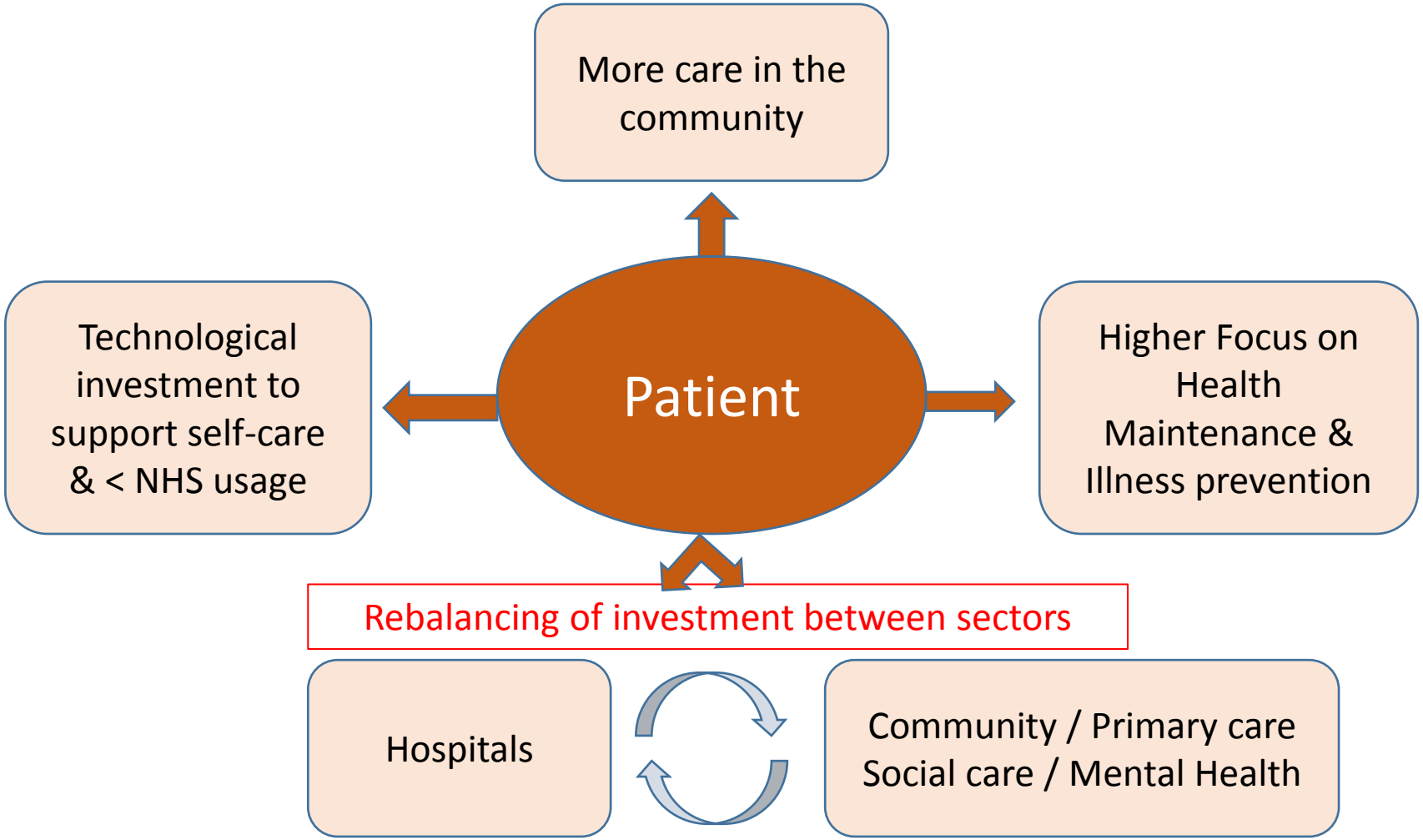
“Community Transformation”

Some out of hospital organisational issues.

South West Clinical Senate

10th November 2016

Five Year Forward View direction of travel



Historic split of Health Services

- NHS 1947 Hospital & Community Health Services (HCHS) & General Medical Services (GMS);
- Intrinsic split between hospital & general practice: -
  - No contracting mechanism for hospitals to provide primary care;
  - GPs not NHS employees but independent contractors who having to run independent 'businesses';
  - There are a range of 'allowances' e.g. rent reimbursement, NHS pensions but essentially **GP pay = practice income – practice expenses**.
- 1997 PMS contract added 'growth money' for employment of practice-based staff, now supported by performance related pay (QOF);
- Meanwhile PCTs mandated to adopt PbR – restricted their opportunity for investment in community sector due to acute growth rate;
- CCGs not charged with developing primary care. NHSE capacity limited;
- Finances have tightened in all sectors post 2008.

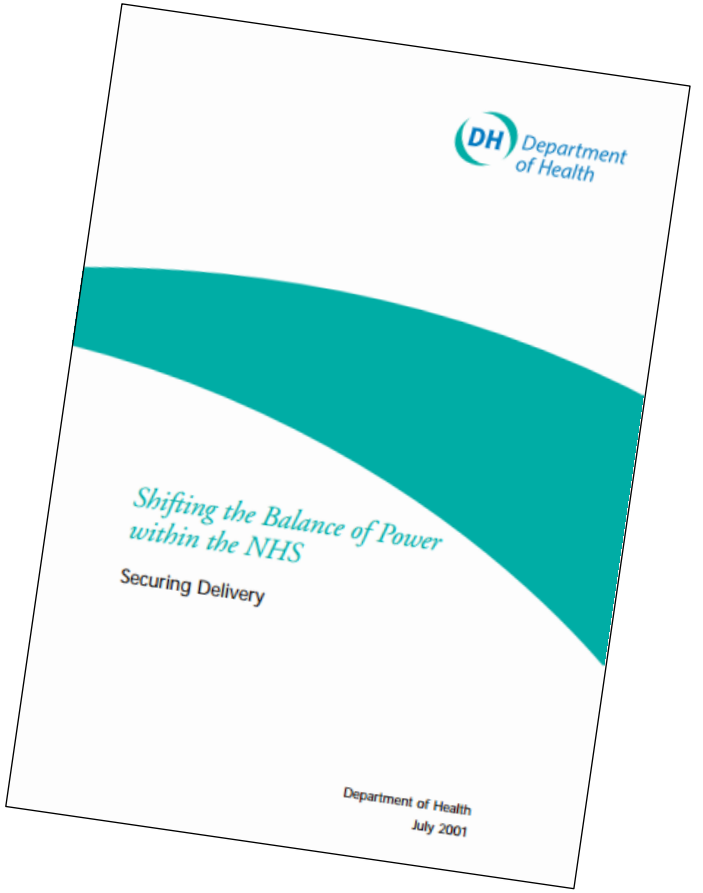
Community Health services history

Community health services usually a directorate of an acute trust, but then not seen as their core business;

Generally adopted & incorporated into PCTs;

Shifting the Balance of Power required a purchaser / provider split:

- Formed arms length organisations;
- Establishment from previous host organisations;
- Organisational forms often as Social Enterprises e.g. CICs.



GP Organisations

Progressive move away from partnership in General Practice:

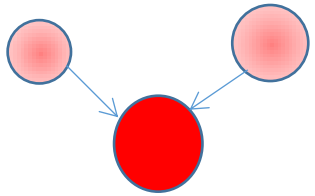
- Younger mobile workforce looking for ‘portfolio careers’;
- Rise in salaried and locum GPs;
- Debt & financial risk, difficulty funding practice purchases;
- Organisational risk & increasing bureaucracy;
- Workload crisis leading to practices returning contracts to NHSE;
- New organisations also relinquishing contracts;

- 39% GP Principals > 50 years – increasing early retirement & recruitment / retention difficulty.

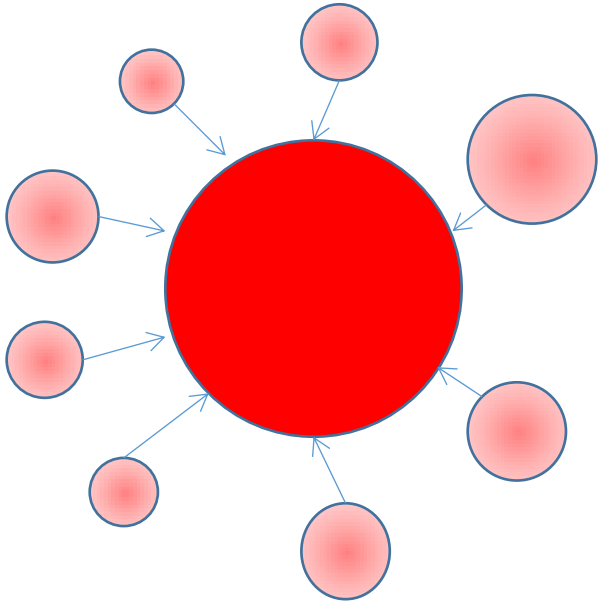
BMA Survey:

- 50% GPs would be now prepared to be salaried;
- 80% do not think independent contractor status will survive 5 years.

Models of Primary Care Emerging

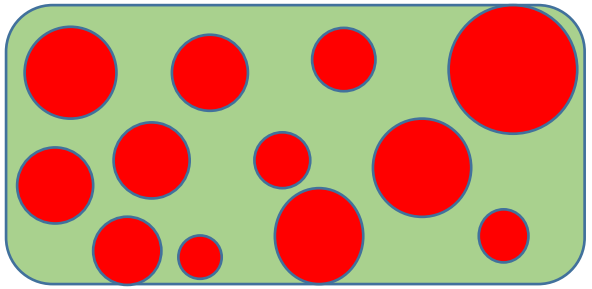


Individual mergers

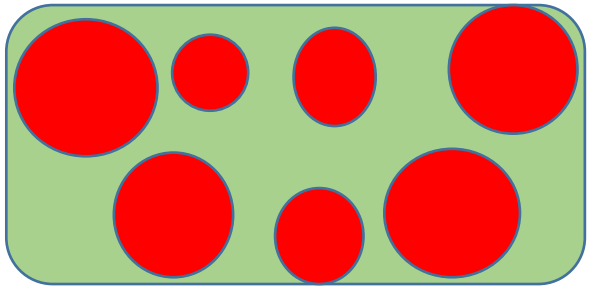


Mega-practices: either geographically compact or spread

Integration with Hospital or Community Trust sector



Loose Network



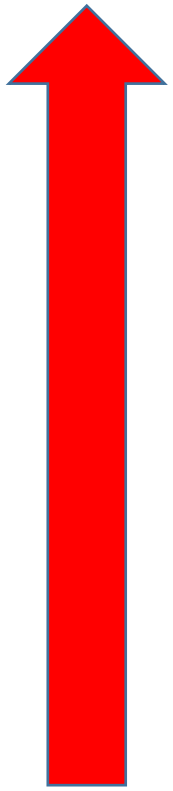
Loose Network with internal mergers

Primary Care Home

- The PCH is a form of *multispecialty community provider (MCP)* model. Its key features are:
- provision of care to a defined, registered population of between 30,000 and 50,000;
- aligned clinical financial drivers through a unified, capitated budget with appropriate shared risks and rewards;
- an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care; and
- a combined focus on personalisation of care with improvements in population health outcomes.

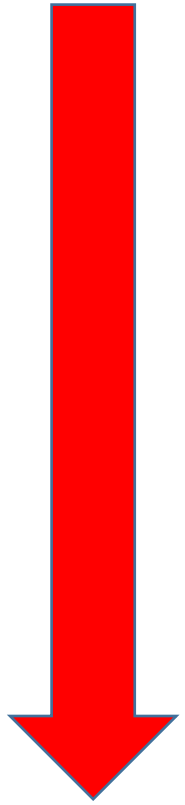
GP organisations real experience of getting going

Proximity to income !!

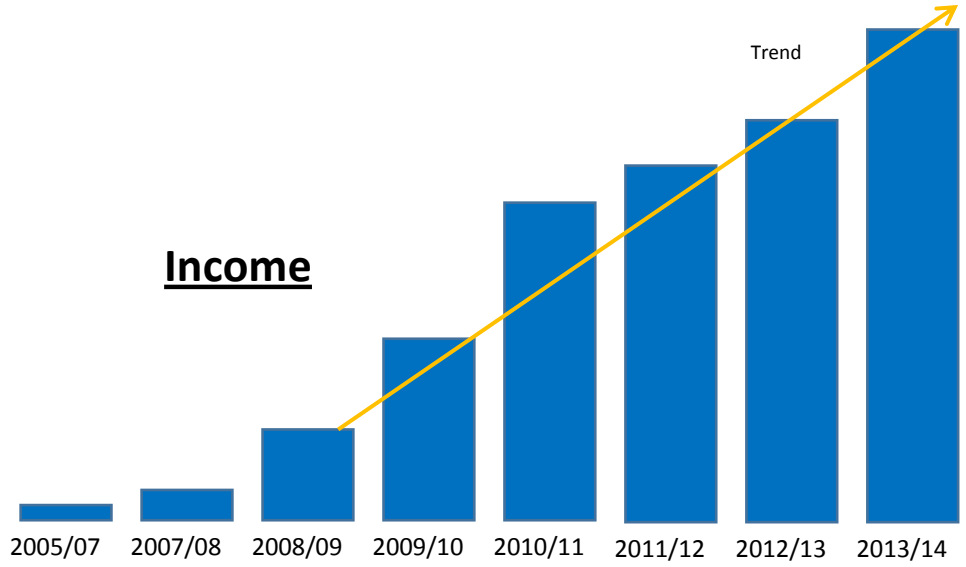


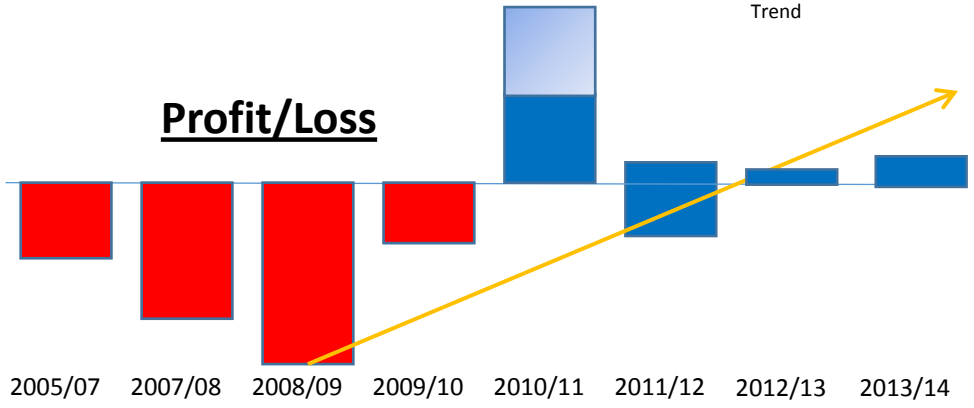
9. Marketing
8. Implementation (including Capex)
7. Contract legals
6. Tender/AQP submission
5. Design new service(s) and find clinical providers
4. Build relationships
    - Commissioners/CCGs
    - Secondary care
    - Referring GPs
3. Clinical & Corporate Governance
    - Policies and procedures
    - Clinical governance framework
    - Care Quality Commission registration
2. Logistics – premises/team/insurance
1. Legal entity (e.g. Ltd Co) & set up funding

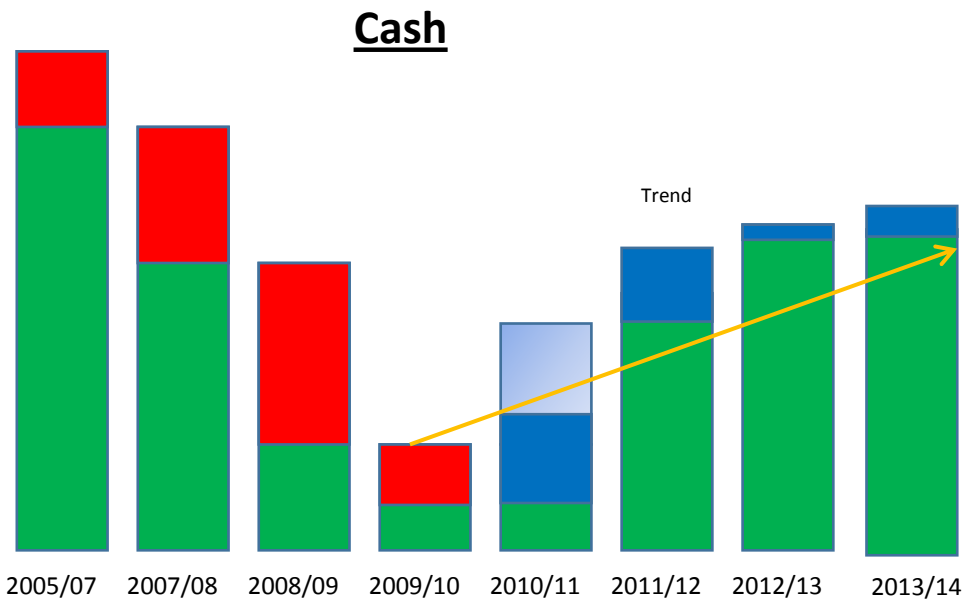
Cash balance !!



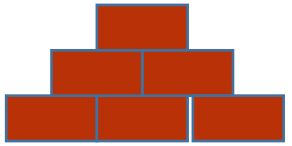
Financial expectations







Set up experience – Contractual



Business infrastructure:

- Finance – banking, invoicing, corp tax, VAT, insurance
- Marketing – website, newsletters, presentations, visits
- IT – Server, N3, eReferrals, HSCIC
- Registrations – CQC, MHRA, NPSA, PCSA
- Clinical and corporate governance, HR

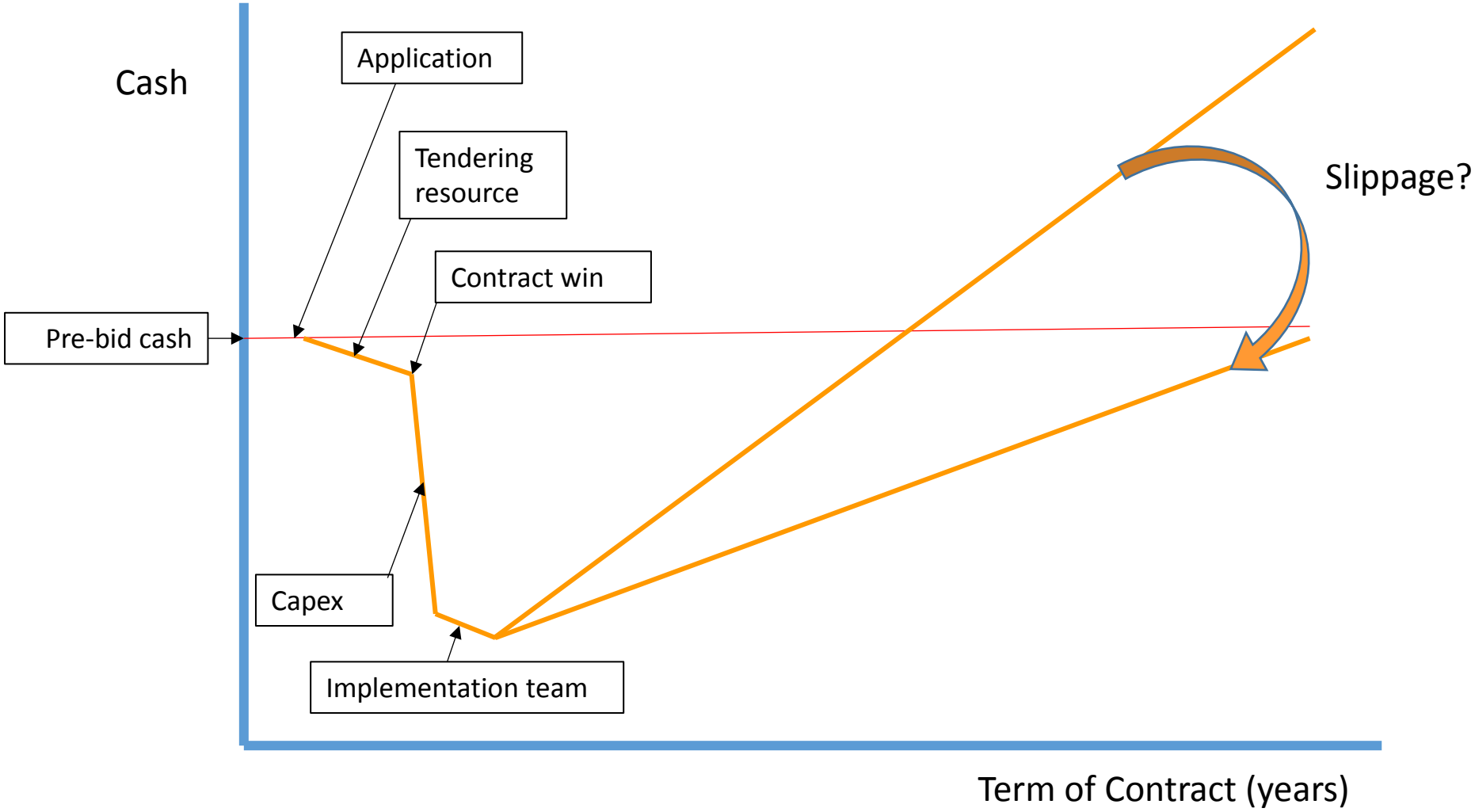
Service specific:

- Contract monitoring/reporting/liaison with commissioners
- Regulatory/best practice changes & service improvements

Investing in next service development:

- Pick projects carefully – run a number in parallel
- Dependent on the appetite / capacity of commissioners

Contracts & real commercial risks



Issues to Consider

- Ownership & leadership of the organisation
- Vision, Organisational culture, values & ethos
- Representation, legitimacy, authority & accountability
- Margin advances – slowness in organisational development
- Relationship with commissioners (link with STPs) and their preconceptions (NHS or private);
- Continuing success / commercial resilience & sources of income;
- Alliances with other providers e.g. community & acute trusts;
- Links creating ‘general practices at scale’.

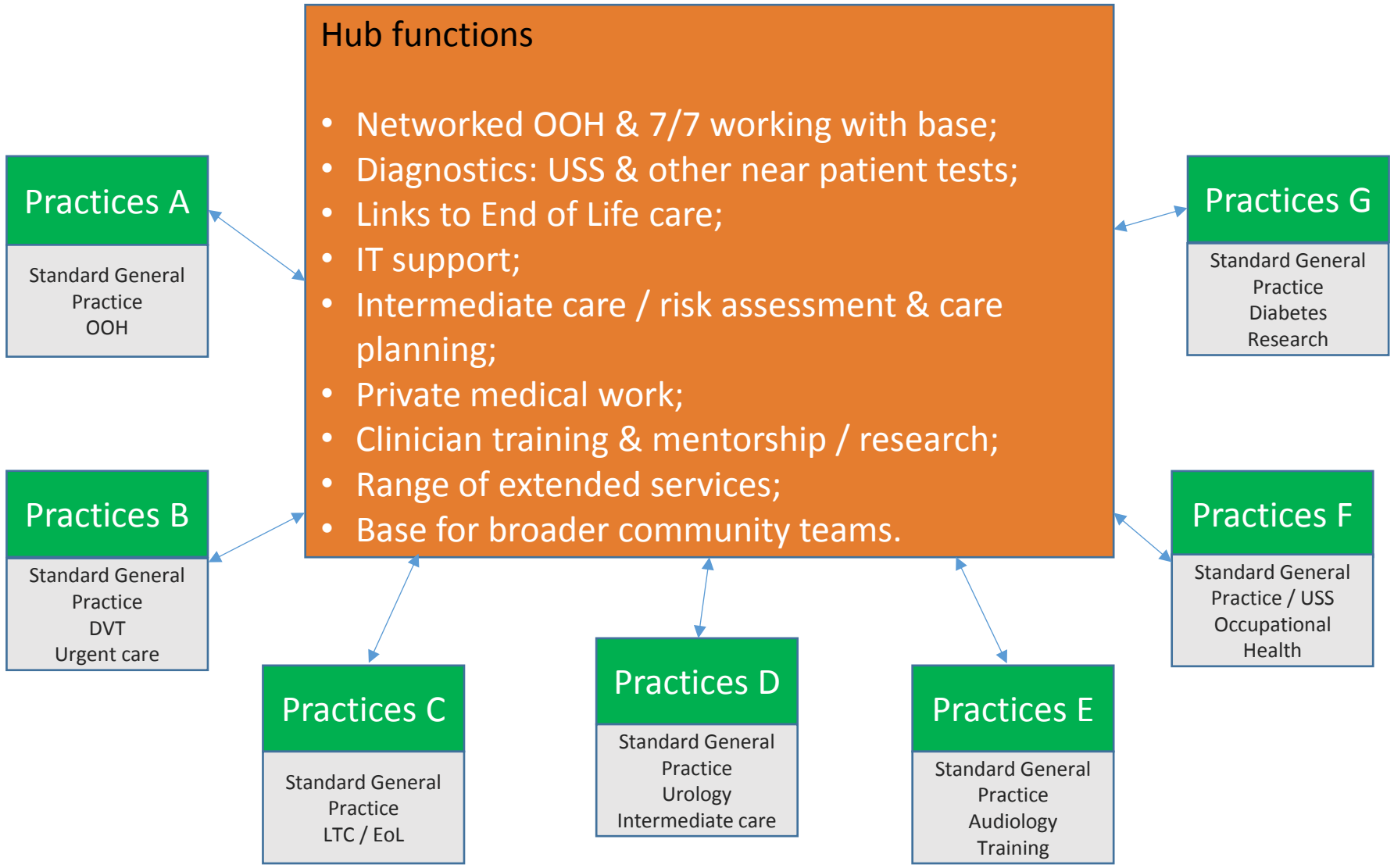
Support for primary care at scale

Provision to each hub of:

- Practices' business development – service development; private services, interface with commissioners and other health & social care organisations, bidding agency for other community based healthcare activities;
- Operations – contract delivery, clinical governance / quality assurance, scheduling & access, infection control, staff deployment, results & document management;
- Human Resources – recruitment, skill mix, locum pool, external & in-house training, policies & procedures; practice team, rostering & disciplinary, community nurses & ESPs
- Relationship & liaison – patient participation groups, public involvement, complaints;
- Clinical – professional behaviour, clinical training, mentorship and development, appraisal;
- Centralised Home Visiting – All practice home, nursing & residential care visits and transportation (from home to surgery and for home visiting / housebound care);
- IT – hardware & software, template setup & management, training and clinician support;
- Data – maximising effectiveness of IT, data quality & record summarisation, IT governance, audit & reporting;
- Finance - payroll, accounts, contracting & bidding, efficiency, remuneration, budgetary control;
- Facilities - Practice premises, CQC & DDA compliance, rental & repairs, space & occupancy planning;

Hub 1	Hub 2	Hub 3	Hub 4	Hub 5	Hub 6
Practices A - G	Practices H - L	Practices M - O	Practices P - T	Practices U - Z	Practices i - v

Primary care - cost base not income centre?



Summary

- Growth has been slow in community trusts and GP organisations restricting their ability to absorb the ‘heavy lifting’ of NHS community provision;
- Margin incomes from current services don’t allow for the type of investment that needs to occur for large scale transferral of services;
- General Practice’s historic model of small independent contractor businesses is possibly unsustainable and new models are slow to emerge. It remains to be seen whether they will contribute significantly to community service redesign;
- Commissioner innovation / capacity has been variable. Some of the community orgs’ growth is now coming from direct ‘deals’ between providers;
- Contractual opportunities from the New Models of Care Vanguards are still not finalised but could allow integration between hospital and community services with true ‘vertical integration;
- Current funding models are still impeding progress. ‘Unified control totals’ may move us towards well-functioning ACOs;
- Most of the STP plans have not got strong engagement with the community sector currently, and may be hard to know with whom to engage.