there are patients with asthma in London, Dubai, Toronto, rural villages in India, China, etc.). The outcomes we want to deliver to these patients will largely be the same even though the exact provider organisation delivering the outcomes and the payers paying for this care (whether it be governments, insurance companies, or out of pocket) will vary over time and across geographies.

- Population healthcare is comprised of the patients and their clinically defined conditions (e.g. familial hypercholesterolemia), their symptoms (e.g. pelvic pain) and their population group (e.g. frail elderly) traverse the healthcare silos.

Outcomes-based Healthcare Systems
An outcomes-based healthcare system operates on three different levels – systems, networks and pathways.

***System*:** The system defines the outcomes (which are equity-based and service independent) delivered to patients.

***Networks*:** The networks are comprised of the individuals and organisations who deliver the outcomes (i.e. GPs, surgeons, social care).

***Pathways*:** The pathways are defined by how the outcomes are delivered.

***Healthcare Service*:** The network and pathway structures used to deliver outcomes to patients and populations. Healthcare services will vary over time and geography.

The focus on systems of care and outcomes is essential if we are going to continue to deliver high-value care given the current constraints on the system of increasing need and demand (ageing and growing populations) and stagnant/decreasing resources (not enough GPs, primary care or time).

To achieve this shift in mindset we must ask ourselves – who are we going to hold ourselves accountable to (our employer, our patients, the populations to which we deliver care)? And then we need to ask what are we going to hold ourselves accountable for? The answer needs to be balanced so that we meet the needs and expectations of all these groups (i.e. our employers, patients and populations) but as healthcare professionals, we know that the reason we went into healthcare is because of our desire to deliver the best outcomes to the patients and populations we serve and care for.

This shift in mindset will help us to deliver better value healthcare as well as helping to tackle the demoralisation of the workforce we see - healthcare professionals didn't go into the healthcare profession to tick boxes, they trained for these jobs to be able to deliver patient and population outcomes, so you must give them the opportunity and drive to do that in a responsible way, that way you will drive innovation and improvement in the system and start delivering better value.

"That's the shift that needs to happen if you focus on outcomes service agnostic outcomes. This is when you start to change the culture", said Dr Jani.

Defining new metrics: there are three levels of outcomes

There are three main categories of outcomes in healthcare: process, patient and population outcomes. The one most focused on is process outcomes and, while these are important, they are usually dependent on the specific healthcare service structures (networks and pathways used) and are normally not going to be widely applicable.

To begin the process of defining outcomes at the patient and population level, which are service agnostic, it is important to ask two questions of the outcomes metrics:

- Will these metrics be relevant for all healthcare services across the world (i.e. even those services in a rural village in India or Africa or China)?
- Will they be relevant in 2040?

Defining New Metrics:

This is done by:

- Defining population needs
- Defining outcomes (patient, population, process). Ask yourselves who will you hold yourselves accountable to (your employer, your patients, your population)? Then ask yourself, what will you hold yourselves accountable for when you are working with/serving these stakeholders?
- Taking a baseline measurement. Any intervention has the possibility to deliver benefits, to do nothing at all, or to do harm. If you don't take a baseline measurement you then have no idea what your intervention has achieved.
- Identifying gaps in the system and filling them
- Identifying the resources available
- Exploring alternative care models
- Repeating ad infinitum to drive continuous value improvement

"Healthcare professionals didn't go into the healthcare profession to tick boxes, they trained for these jobs to be able to deliver patient and population outcomes, so you must give them the opportunity and drive to do that in a responsible way, that way you will drive innovation and improvement in the system and start delivering better value."
Dr Anant Jani

Discussion about new metrics of care

Led by Dr Anant Jani, Executive Director, Better Value Healthcare

Dr Steve Laitner said he had been involved in a piece of work to commission an acute lead provider model for a value-based programme of care for musculoskeletal disease for a registered population.

“We had patients, carers and people from third sector organisations involved. Three patients sat on the selection panel which selected the lead provider. People from Arthritis UK and people with arthritis helped us not only to develop the specification and the outcomes but also to select the provider. It was a shared decision making conversation about what people needed and wanted at a population level. It was an absolute pleasure to work with these people.”

Dr Jani said this was happening at all levels but not yet to the extent that was desirable for the community.

Dr Laitner suggested: “Rather than having patient representation, start thinking in terms of having patient leadership, leading other patients, in the same way that you think about having clinical and managerial leadership, that really changes the way you think.”

Shared decision making

Another attendee asked who defined the population’s needs – was it the clinicians or the population? Dr Jani replied: “I think it's both, it has to be everybody coming together, it has to be multi-stakeholder.”

Elizabeth Butterfield commented: “When you're working with the population to define what their needs are there is a bit more shared realism. This is necessary because sometimes we give the impression that every medicine will deliver an outcome and actually in reality the outcome could be quite different.”

Focus on wellness

Graham Phillips said: “I am concerned that we are looking at this through the wrong end of the telescope. The NHS starts with patients, illness and outcomes and it misses wellness entirely. My starting point is people and wellness and we should start with that and work out how we can encourage people to make healthy choices.

“The Blue Zones are five areas of the world where Western illnesses don't exist and people typically live to over a hundred. Researchers have looked at these areas and tried to define what the characteristics are that led to this and it's certainly not medical interventions, it's very simple things around socialisation, diet and movement.

“That’s why I'm so disappointed with the Five Year Forward View because I thought the focus was starting to shift towards public health and preventive measures but everything that's happened since it was published has been driven diametrically in the opposite direction. So, when we start to look at outcomes the outcome for me is to live a longer healthier life, whereas the outcomes we are defining for the NHS is a model of unhealthy life.”

Dr Laitner said: “There is actually lots of evidence that clinicians overestimate how much the patient wants a prescription. There is a cost to the person to come out from their working life and see the GP and it is our responsibility to a find out what the patient wants. If the evidence is that a drug is worse than a placebo then from a professional point of view we shouldn't be offering it.”

Elizabeth Butterfield said: “We have to recognise that we actually do that a lot of the time and hence 50 per cent of medications are not taken and they all end up in the incinerator because we didn't have that shared decision-making discussion.”

Mr Phillips said: “Can I suggest a metric which is a longer healthier life with the absence of illness so that the focus is on wellness?”

What matters to people

Dr James Kingsland said NAPC had commissioned the Nuffield Trust to do an external valuation of the Primary Care Home rapid test sites but the metrics for measuring this programme require a different approach from commonly used metrics.

He explained that Primary Care Homes were reflecting on hearing what matters to people who are receiving care or what matters to the staff. These metrics, in the form of one off one liners, did not necessarily fit into Patient Reported Outcome Measures (PROMS).

The sort of headlines they were hearing were - a GP saying: “If I land this locally, I am deferring my retirement’, the practice manager who said: “I read the paper, it made me feel young” or the district nurse who said: “This is the first time in a long time that I have felt valued being part of this team”.

‘We need to capture these one liners as metrics and systematise the fact that we have got a well supported staff who feel some ownership of the Primary Care Home and feel valued,” said Dr Kingsland.

Dr Jani said metrics that are service agnostic can be shared across the country and people could learn from the models of care that were working really well. Primary Care Homes provide a really great opportunity to do this. They can define their metrics first, in a multi-stakeholder way, work on defining their different population needs and then share their learning with each other via the network. They will learn from each other’s mistakes and make more effective use of resources.

Dr Kingsland said: “We’ve been talking about scheduling our metrics so they will change over time, so things that are important now may not be what we measure later. As we get more sophisticated things like, can we reduce length of stay, may become important in time.”

He went on to explain that, when he was working as a non-executive director at a surgical care cancer centre, they used to measure issues such as the numbers of people with a DVT, the cleanliness of the hospital, infection rates and Referral to Treatment Times and achieved an ‘outstanding’ rating from the CQC. But when they asked what mattered to people, they discovered that when they came through the doors of the centre they were feeling frightened that they might die. So, they started to look at this as a metric as well because it was about what people wanted from the service.

Delivering outcome metrics

One attendee asked whether any health system was sophisticated enough to really deliver on outcome metrics and whether any real science around what needed to be done to enable goals to be achieved.

Dr Jani said: “This is something that needs to be done. Clinicians need to be trained to take variables and put them in the system and start recognising patterns in a very logical constructive fashion.”

Dr Laitner said public health people had traditionally identified the needs of the population and may be involved in commissioning services to meet those needs but not with the delivery. Clinicians had only been focusing on delivering services to people who walked through the door. So what needed to be done was to get those two skills together, with a group of people working together to identify the needs of the population in such a way that services could then be wrapped around those different segments.

So, for example one segment of the population would be people with severe health problems who needed healthcare delivery and outcomes that measured their experiences and outcomes of healthcare.

“You can't play around with outcome metrics until you've done that population segmentation. You need to develop a framework so that you can define the segments that you're going to work on, it's not difficult,” Dr Laitner said.

Dr Joe McGilligan, a GP, said: “When the NHS was set up it was designed so that people would stay so healthy that they wouldn't need doctors and that's why they didn't nationalise GPs because they thought they would disappear and wouldn't be needed at all.

“What we have missed is working out the determinants of health and well-being – education, housing, jobs and smoking, for example, which could improve people’s outcomes because all the problems that you have are based on not doing the prevention.”

Dr Jani said when some people working with politicians in New Zealand were looking at the problems of people with asthma, a clinician on the health board took a few steps back and identified there was a housing issue that was affecting this group of people’s health. So money was taken from the health budget and given to the housing department to install insulation in order to resolve these health issues.

Primary Care Home programme update

Dr James Kingsland OBE, President, NAPC, led a discussion about the structure of primary care homes and accountable care organisations.

The debate began with an update and review of the Primary Care Home (PCH) programme and how this could be an enabler for both MCPs and PACs.

Part of the discussion revolved around a description of new types and styles of care delivery in the NHS. The PCH may not be the best title, but the multi-disciplinary team and integrated approach to the delivery of first contact care is really important in this model.

It is certainly not best described as out-of-hospital care – it is so much more. Just as hospital-based care is not best described as 'out-of-community provided care'.

Dr Laitner commented: "We should begin to think about outpatient care as specialist ambulatory care and describe other secondary care as hospital bed or inpatient care."

Dr Joe McGilligan said: "The Primary Care Home could be described as a Total Care Organisation – the patient is registered with the GP but can also be put in contact with social care, the district nurse, housing or education specialists who can solve all their problems."

Pharmacist Graham Philips said he would like the Primary Care Home concept to be determined in terms of health and wellness.

Dr Kingsland then gave a more detailed update of the Primary Care Home programme, which has been attracting considerable interest and enthusiasm since it was launched by the NAPC at its annual conference in October 2015.

Since April 2016, 15 Rapid Test Sites (RTS) have been implementing this new enhanced approach to primary care across England. They are not vanguards in the New Care Models Programme but are consistent with the ambitions of the Five Year Forward View.

As a result of the early successes within the RTS, the NAPC was asked to expand the programme, which has now seen another 77 sites identified and approved in December 2016. They will now form a learning network, along with the 15 RTS, called 'The Community of Practice'. This network will be testing the delivery of the wide-ranging components of a PCH. Over four million people in England are now starting to benefit from this new care model.

The programme strengthens and redesigns first contact, primary care, around the health and social care needs of local communities of between 30,000 to 50,000 people. 'A complete care community' provides care to this registered population. Patients are served by a single integrated and multidisciplinary team, including primary, secondary, community, social and voluntary sector carers.

Whilst patients are provided with personalised, coordinated and responsive care nearer to their home, the needs of the registered population are also better analysed to inform early detection, prevention and improved health screening.

The rapid test sites have been working on issues such as managing delegated budgets and using NHS resources more efficiently, workforce development, improving demand management and changing patient flows, improving access and preparing for the different ways of managing patients' health and care needs.

The enthusiasm for the Primary Care Home concept is so positive that consideration is being given to how many people in England might eventually benefit from this model. Clearly, the Community of Practice is only the beginning.

The key features of the PCH are:

- Provision of care to a defined, registered population of between 30,000 and 50,000
- An integrated workforce, with a strong focus on partnerships spanning primary, secondary, social care and the third sector.
- A combined focus on personalisation of care with improvements in population health outcomes.
- Aligned clinical and financial drivers through the management of whole population budgets with appropriate shared risks and rewards

The founding principles of a PCH:

1. 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.

2. Enriching the experience of an individual in a care system with heightened satisfaction particularly in relation to good access and short waiting times.

3. Improving population health through registered lists of people, thereby, gaining a better understanding of the local needs of that population. Screening, early detection and prevention of disease becomes a defining principle of care provision.

4. 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.

5. Improving the working life of the health, social and managerial professionals delivering the care, with better workforce planning and team development.

Dr Kingsland concluded that the PCH is possibly going to be the closest thing we have to fully accountable first contact care within the NHS.

Conclusion and next steps

Dr James Kingsland OBE, President, NAPC

These ongoing meetings are designed to stimulate debate. It is so important to continue discussing a bright future for the NHS and the new ways of delivering care in the 21st century.

I hope that our readers enjoy this report. NAPC will be pleased to receive any comments the report may have stimulated through email. Should any readers wish to participate in future meetings, please do email the office. Our contact details are ab the back of this report.

With thanks to all those who helped create this report:

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Dr Joe McGilligan – Local Government Association (LGA) Health and Wellbeing Champion
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Graham Philips – Director, Manor Pharmacy Group
Nicki Price – Director, 3Sixty Care
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