General practice: is it fit for the needs of 21st century patients and populations?

Dr Judith Smith
Director of Policy
The Nuffield Trust, London

13 March 2014
Monash University, Melbourne
Agenda

- The changing scope of primary care
- New forms of general practice provision
- What these seem to tell us
- What remains to be done
The changing scope of primary care
Primary care as first point of access to health services

- First-line clinical care for **undifferentiated health problems**
- Increasing focus on **prevention and screening**
- May be founded on **general practice**, but is more than the work of generalist doctors, and includes other disciplines
- Provided by generalist clinicians, sometimes working as part of a **multi-professional team** (doctors, nurses, pharmacists or other community health workers)
- Is typically a **level of care** between self-care and specialist care
- May be designed around a **registered population**
Primary care manager of population health

- If a practice has say 10,000 patients, what will it know about their health?
- What preventative services might it decide to provide?
- How might it use population health data to plan care?
- Would this lead to a shift in model of care?
- How might this be incentivised?
The scope is widening

- **Traditionally includes:**
  - prevention and health promotion;
  - assessment of undifferentiated symptoms;
  - diagnosis, triage and onward referral;
  - treatment of episodic illness;
  - provision of palliative care.

- **Increasingly likely to involve:**
  - care coordination for people with complex problems;
  - areas of ‘specialist’ care (e.g. endoscopy, minor surgery, diagnostics) enabled by new medical technologies
  - new forms of access such as e-consultations
Multiple drivers of demand for primary care

- Lack of access to social care
- Rising patient expectations
- New providers/supply induced demand
- Ageing populations
- Rising prevalence of chronic disease
- New medical technologies
Primary care that ‘fit for the future’

Attributes
- Comprehensive
- Patient-centred
- Co-ordinated
- Continuous if required
- Accessible
- Safe and High Quality
- Population focused
- Adapted from Agency for Healthcare Research and Quality 2013

Sustainability
- Financial
- Workforce
- Public trust
- Fit with wider health system
The Primary Care Paradox....

‘... a paradoxical situation: the tension between the relative weakness and un-attractiveness of this level of care versus the intention to assign critical strategic functions to it’

From: *Primary Care In The Driver’s Seat?* Saltman, Rico and Boerma (eds) 2005
New forms of general practice provision
• Project that sought to clarify the case for change in primary care in the UK
• To explore different ‘at scale’ models of provision
• To develop criteria to be used to assess new models
• To propose new thinking for the future organisation of primary care
Four main models of primary care assessed

• Super partnership or merged practice
• GP federation or network
• Polyclinic or community health centre
• Regional or local multi-practice organisations
Case study 1 – Vitality Super Partnership, Birmingham

• Super-partnership of over 40 GPs, population of 50,000 patients, and over 170 staff
• Multi-site organisation with common IT, management, HR, finance and strategic planning and development expertise
• Significant redesign of services, contracts with commissioners for specialist, diagnostic & other services
• Aims to improve quality of general practice care, enhance integration with other services, diversify income streams
• New partnership and career structure for GPs, nurses and other staff
Case study 2 – Tower Hamlets, London

- Practice networks each of 5 GP practices (20-25 GP members) and 45,000 patients – set up as a limited liability company
- Initially formed through funder-led initiative to improve diabetes care
- Local contract pays approximately 70% up front and remainder on delivery of outcomes and KPIs
- Contract includes: diabetes; COPD; CVD; early detection of cancer; minor ops; phlebotomy; alcohol screening; drug treatment; palliative care; anticoagulation and healthy lifestyles
- Aims to improve quality of care, ensure clinical governance, draw practices into more collective working
Figure 6: Tower Hamlets primary care network: organisational overview

Clinical commissioning group board

Locality board
(GPs and other representatives from locality commissioning groups, managers, medicines management advisors, CCG officers, professional support and clinical leads)

Locality commissioning group

Primary care provider network*  Primary care provider network*  Primary care provider network*  Primary care provider network*  Primary care provider network*  Primary care provider network*  Primary care provider network*  Primary care provider network*

*Contains member practices
Case study 3: Nairn Healthcare Group, Scotland

- An integrated primary, community health, mental health and social care centre based in a new community hospital
- Covers a population of 14,500 in a rural area
- GPs do their own after-hours, and all emergency calls handled by primary care nurses
- Dates back to total purchasing pilot in the 1990s – strong clinical leadership and vision
- A merged general practice, with a large multidisciplinary team and care network
- Aim to secure a capitated locality budget for primary, community and older people’s care
Case study 4: The Hurley Group, London

- Partnership of 12 practices aiming to provide care for deprived populations in particular
- Corporate-style management structure with CEO and director team – lead salaried GPs located in each practice
- Provide diagnostics, specialist clinics, mental health, minor surgery, addiction and homelessness services
- On-line consultations, prescription requests and health advice
- Diversification of income stream, economies of scale across organisation, focus on quality improvement
An example of the organisational arrangements of a multi-practice organisation, the Hurley Group, is set out in Figure 8.

**Figure 8: The Hurley Group, London: organisational overview**

- **Hurley Group partners**
  - GP partner: Quality and innovation
  - GP partner: Medical director
  - GP partner: CEO and new business
  - GP partner: Operations and urgent care

- **Deputy medical director**

- **Director of operations and organisational development**

- **Regional manager**

- **Lead nurse**

- **Lead GP: Local medical director**

- **Practice operational manager**

- **Practice leadership team (one team per practice)**

- **Nursing team**

- **Salaried GP**

- **Salaried GP**

- **Practice admin and reception team**
Securing the future of general practice report: conclusion

- Status quo is not an option
- Need a mix of support, incentives and contractual levers within a national framework for primary care
- Benefits of ‘at scale’ general practice need to be considered alongside choice (and people like it local) and competition
- New models of provision need full evaluation of outcomes
- GP provider leadership is critical
- Funders and policy makers can set strategic direction but…..
- GP providers need to drive their own business future
What these seem to tell us
Reported benefits of new models of general practice

- Standardised and improved clinical care
- Reduction in hospital care
- Improved career pathways for staff
- Improved recruitment and retention
- Greater ability to bid for new business
- Greater level of local influence
- Efficiencies through new management model
- Renewed ‘energy and motivation’ for clinical leaders
A tough context for change however

- Flat funding for healthcare in England over the coming decade
- Interactions between health and other sectors (e.g. social care having deeper cuts to funding)
- Feminisation of the workforce and increased part-time and salaried working
- Coordination of care increasingly important as more people live with multiple complex conditions
- Much more effective continuity of care required for some people
- Access a core priority for others (and often policy makers)
We propose design principles for primary care

For example, clinical principles:

• Patients see a senior clinician, capable of making good decisions about clinical management, as early as possible

• Patient access to primary care advice and support is underpinned by the latest technology

• Patients have the minimum number of consultations that are necessary

• Patients are offered continuity of relationship where this is important and access at the right time when it is required

• Where possible, people are supported to identify their own goals and manage their condition and care
For example, organisational principles:

- Primary care practitioners have immediate access to common diagnostics, guided by clinical eligibility criteria.
- There is a single electronic patient record that is accessible by relevant organisations and the patient.
- Primary care organisations make information about the quality and outcomes of care publicly available in real-time.
- Primary care has professional and expert management, leadership and organisational support.
What remains to be done
Contracting for such models of primary care

- Likely to need population-based funding approach
- Enable groups of primary care practitioners to take on a collective budget for local health and care (perhaps with others)
- Could be for primary care, long-term conditions, mental health and urgent care
- Needs to have risk-sharing between the providers and funders, depending on services and scale
- Local primary care providers in return should be expected to design services to meet local needs - using design principles
- Need an outcomes-based approach – health, service quality, cost
Essential ingredients for success

• A clear focus on quality and patients
• Strong clinical and managerial leadership
• Investment in professional managerial support – finance, property, planning and investment
• Data-driven decision making
• Good financial management skills – too easy to take on loss-making services
• Transformation of practice ‘operations’
Where next?

• Need a coherent national strategy for primary care – it’s been a long time…

• This needs to be underpinned by aligned primary care contracts that incentivise providers to collaborate

• Need for resource and support for primary care providers to undertake strategic reflection and planning

• Refocus future workforce priorities and training to support integrated community, and social care organisations

• Enable collectives of primary care (and other) providers to take on population-based prime provider contracts