PACESETTER SCHEMES 2018-19

Health Board	Hywel Dda University Health Board
Pacesetter Title	**Networked model for primary care contractors**
Context: what is the current evidence and how does this project add value?	Primary Care is the foundation of health services; within Hywel Dda University Health Board (HDdUHB) it delivers in excess of 6 million episodes of care for our population every year. When it works well it is often taken for granted; when it struggles and changes, it generates high levels of public and political anxiety. When it fails it has a profound systemic impact, with the capacity to undermine and destabilise the rest of the healthcare system. This proposal considers how a solution for core Primary Care services can be developed that will fit and align with the needs and opportunities across the wider system and create a platform for the implementation of the emerging model for Primary Care and our Transformed Clinical Services Strategy. It focuses on General Medical Services (GMS) as the principle provider of the lifelong health care for individuals, families and communities and how the stabilisation of this sector, through different approaches to collaborative service delivery will support whole system change.
	Sustainable Funding Challenges
	GMS receives an annual allocation from Welsh Government to deliver services. The amount received is negotiated centrally and over the past few years there has been a centrally-held view that it is the role of Health Boards to enhance these allocations from the wider Health Board allocation in order to deliver more services in a more sustainable way. Core GMS has received very little, if often no, additional funding above the ring fence until 2017/18 when this was made available to support the new Care Homes, Warfarin Directed Enhanced Services and phlebotomy management. The challenge needs not to be linked to how we can continually find additional funding to deliver existing core services sustainably, especially in our austere financial climate. Instead, how we can enable contractors to work differently together to generate efficiencies within their systems to enable them to meet the rising needs and implement new ways of working as defined within the emerging model. HDdUHB directly manages 3 GP Practices and there has been significant learning from this, not least is that without a strong cohort of clinical leaders taking direct responsibility for service delivery, the costs rise significantly. Learning from Healthy Prestatyn is that with sufficient numbers services can be rearranged to good effect, but this is difficult on a smaller population basis. This is complemented by the cluster

	learning that enabling independent contractors the freedom to be adaptable and nimble provides the fertile breeding ground for rapid transformation and ownership from the grassroots. Our proposal seeks to combine this learning.
	Demand for Primary Care Services
	It is well recognised that the needs of our population are growing. Concrete data on activity levels within core GMS is not readily available. However, a number of projects based on sample data have been conducted. They indicate that in 2013/14 the level of activity in GMS per annum was 1.8m episodes of care. In 2016/17 an estimate using the Integrated Unscheduled Care Dashboard data increased this activity to 2.5m. A recent Kings Fund report indicates a 15% increase in the last 5 years, although HDdUHB data would indicate that this is higher in Hywel Dda due to the older age demography. Any future solution therefore needs to be able to respond to the key drivers for access, ensuring that on the day demand is managed by the right person at the right time, that more time is devoted to complex and frail individuals, and that the planned elements of care can be effectively co-ordinated and supported in a sustainable way. GMS is funded through a capitation block contract, which has meant that this increase in activity has been absorbed within the flat cash funding environment. In real terms, General Practice is undertaking a lot more, for a lot less, for a longer period of time.
	Workforce Changes
	At the same time as our population is ageing, so is our Primary and Community workforce. The shortage of GPs is not unique to HDdUHB however, it is being felt particularly keenly. This shortage is also being experienced in other professional disciplines such as nursing and physiotherapy although it is the Advanced Practice roles in particular which are in short supply and are highly sought after across the professional boundaries. Historically, Primary Care has been seen as a less demanding and less desirable role for clinical professionals, however this is starting to change. The opportunities to develop diverse portfolio careers, grow skills, autonomy and specialism and have an earlier impact on the health and well being of our whole population is attractive. This presents the opportunity to work very differently but will require more systematic co-ordination and development utilising also our links with local Universities.

	The new model for Primary Care therefore needs to be team based, utilising the professional skills across multi -professional boundaries in an integrated and supported environment.
	Engagement with our Public and Stakeholders
	Any new model within an Independent Contractor system will need to be located in and catering for the various needs of the 391,000 registered patients across HDdUHB. Their views and local knowledge on what will, or will not work is essential in developing a viable, sustainable and accepted model for future services. A significant level of engagement has been undertaken to date to inform the future models and how this can be co-created with our population. **Big Proactive Conversation:** an initial conference has been held asking our professionals and patients what 'good' looked like for them. The outcomes of this have been shared and combined with the Transforming Clinical Services stakeholder engagement. **Locality Sustainability Workshops:** 6 out of the 7 Localities have held these workshops, which inform the skill mix, location and level of collaboration sought for a viable future. **Transforming Clinical Services:** The Community Care Group has considered and inputted into the model to date. **Primary Care Applications Committee:** Has considered and sanctioned the current scope of the model. **Executive Team:** has considered and sanctioned the current scope of the model whilst recognising that it does not currently provide a solution for the evolving integrated model based around Localities. **Key Practice Stakeholders and Locality Leads:** discussions have been held to inform the development of the model with key primary care clinicians and the Locality Leads. **Community Health Council:** An initial discussion has been held regarding the challenges and future direction; ongoing discussion and engagement will be required. Our rural population requires a local solution to the majority of their care needs. During the Transforming Clinical Services (TCS) engagement process, our communities said that whilst they were willing to travel for specialist services, there is an expectation that Primary Care services remain local. Therefore, any future model needs to ensure the following principles are met :

	• Relentless focus on continuity of care for those with ongoing or complex conditions or needs and their carers to build trust and key team relationships. • Reducing the need for patients to travel unless the need is more complex or specialised. • Supporting wellness, self care and community cohesion. • Developing trust in service provision, access and clinicians. • Delivering excellent patient care and experience. • Creating a learning and fulfilling working environment for staff which supports team based models and retention. This aligns well with the Royal College of General Practitioners (RCGP's) 4Cs model of Contact; Comprehensive; Continuity; Coordination.
	Learning from Best Practice
	In addition to local engagement, Welsh Government strategy and the evolving and emerging new model for Primary Care across Wales, national and international learning has also been considered and applied for example : Baird et al (2016). *Understanding pressures in general practice.* Available at: www.kingsfund.org.uk. BevanCommission (2016). *Roadmap for Sustainable Healthcare – Perspectives on Prudent Health, How Wales is getting it right.* British Medical Association (2015). *Collaborative GP Networks – Guidance for GPs on the Basic Legal Structures.* Available at: www.bma.org.uk. British Medical Association (2015). *Developing General Practice today – Providing Healthcare solutions for the future.* Available at: www.bma.org.uk. Deloitte . *Primary Care: Working Differently – Telecare and telehealth, a game changer for health and social care.* Department of Health (2014). *Transforming Primary Care – Safe, proactive, personalised care for those who need it most.* Horvath-Howard et al (2011). *How to make a difference – A guide to Local Medical Committees and the BMA General Practitioners Committee in Wales.* Available at: www.bmawales@bma.org.uk. Hussey et al (2014). *Redesigning Healthcare – Learning from the Nuka System of Care to inform the development of healthcare in NHS Wales.* Available at: www.1000livesi.wales.nhs.uk.

	KPMG et al (2014). *The Primary Care Paradox – New designs and models.* Available at: www.kpmg.com/healthcare. Matthias et al (2014). *Achieving prudent healthcare in NHS Wales.* NHS England (2016). *General Practice Forward View.* Available at: www.england.nhs.uk/gp. Oldham et al (2012). *Primary Care – The Central Function and Main Focus. Report of the Primary Care Working Group.* Royal College of General Practitioners (2013). *The 2022 GP – A Vision for General Practice in the future NHS.* Available at: www.rcgp.org.uk. Timmins et al . *The quest for integrated health and social care – A case study in Canterbury, New Zealand.* Available at: www.kingsfund.org.uk.
	Added Value
	There is currently no system in place in Wales which brings Independent GMS contractors together to focus on their own core service delivery, efficiency and sustainability issues. Having a stable and resilient service model for the future, upon which the emerging model can hang is critical. Clusters locally are not focussing on GMS sustainability as a key area but are focussing on the wider population health needs and what adds to the system. Clusters are also intended to develop their approach to integration and not focus exclusively on GMS. For contractors to work well together they also need autonomy to define their networks with greater flexibility than the cluster structure affords them based on the Kingsfund and Vanguard learning of populations around 30,000. Some Federations have emerged and these provide one opportunity for GMS contractors to work collaboratively however, this model does not suit and appeal to all contractors. A model needs to evolve which can provide the framework for independent contractors to share service delivery or back office functions without loosing their ability to be nimble, creative and have local ownership and autonomy. What will be new in the services offered will be where networks develop some of the following services, the learning from which can be shared locally and nationally : • Hub and spoke models where a central hub delivers services to and with local independent surgeries that scale back their delivery, thereby reducing duplication and enable small practices to survive. • Network models where a group works on an equitable basis but develops new centralised services collectively.

	• Centralised back office remote functions which may include patient communication hubs where all calls can be managed, enquiries responded to, appointments booked to the appropriate professional, e-consulting introduced and repeat prescriptions managed. • Joint staffing models to enable training and development of whole teams with shared clinical resource to provide strong supervision and support. This will also apply to locally recruited medical students able to engage across a network to access a wider range of exposure to Primary Care. It will also be interesting to see whether this networked model enables a strong basis to enable shift from secondary care to happen.
Aims of project	**GMS Sustainability :** the overall sustainability risk with GMS contractors will reduce through the network approach reducing the likelihood of contractual notice, list closures and boundary or branch changes. **Population Based Care :** through networks our communities will be able to receive equitable access to enhanced services which is not currently delivered through the DES and LES structure of funding. **Strong Development of Teams :** through the clinical leadership created in networks, the emerging multi-disciplinary teams will have a "home" and clear access to support to enable them to grow in confidence, capability and capacity. It will also provide opportunities for new GPs who may not want to become a partner of a small practice through fear of becoming the last man standing, by creating employment and network links with a wider support group. It will also enable a different approach to training across a range of clinical professions. **Improved Patient Experience & Engagement :** through networking services, patients will more consistently receive a more timely and consistent service which is impacted on less by individual staff absences or differences in Practice. They will engage directly with the network to co-design services, become champion groups and enable culture change in communities through local influence and work of mouth. This includes how patients can lead and inform education around self care, chronic condition management and carer support. **Informing Contractual Negotiations :** learning from networks will be able to inform the contracting negotiations for Wales, particularly in relation to the GMS and APMS contracts. **Reinforcing Contractor Vision & Purpose :** there has been a decreasing morale across Primary Care and this seeks to support and encourage a refreshed approach and viable alternative for a stronger future for Primary Care.
Allocation	**£0.488m** – this will be cross subsidised taking the entire project spend to £1.047m.

Start date of project	**1st April 2018** – initial scoping and development work has been underway since June 2017.
Alignment with Emerging Model	This proposal will deliver a framework upon which the emerging model can hang. It is expected that networks will develop in such a way that will : • Empower and inform their populations which will include education, co-creation of services and the spread of well being through champions. • Deliver a stable primary care model which works with the independent contractor grain. • Provide an environment for motivated professionals to work together. • Provide a home within which evolving integrated community and cluster teams can be based. • Provide a stable structure to enable services to be shifted into the community and thereby deliver more local complex and specialised care. • Improves access and equity of access.
Potential to demonstrate financial redesign / resource shift	This project is about financial redesign across GMS and provides the potential to realise resource shift both in terms of direct finance as well as human resources. The training and development element will create potential pathways for staff to learn and grow who may not have historically worked in Primary Care. The strong foundation will enable funding to be shifted in order to deliver services differently in Primary care. The population health focus will enable equitable access for the population to enhanced services. The GMS budget in Hywel Dda is approximately £60m per annum, this project is about enabling contractors to consider collectively how this is best utilised.
Dates for submission of Business Plan and Delivery agreements	End March 2018 – Networks to submit initial proposals End April 2018 – notification to Networks funding agreed against each identified project, final whole Programme business plan to be finalised.

	Networks are expected to submit quarterly delivery and learning reports against agreed metrics. Programme quarterly reports will be available and a newsletter will be completed to share learning across all contractors. Proposals can be amended and reprioritised on a 6 monthly basis throughout the Programme of 3 years to enable plans to evolve based on shared learning.
Status within: **HB strategy** **IMTP process** **Cluster Action Plans**	 Proposal is fully consistent with Health Board Strategy, it is aligned within our IMTP process and our Transforming Clinical Services Programme. Proposal has been fully informed by Cluster Plans, their engagement and feedback through the design phase. All Clusters have been presented to and engaged with regarding the opportunities and next steps.
Timescales for each stage of project, with rationale	**Stage 1 : Development & Preparation of Vision :** June 2017 – January 2018 – this essential stage has enabled a co-created vision to be developed with our contractors, stakeholders, public and Board. **Stage 2 : Scoping Network Proposals :** January – March 2018 – workshops at county and potential network level to develop clear plans for individual network development. **Stage 3 : Implement Network Development :** **Year 1 : April 2018 – March 2019** • 3 networks – ready to finalise and implement plans in first year • 3-6 networks – developing relationships and projects for year 2 implementation • Quarterly reporting against agreed metrics – this will include the identification of new projects to be developed into business cases for IMTP mainstream funding • Quarterly newsletters to share learning • End of year conference to share pacesetter and cluster learning • Development of mainstream funding business case process to support shift of resource **Year 2 : April 2019 – March 2020**

	• 3 networks establish and evaluating (with university and partner support) outcomes and learning to date • Review of prioritised projects and networks against available funding • 3 – 6 networks – ready to finalise and implement plans in second year • Quarterly reporting • Quarterly newsletters • Potentially additional networks – developing relationships and projects for year 3 implementation • End of year conference to share pacesetter and cluster learning **Year 3 : April 2020 – March 2021** • Commence critical appraisal of learning to date – supported by university and partner support • Alignment with Transforming Clinical Services Programme • Review of projects and funding to enable remaining networks to implement models • Quarterly reporting • Quarterly newsletters • September – evaluation report for Board review • End of year conference to share pacesetter and cluster learning **Stage 4 : Mainstream Implementation :** Business cases will be submitted throughout Stage 3 where sustainable funding is evidenced.
Evaluation methodology and measures to be used	Evaluation on individual networks will be developed through their proposal submission document :  Proposal Document for Hub-Networks Jar The overall project will develop metrics to enable the aims to be assessed : **GMS Sustainability :** baseline sustainability matrix scores – reviewed quarterly for network practices and annually for non-network practices. **Population Based Care :** baseline enhanced service spread to be refreshed bi-annually. **Strong Development of Teams :** workforce information against existing baseline to specifically identify the growth of different roles and the senior clinical workforce per head of population.

	Improved Patient Experience & Engagement : comparison of baseline information on the Patient Engagement Framework and Patient Participation Groups. Qualitative information on feedback from patients involved in the programme development. **Informing Contractual Negotiations :** qualitative information and outcome of the contract changes. **Reinforcing Contractor Vision & Purpose :** Baseline survey to be completed and refreshed annually throughout the project, pending design.
Project support available	• WTE Project Manager • Data analyst support through the Transforming Clinical Services Programme • Senior Manager support through the Primary Care Team • Clinical Support through the Locality (cluster) leads
Describe anticipated impact on health inequalities	It is anticipated that this project will provide a stable basis for sustainable and equitable services. Primary Care provision plays a significant impact on health inequalities and those practices with structure prevention programme, capable or risk stratifying and delivering services based on need will support addressing specifically identified inequalities.
Potential for rollout at scale, with indication of costs and workforce implications	The potential to roll this out is addressed within the paper. Roll out will be subject to evaluation criteria and costs and workforce implications will be managed through the Transforming Clinical Services Programme.

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.