ASHFORD CLINICAL PROVIDERS Ltd. Agenda Item 7 (c)

Enhanced Primary care at scale and a vehicle for "New Models of Care". -Dr. Jim Kelly

A federation of all 14 local GP practices who have come together to work with the CCG address the health needs of Ashford's population through "joined up" service redesign and delivery.

Arose out of;

A desire to build on the strengths of local Primary care.

A recognition that commissioners needed robust locality wide cost effective alternatives to allow shift from hospital to community care and prevent "commissioning in a vacuum".

A frustration that the primary care team had been systematically dismantled to the detriment of patient care.

A belief that by working at scale in general practice we can support the commissioning of a wider range of Primary Care services and collaborate more effectively with other providers in integrated care initiatives.

Opportunity for;

Development (perhaps through a joint venture with KCHFT) of the whole range of health and social care services from 3 distinct Hubs within our community by becoming a "Multidisciplinary Community Provider" (MCP) holding its own unified budget for the provision of all local care and purchasing selected additional specialised services from a smaller "hotter" acute secondary care service.

Recognising the challenges of;

Rapid Local growth and increasing pressure on a National (and Local) Health Service in crisis compounded by an ageing population, rising obesity and LTC, Increased demand (both needs and wants) on all services within the NHS, Falling/Static NHS investment.

National drive to move care closer to home (FYFV) and a recognition that integrated models of health and social care should be more clinically and cost effective.

The Vision;

The NHS 5 Year Forward View describes Multispecialty Community Providers (MCPs) as care models based on 'extended group practices' in the form of federations, networks or single organisations offering a wider range of care using a broader range of professionals. The document specifically mentions primary care employing consultants or taking them on as partners, bringing in 'senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social works and other staff… shifting the majority of outpatient consultations and ambulatory care out of hospital settings'.

Encompass (Canterbury/Whitstable vanguard) is an example of this with a super-partnership federating several other practices to form a fledging MCP.

Our federation hopes to be a fast follower but will need our CCG to share our "primary care led" vision to make this a reality!

Stabilising Primary care has to be the priority.

Historic variation in funding and contracts.

CCG and Federation commitment to support practices by "levelling up" those with access to fewer funding streams.

GP + as a means of enhancing the Primary Care offer- The evidence from one local Practice.

Community Practitioner/Matron for complex care co-ordination and navigation. Complex Diabetes Care with GPSi and PNSi. Urgent Telephone Access service using senior GPs.

Resulted in Lowest activity and costs in all unscheduled health and social care sectors (in all of East Kent).

Conclusion is that; Investment in high quality frontline primary care staff and systems actually cools down activity in other more expensive sectors and streamlines the patient journey.

Deliverables 2017?

More timely access to health and social care needs through service redesign including:-

IT integration (EMIS Web with MIG)

Ever expanding GPSi and consultant delivered local patient triage, assessment and treatment services

Relocation of care/community teams (mental health, health visitor, midwife, social worker, district and community nurses etc). Weekend/evening GP access in all 3 Ashford Hubs.

Formation of GP Federation led MCP shadow board as a joint venture with KCHFT involving all local stakeholders.

Acute care collaboration between ACP and EKHUFT.

Risks and potential "blocks."

1) Lack of grassroots GP involvement and approval of Strategic Transformation Plans.

2) Over representation of larger providers to the detriment of local GPs (see above)

3) "Transformation" is not a substitute for adequate funding –"false economies of scale".

4) Risk averse commissioning. Failure to pump prime, use" preferred provider" procurement to boost Primary care workforce and skill mix (to include consultants).Federation/MCP management and business development expertise.

ASHFORD CLINICAL PROVIDERS Ltd.

Enhanced Primary care at scale
and a vehicle for New Models of Care.

Becoming part of the Sustainability and Transformation agenda.

Dr. Jim Kelly

INTRODUCTION AND OVERVIEW

- Who and Why ?
- Our Vision
- Local Drivers
- National Drivers
- Five year forward View and New Models of Care
- MCP – what is it, why is it our preferred model, how far away are we?
- Achievements and shared CCG priorities
- Stabilizing and Energizing Primary care through brave co-commissioning.
- What can be achieved by investing in Primary Care.
- Outcomes and deliverables
- Potential Risks, blocks and resource implications.

Who we are….

- **A Locality wide federation of every single practice within the Ashford CCG boundary:-**
- **Sydenham House Medical Practice**
- **Kingsnorth Medical Practice**
- **New Hayesbank Surgery**
- **Willesborough Health Centre**
- **Hollington Surgery**
- **Sellindge Medical Practice**
- **Wye Surgery**
- **South Ashford Medics**
- **Ivy Court Surgery**
- **Woodchurch Surgery**
- **Singleton Medical Centre**
- **Singleton Surgery**
- **Ham Street Medical Practice**
- **The Charing Medical Practice**

- Combined list size circa 125,000 co-terminus with Ashford CCG.
- Facilitating the CCG plans for integration within and between the 3 Ashford Locality Hubs (North, South and Rural),
- Developing partnerships with all local providers including:-
- Kent County Council/Social Services
- East Kent Hospital University Foundation Trust
- Kent Community Health Foundation Trust
- South East Coast Ambulance Service (SECAMB)
- Kent and Medway Partnership Trust (Mental Health)
- And a range of community and voluntary sector stakeholders.

Why?

- A desire to build on the strengths of local Primary care.
- A frustration that the primary care team had been systematically dismantled to the detriment of patient care.
- A belief that by working at scale in general practice we can support the commissioning of a wider range of Primary Care services and collaborate more effectively with other providers in integrated care initiatives.
- A recognition that commissioners needed robust locality wide cost effective alternatives to allow shift from hospital to community care and prevent “commissioning in a vacuum”.

Our Vision

- Short term –
- Provide support for existing Primary care services to allow CCG co-commissioners to boost investment by the use of **GMS/PMS Plus** services.
- Work with the CCG and NHS England to secure investment in high quality healthcare **Premises** which are fit for the future.
- **Expansion in the provision of referral triage, outpatient clinics, diagnostics, screening, physical and psychological therapies** all as one stop services closer to home (preferably within a patients own practice/hub).
- **Repatriate** community/specialist nurses and health visitors back to the practice/Hub based **PHCT.** Facilitate re-ablement of patients to their own homes wherever possible by reconnecting primary care with community ICTs/social services.
- Introduce a **'virtual ward'** where patients in the community at risk of hospital admission can be discussed by MDT's –getting meaningful community matron access to A+E and the wards to facilitate appropriate early patient discharge using a fully integrated IT solutions **(single care record).**
- Adapt the **weekend service** currently running in the rural Hub to both North and South Hubs for the benefit of patients and to "decompress" 111, OOH and A+E.
- Reduction in hospital admissions by horizontal collaboration with EKHUFT by providing **an in-reach service at the front door of A+E.** Ramp up this service to cope with additional demand during peak winter pressures.

Our Vision

- Medium term –
- Development (perhaps through a joint venture with KCHFT) of the whole range of health and social care services from 3 distinct Hubs within our community by becoming a “Multidisciplinary Community Provider” (MCP) holding its own unified budget for the provision of all local care and purchasing selected additional specialised services from a smaller “hotter” acute secondary care service,

Local Drivers (growth/complexity)

- 2014 approval to build 5,750 homes at Chilmington Green (3,350 by 2021);
- IN ADDITION; Newly published Ashford Area Plan by 2030…
- 2300 new dwellings in smaller developments clustered in Southern Urban fringe (in addition to the 1000 already agreed at Finberry/Bridgefield).
- 2200 new dwellings elsewhere in Urban Ashford.
- Proposed development at Tenterden – 250 houses (and other villages another 250)
- Potential of 28,200 new residents.
- Average life expectancy in Ashford is 83.4 years for women and 80.7 years for men;
- Long Term Conditions increasing – more than ¼ of population have LTC of which 12% have 3+ conditions;
- Kent and Medway Public Health Observatory estimates by 2019 Ashford 0ver 65's will grow by 10% and comprise 20% of the population

National Drivers

- Demographic;
- Ageing population, rising obesity and LTC
- Increased demand (both needs and wants) on all services within the NHS.
- Socio/Political;
- Recognition of the erosion of Primary care funding from 11% to less than 8% in last 10 years! (GPFV)
- Recognition that integrated models of health and social care *should* be more clinically and cost effective.
- National drive to move care closer to home (FYFV).

Five Year Forward View and New models of care (NMC)

October 2014 set out several NMCs designed to ‘dissolve traditional boundaries’ between general practice, community services, hospitals and social care.

- Vanguard sites have now been selected to test these new models of integration, though movement towards more integrated care is already well underway in many parts of England.
- This was demonstrated by the large number of applications for vanguard site status from providers and commissioners already engaged in integration work, including some organisationally ambitious projects (of which we were one).

FYFV and NMC (cont)

- The current arrangements of competing providers and, at times, rigid separation between general practice, community providers, secondary care and social care are having a detrimental effect on patients, with disjointed service delivery, duplication, increased costs and flows of funding which create perverse incentives that do not reflect patient needs.
- There is incongruity between competitive procurement policy (and law) and more collaborative working. Most new models of integrated working will have implications for commissioning practice and policy as commissioners work closely with a defined group of established providers. As the need for increased collaboration becomes increasingly important, tensions with current competitive procurement policy may ultimately need to be resolved centrally (and pending this, negotiated locally).

Multispecialty Community Providers (MCPs)

- The 5YFV describes Multispecialty Community Providers (MCPs) as care models based on ‘extended group practices’ in the form of federations, networks or single organisations offering a wider range of care using a broader range of professionals. The document specifically mentions primary care employing consultants or taking them on as partners, bringing in ‘senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social works and other staff… shifting the majority of outpatient consultations and ambulatory care out of hospital settings’.

- The variation in current MCP models is very evident. It seems there are three broad types of MCP model, each of which have different implications for general practitioners and service development:

- ☐The ‘soft’ MCP; Larger practices secure locality wide contracts for services under AQP.

- ☐The ‘directed’ MCP; Where practices are grouped - by the commissioner - into locality provider groups.

- ☐MCP development through large scale GP provider networks or geographically based collaborative arrangements between GPs and other providers

MCP development through large scale GP provider networks

- The GP provider in this model could be a GP network, a large super-partnership or in some cases an MCP created through collaborative working between, for example, a large community provider and a large, well organised group of GPs.
- Encompass is an example of this with a super-partnership loosely federating several other practices to form a fledging MCP.
- Our federation has a more formal structure and will need our CCG to invest time, money and expertise into a New MCP for Ashford whilst sharing our “primary care led” vision!

Achievements so far- MSK

An MSK Triage service was started in December 2014 in response to an unprecedented rise in referrals into EKHUFT.

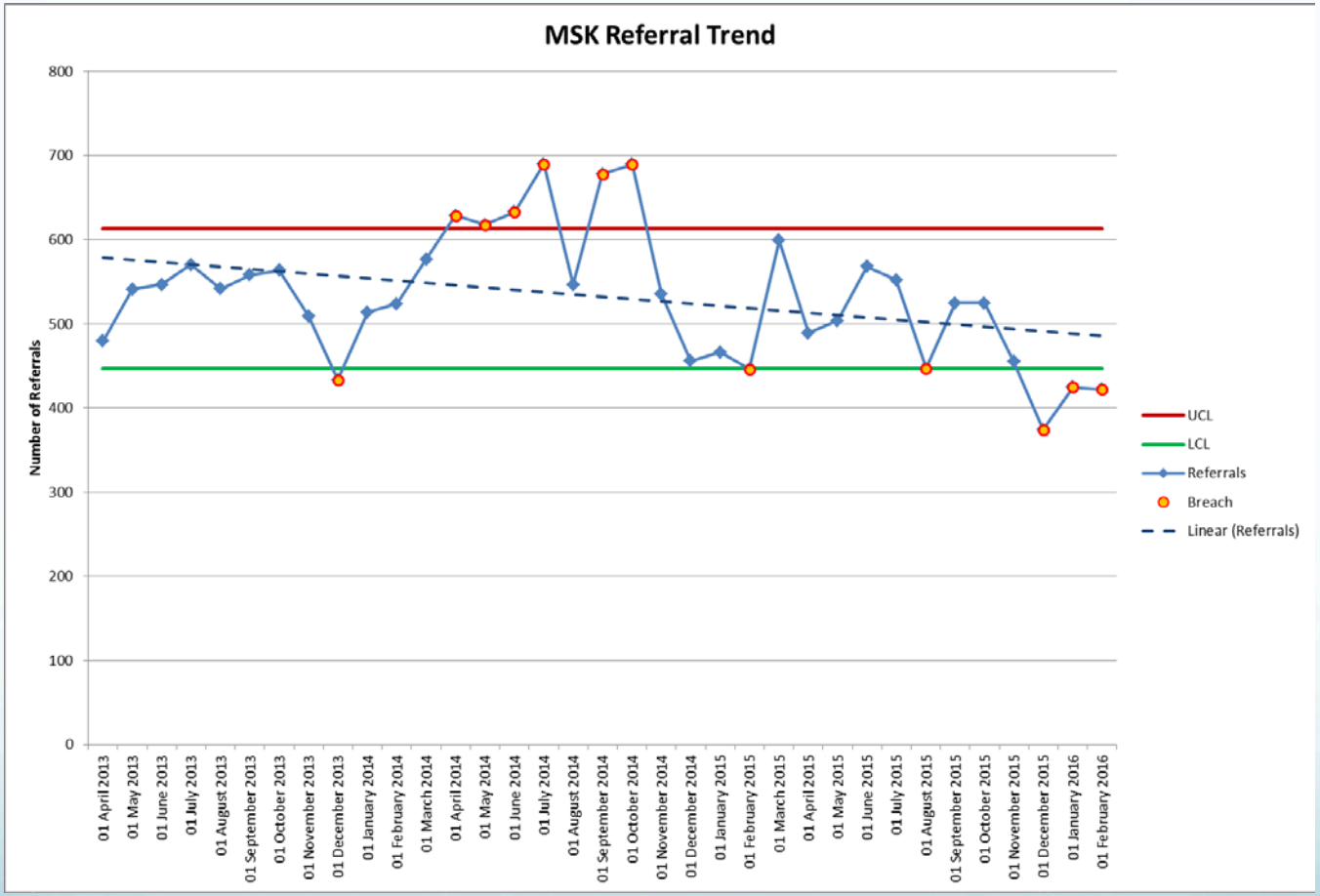
This has had the impact of reducing referrals to EKHUFT by 21.9% from 2014/15 to 2015/16 and by 33% from the peak referral period of April-November 2014.

Referral levels are now less than 2012/13 which is a considerable achievement particularly that Triage has addressed the normal growth in referrals year on year associated with population growth.

£900k of the targeted £1.4m savings was achieved. Although the project did not achieve its full savings target, the financial impact on the CCG would have been significant if the level of referrals had not been addressed alongside extended waiting times, a higher level of breaches of RTT targets and higher numbers on the waiting list.

It is recommended that MSK Triage is continued and becomes business as usual by the CCGs own Post implementation review

MSK Continued



Learning from MSK Triage Pilot

- Joined up working with CCG/EKHUFT has released savings in first 12 months of pilot
- Patients are being seen quicker and closer to home
- Surgeons only consult with surgical cases. De-pressurised hospital outpatients for the benefit of all East Kent residents.
- GP referrers have peer to peer education and feedback
- Increased trust and collaboration between practices.
- Increased confidence for commissioners to think “outside the box” by utilising local skills and expertise.

Achievements so Far-TeleDerm

- In conjunction with the CCG, role out of Dermatology Triage and consultant led clinics incorporating GPSI and Telederm;

- 6 practices currently. CCG anxious to roll this out to all practices.

- Novel arrangement in that the savings are shared between provider and commissioner.

What next?

- Build on the success on GPSI led Referral triage and expand to Cardiology, ENT, Urology etc.
- Consultant led and delivered outpatient slots for those deemed by triage to need surgical treatment to allow direct listing at a surgical provider.
- In partnership with the CCG further develop the rural hub model of weekend working.
- Integration of the Community Teams into primary care with the help of the CCG/KCHFT.
- Pursue the Multispecialty Community Provider model through a joint venture with KCHFT.
- Work with the CCG to **boost investment into GMS/PMS Plus**, premises, workforce development and retention and integrated IT.

Stabilising Primary care

- Historic variation in funding and contracts.
- CCG and Federation commitment to support practices by “levelling up” those with access to fewer funding streams.
- Support those on APMS to secure longer term GMS contracts.
- Support those on GMS to increase funding for enhanced Access/Quality/Scope of services by commissioning GMS+
- Support those on PMS who have developed GP+ services to retain funding for these whilst the CCG/Federation work up GMS+

GP + as a means of enhancing the Primary Care offer- What one local practice did….

- Employed Community Practitioner/Matron for complex care co-ordination and navigation, virtual ward, End of Life and 1st response
- Urgent Telephone Access service using senior GPs and Matron. Allowed increased access without compromising continuity of care and facilitated longer face to face GP apopointments as appropriate.
- Complex Diabetes Care with GPSi and PNSi
- So what were the Results….

Why greater and sustained investment in front line primary care might be the solution?

- Size doesn't matter (that much)!
- Adequate staffing and appropriate Skill mix and IT utilisation DOES!
- Results in Lowest activity and costs in all unscheduled health and social care sectors (in all of East Kent).
- Conclusion is that; Investment in high quality frontline primary care staff and systems actually cools down activity in other more expensive sectors and streamlines the patient journey.
- For every single patient an additional £30/year spent in Primary Care can release £60 in Non-elective and £150 in total costs elsewhere.

Deliverables 2017

- More timely access to health and social care needs through service redesign including:-
- Weekend/evening GP access in all 3 Ashford Hubs.
- IT integration (EMIS Web with MIG)
- Ever expanding GPSi and consultant delivered local patient triage, assessment and treatment services
- Relocation of care/community teams (mental health, health visitor, midwife, social worker, district and community nurses etc).
- Acute care collaboration between ACP and EKHUFT.
- Formation of GP Federation led MCP shadow board as a joint venture with KCHFT involving all local stakeholders.
- .

Risks and potential “blocks.”

- 1) Lack of grassroots GP involvement and approval of Strategic Transformation Plans.
- 2) Over representation of larger providers to the detriment of local GPs (see above)
- 3) “Transformation” is not a substitute for adequate funding –“false economies of scale”.
- 4) Risk averse commissioning. Failure to pump prime, use” preferred provider” procurement to boost Primary care workforce and skill mix (to include consultants).

Resource Implications

- Both Human and Financial!
- Need to boost;
- Primary care workforce and skill mix (to include consultants).
- Federation/MCP management and business development expertise.
- Will require local commissioners to make brave decisions to stabilise, enhance and energise a Primary care led Local Health and Social Care Service designed around and involving the residents of Ashford.

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Presentation to the Ashford Health and Well Being Board – Per capita cost analysis using the Kent Integrated Dataset.

20 July 2016

Gerrard Abi-Aad, Head of Health Intelligence, Kent County Council and Dr James Kelly, Kingsnorth Medical Centre

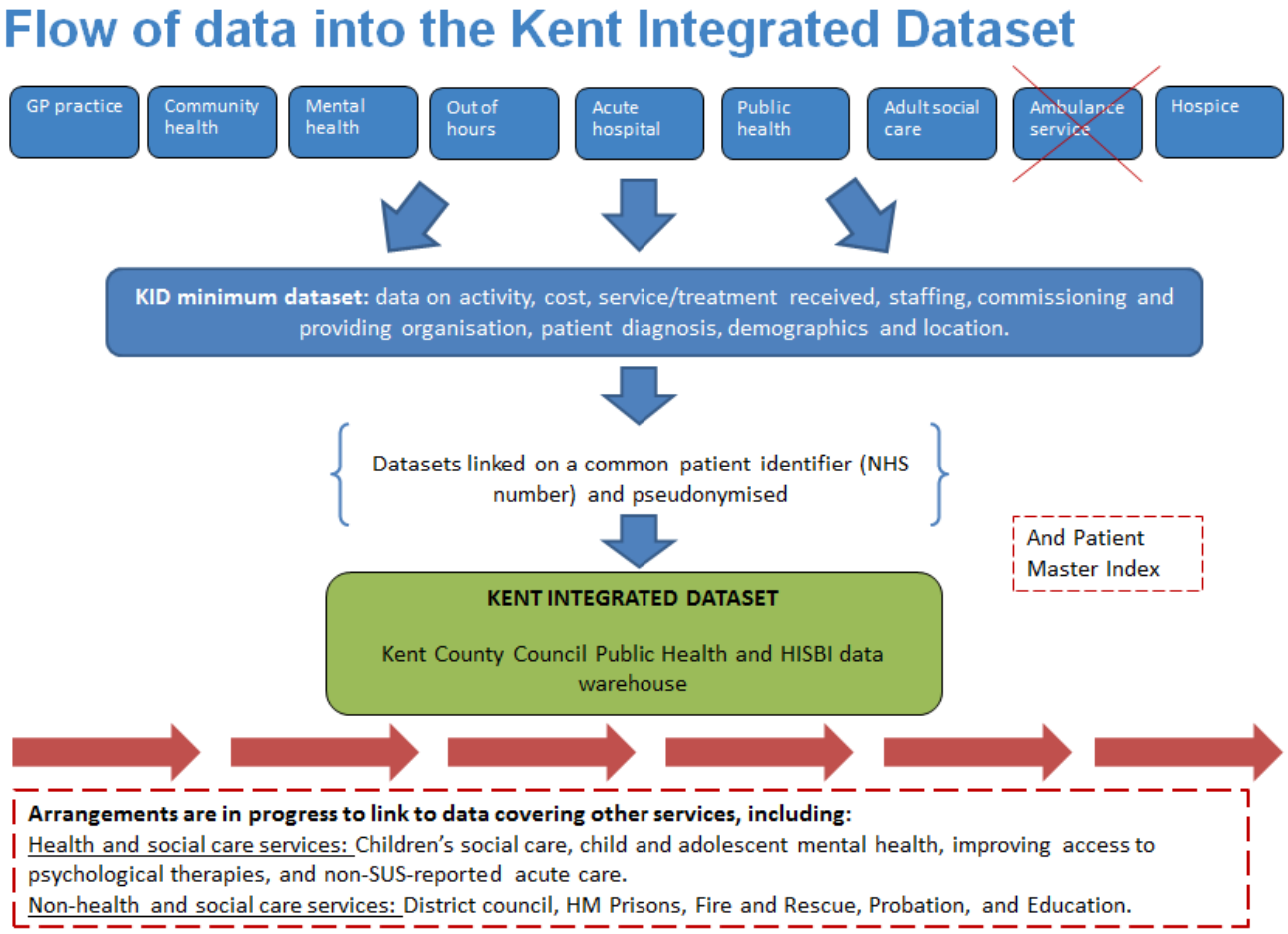
Version: 01
Last updated: March 2016

Introduction

- Null hypothesis:

'Hot primary care confers no cost containment with regard to summed per capita costs associated with ASC, Community care, in-patient elective/non elective care, Outpatient and A&E attendances and OoH care'.

Data flows


Flow of data into the Kent Integrated Dataset
GP practice
Community health
Mental health
Out of hours
Acute hospital
Public health
Adult social care
Ambulance service
Hospice
KID minimum dataset: data on activity, cost, service/treatment received, staffing, commissioning and providing organisation, patient diagnosis, demographics and location.
Datasets linked on a common patient identifier (NHS number) and pseudonymised
And Patient Master Index
KENT INTEGRATED DATASET
Kent County Council Public Health and HISBI data warehouse
Arrangements are in progress to link to data covering other services, including:
Health and social care services: Children's social care, child and adolescent mental health, improving access to psychological therapies, and non-SUS-reported acute care.
Non-health and social care services: District council, HM Prisons, Fire and Rescue, Probation, and Education.

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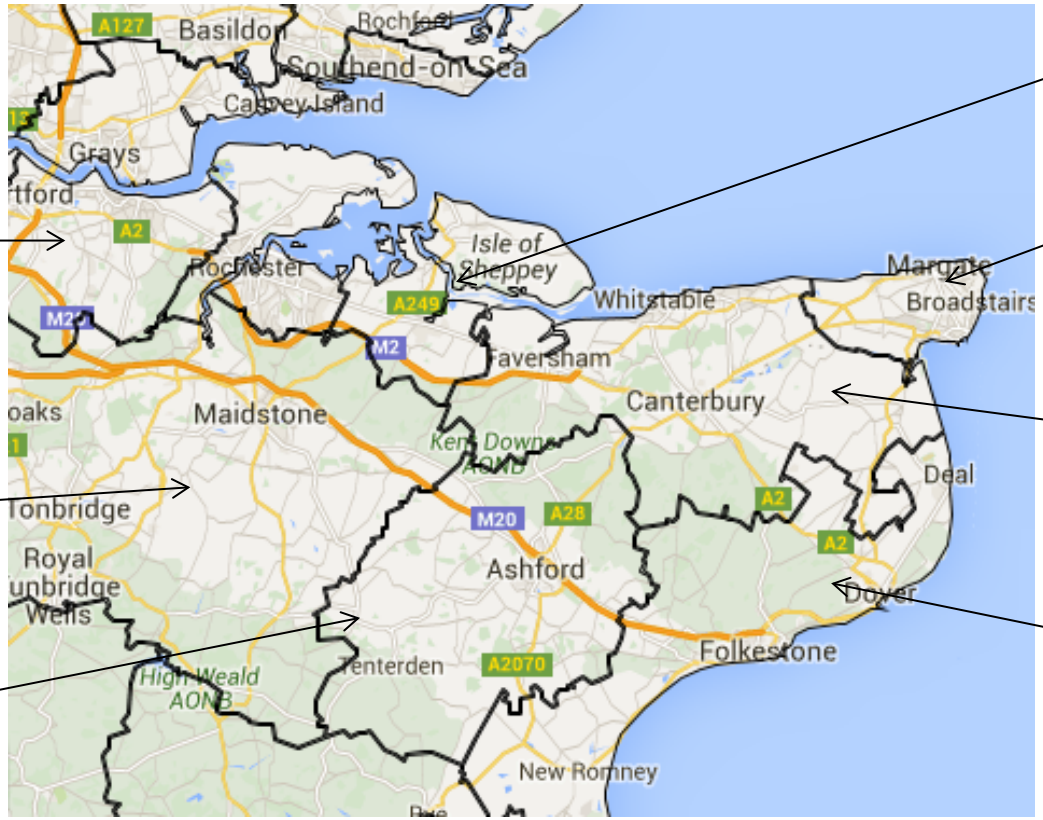
Current practice sign-up rate: 67%



33 of 34 flowing

36 of 61 flowing

10 of 14 flowing

15 of 19 flowing

15 of 17 flowing

19 of 21 flowing

22 of 30 flowing

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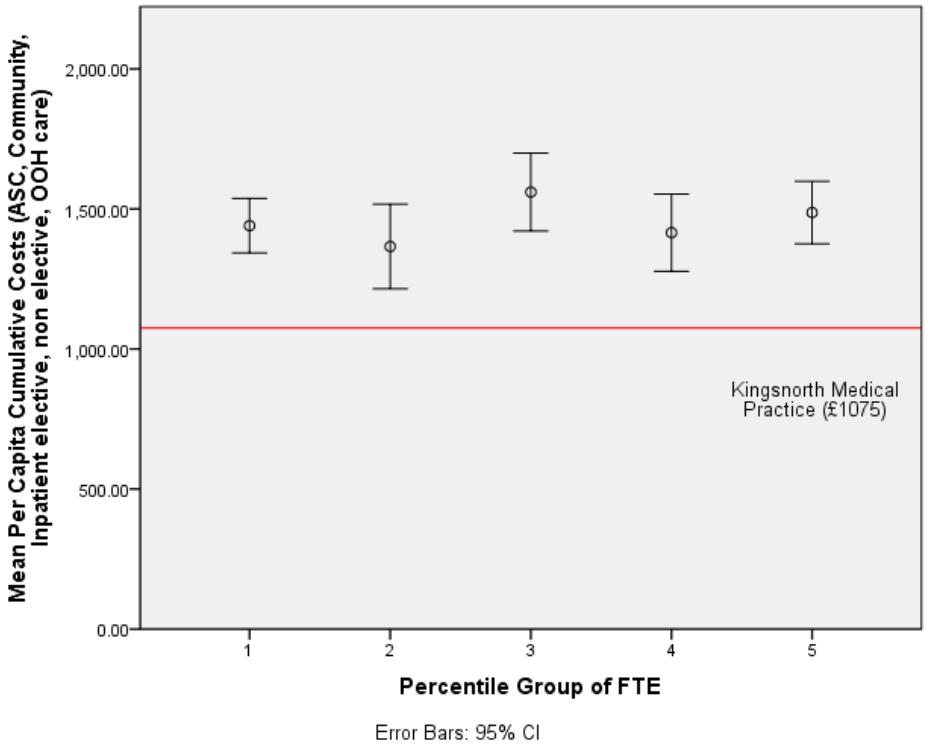
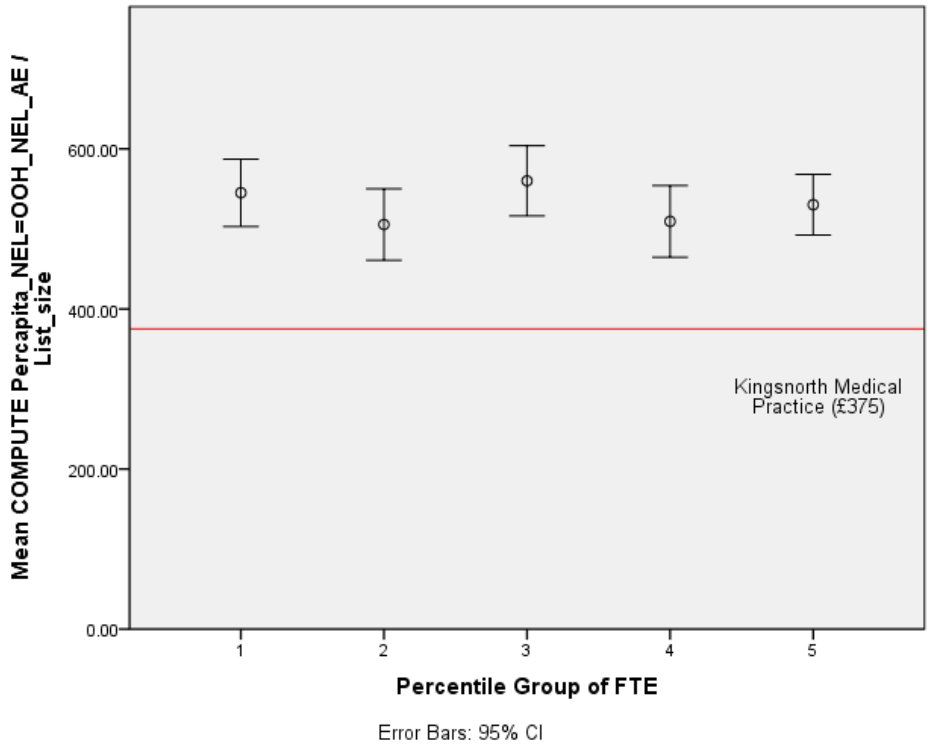
Costs vs Quintile of FTE





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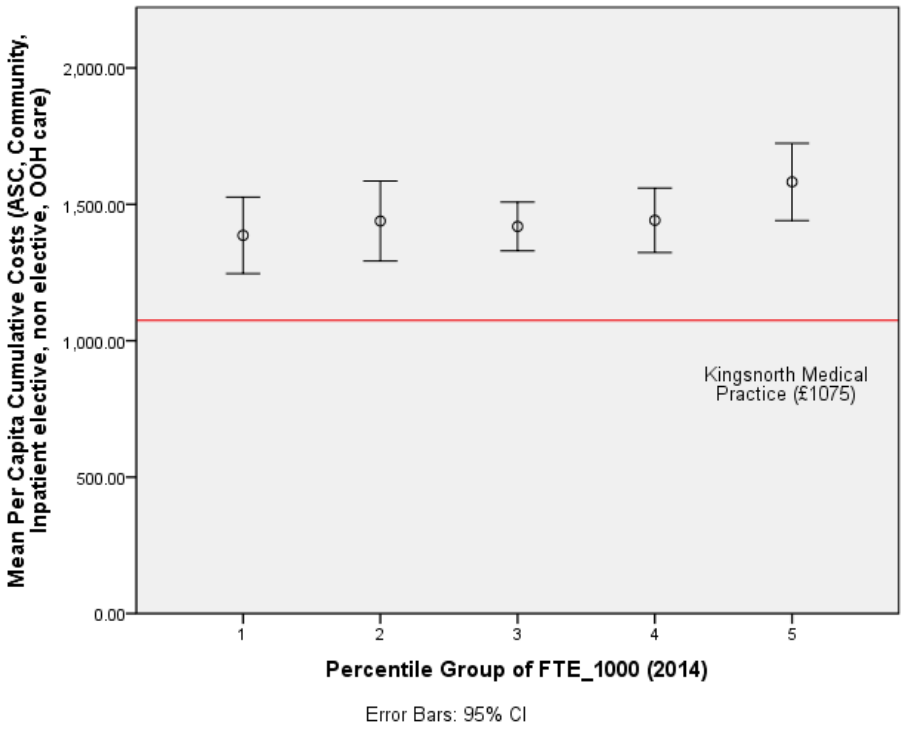
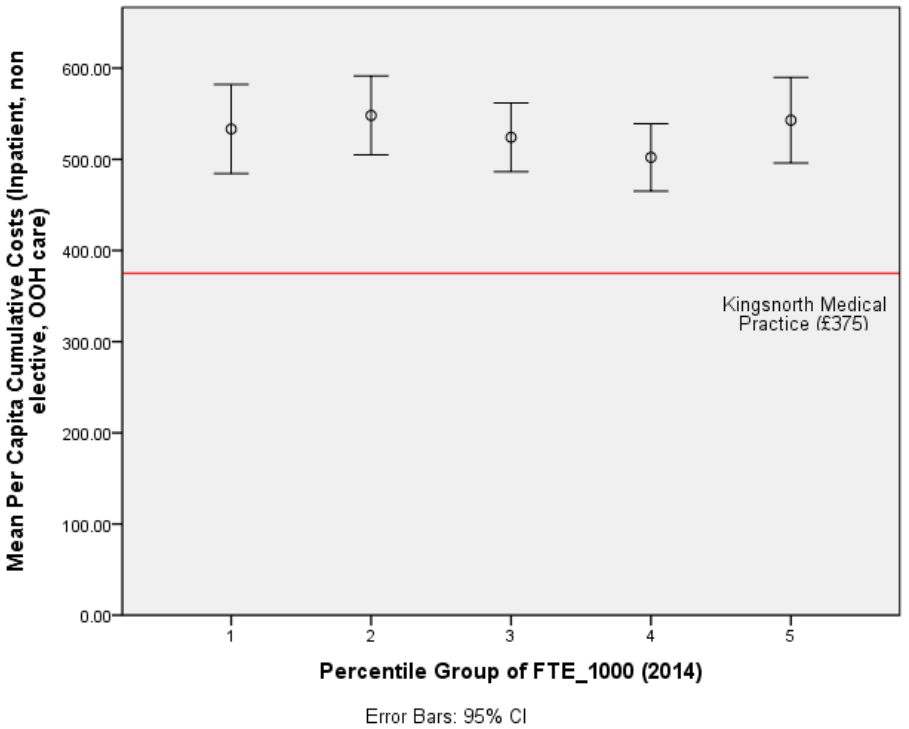
Costs vs Quintile of FTE_1000





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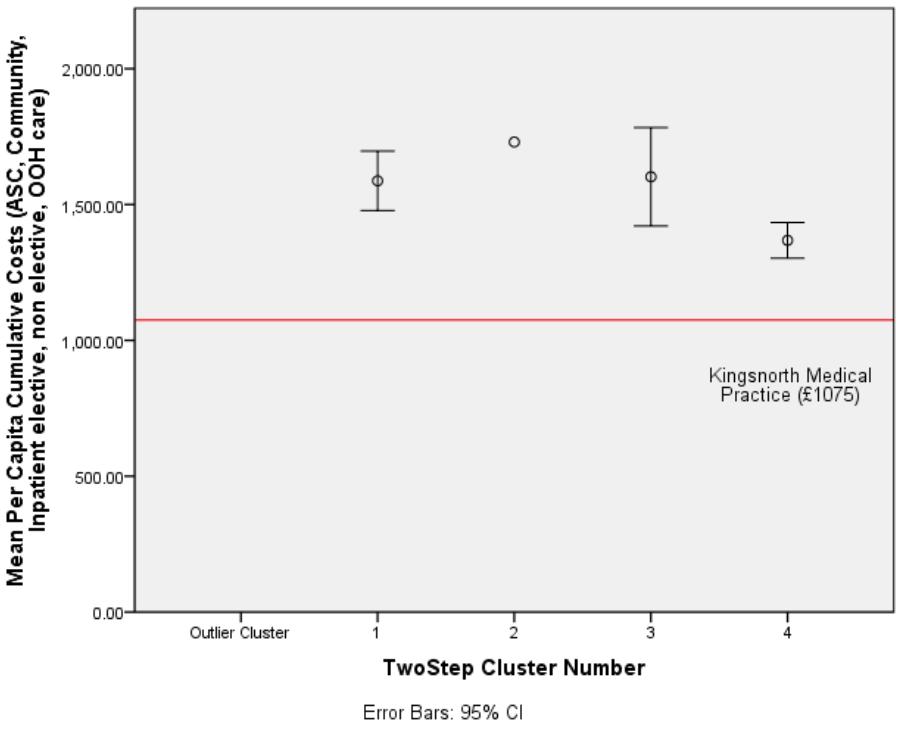
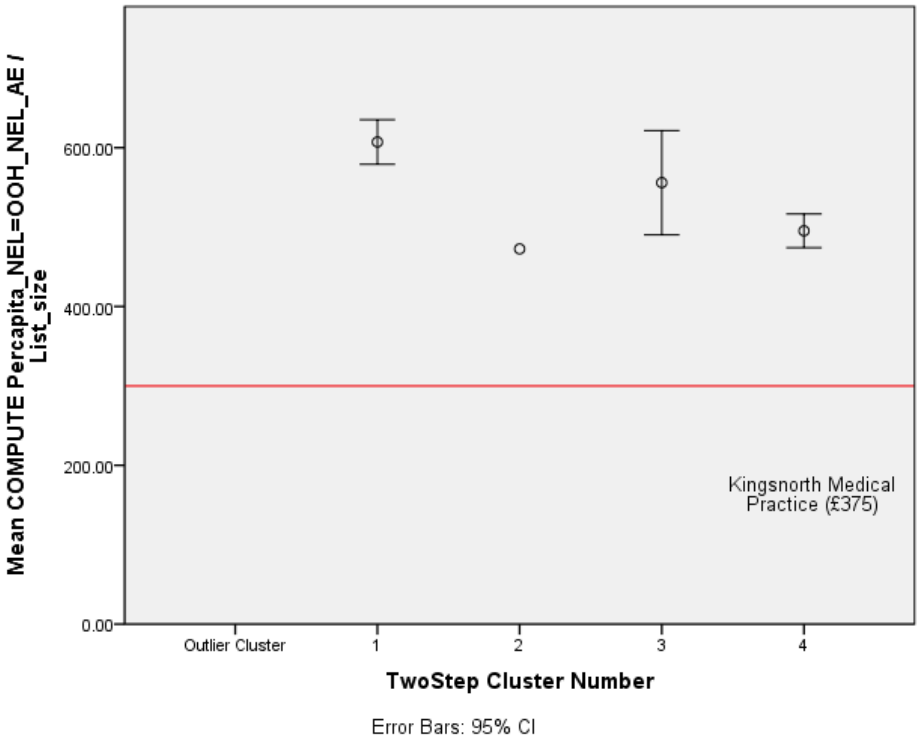
Costs vs statistical cluster (FTE_1000 & IMD_2015)





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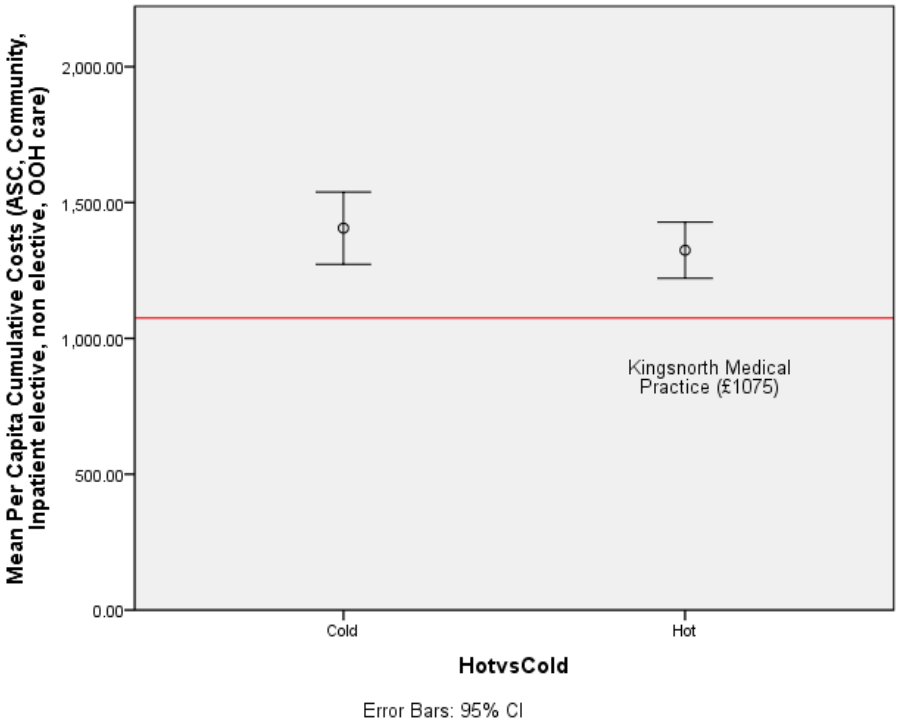
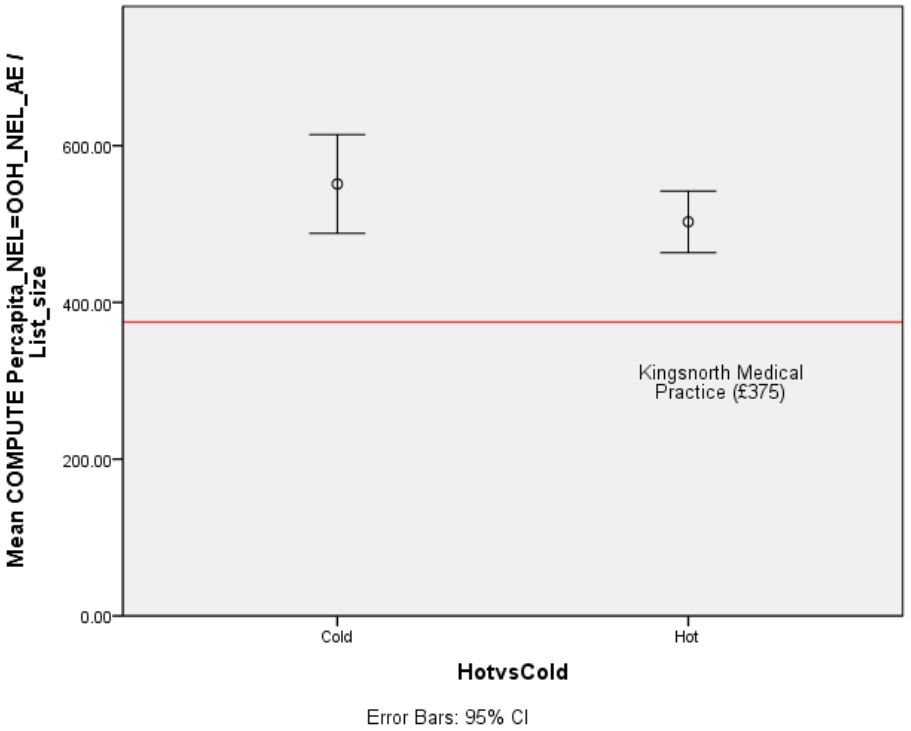
‘Hot’ vs ‘Cold’(SAR/100,000, Q1 vs Q5)





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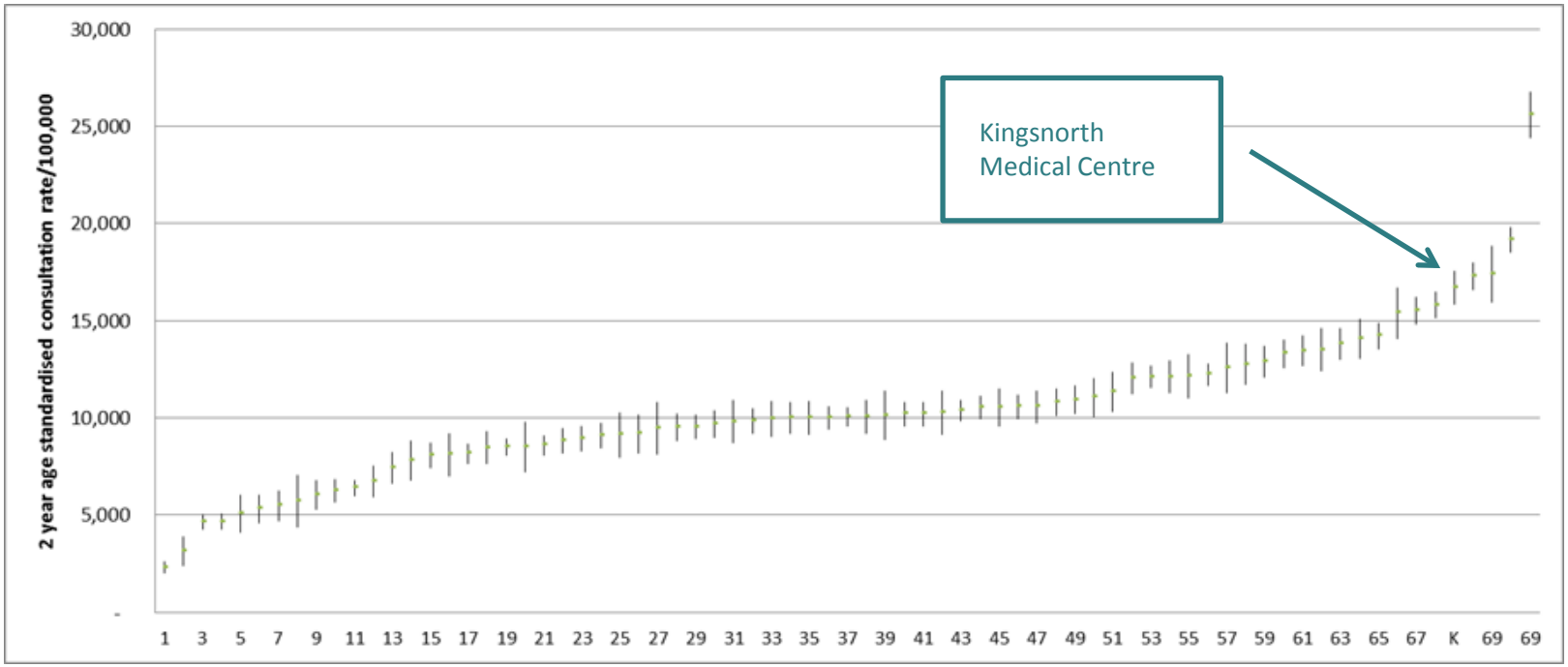
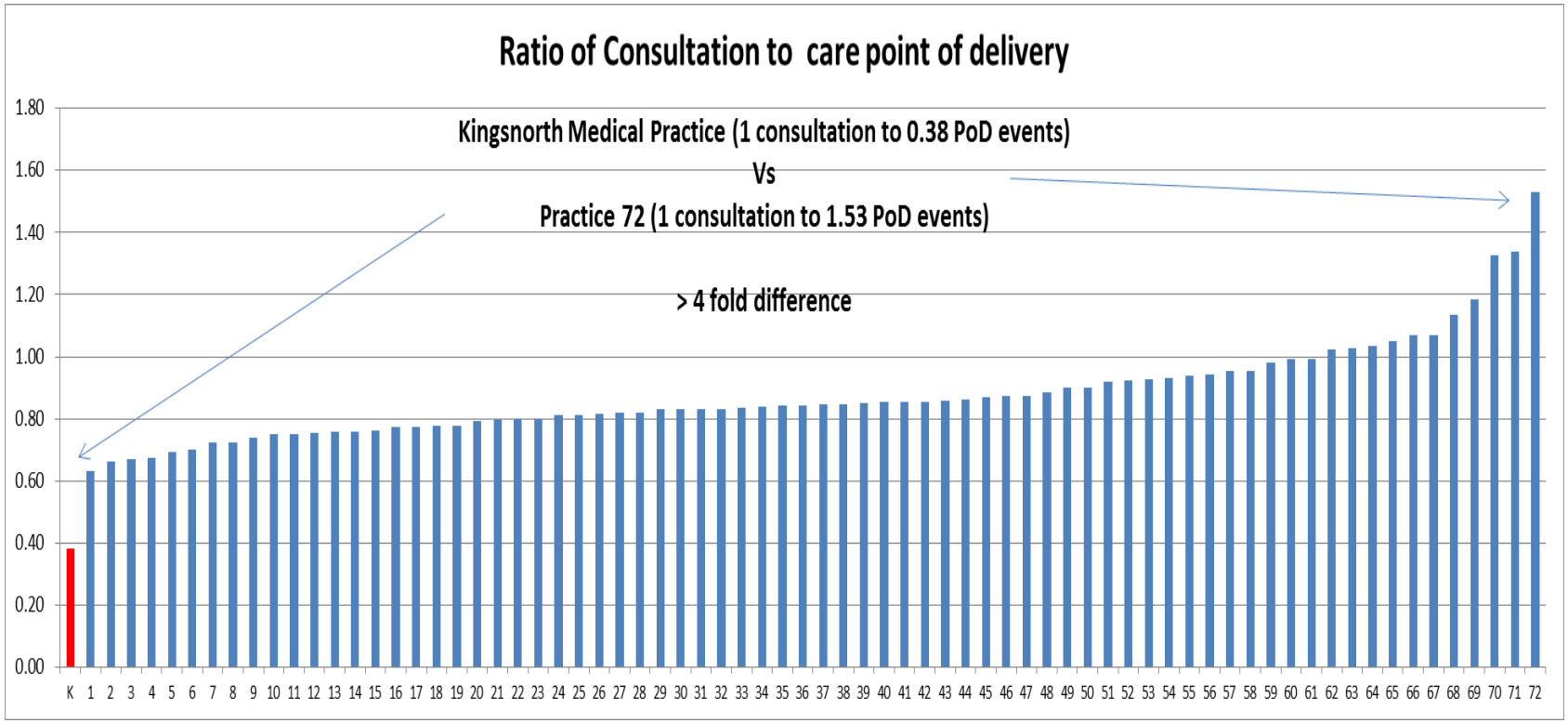
Distribution of consultations/100,000



KENT PUBLIC HEALTH OBSERVATORY

Distribution of SAR/100,000



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Ashford CCG

Practice	Practice	CCG	List_size	Percapita	Percapita_NEL
G82730	**Kingsnorth Medical Practice**	**Ashford CCG**	**11,188**	**£ 1,075**	**£ 375**
G82688	Singleton Surgery	Ashford CCG	3,809	£ 1,060	£ 410
G82712	Singleton Medical Centre	Ashford CCG	3,086	£ 996	£ 410
G82186	Hamstreet Surgery	Ashford CCG	6,843	£ 1,457	£ 428
G82658	Sellindge Surgery	Ashford CCG	4,714	£ 1,736	£ 448
G82142	Wye Surgery	Ashford CCG	8,341	£ 1,182	£ 450
G82094	The Charing Surgery	Ashford CCG	8,823	£ 1,488	£ 453
G82114	Ivy Court Surgery	Ashford CCG	14,463	£ 1,451	£ 466
G82053	Woodchurch Surgery	Ashford CCG	3,563	£ 1,730	£ 473
G82080	The Willesborough Health Centre	Ashford CCG	13,107	£ 1,536	£ 492
G82050	Sydenham House Medical Centre	Ashford CCG	20,247	£ 1,610	£ 512
G82735	South Ashford Medics - St Stephens	Ashford CCG	8,427	£ 1,347	£ 517
G82087	New Hayesbank Surgery	Ashford CCG	16,685	£ 1,547	£ 519
G82049	Hollington Surgery	Ashford CCG	3,394	£ 1,454	£ 530

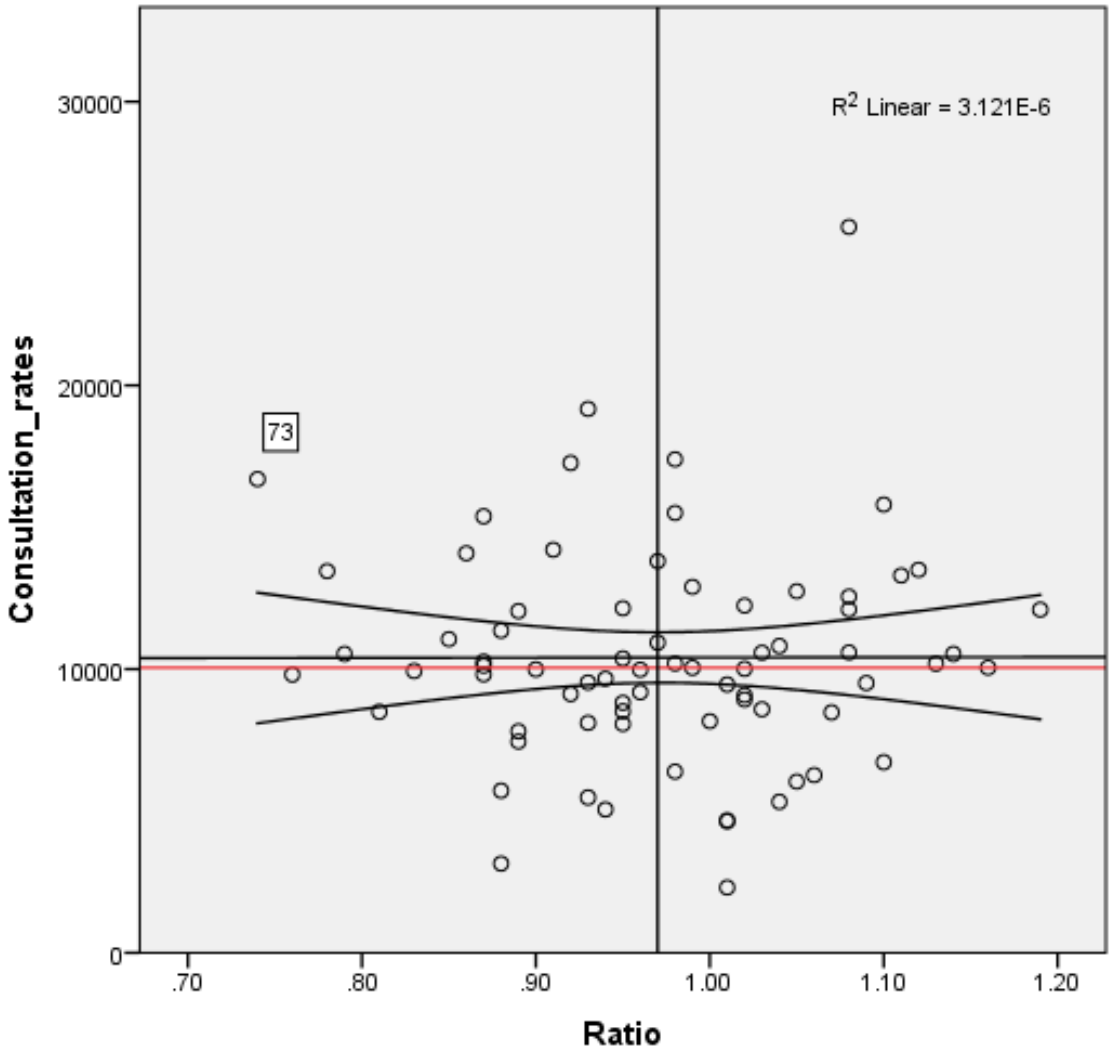
Potential per capita savings

	Statistical Cluster	5% Trimmed mean (All). Per capita costs	5% Trimmed mean (NEL). Per capita costs
a	TC_1	£1554	£607
b	TC_3	£1600	£554
c	TC_4	£1363	496
d	Kingsnorth Medical Centre	£1075 (actual per capita cost)	£375 (actual per capita cost)

Average per capita savings	£ (all)	£ (NEL)
(a-c)	£191	£111
(b-c)	£237	£58
(a-d)	£479	£232
(b-d)	£525	£179

KENT PUBLIC HEALTH OBSERVATORY

Does the weighted formula adequately account for need?



Findings

1. Practice size does not discriminate for cost efficiency.
2. Also, when practice costs were compared using FTE_1000 population ratio clusters, per capita costs gradients were accentuated with better resourced practices generating higher mean per capita costs
3. Significant differences were observed between statistical cluster groups 1 and 4, with cluster 4 having a significantly lower mean per capita total and non-elective cumulative cost per patient.
4. Kingsnorth Medical Centre (KMC) is a statistical outlier at the low end of the cluster distribution (i.e. beyond the 95% lcl)
5. Despite the fact that there are highly significant variations in consultation intensity, for the majority of practices included in the analysis, there were no significant differences in cost per capita between 'hot' and 'cold' practices (notable exception was KMC)
6. If the cost efficiencies observed in the KMC are attributable to the configuration of the practice (running 'hot' with notable nuances in the way business is done) – potential cost savings are likely to be highly significant if the KMC operating model were rolled out across the CCG

Next steps

1. Matched cohort linked person level analysis to ascertain true differences – for example between Kingsnorth configuration and other configuration types
2. Compare ‘appropriateness’ of fit of the Carr-Hill weighted practice populations?