The Mature Primary Care Home

This is the third in the trilogy of articles on the Primary Care Home from co-creator, Dr James Kingsland OBE., building on the previous two articles published in January and March of this year.

The Primary Care Home programme is still in the early stages of implementation and will evolve over time. Maturity and full functional delivery is expected to be achieved in different sites at different times. The programme was designed to be developed over a ten-year period from its official launch in October 2015. This does mean that it will transcend the current political cycle - and the next. If it delivers the outcomes and ambition consistent with its design, then it will survive changes in administration, unlike so many previous reforms.

Early signs are that it will be sustainable, not least by the enthusiastic and widespread uptake of the programme already.

From its inception and then the launch of 15 rapid test sites in April 2016, the number of sites developing the model nationally currently stands at 175.

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This means that one in eight citizens in England are being served by a developing Primary Care Home – that's more than 7 million people.

At the current rate of adoption, the mature model and completed implementation may be accomplished sooner than first envisaged.

The Primary Care Home is now the most extensive new care model for the reform of community based care provision within the NHS.

Its core strength is that clinicians, managers and patients, locally, lead this programme.

The clinical and patient centric thinking innately built into this model is the reason behind its rapid spread with the workforce advising '*it's what they've always wanted to do*' because they have ownership of the development and delivery of services.

This 'complete care community' does not therefore have to be engaged or enticed into this model.

Whilst the adage 'form follows function' is inherent in the construct, it will be important to realise an organisational form over time.

Functional development using the four core principles of the model is the right place to

start with a registered population of between 30,000 – 50,000 people.

Benefitting from list-based practice and equipped with the evidence supporting this size of population makes the PCH a complete model and different from other 'hub', 'locality', 'neighbourhood' or 'network' developments.

The Primary Care Home is a provider of services based in a community setting, but incorporates some appropriate secondary care services and personnel and so enables primary care, community health and social care professionals to work in partnership with hospital-based specialists.

A detailed understanding of the needs of the registered population (and therefore the expected volume and type of workload) will enable the creation of the right team at the outset who can then strengthen their efforts on maximising efficiency in the deployment of care resources and specifically in the 'provide or refer' decisions with their patients.

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Current outcome metrics, particularly in relation to general practice performance, may need to be discontinued in preference for PCH population outcome metrics.

This is to focus on outcomes that matter to people receiving the service, reduce bureaucracy and prevent duplication of effort.

With specialists involved in a more community focused service, the PCH offers the ability for these clinicians, currently working exclusively in a hospital setting, to provide some specialist care closer to (or within) a patient's home; particularly those with a responsibility for long term condition care, rehabilitation and reablement, and surgeons who particularly specialise in 'office based' procedures.

The workforce model promotes opportunities to design and develop the roles of the wider health and social care team to best meet the needs of the community served. A 'one team' approach allows for staff to know each other as individuals and facilitates team members to focus their efforts in the most effective way consistent with their skills and competencies.

Targeted use of the skills of the whole PCH team improves patient experience and outcomes, builds morale and enhances staff satisfaction.

There must be a balance between national approaches to workforce planning, which tend to be supply driven, with a more locally sensitive approach for the PCH model in order to create a workforce more suitable for local population needs.

The importance of having the option to maintain an independent contractual status for those primary care clinicians wishing to be involved (including dentists, optometrists and pharmacists as well as general practitioners) is a core principle to a PCH development.

Self-employment and partnership working must be an option in the contractual arrangements for PCH provision.

The ability for the entire care workforce, whether health, social or managerial professionals, voluntary sector, administrators or support workers to have an equity stake and a say in how the organisation is run is also essential.

Those who wish to be employed by the mature Primary Care Home have that option too.

However, a mature PCH works more like a mutual organisation or society with strong social values, rather than the form of an NHS Trust.

It may be that the Employment Ownership Trust described in the Finance Act 2014 should be explored, or an approach through a 'medical chambers' type arrangement with shared equity.

Further alternatives might include the formation of a company in which clinicians and managers can become directors (e.g. a community interest company or a not for profit company limited by guarantee) or through an alliance contract. Any such arrangements should work under the principles of a social enterprise.

The greatest influence on practitioner behaviour occurs when there is alignment between clinical decision-making and financial responsibility

Where staff are salaried or on initial sub-contracted arrangements, incentives will be needed to foster an inclusive approach to the delivery of high standards of responsive care.

The type of 'partnership' model will depend on the degree of the risk and reward that individuals are willing to take, the scope for existing contractual arrangements which may be folded into a PCH budget and the likely minimum duration of such an agreement.

Trying harder at previously failed attempts at integrating care through loose collaborations with incentives still focused on individual institutions should now be recognised as unproductive.

The PCH requires a whole population-based budget formulated on the registered lists of the constituent practices, with a level of funding dependent on the need of the population and the scope of responsibilities within the contract, which ultimately might include primary care funding.

A PCH takes responsibility from the commissioner for this delegated budget to maximise quality and efficiency in both those first contact PCH provider services and for the sub-contracted care, which it has not been commissioned to provide, but unavoidably necessitates a referral to other NHS organisations.

The transition to a full risk model may entail a phased approach to budgetary responsibility and then extending this as organisational experience and expertise is developed.

The Primary Care Home cannot legally commission services but it can overcome the fragmented responsibility for the commissioning and provision of care in the NHS.

Whilst a PCH may take many different forms at the outset, with loose alliances and networks, it must mature over time into a fully integrated care provider.

A PCH therefore brings together health and care providers into one organisational model to take responsibility for both the quality of outcomes for patients and per capita costs across the continuum of care for the defined registered population. It is a practical expression of 'place-based' working.

The greatest influence on practitioner behaviour occurs when there is alignment between clinical decision-making and financial responsibility (this is the case for both primary and secondary care clinicians).

This was a founding principle of the Health and Social Care Act 2012.

Administration and transaction costs can be alleviated through a focus on the use of information technology, defining a limited number of meaningful outcomes, and encouraging the 'making' rather than the

'purchasing' of services, thereby reducing the need for hospital based care.

The alignment of clinical and financial drivers is essential to ensure a collective approach to risks and rewards.

This also establishes an emphasis on productivity consistent with the recent review of operational productivity in the NHS by Lord Carter and the inherent business efficiency established within primary care contractor services.

It is not envisaged that the PCH will necessarily need any new buildings or facilities other than those already available in the community.

The model espouses a campus approach with better management of current estates and networked arrangements of estates and facilities.

The PCH campus will be inclusive of the existing general practice premises, community services facilities and any other existing NHS or social care premises deemed appropriate to be involved to meet the needs of the population served.

The mature PCH should have;

- **Payments** linked to quality improvements and reduced costs
- **Reliable** and increasingly sophisticated performance measurements to support improvement and provide confidence that savings are achieved through these care improvements
- **Improved** population health analytics using predictive and new case management tools
- **Accelerated** implementation of comprehensive electronic care records with better care co-ordination across the primary - secondary care divide.

In summary, a PCH is probably the best expression of an accountable care organisation (ACO) within our existing accountable care system (aka the NHS) with particular focus on a unified budget, single integrated workforce and an uncomplicated consolidated range of outcome measures.

Tolerance levels for individual patient costs may need to be negotiated so that there might be a maximum cost levied against the PCH budget for any registered individual's care, especially when provided through a sub-contracted service, with the aim to reduce the financial impact in relation to the variation in high cost patients.

New ways of commissioning and payment mechanisms for care are now required including longer term, outcome-based contracts through the utilisation use of 'whole population budgets' in new provider models of care.

The NHS can realise accountable care through the mature Primary Care Home model, with a focus on improving quality whilst controlling costs and being held accountable for the care outcomes it achieves.

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Find out more about the Primary Care Home by emailing…

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