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How do we secure more effective place-based primary care networks for the long-term?

Discussion Paper

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Over the next few weeks many leaders will have the task of reviewing what has happened to health and care services since the coronavirus pandemic, and of proposing ways forward for the future. This paper is addressed to them. It explores why place-based primary care networks are so challenging to sustain, why they are worth it, and what might be needed to secure their further effectiveness in the longer term.

I have argued previously that health, wellbeing and social care partners might do well to use the concept of place-based primary care networks as a building block for effective health and social care in the future and I will use that concept here. A shared approach to primary care in its widest sense (World Health Organisation, 2019) - involving all key partners in a local area, much more wide- ranging than the current UK NHS, GP-focused concept - has long been an aspiration of national policies across the western world, along with a strong desire to deliver more effective and extensive care at home and to reduce demand for complex and expensive acute and substitute care. The Institute of Healthcare Improvement for example, sees these as key elements in securing the Triple Aim (Institute for Healthcare Improvement, undated), used as a guiding development framework by many health care systems:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

Policy across England, Scotland and Wales has focused on promoting greater collaboration and better co-ordination of primary care in recent years and implementation appears to have accelerated during the initial response to the coronavirus pandemic. NHS England for example, has been driving the set-up and advancement of Primary Care Networks and Integrated Care Systems as part of its long-term plan for better quality care. In Scotland the Government has established Health and Social Care Partnerships co-ordinating care for local areas (Scottish Government, 2016). In Wales, Regional Partnership Boards are taking on much of the responsibility for implementing the national plan for more effective integrated health and social care across the country (Welsh Government, 2019). Implementation has not always proceeded as quickly or effectively as desired, but since March 2020, many traditional barriers between local partners have been swept aside. We are yet to understand the medium or long-term impact of this sudden change but there are many examples already of newly integrated services, flexible pathways and different ways of working in response to sudden local critical needs. Many new approaches have been enthusiastically tested or extended from pilots to full implementation across networks, including for example, more flexible referral routes to primary, community and secondary care facilities, new flexible job roles such as Physician Associates and Clinical Pharmacists, new cross-service information-sharing arrangements, intensive re-ablement and alternative care packages for people coming out of hospital, intensive support for former ITU patients, changes to contracts and performance management, virtual consultations and new provider alliances working to outcome-based support plans.

Not surprisingly perhaps, many are very enthusiastic about the way primary care partners have responded. A colleague responsible for promoting greater collaboration across primary care in a local area told me recently, for example, that the initial lockdown period had been the most rewarding and positive period they had ever experienced in their role. But are these developments really sweeping away the long-

term challenges that so many professionals and managers have experienced over the years in working together to better meet the needs of their local populations?

To answer this, we need firstly to recognise just how complicated it can be to sustain improvement or transformation in place-based primary care networks. The well-realised diagram below, based on a description of arrangements in Canterbury New Zealand (Schluter *et al*., 2016), gives a starting point for considering some of the issues particular to these networks.

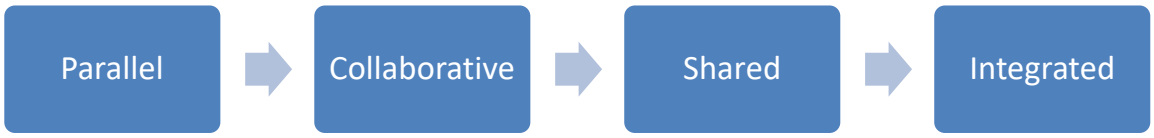
1. Leadership arrangements are complex. There is no standard model for a place-based primary care network, as a key characteristic is that they are based on natural local community and geographical boundaries and comprised of all the relevant organisations and professionals working within that network boundary. This includes local authorities, NHS bodies, local GP surgeries, other public sector organisations, private providers of health and social care services, the voluntary sector, and the wider wellbeing services delivered for and through local communities. They all have their own business models and priorities, geographical or cohort boundaries, service criteria, expertise, funding sources and staff salaries to pay. While in a crisis period such as the coronavirus pandemic partners have stretched across these boundaries to respond to immediate needs, this is not likely to work as a model in the long-term, and we will have to recognise that there remains no golden thread of management or leadership across these networks.
2. The people involved have developed their skills and experience in very different professions, with different roles, terms and conditions. There is no single common shared professional grounding or discourse for them in how to work together and complement each other.
3. Organisations within a network often play different roles depending on the characteristics or needs of the population. There are commissioners, providers, contractors, sub-contractors, lobby and interest groups, advisors and inspectorates of care quality and patient safety for instance, and many organisations have multiple roles and responsibilities depending on particular cohorts, needs or contracts.

These fluid and complex relationships take a long time to understand and it is not straightforward to secure change within them. Any future 'new normal' state will still have to deal with these complexities.

4. The economics of primary care are complex and the incentives for the different players within the network are very different. There are different sources of funding (sometimes trying to address the same needs), different types of contracting arrangements, and different levels of influence in the design and delivery of services. This varies, for example, from direct management of public services in a local authority or NHS provider, to block contracts based on national-bargaining arrangements between CCGs and GPs, to single-person service contracts for nursing home, residential or domiciliary care between local authorities and independent providers. As we work towards future new arrangements for health and care, we know that within existing arrangements the opportunities to improve or re-design services will come at different times with different organisations, and there is no profession or leadership function with the ability to drive changes through the network, no matter how badly it might be needed.
5. Access and delivery criteria for services tend to be developed by organisations and professions either separately or at most with just reference to (rather than jointly with) other services. They are then negotiated on an individual basis between professionals trying to respond to a person's need but also to maintaining their own capacity and boundaries at the same time. This can lead to complex pathways, delays and frustrating or traumatising experiences for patients, service users and carers trying to secure the support they need. The pandemic has demanded temporary changes to these arrangements and partners have responded, but there is no guarantee that long-term demand management arrangements will be able to maintain any shared approaches which have been developed for the short-term.
6. Performance, information and communication systems are run by separate organisations and have different purposes, access criteria, security and confidentiality arrangements and availability. The quality of information shared between different professionals and organisations is often much poorer than that shared within professions and teams, despite the fact that primary care interventions are often concerned with the interplay between different factors affecting the whole person over a long period. Issues such as long-term conditions, complex morbidities, helping people live with physical and psychological health problems or supporting carers are generally deep-rooted and do not lend themselves to the straightforward measurement of impact of a single intervention. The influence of the family, community and wider environment beyond health and social care services also make it difficult to separately judge the impact of primary care interventions on patient outcomes. Partners need more subtle shared systems of information and intelligence to be able to fully understand this complex interplay.

The place-based primary care network is not an easy thing to get right. There are failures. Anecdotally, one local head of psychological therapies described recently how they are considering setting up a specific support service to respond to patients and carers who have been traumatised through negotiating care packages with primary care professionals, and another senior primary care professional estimated that they spend 70% of their work life negotiating the respective financial and professional responsibilities of partner agencies for people with complex health and care needs. On the simple continuum below, the anecdotal experience from our work in recent months is that in most primary care networks partners are still trying to work together as parallel

autonomous bodies or at best within a collaborative framework, never mind the aspirations of national policy makers for shared or even integrated care.[1]



This of course contrasts with the characteristics of a single body such as an NHS hospital where many such arrangements are by necessity shared or integrated. It is a complex but single organisation with, ultimately, one management structure where key quality, resource and people decisions are made; many basic employment, communication, information and quality systems are consistent; there are standard frameworks within which the organisation is able to review performance and plan changes; and services tend to have well established internal pathways and protocols within which many of their patient responses are framed, making it clear as to who has responsibility and accountability for decisions about interventions, care and support, and when and how these should be determined and allocated priority.

Perhaps, over the initial stages of the coronavirus pandemic, hospitals offered some professionals a level of confidence about their role and the rules they work within; some policy makers confidence because they appeared to be able to deliver on policy commitments relatively quickly; and some public confidence because they are clear physical entities, giving the impression of cohesiveness and competence. Perhaps this recent experience builds on a perception built up over many years that hospitals are safe places to invest public resources in – and why, when push comes to shove, the public often wants services concentrated in hospitals?

The pandemic period, however, has shown that despite their complexities, and the well-publicised service failures in some parts of the country, place-based primary care networks can complement hospital services by responding more flexibly and effectively to local needs, and that the way that they operate has many strengths and advantages. For example, within just a few weeks we have seen huge adjustments such as: clusters of surgeries coming together to respond to local population needs; health and social care colleagues communicating effectively about the needs of individuals; networks extending the availability of reablement and patient support services across the working week; and health professionals supporting residential and nursing home populations with new innovative approaches to monitoring and care. The strengths of the primary care network that have been in evidence on the ground are:

- The willingness of professionals to collaborate quickly and effectively across professional and agency boundaries.
- The flexible and creative use of digital technology to assist assessment, diagnosis and delivery of care.
- The confidence to work in partnership with patients and people using services on key health and care decisions, sharing assessments and managing risk together.

[1] The continuum comprises four different types of decision making within a network: Parallel - independent decisions by agencies; Collaborative - decisions taking the views of other agencies into account; Shared - decisions agreed between autonomous partners; Integrated - decisions made by a single body comprising or representing partners.

- A shared perspective across the network about the need to understand people on a 'whole person' basis, and that for many their problems cannot be addressed by one agency or service working independently.

At the same time some of the limitations of previous pre-pandemic arrangements have been exposed during this period, in particular:

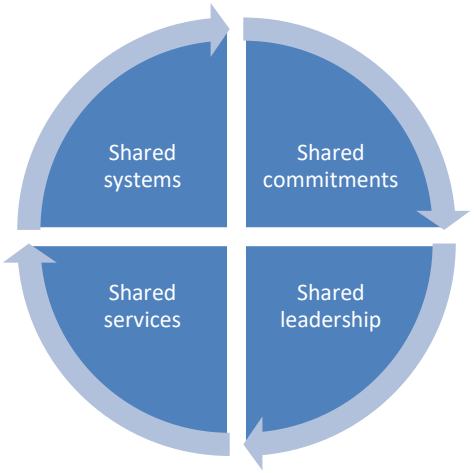
- The inability of existing performance and activity data to support meaningful analysis of whole-person or whole-system impact.
- The challenges in ensuring supply for some local areas when services are contracted through a range of independent providers such as GP practices, care homes and domiciliary care agencies, and the difficulties facing commissioners who are trying to do this without shared approaches or pooled budgets.
- The issues faced by partners across the network when local capacity for direct care and support is compromised, and recruitment and retention are problematic.

We may see policy and guidance emerging in the four UK nations in the next few months in attempts to build on the progress that has recently been made and address some of these continuing challenges. Certainly, the policy advice bodies are losing no time. The Policy Exchange, for example, have already made recommendations that *"The Government should use this crisis to undertake long term social care reform that delivers improvements in the care sector and removes the historic funding barrier between health and social care."* ... "*The NHS and Government should conduct a rapid review and staff engagement exercise to build the evidence for removing unnecessary processes that should never return to NHS and social care services."* (Sloggett R., 2020, p.7)

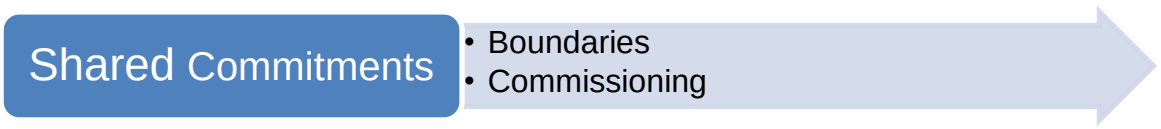
However, while we need to keep a weather-eye on national government pronouncements, on national funding for health and care and where this is directed, there is a huge amount that local partners can do in the meantime to continue to build the effectiveness of place-based primary care networks in their own areas. In particular, while it might be unrealistic to try to establish fully integrated arrangements in primary care at the moment without further legislative change, particularly in Wales or England, the aim of partners in the period after lockdown can be to build on the success of recent developments to build **shared** place-based primary care networks for the long-term.

Although these aims are not new[2], the specific actions, responsibilities and levels of urgency which apply at the current time are, and the pandemic experience so far gives clear examples that partners can draw on to inform their shared priorities. Using the principles of 'Stepping Up to the Place' as a starting point (Institute of Public Care, 2018), I suggest the following four elements as the basis for best shared primary care practice for the long-term.

[2] For example, LGA, NHS Confederation and ADASS produced guidance promoting further integration entitled 'Stepping up to the Place' in 2016, which IPC reviewed for these bodies in 2018, and they are articulated in the NHS Long-Term Plan and NHS People Plans both published in 2019.



So, what might be the priorities for partners who are determined to work together to secure a more effective shared approach to place-based primary care for the long-term in their local area? Considering each of the 4 elements in turn:



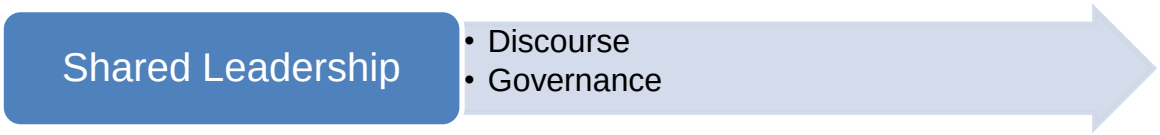
Shared boundaries
Partners need to work together to establish and maintain the whole place-based primary care network as the basic service design unit, and to use this as the starting point when looking at how partners plan services, investments and resources for the future. There will be huge temptations for leaders and professionals to return to thinking about their own particular areas of interest such as how to address particular conditions or develop specific services, practices or professions, but by doing so without a shared frame of reference this is likely to undermine a comprehensive perspective about the needs of the local population and how to respond as a network.

In the first instance, it may well be necessary simply to get agreement from partners about the most sensible network boundaries, and to ensure that wherever possible partners are using a shared view of the geographical and population boundaries within which they are working, minimising overlap where possible and reducing the likelihood of complex governance arrangements. Partners will need to challenge each other to ensure that they meet their commitments to the local network, and that wider responsibilities outwith the network do not undermine them, and however uncomfortable it might be, formalising these commitments in agreements and plans is likely to be crucial.

Shared commissioning
Partners also need to work together on shared commissioning arrangements within those primary care boundaries. Areas to explore include shared commissioning plans and priorities, joint commissioning and planning teams, pooled budgets, procurement and contracting arrangements and market engagement. These all need to be based on the network boundary, all based on a shared responsibility across agencies, and the subject of strong agreements between partners. By doing so partners will be able to build much greater shared understanding of the risks and opportunities of services and

make better informed judgements about where to focus resources, and how best to manage the complex economics of place-based primary care provision.

It is likely that the next period will see a very volatile financial environment with potentially a wide range of different solutions being proposed to things like service configuration, ownership or contracting arrangements. Partners will need to work closely together on these issues and have a shared view on employment arrangements for workers, ownership vehicles for health and care businesses, and contract and risk sharing arrangements between commissioners and providers to maximise effectiveness and minimise the risk of market failures or problems with patient safety or outcomes. It may be more important to secure shared consistency across a place-based network than for approaches to be consistent within any one partner's wider organisation.



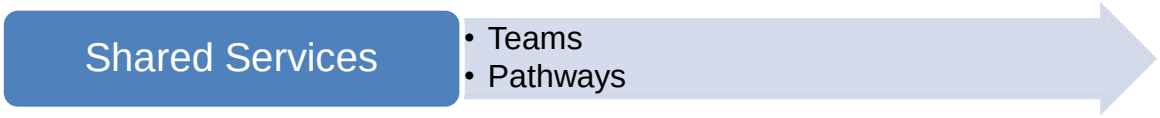
Discourse
Partners need to create a shared common language which recognises the joint contribution of all partners to effective primary care across the network, and the co-productive partnership needed with individuals and cohorts of patients and people who use services and their carers in the local community. Currently, huge amounts of time and energy are still wasted across networks in dealing with misunderstandings between professionals, patients, people who use services and carers. Partners within a network need to work together to drive forward the use of shared forms, shared guidelines and shared protocols wherever possible, and it may be more important to ensure that these are consistent within a place-based network than across separate agencies within a wider geographical footprint. More fundamentally, partners need to work together to develop and promulgate the local primary care model that they are all working towards. They need to say jointly what they mean by primary care services and what citizens should expect from them. They also need to describe the roles of different professionals and services within a shared overall responsibility, how they want the population to experience primary care, what they intend to do together to reduce health inequalities, and the outcomes the local population should expect to secure in the future. In many place-based primary care networks the amount of work that is undertaken to develop these shared ideas is dwarfed by the resources that go into promoting individual services or separate professional descriptions, and partners need to address this, including perhaps through combining the resources available for communication and engagement within local networks.

Governance
Closely linked to discourse, partners will need to establish stronger shared governance arrangements for the local area. They will need to explore how these arrangements can replace, rather than replicate, existing separate arrangements across wider footprints, to minimise the number of different places where decisions are made and communicated. While it is important to recognise that the primary care network is not a single organisation, partners need to be committed to shared decision-making wherever possible

This is very challenging, particularly where organisations with a wider footprint are involved in a local area. Without this shared governance however, the complexity of

decision-making will become too burdensome and partners will not be able to drive change together. For many partners across the UK the coronavirus experience to date has not been one of strong shared governance. Partners have often retreated to individual governance arrangements which have been seen as more robust and reliable in times of crisis, To address this, perhaps a key element of securing an effective shared approach will be for partners to establish delegated responsibility and resources for the local place-based primary care network from parent bodies, supported by appropriate levels of monitoring and oversight – including in areas, for example, such as workforce, budgets and performance management.

Where local networks are responding directly to the needs of their local population this will often mean that parent bodies have to recognise that consistency of approach between networks is not necessarily attainable or desirable, and that maintaining separate agency arrangements for dealing with crises might not be in the best interests of the population.



Pathways

Partners in place-based primary care networks will need to work closely together and more effectively with the public, to ensure that links between services, and across the network, are clearly articulated and well understood. Care pathways, a well-established health services design tool, has the potential to be valuable to partners here. However, traditionally, pathways have often been limited in two ways. Firstly, they have often been used to describe care processes but have not considered standards of care or practice. Secondly, they have often tended to focus only on health interventions and not considered the wider care and wellbeing elements in a pathway. Partners will need to address both of these limitations in the application of care pathways within their local place-based network, and assuming they do so, this offers an important frame of thinking to enable networks of services to build shared assumptions about the routes that they think that people with different needs might follow, and the quality of care and support they get at each point to ensure that they get what they need from shared services. This is a crucial area where the person's voice needs to have greater influence, and where the huge value of the care provided by unpaid carers needs to be better recognised. It is also where a shared approach can ensure that a person's whole experience can be properly understood by partners together to influence practice and service improvement. Place-based inspection and review arrangements across health and social care will need to continue to evolve to support this.

Teams

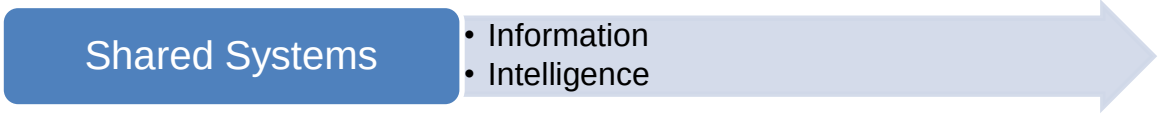
Partners will need to work together to build services which respond most effectively to the needs of different populations and cohorts, and in many circumstances, this will mean further development of joint teams of multi-disciplinary professionals working together to support particular cohorts of patients or service users effectively, as well as new roles and responsibilities across health and social care. We have also seen since March 2020 how new digital communications technology is enabling colleagues in different settings to easily link together, share information and intelligence and engage with people. This points us perhaps to a long-term rethink of what the concept of the team means. Certainly, the idea that a competent professional has to be physically

located with other similarly qualified people to be able to do their job has now been debunked, and partners in place-based networks across the UK are moving towards greater integration including through co-location, shared or single management of teams, and place-based multi-professional services.

For many, the role of the GP will remain fundamental to the successful working of a primary care network, but within this partners across the UK are seeking ways to ensure that no professional ends up acting as a 'bottleneck' for patients or people who use services, and that access to assessment, services and support are as open as possible within a safe and responsible system.

In many parts of the UK the constructive and flexible recent response by primary care networks will have confirmed that many more services can be delivered in the community, and that they do not need a hospital base. Partners will need to move forward from this experience by testing the potential for longer-term primary care-based services and by reviewing the combined estate to explore how this can be made to work more effectively and efficiently in the future.

Both team and pathway design should help partners to redesign services to meet the developing needs of the local population but there is a further factor which is crucial here. Partners will need to work together to develop shared approaches to evaluating and reviewing these teams and pathways, and to using their findings to inform future service development. Research and evaluation in primary care needs to focus often on the impact of services on cohorts or communities – it is rarely concerned with the impact of a single intervention. As a result, methods and approaches need to be geared towards understanding complex causal relationships. Real time evaluation and similar approaches are needed, and to be successful these need to be commissioned or undertaken by partners on a shared basis rather than separately.



Intelligence

Partners across the public, private and voluntary sectors need to work much more closely together to develop and distribute shared intelligence to inform future services. This means building joint population assessments and analyses of needs across health, wellbeing and care boundaries. Currently in many parts of the country different partners with responsibility for building this intelligence undertake activities independently, using different methodologies, different population and geographical boundaries and different analysis criteria, and this leads to unnecessary repetition of activity and conflicting views on priorities. Partners need to ensure that bodies such as public health and local authorities use the place-based primary care network boundaries as the baseline framework for shared intelligence gathering and analysis, and that they set realistic targets and measures for each local population and compare progress against historical trends within those populations rather than only against other areas. In some parts of the country local authorities and their partners have made huge strides in working together to identify and engage with people who are vulnerable or in need in their local communities and this may offer a building block for more long-term arrangements to identify and support people at risk or in need. Partners also need to engage together with local people on the kind of care and support they experience and that they want to

see in the future, rather than undertake separate activities to secure this intelligence. Complaints and consultations perhaps need to be under the auspices of a shared approach by partners in a network rather than independent activities by separate bodies.

Systems
Finally, partners need to work together to build common, shared information systems, digital working protocols and practices, common shared staffing and workforce frameworks, performance monitoring and management arrangements. In the first instance it may opportune at this point to build shared quality assurance arrangements, as partners try to ensure that the limitations of primary care networks exposed in the pandemic are addressed for the future. Shared primary care systems, such as the ambitious CCIS system in Wales, will be needed across the UK to help partners to move beyond the traditional measures of health care interventions to include a more subtle understanding of things like person-based measures, multi-factorial impact, effects on communities and populations, impact over time and across a range of health and wellbeing factors, if we are to really understand what good quality primary care looks like and how best we can work together to deliver it.

The challenges, opportunities and potential agenda outlined in this paper will hopefully resonate with many people working with place-based primary care networks in the UK, and it may be usefully complemented by other recent papers by IPC on Real-Time Evaluation, supporting managers and commissioning out-of-hospital services. The next few months will be part of a long period of recovery (sometimes quicker, other times slower) in this sector, and like all crises, the pandemic offers an opportunity for those who want to move forward and create a more effective shared place-based primary care network to do so. Let's hope that the stress and suffering experienced by so many as a result if this pandemic is not followed by a failure to build the kind of place-based primary care systems across the UK that our populations need and deserve in the future.

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Many thanks to the leaders and clinical professionals who I interviewed on condition of anonymity for this paper in May 2020. They enhanced it hugely with their insights suggestions and examples. You know who you are!

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