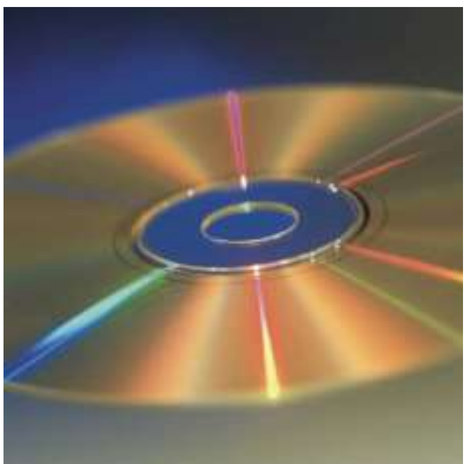
Centre for Health Services Studies

What is needed to scale up innovations in primary health care across Canada: looking at the UK experience

Professor Stephen Peckham



1st
Place

The UK NHS

- UK is a tax funded public health system
- Separate NHS for England, Northern Ireland, Scotland and Wales
- Private finance is limited
- Functions through a universal gate keeper system from primary to secondary care
- Decentralised delivery system but strong central political and regulatory control
- Trying to shift from health care to public health (prevention) focused approach
- Introducing pluralistic provision and expand patient choice
- Needs to re-orientate to supporting people with LTCs/chronic health problems

The traditional general practitioner

- The lone GP
- The GP in partnerships and teams
- Professionalisation
- Changing context of autonomy, accountability and control
- The GP as employee
- Feminisation of practice
- More flexible practice patterns

The GP and the practice – the need for an organisational perspective

- General practice as a small business
- General practice as employer – practice nurses and administrative staff
  - Increasing numbers and wider range of staff Increasing size of practices
- More complex and detailed administration and need for management
- Corporatisation and general practice (178 APMS contracts)
- Introduction in 2004 of a flexible organisational contract
  - Quality and Outcomes Framework
  - DES and LES
- The inter-relationship between commissioning and practice contracts

Increasing organisational complexity

- About 9,800 practices in the UK
  - Trend towards larger practices - average 6,100 – 9,200 patients
- In England the 7,964 practices employ:
  - 42,000 GPs (35,000 FT equivalent)
  - 23,100 practice nurses (15,700 FT equivalent)
  - 94,000 admin staff
  - 15,000 others involved in direct patient care
- Increasing numbers of people rely on general practice support:
  - 350 million patient consultations per annum
  - Increase in numbers of people with long term chronic conditions
  - Increasing number of patients with co-morbidities
  - Increase in prescribing – 587m items in 2001 to over 1,000m in 2016

UK approaches to scaling up

- Developments driven by the profession:
  - Increasing use of wider staff mix in practices
  - Forming networks of practices (federations)
  - Merging into larger practices
  - Embracing new models of care
- Developments promoted through government policy:
  - Place primary care more at the centre of the healthcare system
  - Introduce greater opportunities for GPs to influence the system but with increased regulation
  - Push for greater integration of general practice with community health and social care services
- Some similarities between professional and policy responses but not very interlinked or co-ordinated

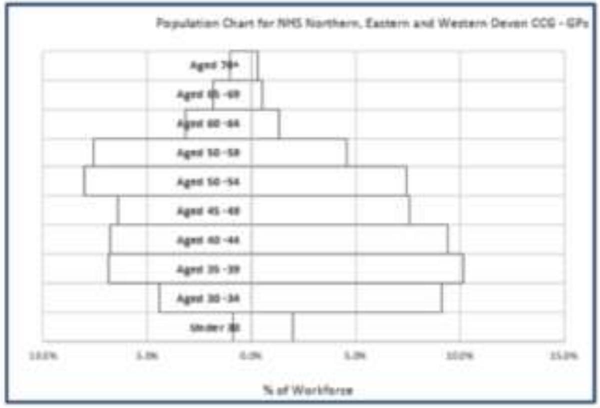
Evolving roles and organisational models

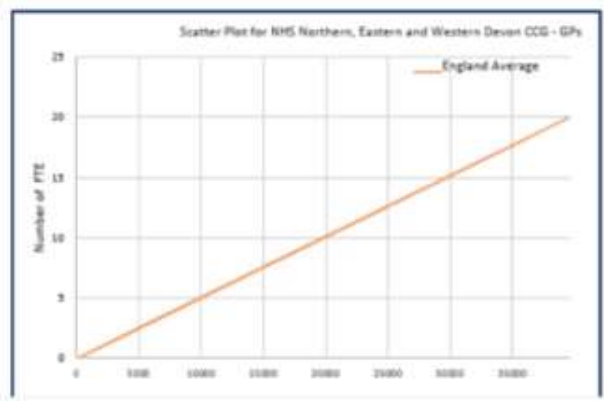
- Policy commitment to develop a primary Care Led NHS – placing primary care at the heart of the system
- Development of management for general practice through commissioning and expansion of monitoring
- Greater performance scrutiny introduced elements of performance-related pay.
- Expanded roles for nurses and other practice staff.
- Encouraging practice networks for co-operation – mainly regarding influencing service design decisions but also opening up practices to peer review or at least peer pressure.
- Emphasis on audit and monitoring of practice
- GP patient survey introduced in 2007 (850,000+ responses)

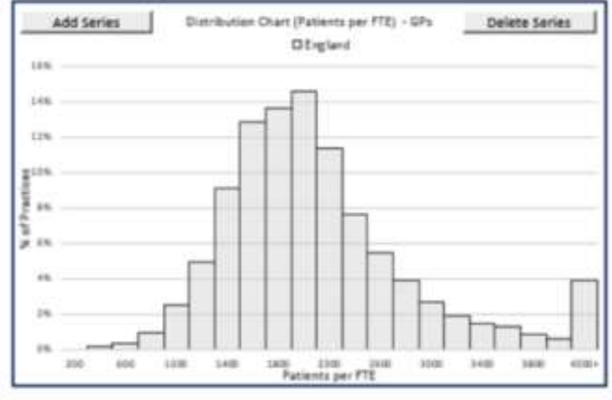
Comparing practices: analysis tools

General Practice
Workforce Analysis Tool

Double click here to email SWAHSN







GP – patient survey data

	New Dover Road Surgery	Add Practice	Add Practice
% of patients who say the last GP they saw or spoke to was good at giving them enough time	93%		
Show breakdown	National average: 87%		
% of patients who say the last GP they saw or spoke to was good at listening to them	97%		
Show breakdown	National average: 89%		
% of patients who say the last GP they saw or spoke to was good at explaining tests and treatments	96%		
Show breakdown	National average: 86%		
% of patients who say the last GP they saw or spoke to was good at involving them in decisions about their care	95%		
Show breakdown	National average: 82%		
% of patients who say the last GP they saw or spoke to was good at treating them with care and concern	96% Local (CCG) average: 87%		
Show breakdown	National average: 85%		
% of patients who had confidence and trust in the last GP they saw or spoke to	98%		
Show breakdown	National average: 95%		

Available genders for this practice
Men
Women

Available age groups for this practice
35 to 44
45 to 54
55 to 64
65 to 74
75 to 84

Available ethnic groups for this practice
White: English / Welsh / Scottish / Northern Irish / British

Available health conditions for this practice
Long-term back problem
Another long-term condition
Arthritis or long-term joint problem
Asthma or long-term chest problem
High blood pressure

Comparing results

	New Dover Road Surgery	Cossington House Surgery	Canterbury Health Centre
% of patients who say the last GP they saw or spoke to was good at giving them enough time	93%	91%	92%
	Local (CCG) average: 90%	Local (CCG) average: 90%	Local (CCG) average: 90%
Show breakdown	National average: 87%	National average: 87%	National average: 87%
% of patients who say the last GP they saw or spoke to was good at listening to them	97%	93%	87%
	Local (CCG) average: 91%	Local (CCG) average: 91%	Local (CCG) average: 91%
Show breakdown	National average: 89%	National average: 89%	National average: 89%
% of patients who say the last GP they saw or spoke to was good at explaining tests and treatments	96%	92%	94%
	Local (CCG) average: 89%	Local (CCG) average: 89%	Local (CCG) average: 89%
Show breakdown	National average: 86%	National average: 86%	National average: 86%
% of patients who say the last GP they saw or spoke to was good at involving them in decisions about their care	95%	88%	88%
	Local (CCG) average: 85%	Local (CCG) average: 85%	Local (CCG) average: 85%
Show breakdown	National average: 82%	National average: 82%	National average: 82%
% of patients who say the last GP they saw or spoke to was good at treating them with care and concern	96%	92%	89%
	Local (CCG) average: 87%	Local (CCG) average: 87%	Local (CCG) average: 87%
Show breakdown	National average: 85%	National average: 85%	National average: 85%
% of patients who had confidence and trust in the last GP they saw or spoke to	98%	96%	98%
	Local (CCG) average: 97%	Local (CCG) average: 97%	Local (CCG) average: 97%
Show breakdown	National average: 95%	National average: 95%	National average: 95%

Widening the scope of practice

- Practice based responses:
  - Share services
  - Practice mergers
  - Federations and networks
  - Polyclinics
  - Corporatisation
  - Integration with community health services
  - Greater skill mix
- Policy driven responses:
  - Urgent access clinics
  - Integrated networks
  - Larger practices with multiple services
  - New workforce roles

Current policy framework

- Five Year Forward View' (5YFV) published October 2014

The future NHS

The Forward View identifies three 'gaps' that must be addressed:

	Gap	Response	Actions
1	Health & wellbeing gap	Radical upgrade in prevention	• Back national action on major health risks • Targeted prevention initiatives e.g. diabetes • Much greater patient control • Harnessing the 'renewable energy' of communities
2	Care & quality gap	New models of care	• Neither 'one size fits all', nor 'thousand flowers' • A menu of care models for local areas to consider • Investment and flexibilities to support implementation of new care models
3	Funding gap	Efficiency & investment	• Implementation of these care models and other actions could deliver significant efficiency gains • However, there remains an additional funding requirement for the next government • And the need for upfront, pump-priming investment

Vanguard sites: New models of care

- New models of care pilot programme – ‘the vanguard’
- First wave of 29 sites announced in March
  - 9 PACS; 14 MCPs; 6 Enhanced health in care homes
- Investment and support began in April
- Movement from ‘aspirant’ to ‘actual’ not guaranteed
- National evaluation
- Benefits and costs known by end of next Parliament
- However many similar unofficial models and practice groupings running in parallel at the same pace

New models of care

- Need to break down divisions between different parts of health service, as well as between NHS and social care
- Provide a flexible framework
- Different frameworks:
    1. Multispecialty community providers (MCPs)
    2. Primary and acute care systems (PACS)
    3. Urgent and emergency care networks
    4. Viable smaller hospitals/acute care collaboration
    5. Specialised care
    6. Modern maternity services
    7. Enhanced health in care homes
- Shift from a focus on provision not commissioning as a lever for change

Horizontal co-ordination/integration

- Horizontal integration - Multispecialty community provider:
  - Groupings of GP practices offering a wide range of care
  - Take on as partners, or employ, wide range of doctors, other clinical staff and social/care professionals
  - Shift outpatient and ambulatory care out of hospital
  - Develop new clinical roles ‘generalists/hospitalists’
- Vertical integration – primary and acute care systems
  - Single organisation providing NHS list-based GP and hospital services, with mental health and community services
  - Reinforce out-of-hospital care – not a ‘feeder’ for hospitals
  - Redefine workforce roles e.g. blend gen. physician with GP
- Both systems have the potential for delegated, capitated budget for registered list of patients, including social care

New workforce roles

- Role substitution
- New primary care roles:
  - Advanced nurse practitioners
  - Physicians assistants
  - Clinical pharmacists
  - Increasing number of para professional roles
- Widening the staff mix:
  - Support workers
  - Linking with community and social care staff
- Developing more flexible professional roles
  - Merging health and social care training
  - Working across acute and community sectors

Salutary lessons

- Pay for performance:
  - Quality and Outcomes framework introduced in 2004
  - Not clear if it improved health outcomes
  - Reduced variation in practice or at least in reporting
  - Probably didn't measure the right things
- Market values:
  - Never really developed a pure market
  - Transaction costs have been high
  - Set up costs are high – especially when you keep reforming the system
- Don't throw the baby out with the bath water
  - Need to retain the essence of primary care

Meso structures are important but accountability is complex

Figure 1: CCG external accountabilities

Managerial accountability, with potential sanctions

Liability to 'give an account' – political accountability

DH Secretary of State

NHS England

Monitor

LA OSC

CCG

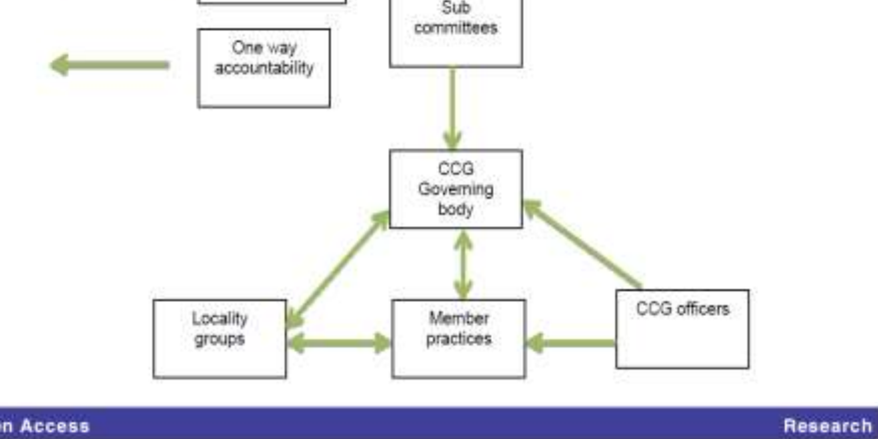
HWB

LMC

The public

Local Healthwatch

Figure 2: CCG internal accountabilities



Open Access Research

BMJ Open **Accountable to whom, for what? An exploration of the early development of Clinical Commissioning Groups in the English NHS**

Kath Checkland,[1] Pauline Allen,[2] Anna Coleman,[1] Julia Segar,[1] Imelda McDermott,[1] Stephen Harrison,[1] Christina Petsoulas,[2] Stephen Peckham[3]

To cite: Checkland K, Allen P, Coleman A, *et al.* Accountable to whom, for what? An exploration of the early development of Clinical Commissioning Groups in the English NHS. *BMJ Open* 2013;3:e003769.

ABSTRACT

Objective: One of the key goals of the current reforms in the English National Health Service (NHS) under the Health and Social Care Act, 2012, is to increase the accountability of those responsible for commissioning care for patients (clinical commissioning groups (CCGs)), while at the same time allowing them a

Strengths and limitations of this study

- The study took place in the early phases of CCG establishment, and therefore provides a snapshot of a developing situation.
- The study included detailed case studies in eight sites across England, and so provides a robust

THUMP THUMP!
IN PRINCIPLE WE'RE HAPPY WITH THE 'TRUST' IDEA...AS LONG AS IT'S PROPERLY MONITORED AND REGULATED!
GP
DOH

Key characteristics for scaling up primary care

1. Better to develop things from the bottom upwards:
   - Develop local networks
   - Adopt a problem solving approach
   - Collectively develop responses
2. Practitioners need to be responsive to peer pressure
3. Policy makers need to establish permissive and supportive systems and frameworks:
   - Flexible structures
   - Establish key governance frameworks
   - Know when to nurture and when to push
4. Practitioners and policy makers need to agree on limits of power and accountability – it will involve a trade-off
5. Both need to recognise they have shared goals

Key lessons from the UK

- Importance of working with primary care professionals – need primary care leaders
- The existence of multiple representative organisations for primary care
- Recognition that top down initiatives are not always successful but sometimes necessary
- Allow different approaches to develop – allow variation
- Need contract flexibility – blended funding but capitation core
- Funding streams need to be aligned at a local level
- Primary care influence can be positive
- You don't need financial incentives for individuals – improving care may be incentive enough

We are dealing with uncertainty

Fallibilism is the doctrine that our knowledge is never absolute but always swims, as it were, in a continuum of uncertainty and of indeterminacy.

(C.S.Pierce)

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