Working better together: community health and primary care

October 2014
Introduction

This slide pack captures the main points from a workshop on integrated working between primary care and community health services.

The points captured are those raised by speakers and delegates; this does not necessarily represent NHS Confederation policy.

The workshop was organised by the NHS Confederation Community Health Services Forum in partnership with the National Association of Primary Care, in September 2014.
Rethinking models of joint working

Challenges we need to overcome:

- Decisions about reshaping care can take far too long
- Fragmented organisational structures not suited to integration
- Financial sustainability: insufficient funds to meet patient expectations
- Risks and benefits not evenly shared
- Conversations which tend to start with money
- GPs’ contractual arrangements separate them from wider system
Aspirations for future models of joint working

- Reduce hospital admissions for the 2% of patients who attend most
- Patients aware of services beyond General Practice
- Greater shift to prevention and self management
- Single point of access for patients
- More virtual wards
- Ability to communicate systematically with all providers, and shared data across the system

Integrated workforce:
- Staff who can work across organisation boundaries
- Other staff co-located with GPs

General Practice models supporting whole system integration:
- Accountable Care Organisation approach for people with complex needs to release pressure on primary care
- Community of practice ‘wrapped around’ a federation of GPs to look after shared population using predictive tools to identify best provision.
Case Study 1: community services supporting ‘named GP’ role in Suffolk

Suffolk Community Healthcare is working with 10 GP practices to pilot an extensive role for named community matrons in supporting the ‘named GP’ role in co-ordinating care for frail older people.


Matrons work with surgeries using System One, an agreed template to integrate and share data.

The matron and community service will act as the initial point of contact (via the CCC 24 hours a day) for the patient rather than the GP surgery.

OUTOMES: Reductions in hospital admissions and unscheduled GP visits, as well as perceptions of improved care and wellness (capturing patient experience via a patient survey and Friends and Family).
Case Study 1 continued

The model builds on past learning, but a key difference is far more systematic measurement and demonstration of the outcomes achieved. The project hopes to provide evidence that it has helped manage the growing demand on GPs, reduce hospital admissions and improve patient experience, through highly skilled practitioners (Community Matrons) working alongside GP practices to develop a ‘single point of access’ service for highly vulnerable patients.

The model and its outcomes are expected to influence the CCG’s approach to engaging the community matron services – particularly as it aligns with and helps to address the CCG’s priorities.

Further information: Julie Gaughan, Project Manager, NAPC: juedrop@me.com
Case study 2: winter pressure wards in North West London

For winter 2014-15, community-based winter pressure wards provided by Central London Community Healthcare will be aligned with GP practices, rather than acute.

- Links to general practice mean patients retain link to own GP
- District nurses up-skilled to ensure good handovers
- Maintained link to the local acute provider to retain specialist cover
- Whole ward accountability structure, with a lead GP practice. This was costly on a one-off basis, community provider had to lead
- Major challenge of consistency across communication, clinical governance and approaches to safety
- Evolving model to include broader spectrum of care, including partnership with nursing homes
Case study 2 continued

2013-14 winter pressure wards added extra capacity aligned to the hospital, at 6 weeks’ notice, but did not improve the model of care. To develop new model, moved away from short period (6-8 weeks) covered by winter pressures money, partly driven by ongoing pressure on acute.

Pace of change is key. Community services built a partnership with primary care, to understand what specification will work, and develop clear agreements. Cannot simply tell people their roles will change or try to go too fast.

Further information: Dr Joanne Medhurst, Medical Director, CLCH: joanne.medhurst@nhs.net
Overcoming barriers to developing and implementing new models
## Developing shared leadership

### Challenges
- Hierarchical and silo-ed system
- Clinicians needing support to develop leadership
- Lack of obvious system leaders
- Lack of shared, ‘corporate’ vision leading to organisations protecting own territory
- Political leaders imposing changes to agenda
- Local politics
- Organisations working to different contractual mechanisms

### Solutions
- OD across organisations and for those in leadership roles. Support development of clinical leadership skills
- Workforce training and planning to incorporate development of future leaders (‘succession planning’)
- Recruit for values as well as skills
- Consistency: shared goals across system, and political support for stability
- Develop shared vision with common goals across health / social care and commissioners / providers which is owned throughout the organisation, not just at the top
### Challenges

- Lack of trust and communication across organisations
- Lack openness / transparency
- Don’t value others’ contribution
- Lack autonomy / need to seek permission
- Failing to have ‘grown up’ conversations
- ‘Different systems
- Financial risk sharing across different funding systems
- Data sharing
- Competitive environment and tendering process – impact on relationships. Can feel like ‘partnership with menace’
- Internal focus of organisations – ‘doing the day job’
- Negative media coverage
- ‘Passive patients’
- Underlying ‘can’t do it’ mindset

### Solutions

- Openness/transparency/honesty re own agenda
- Bring frontline staff together – they will find solutions together, and learn from each other
- Leadership: bring staff with you and celebrate success
- Patient ownership / control, incl. access to information: change driven by responding to their needs
- Alignment, including standardised data and outcome measures; shared outcome performance framework
- Better use of IT to share information
- Role of education system building skills for collaboration more widely
- Unravel the wool [of multiple services] and learn to knit [care together]. Change mindset – more proactive
## Aligning metrics and financial incentives

### Challenges

- Perverse incentives in system
- Contract indicators can frustrate service development if they don’t reflect objectives we need
- Commissioners need to understand how costs move between providers as models change
- BCF process focused on reducing acute activity not building community provision
- Regulators’ assessment of provider sustainability ignores innovations in contracts
- People want different measures; acting on this is the challenge
- Change can affect cross subsidies within orgs, preventing change – plan together to manage

### Solutions

- Seek models that deliver mutual benefit
- Develop joint proposals at local level and seek replacement of old contract
- Ensure commissioners know the wider implications of delivering the CQUIN
- Commissioning of population outcomes requiring cross-sector delivery
- Develop metrics capturing outcomes and experience e.g. when setting up Enhanced Service.
- Avoid just using acute measures
- Need to develop and populate community indicators dataset – underway but challenging
- Some process measures still have value e.g. waits can affect people’s outcomes
Enablers of change

- Leadership for change
- Spread of innovation
- Engagement to mobilise
- System drivers
- Improvement methodology
- Rigorous delivery
- Transparent measurement

Source: NHS England
Enablers of change

Future care offer
- Wider primary care at scale
- Premises
- Workforce

Workforce
- GP recruitment, return, retention
- Practice & community nursing
- Practice management
- Community pharmacists
- Wellbeing workers
- Specialists

Infostructure
- Funding model
- Innovations Hub
- National guidance
- Change leadership capabilities
- OD & Ops capabilities
- Information infrastructure

Source: NHS England
Key learning: be ambitious for the future

- Get the whole system to see community services as the place where change happens. Community services may in future be the part of NHS that people interface with the most
  - Bear in mind when developing models (and for NHSE 5YFV)
  - Community nurses can activate populations and are well placed to have the discussions needed to personalise individuals’ care

- Work together to ensure community settings have enough staff

- Push the barriers in terms of what a joined up model may look like
  - Bring together roles of primary care, community services and wider (e.g. local authorities): universal support for our whole population
  - Be clear who is best placed to do what

- Don’t reinvent the wheel: share models and information about what works

- Give people permission to try different models – it is hard to stop a good argument for change

- Community services as a/the “place where change is possible” The barriers are not as great as we think they are – often they are in our own head
The Community Health Services Forum
- supporting our members

- Working with LGA to lobby government on key actions needed to enable local leaders to deliver integrated care. Highlighted in our joint report *All together now, Making integration happen*

- Sharing learning and good practice on successful ways of integrating care – and overcoming the cultural, behavioural and information-sharing barriers

- Working with NAPC to influence HEE vision for the future of the primary care workforce, to ensure it can better facilitate more integrated working across professional boundaries.

- CHSF lobbying to reform payment mechanisms

- **2015 Challenge**: Calls include faster progress reforming payment mechanisms, workforce development to support working across boundaries, and support to put coordinated information systems in place