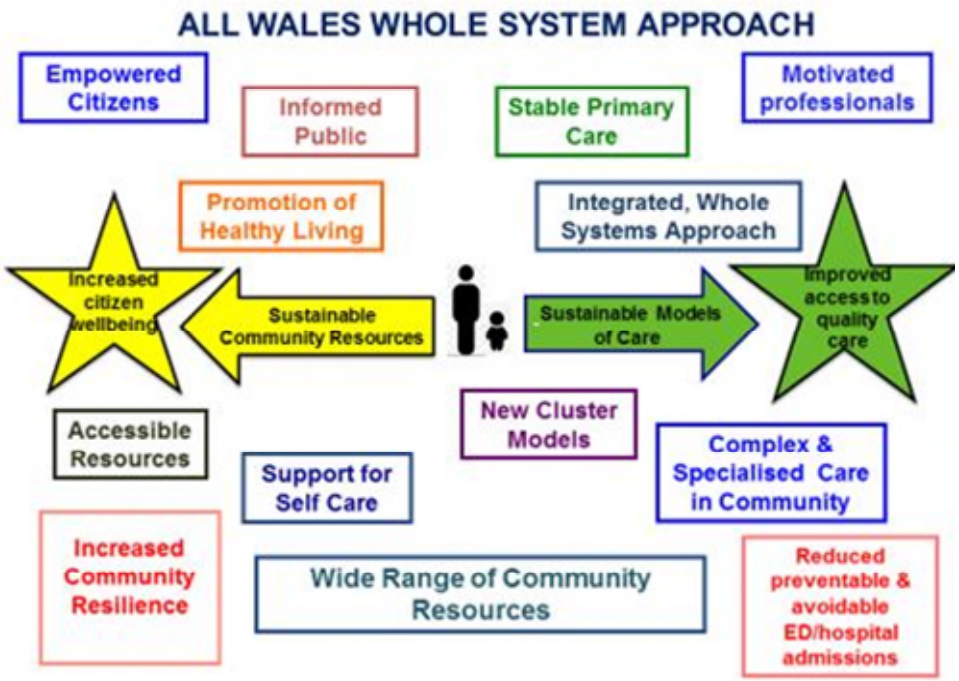
PACESETTER SCHEMES 2018-19

Health Board	**Aneurin Bevan University Health Board**
Pacesetter Title	**Establishment of a transformation team to introduce, implement and embed the new and emerging integrated models of care across Gwent (within first 2 years focussing on the Brynmawr directly managed practices as an area of focus and testing)** **Transformation Model within Primary Care** *(24 months pacesetter funding)*
Context: what is the current evidence and how does this project add value?	The sustainability of Primary Care is a key issue facing many Health Boards across Wales and the UK. There is increasing awareness that a new model of integrated primary care is required and there is strong political and stakeholder support for this. The Primary Care Plan for Wales and supporting evidence indicates that the sustainability of Primary Care is reliant on the implementation of a new model of integrated care to reduce the reliance on General Practitioners and support the pathways with a full multi-disciplinary team ensuring that the needs of the local population are met through a new and transformed workforce. The Clinical Futures Strategy which sets out the vision for health and health services in Gwent places significant importance on the role of integrated teams in the further development and sustainability of primary care in the area. We are in an exciting period of transition towards the full implementation of the Clinical Futures programme with the next four years realising the delivery of a Specialist Critical Care Centre, the redefinition of local general hospitals across Gwent and the introduction of a new model of care in Primary Care. The strategy expresses that a sustainable 24/7 primary care service will be available that enables urgent and planned primary care to be locally accessible to enable patients to receive care closer to home. There are also plans towards place based organisation and delivery of care and the introduction of a range of health and well-being hubs. Neighbourhood Care Networks in Gwent have been established for some time and have been progressing in their maturity. Their composition (which was designed to be broader than a traditional primary care model) lends itself well to the introduction of a new model as they are multi-agency and have already started planning together to find joint solutions to locally defined challenges. They have begun to give some thought to how the new models of care can be progressed and developed in a way that is conducive to the needs of the populations they serve and to address the issues of sustainability in their areas. There is significant vulnerability in primary care in some areas and the Health Board is working to strengthen primary and community services as well as to introduce a new model, whilst facing vulnerability of the current configuration of services with regards to staff recruitment and retention. Alongside this, is a need to develop a new organisational context within which the new models can emerge and be successful. The risk assessment

	matrix undertaken in accordance with the requirements of the General Medical Services (GMS) Contract has highlighted significant GP sustainability issues within Gwent and whilst needing to target all areas for growth, we have also been able to identify those areas at highest level of risk to unsustainability. NCN leads across Gwent have been active in exploring alternative provision and have sought learning from across the UK to inform the development of new systems of working. This includes the Royal College of General Practitioners / Nuffield Trust General Practice at Scale Programme which aims to promote better understanding of the formation of networks of practices to improve care through working in a more efficient and effective way, and visits to see the Prestatyn model in action. Much of their learning is in line with the Transforming Primary Care model established through the work of the Pacesetter Programme. Contextually the Parliamentary review of health and social care talks of a different relationship between citizens and services and the Health Board has a well established approach to community engagement which seeks to enable this. Whilst not achievable overnight, progress to date is positive and there is a shift towards establishing an Asset Based Community Development approach across Gwent and across partner agencies. Discussions locally pertain to the development of care co-ordinators and navigators who will receive specialist training on empowering our communities to be resilient and take ownership of their health through self -care and education, signposting to a range of alternative services which remove pressure from GP's and support early intervention/prevention will help strengthen the community response for integrated service delivery. Current risks and planned changes (eg sustainability, introduction of new health and social care hubs) within Gwent offer many opportunities for the testing of the emerging model of care, offering the potential for transformation across the system. There is a clear vision emerging as to how this would be implemented however insufficient capacity within existing teams to manage full transition which requires a well executed Transformation Programme supported by a strong focus on organisational development and reform. General Medical Practices provide the gateway to most National Health Services and strong primary care provision contributes to the effective and efficient use of health care resources. Approximately 90% of all patient interventions take place in the primary care setting. There are currently 80 GP practices across Gwent with all required to complete a Sustainability Framework Risk Matrix. Results of this assessment identified that 14 practices were deemed as high risk and 22 as medium.
Aims of project	The programme will seek to answer two key questions : • Is there a different way of managing primary care demand (through different roles, ways of working and a new relationship with the public) • Can we create the leadership and culture to enable this

	This proposal seeks to : • Create the transformation capacity to move from the current position to the future state • Establish a programme of transformation that can be taken forward at scale and pace (initially though the number of Directly Managed Practices in the area and in the creation of health and well-being hubs) • Manage the transition from a traditional model of primary care to an integrated place based delivery model staffed through multi-disciplinary teams. • Test the skill mix of multi-disciplinary teams • Work with communities to affect a different behaviour in the use of services (note first areas of focus will be through directly managed practices) The pacesetter fund would support the health board in implementing the transformation model, allowing the sustainability and viability of the model to be tested. The vision is one of system transformation which starts with primary care however extends to the full scope of primary and community services and as such with a strong interface through existing community teams and resources (eg Frailty teams and community hospital provision eg step up beds). The success of the new model of care is reliant on a much greater focus on self-care, healthy living and the use of community assets that support people outside the traditional medical approach. Promoting independence and mental well-being, through access to a range of local community resources will be integral to the success of the model. Anticipated outcomes of the proposal are: • Increased capacity to manage the necessary change • Development of integrated team through an alternative skill mix • Creation of a new relationship between primary care and the public • Changed navigation of the healthcare system resulting in increased capacity for GPs and other members of the healthcare team • Support behaviour change of the local population through raising awareness of self-care, early intervention and prevention • Develop collaborative and joint working for community, primary care and social services colleagues to achieve shared outcomes for the benefit of the local population and support the development of organisational resilience, • provide access to a range of specialist skills in a community setting • Right Resource, Right Skills, Right Patient, Right Time • Release Capacity in GP Surgeries to enable Doctors to concentrate on planned and complex care,

	linking with Secondary and Social care partners to maximise health outcomes and improve care to our citizens.
Allocation	**£218,688** for period of two years to prove concept with ongoing funding built into the Health Board IMTP process and through service / funding realignment. Financial Breakdown attached in Appendix 1 Trac as per discussion this morning this figure would need to change if we are including a programme Director role at 8D
Start date of project	1st April 2018
Alignment with Emerging Model	Our proposal is entirely consistent with the transformation of primary care work. The objectives are to release GP capacity through the re-direction of a significant volume of work to the wider multi-disciplinary team thus supporting GP sustainability through utilising and maximising the skills of specialist teams, patients will have improved access to health and community based services in a timely manner, through increased place based working and access to care as detailed in the model below:



This will further support skill mix and workforce diversification within the primary care setting and pilot a new way of working through earlier identification and community management and enabling the creation and utilisation of a more suitable service to serve the needs of the population.

The service is aligned to the Care Closer to Home strategy and forms part of the 2018-2019 Primary Care IMTP. The scheme adds to the strategy for transforming the way services and healthcare is delivered in Primary Care and adds to the model of developing the multidisciplinary team that surrounds the GP.

The scheme is an innovative change in the delivery of care and is a model that will improve the satisfaction of both the users and the clinicians that are the providers.

The proposal would enable the creation of different roles that would support a new way of working :

- **Navigator** – Around 15-20% of GP consultations are concerned with social problems such as housing, debt management, loneliness and benefits advice. The model enables a trained member of staff to be the

	link between the public sector of health, social care and the third sector, accessing and signposting to non-medical support which best supports citizen's needs, highlighting that there is alternative advice and support that may otherwise have been initially dealt with by our GPs. • **Care Co-ordinator** – We have piloted the use of Stay Well at home plans through the Newport Older Persons Pathway. Care co-ordination allows a targeted group of people who undergo a comprehensive review of their needs and receive personally targeted service provision and support which enables them to manage in their own homes for longer than would otherwise be the case. Practice populations in would be risk stratified, with care co-ordinators employed from the third sector to proactively engage with older people identified as at risk of unscheduled hospital admission. This proposal would enable the extension of this approach to the areas identified. • **Care Co-ordinators would also be key promoters of Supported Self Care, creating** opportunities to support people to play a greater role in their own health and managing their long term conditions. To be successful the new model will focus on the people and not the issues and conditions that affect that community. This includes new approaches to patient activation which encourage people to take a greater role in managing their condition through, for example, self-management courses or rehabilitation programmes such as EPP and the OAK Service, new initiatives that are designed to be integrated within the current out-of-hospital care system. • **Pharmacy Technician** –The new model builds in the ability to explore new ways of reducing wasted time and ensuring that uncomplicated follow ups with patients is less reliant on GP consultations. Patients can consult a community pharmacy for a defined list of common (minor) ailments instead of making an appointment to see their GP. • **Project Support Manager** – The model is founded on the principles of holistic, person centred care, provided as close to home as possible, focussing on prevention, early intervention and the support people need to make behaviour changes and manage their long-term conditions. It is anticipated that improving access to an integrated, multi-professional workforce in the community, will help to prevent unnecessary admission to hospital and facilitate timely and effective discharge. Supporting communities to make significant changes to the way they think about the existing health system will require support at a Divisional level and this role will support the Senior Leadership team to communicate changes with our citizens and support implementing the changes, managing the project at an operational level. • **Nurse Practitioner** – *T***he** model develops the NP role to complement services provided by GPs, delivered by an experienced nurse, acting within their professional boundaries and providing care our

	citizens from taking medical histories, clinical assessment, diagnosis, treatment and evaluation of their care. Working collaboratively with staff around the transformation model to deliver a person centred, place based approach to health and wellbeing. • **Advanced Nurse Practitioner** – Developing the ANP role to provide an enhanced service for our citizens from initial history taking, clinical assessment, diagnosis, treatment and evaluation of care. They will demonstrate safe, competent clinical decision-making and expert care, including assessment and diagnostic skills, for patients within the transformation model. The post holder will commit to demonstrating critical thinking in the safe clinical decision-making process. They will communicate and work collaboratively with staff around the transformation model to deliver a person centred, place based approach to health and wellbeing.
Potential to demonstrate financial redesign / resource shift	This scheme is designed to demonstrate the use of appropriate Health Care Professional to meet the needs of the local population. The scheme will support:- • Citizens to have a focus on own well-being • Increased connections between citizens and the resources in their communities • Patients to have their needs met by the right person in the right way (this may or may not be a medical professional) • Potential for increased GP capacity and more effective utilisation of the wider care team • Enhancement of MDT within a Practice and as a result supports the sustainability of that Practice.
Dates for submission of Business Plan and Delivery agreements	This will be submitted with the other funded delivery agreements at the end of February. A business case to inform IMTP service commissioning and service / budget realignment across the healthcare system will be developed to inform the 2019/20 service planning cycle.
Status within: **HB strategy** **IMTP process**	• The Gwent Clinical Futures Strategy places considerable importance on the safe delivery and development of primary care services in the area • The Scheme is aligned to the IMTP being developed within the Primary & Community division and meets the aims of primary care funding in terms of sustainability, access and service redesign. • The Scheme provides an opportunity to deliver the services is a different way within the managed practice portfolio. There is opportunity for creativity; innovation and to lead the change in the NHS.

Cluster Action Plans	• This supports the IMTP plans in terms of recruitment and retention within primary care to contribute to a sustainable Primary Care workforce of the future. • The NCN action plans include sustainability and alternative workforce development and implementation.
Timescales for each stage of project, with rationale	**Phase 1** Appointment of Programme Director and project manager and development of job descriptions for new roles (We are optimistic that appointment to these roles could happen relatively quickly) Agreement of the programme structure and governance Consolidation of model within the NCN clusters to which this would apply and commitment from lead personnel Agree evaluation criteria, key performance and quality indicators and confirm exit strategy for the end of the Pacesetter period. Conclude analysis and planning phases. Finalise detailed implementation plan (to enable programme director to have ownership of implementation) **Phase 2** Appointment of other key roles Creating the culture and new team ethos – as part of induction establishing a new norm for ways of working that move people from a traditional primary care perspective to a broader community based approach Testing and learning Commence communication with patients and communities about a different way of working Do we have timescales for the few practices we have already identified for this – of so would be good to put them in here. Evaluation at end of phase 2 **Phase 3** Communication with patients and communities about a different way of working Intensive OD programme to help consolidate new ways of working and different relationship with teams and communities

	Evaluation at end of phase 3 **Phase 4** New model established Evaluation at end of phase 4 **Phase 5** New model embedding Final Evaluation Recruitment, induction and implementation phase. Evaluation of progress.
Evaluation methodology and measures to be used	Through a level of demand management, identification of current demand that can be transferred to the MDT. This will set the baseline. The primary evaluation will therefore be the quantity of workload safely and effectively transferred from the GP to the wider MDT and an improvement in access to GP required appointments. Each service delivered within the practice will have a specific monitoring and outcomes framework attached to it
Project support available	Programme Director and programme manager to be appointed to lead the strategic and operational introduction of the model. Head of Primary Care will provide senior oversight for the development as pertains to the implementation of the primary care contracts Clinical supervision for the new roles will be provided through an agreed partnership with the professional bodies involved. Other support as required at key stages of progress to be managed within the division
Describe anticipated impact on health inequalities	GPs have a greater holistic understanding of their patients, and management can be supported by the use of a wider multi-disciplinary team. There is also a commitment to the provision of social prescribing to support patients requiring healthcare, as such the redirection of patients to a more appropriate pathway earlier in the patient journey will:-

	• reduce pressure on existing GPs • Increasing ability to recruit to posts through improved demand management • Reduce inequalities caused by variability of access • Provide an opportunity to improve services to patients. • Provide an opportunity to sustain and improve care • provides an opportunity to test out this model The model will take a differentiated approach in each community, adapting its processes to ensure that they better meet the needs of the local populations depending on their needs and complexities. The model uses a multi-pronged approach to delivering services, via the Care Coordinator, to embed sustainability via early intervention, prevention and the promotion of self-care to our citizens are active partners in their care, ensuring that care is delivered at the right time by the right person to achieve maximum outcomes for the citizen and the most effective use of resource for the Health board.
Potential for rollout at scale, with indication of costs and workforce implications	Allowing 24 months to test this model would enable buy in from NCN leads The opportunity would exist to roll out this model through the current managed practices within the healthboard, taking into account the opportunity to expand the service to incorporate the integrated service provision through community services and placed based care. The financial impact of this will be dependent on the service provision within each NCN and locality and the full impact of this will fully identified during this pilot. Workforce implications are determining factor and as such services will look to support NCNs rather than individual practices. The aspiration of the pilot is that with improved sustainability we will improve our recruitment and retention whilst enhancing the skills and the knowledge base of existing and new staff, improve efficiency and lead to better patient outcomes

Appendix 1

Scheme Financial Breakdown

BRYNMAWR
TRANSFORMATION TEAM

PAY

Description	Grade	WTE	Scale
Strategic Transformation Director (see note above in yellow)			
Advanced Nurse Practitioner	7	1.00	£52,645
Nurse Practitioner	6	1.00	£44,655
Project Support Manager	6	1.00	£44,655
Pharmacy Technician	5	1.00	£35,865
Care Co-ordinator	4	1.00	£28,062
Navigator	4	1.00	£28,062
TOTAL PAY COSTS			**£208,688**
NON-PAY			**£10,000**
TOTAL COSTS			**£218,688**

NATIONALLY AGREED CRITERIA FOR PACESETTER PROGRAMME – 2018/19

1. The schemes should be aligned to the work of the Implementing the Emerging Model Group in terms of building on:

    - Outcomes of previous Pacesetter projects
    - The whole system emerging model for primary care
    - Outcomes of the Pacesetter Critical Appraisal
    - Outcomes of the Parliamentary Review into Health and Social Care

2. Projects should actively explore the potential for whole system financial redesign and resource shift between sectors

3. Each project to be underpinned by a clear business plan and delivery agreement that has been agreed by the Health Board executive team, PC Directorate, cluster leads, the relevant cluster and the professionals responsible for delivering project outcomes.

4. A clear and realistic approach to timescales for project outcomes that takes account of bedding in, transforming care and reporting arrangements.

5. Robust measures for evaluation to be defined at the outset and using an appropriate range of methodologies to give a clear understanding of outcomes and benefits, including costing

6. The programme of work to be an integral part of the relevant cluster action plan, the health board strategy and the IMTP process

7. Evidence that the project team will be supported through appropriate backfill arrangements; dedicated project management; access to expertise in research analysis, IT systems usage and data analysis.

8. Consideration should be made of the specific challenges faced by professionals working with deprived communities in relation to innovation and redesign. Primary care teams in these areas often need more support and/or resource to initiate new ways of working and a proactive approach is required to promote innovation.