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Formerly;

GP in Castlefields, Runcorn for 36 years,

National Clinical Director of Primary, Dept of Health England 2001- 10,

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Originator of the Primary Care Home and NAPC adviser

ECC the way forward. Congratulations Ireland

Sláintecare ‘to shift care to the left’

- Establishing a universal, single-tier health service
- Reorienting of the health system “towards integrated primary and community care, consistent with the highest quality of patient safety in as short a time-frame as possible”
- The ECC Programme’s objective is to deliver increased levels of healthcare with **service delivery reoriented towards general practice, primary care and community-based services**
- Fundamentally the ambition for this programme is to bring care closer to home
- Provide services on a **population** basis following assessment to those that need it, in a timely manner and local to where they live.

Primary Care

- Recognition of the importance of primary care to health services systems. WHO, 1978 and 2003
- If general practice fails, the whole NHS fails'-BMJ leader
- "The well known but underappreciated secret of the value of primary care is its person and population, rather than disease focus" (Starfield)
- "The soul of a proper, community orientated, health-preserving care system." (Berwick*)*

Primary Care Opportunity

Countries with strong primary care:

- Have lower overall costs
- Generally have healthier populations

Within countries:

- Areas with higher primary care physician availability (but not specialist availability) have healthier populations
- More primary care physician availability reduces the adverse effects of social inequality (Barbara Starfield)

Watershed UK GP policy developments 1966-2019 that shaped my thinking but, initially, not many others

- GP Contract 1966
- GP Contract 1990
- NHS Reforms 1991
- GP Contract 2004
- Primary Care Networks 2019

My Journey

- GP from 1971
- Influences to go beyond reactive care-RCGP, Hart, Marsh, Ashton.
- Became a local authority councillor(1979-1990)
- Fundholding 1991
- Primary care ‘czar’ 2001
- Primary Care Home 2009

Primary Care Home
Big is not beautiful

- 'The Primary Care Home' (PCH) is a population community based provider preferably budgeted
- A home not only for general medical practitioners and their teams but for all primary care independent contractors (Pharmacists, Dentists, Optometrists) and their staff, community health services and social care professionals. And potentially a home for many currently working in hospitals
- Policy created uniquely from the 'bottom up'.

PCHs have seen:

- The model is energising and empowering staff, delivering benefits for patients and the wider health system
- A rise in staff satisfaction and retention
- Reduced prescribing costs
- Patients have experienced a drop in average waiting time to see their GPs and reduced stays in hospital
- System benefits include reductions in A&E attendances, emergency admissions and GP referrals to hospital.

Insights from the spread of the primary care home
The King's Fund 2019

- Our work shows that a dual focus is needed. It is essential to address these barriers, as well as support enablers, in order to deliver meaningful change
- The right type of leadership we know is critical - we are supporting PCNs with this approach through our own team-based leadership programme
- 'The report also highlights the importance of building system-wide relationships to improve population health – we know investment in relationships will determine the speed of a primary care network's progress – and the need to support and encourage colleagues to stay focussed and persevere amid all the current pressures and challenges we face on a daily basis'
- The report recommends the insight from the PCH programme is used to support local efforts to spread primary care transformation efforts further into and across their health and care economy and to articulate the primary care contribution to improving population health.

PCH to PCN

- As an example of a PCN, what does the PCH model offer? The primary care home is based on four characteristics, it's these key elements embedded in the model that are driving change:
  - an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care
  - a combined focus on personalisation of care with improvements in population health outcomes
  - aligned clinical and financial drivers
  - provision of care to a defined, registered population of between 30,000 and 50,000.
- The PCH's growing community of practice comprises 216 sites (as of 2 August 2018) - providing a unique opportunity to support general practice, localities, STPs and ICSs to achieve rapid local transformation to improve the care for their population. PCH impact Initial analysis has shown that the primary care home model can drive positive change in a relatively short period of time.

A Triple aim for primary care

- To level up quality and increase the range and scope of primary and community service provision.
- To significantly contribute to reshaping hospital services which acute providers and commissioners have failed to do.
- To have a central role in health and wellbeing beyond healthcare by developing a public health for primary care.
- It has been done in Israel already including resource shift and thus a huge opportunity for General Practice and ECC

Some evidence on effective health systems reform

Pieter Degeling, formerly

Professor of Health Management at the University of Durham and Visiting Professor in Health Policy and Management at the University of Technology, Sydney

The evidence shows that:

- the effectiveness of efforts on service improvement depends on a coordinated set of strategies that at one and the same time operate at three levels
  - at the level of care provision;
  - at the level at which care provision is managed;
  - at the level of funding and system's wide regulation

The Future Challenges

- Centrality of community based services as an alternative to hospital centricity
- "The hospital is dead, long live the hospital”
- The continuing development of ‘integrated care systems’
- The public’s health with key Local Authority role
- Accountability to public and individual patients
- Underpinned by a new approach to governance.

Primary Care

Chambers and Colin-Thomé

Doctors Managing in Primary Care. Journal of Management and Marketing in Health Care 2009

1. First point of contact care
2. Continuous person and family focussed care
3. Care for all common health needs
4. Pro-active management of chronic disease
5. Referral and coordination of specialist care
6. Care of the health of the population as well as the individual.

Primary Care KPMG & Nuffield Design Principles

- The following present a suggested set of design principles for primary care. They will need to be adapted to local contexts and take into account the wide variety of different approaches found across Europe. At their heart, however, there is a key idea that patients have a professional who can work with them over time to manage and improve their health and that there is more standardisation in the approach taken.
- Our case studies, and conference findings suggest that primary care systems will need to:
  - Be larger
  - Have access to a wider range of professionals as part of the team or working alongside them
  - Offer a better organised out of hours service
  - Provide better continuity to those patients that need it most. Models that follow this logic will be better placed to go beyond traditional primary care and develop more ‘integrated care’. This creates the opportunity for them to take on risk sharing and capitation budgets – as outlined in the journey to accountable care organizations envisaged in the US.

“The hospital is dead, long live the hospital”

- Much of what is done in hospitals does not need to be hospital based
- Outpatient care a relic of 19th century medicine
- Unwarranted variation in admission rates, length of stay and discharge. Readmission closely related to an poor discharge process
- Such variation and prolonged trolley waits more common in care of the elderly especially for those that are frail
- Extended primary care provision can revolutionise hospital usage. Commissioners can focus on financial flows not contracting.

The Public's Health

- Healthcare the least influential but important with a good evidence base- Vaccination & Immunisation, Children eg. Family Nurse Partnership and Sure Start, Screening. Systematic evidence smoking cessation. CDM co-morbidity. MECC. Distribution of PC services. Protection from unnecessary interventions- of low value and by utilising patient decision aids

- Local Authority Services in particularly education

- More fundamentally building on the Marmot Review, Place Based Approaches to improve community capital and reduce social isolation across the social gradient.

Chronic Disease Management

As a starting point for action and where a population and individual care both clearly conflate and as a national priority is in better support and care for those with chronic diseases. Conditions that have a major impact on health inequalities. To achieve a more holistic approach to prevention (and indeed early diagnosis) involvement of local authorities, community based organisations and local leaders is essential.

Patients as citizens and customers

No longer the grateful supplicant

- Choice in access to services and of responsive services
- The clinical consultation - the meeting of two experts
- Public health aspect of the individual consultation
- Commissioning for the individual patient
- Personal budgets
- New forms of accountability to the patient
- For whom is integration?

Governance

- A sound governance of which devolution and trusting relationships are key principles - in contrast to the compliance focused traditional hierarchical governance approach. A useful mantra is, “We need relationships underpinned by contracts, not relationships defined by contracts”.
- Essential governance prerequisites are the acceptance of subsidiarity, two-way accountability between organisations and at least the partial devolution of budgetary responsibility.
- All well managed organisations set their own accountable targets
- All agencies involved are focused on the population to be served – not the agencies wellbeing
- People in one organisation are concerned about possible adverse effects of decisions on others and seek to mitigate them.
- To be ‘small and big’
- Population and individual focus

The New Normal – going beyond the past

- Healthcare where a generalist service with personal continuity of care, population responsibility , connected to its local communities offers far more than a specialist partialist service

- New kind of leaders who can handle the inherent dichotomies and uncertainties of all health care system.-

  - **Patients as customers as well as citizens**
  - **Population Health and personal care**
  - **Big and strategically important and yet small and local**
  - **I repeat, for whom is integration?**

- Primary and Community Services leadership- of the NHS leading to increased influence, leverage and more resources