What is the national and local policy context for Primary Care Transformation?

- Policy at a national and regional level is focusing on ensuring a sustainable high quality primary care landscape
  - NHSE Five Year Forward View
  - London Health Commission
  - Strategic Framework for Primary Care in London
  - Think tanks (Kings Fund, Nuffield Trust)
  - Care Quality Commission
- Move funding from acute to primary care
- New incentives and models of care – networks
- Expand primary care workforce
- Ambitious quality standards
Three areas of care form the basis of a vision for General Practice in London

Patients and clinicians alike have told us about the importance of three areas of care; this forms the basis of the new patient offer (also called the specification)

Accessible Care
Better access primary care professionals, at a time and through a method that’s convenient and with a professional of choice.

Coordinated Care
Greater continuity of care between NHS and other health services, named clinicians, and more time with patients who need it.

Proactive Care
More health prevention by working in partnerships to reduce morbidity, premature mortality, health inequalities, and the future burden of disease in the capital. Treating the causes, not just the symptoms.
Local GPs and their teams have identified issues with primary care as it is now.....

- Workload
- Ageing workforce
- Assurance of QA
- Patient experience
- Improving patient experience
- Patient access
- Funding
- Ageing & increasing population
- Management of LTC & co-morbidities
- Variation
- Estates
Practices have provided their perspective on these challenges based on feedback from locality discussions.

We are facing a crisis in recruitment and retention of GPs and nurses, with many people about to retire too.

My practice isn’t financially sustainable.

The current workload in general practice is unsustainable - GPs are seeing patients, coordinating care, chasing others for information and doing too much admin and not enough of the pro-active patient care that make being a GP rewarding.

I value my autonomy and the freedom to run my practice in a way that works for my patients and me.
Healthy life expectancy:
- Female: 63.4 years (London average 63.8 years)
- Male: 61.1 years (London average 63.6 years)

Deprivation:
- Ranked in order of most deprived in England:
  - London average: 119th
  - Male: 166th

Health and wellbeing challenges:
- BHR: 24% Obese adults, 23.1% Obese children
  - vs London: 19.6% Obese adults, 22.4% Obese children

Care and quality challenges:
- 1 in 4 People over 40 are living with at least 1 LTC
- 1 in 2 People over 75 are living with at least 1 LTC

Funding and efficiency challenges:
- Local Authority funding reduction
- Public Health budget reduction

Out of work benefits:
- BHR: 12.2% (B&D 16.7%) vs London 11.6%

2025 population: 750,000
- +15% increase
- +110,000

2015 population: 750,000
- 75+ 22% growth
- 0-15 year olds 20% growth

Jobs section:
- BHR: £400m
In summary, we need to find a solution that addresses the following points

**Barking and Dagenham Clinical Commissioning Group**

<table>
<thead>
<tr>
<th>Patient experience</th>
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<tbody>
<tr>
<td>▪ Our patients can continue to benefit from a relationship with their local GP</td>
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<tr>
<td>▪ Our patients receive a joined-up cost-effective care service with unnecessary duplication avoided</td>
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<th>Delivery</th>
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<td>▪ We have the capacity and capability to meet the health and care needs of BHR’s growing and ageing population</td>
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<tr>
<td>▪ We meet the health and care needs of our diverse local communities</td>
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<tr>
<td>▪ We contribute substantially to the improvement of health outcomes for our populations</td>
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<tr>
<td>▪ We meet, as a minimum, national and regional quality standards for primary care – care that is accessible, co-ordinated and proactive</td>
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<tr>
<td>▪ The skills and assets of local professionals and provider organisations are effectively harnessed and co-ordinated</td>
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<tr>
<td>▪ Our solution contributes significantly to the financial sustainability of the BHR care economy</td>
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<th>General Practice</th>
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<tr>
<td>▪ Productive GP practices can retain their autonomy and have a financially sustainable future</td>
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<tr>
<td>▪ GPs have the time they need to provide quality patient care</td>
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<tr>
<td>▪ Minimise the time spent by GPs and practice colleagues on administration</td>
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<tr>
<td>▪ Respective roles and responsibilities of all local care providers in delivering care are clearly defined and consistently applied day-to-day by all parties</td>
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<th>Infrastructure / enablers</th>
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<td>▪ GPs and colleagues can rely on IT to present the information about their patients that they need to make the best decisions for patients at each point of care</td>
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<td>▪ Care is delivered in premises that are fit for purpose in a way that makes the best use of existing assets</td>
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<th>The GP &amp; their teams</th>
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<td>▪ Good career offer and working environment for GPs - retain existing GPs and attract new recruits</td>
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The emerging vision is primary care-led locality-based care, founded on strong practices

Patients

Co-producing their care
Registered with a local practice, with treatment, referral and care oversight from their GP
When needed, receiving personalised, joined-up care and support, mostly near home

B&D

Network arrangements

- Care provision
- Prevention
- Administration

GP Practices

High quality care
Productive
Finanically sustainable
GPs with time for patients

Other services to be agreed

A team of around 100 professionals, with trusted relationships, working together to design and deliver a high quality locality care service that meets local needs cost-effectively

Network arrangements

- Community Nursing
- Social Care
- Dental
- Optometry
- Pharmacy
- Outpatient services
- Voluntary Sector
- Other services to be agreed

Workforce development, recruitment and retention

Digitally-enabled scheduling and administration
Patient-level information sharing at point of care
Business intelligence: Ops management, Outcomes
Smart use of available Locality estate
Locality-based care would be designed and delivered within a wider set of standards and priorities.

SPG / Borough level plan and priorities – supporting implementation of BHR transitional programmes and CCG assurance measures.

SPG / Borough

GP Network and extended team:

‘Locality’ development

Individual GP practices

Outpatient services

Social Care

Community Nursing

Pharmacy

Optometry

Dental

Voluntary Sector

Other services to be agreed

OUTCOMES

Delivery Improvement

- Primary care-led locality team forms and develops (framework in development)
- Locality team sets outcomes and priorities to best meet local health needs
- Locality team defines local pathways and division of workload across practices, practice networks and extended locality team
Localities make sense for Place Based Care – Barking and Dagenham

- **Locality level**
  - 50,000 – 70,000 per locality

- **Borough level**
  - B&D: 200,000
  - Local plans to address local gaps and challenges
  - Devolution test/ACO development
  - Delivery via contracts (lead commissioner)
  - Local enabler plans
  - Local out of hospital plans

- **BHR Level**
  - 750,000

- **NEL Level**
  - 1,800,000

- **London Level**
  - 8,500,000

- Overall Sustainability and Transformation plan strategy – clinical and financial sustainability
- Issues needing a plan
  1. Acute reconfiguration / pan NEL flows
  2. Mental Health
  3. Cancer
  4. Urgent and Emergency Care (incl. LAS)
  5. Maternity
  6. Specialised
  7. Estates and workforce coordination of enablers and interface with HEE/HLP etc.
  8. Transformation funding

- Interface with HLP on agreed plan
- London initiatives

Evidence advanced by the Kings Fund, drawing on examples from New Zealand, is that place-based care works best with a population of 50-70,000 people.

Barking & Dagenham has a history of working in localities which contain populations of this size, and it is proposed that place-based care be established within these boundaries.

The commissioning and provider landscape in BHR can be layered into locality level, borough level, BHR level, North East London level and London level, allowing services to be commissioned for specific groups, achieving a degree of local autonomy at the same time as achieving economies of scale where appropriate.
The vision would have positive benefits for patients

- **Quality improvement** – an overall improvement in the quality of services provided and a reduction in variation in quality between GP practices

- Patients will experience a more **integrated** service that improves their health and wellbeing and ability to self-care

- Primary care will be **personalised**, responsive, timely and accessible and provided in a way that is patient centred and co-ordinated

- Practices will show **improvement in outcomes** for key cancer, COPD, diabetes, mental health and patient satisfaction indicators

- Patient access will be improved by providing **seven-day primary care** with integrated IT

- The locality model will provide the opportunity for more care to be provided **closer to home**
The vision would have positive benefits for practices

- **Retain autonomy** - allow step-by-step change with GPs leading

- Working together help to **ease financial pressures** - pooling resources to reduce costs and creating new opportunities to generate income

- **Partnership working** - GPs have confidence to devolve routine work to other members of the primary care team (e.g. repeat prescriptions) i.e. **reduce workload & free up GP time**

- **Integrated IT** will help **reduce duplication of work** in the wider primary care team, including chasing information

- **Integrated IT allows new ways of working that save time** (e.g. e-consultations or multi-disciplinary team meetings)

- **Attractive career offer to retain and recruit staff:**
  - Model will allow for **more diverse job roles** within the extended primary care team
  - Enable **new ways of working**
  - **More rewarding work** focusing on patients
  - Create opportunities for **career development** for both clinical and non-clinical staff
Our Implementation Approach

King’s Fund framework to develop place-based care

- **Define the population** served and the system boundaries.
- **Identify the partners and services** that need to be included.
- Create a **shared local vision and objectives**, based on local need and the priorities and preferences of the population.
- Develop an appropriate **governance structure** which must include patients and the public in decision-making.
- Identify the right **leaders** to manage the system, and develop a new form of system leadership.
- **Agree how conflicts will be managed and resolved.**
- Develop a **sustainable financial model** for the system across three levels:
  - the combined resources available to achieve the aims of the system
  - the way that these resources will flow down to providers
  - how these resources are allocated between providers and the way that costs, risks and rewards will be shared.
- Create a dedicated team to manage the work of the system.
- Develop ways to allow different members of the group to focus on different parts of the group’s objectives.
- Develop a **single set of measures** to understand progress and use for improvement.
What are the next steps?

Q1 16/17  Q2 16/17  Q3 16/17  Q4 16/17  Q1 17/18  Q2 17/18

Initiation
- Aspirational design agreed
- GPs and all stakeholders bought in to proposals and engaged

Pilot Design
- Pilot localities designs complete
- Lessons learned from initial challenges

Pilot Implementation
- Pilot localities fully operational
- Pilot localities partially setup and ready to deliver against strategies

Non-pilot Design
- Non-pilot localities designs complete

Non-pilot Implementation
- All localities fully operational
- Non-pilot localities partially setup and ready to deliver against strategies

Practice productivity
- Practice productivity increased
- Practices exploiting capabilities of IT

Better use of IT
- GP IT and BI user group established