Health Services Transformation

The NHS is evolving, at a rate that is hard to keep up with.
In the last 8 years we've gone from PCTs, to CCGs, to STPs, via ACSs to ICSs as the local and not so local decision-making structures. Now throwing in PCNs and ICPs….
We've had the Care Act, Five Year Forward View, 5YFV next steps, the NHS Long Term Plan, along with annual NHS guidance and a host of other initiatives….

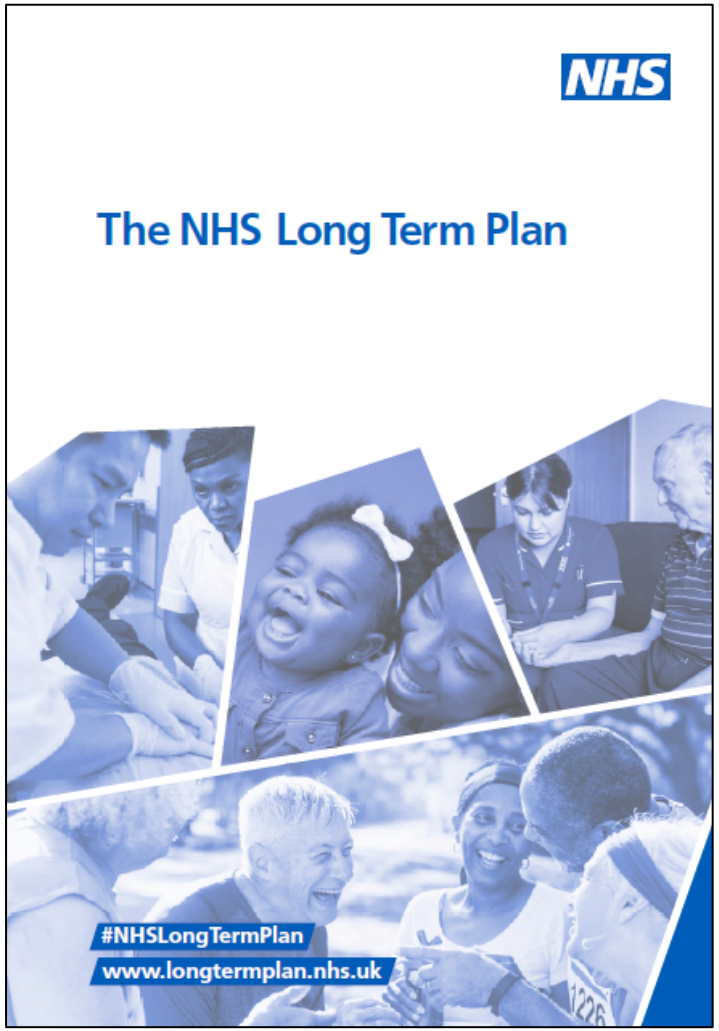
https://www.youtube.com/watch?reload=9&v=DEARD4I3xtE

Primary Care Networks

What are Primary Care Networks?

“A PCN is defined as GP practices (and other providers) serving an identified Network Area”

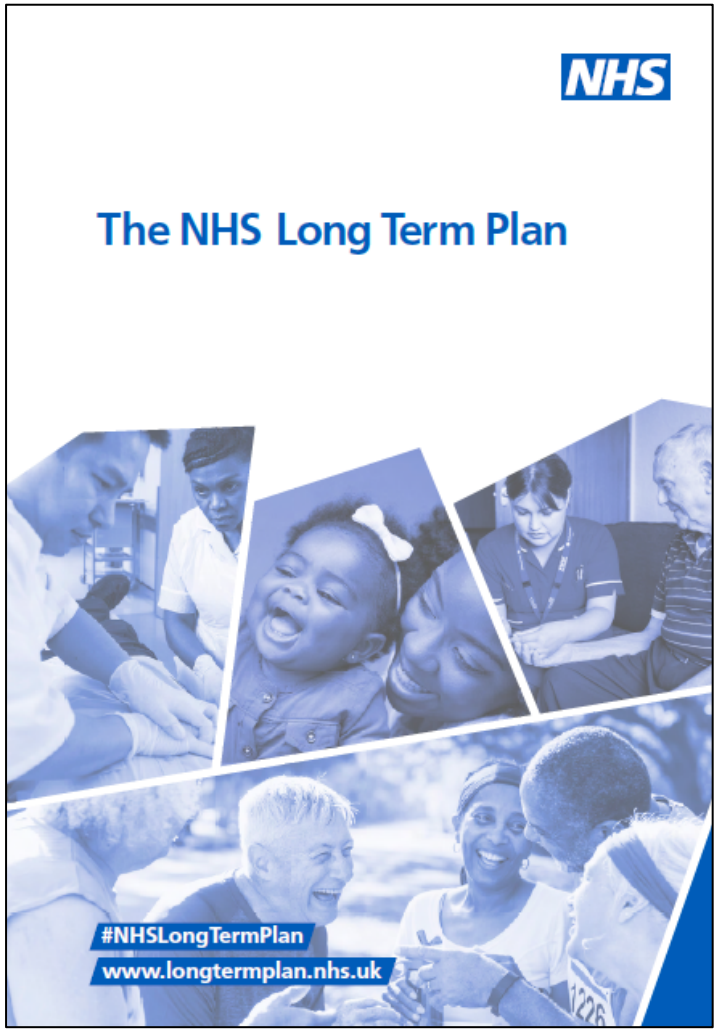
DES contract specification 2019/20



What are PCNs?

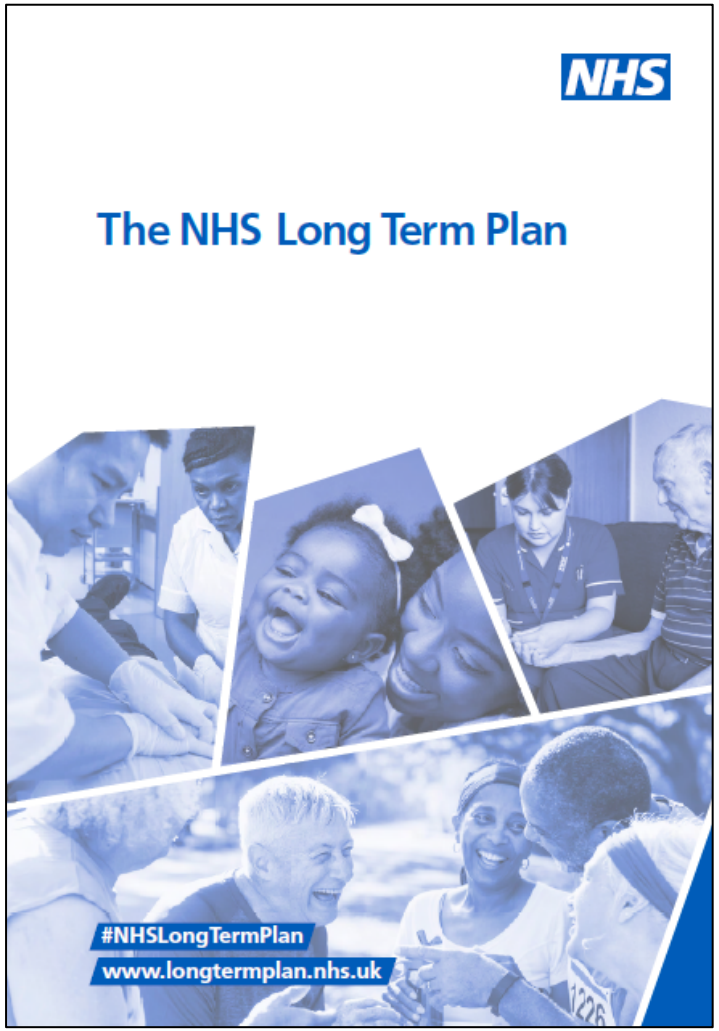
- Mechanism for improving services, sharing staff, systems and resources
- PCN covers population of 30,000 - 50,000 people
- Approx 1,300 PCNs across England
- 1.8bn available to form PCNs
- Each PCN will have a Clinical Director

A big push on getting people to be healthy



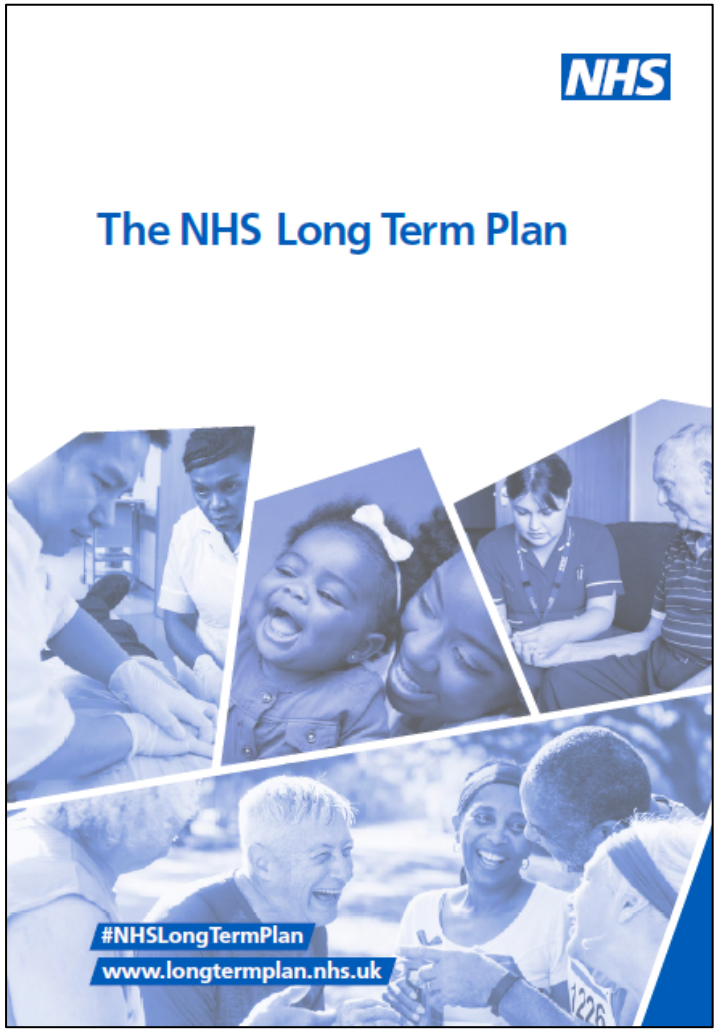
What will they do?

- Designed to deliver the commitments in Long term Plan – 7 services specs
- Deliver additional roles in primary care (ARRS)
- Platform for integrating primary & community care
- Placing the provision of services in the community



How will they do it ?

- New 5 year GP contract published Jan 2019
- ARRS address workforce gap
- PCN requirements, and funding arrangements, will be informed by the Network Contract Directed Enhanced Service (nationally negotiated and defined)
- DES will apply from 1 July 2019, and will remain in place, ‘evolving annually’, until at least 31 March 2024

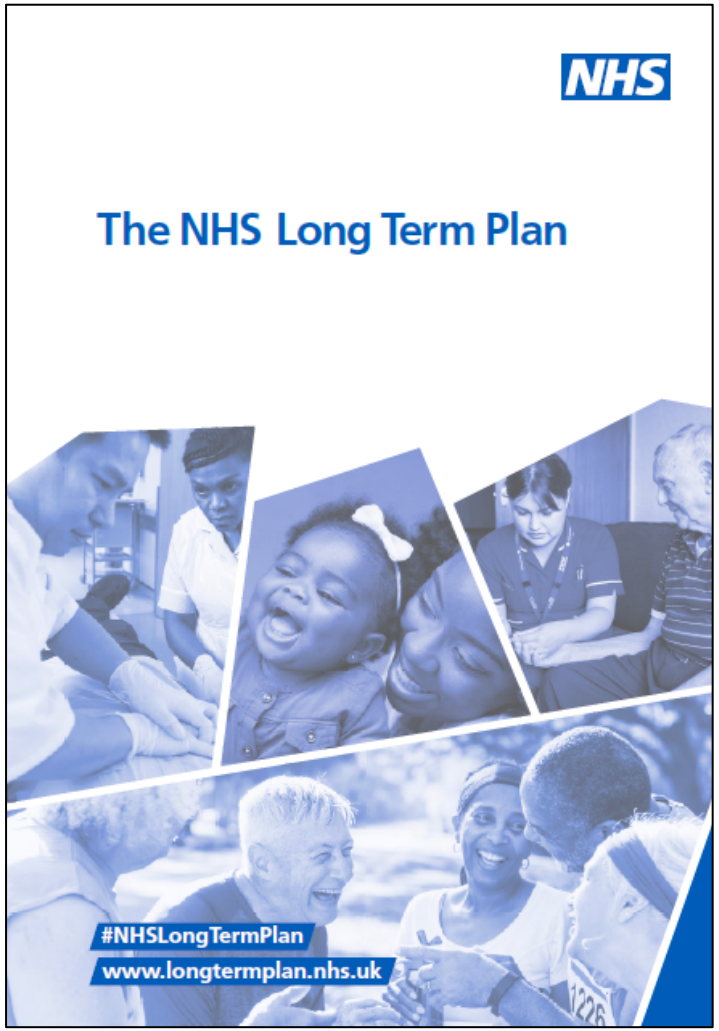


Additional Roles Reimbursement Scheme (ARRS)

Five reimbursable roles:

- Clinical Pharmacist - by end 2019
- Social Prescribing Link Worker - by end 2019
- Physician Associates - by end 2020
- First contact physiotherapists - by end 2020
- First contact paramedics - by end 2021

ARRS will cover 70% of cost for roles, apart from SPLW, which will be 100%



Investment and Evolution – GP Contract Reforms

- On 31st January NHS England and the BMAs GP committee announced a five year agreement for Investment and Contract Reform, which introduces widespread changes aimed at addressing both the workforce and workload pressures currently experienced by GPs in England, and improving services for patients by beginning to realise ambitions laid out in the NHS Long-Term Plan

- The contract gives practices almost £1bn across five years, while another £1.8bn will be invested to support the formation of Primary Care Networks , in which practices will work together to provide care to patients across a wider geographic area

- As part of this a Network Direct Enhanced Service (DES) will be introduced from 1st July 2019. Full details of the contract changes for the next three years can be found here https://www.swahsn.com/2019-GP-Contract-Timeline/

This provides a vehicle for achieving improved practice collaboration and wider system joint working

The national aim

- Primary Care Networks are not just about General Practice – they are to form the foundations of Integrated Care Systems

- Other NHS Providers will likely be expected to align services where they support PCN outcomes
  - NHS Standard Contract 2019/20, Service Condition 4 for Community Services states
    - *The Provider must use all reasonable endeavours to ensure that, with effect from 1 July 2019, the Services are organised and delivered in such a way as to integrate effectively with the local configuration of any Primary Care Networks established in the geographical area within which the Services are to be delivered.*

- PCN Metrics will go beyond General Practice, and possibly into wider determinants of health
  - Investment and evolution: A five-year framework for GP contract reform to implement *The NHS Long Term Plan* makes claim "*that … by* 2020, a new *Network Dashboard* will set out progress on network metrics, covering population health, urgent and anticipatory care, prescribing and hospital use."

- National evaluation of PCN maturity goes beyond General Practice, and requires collaborative system working as clarified within the following PCN Maturity Matrix

PCN Development

Service Specifications

From 2020/21:	During 2020/21 onwards:	From 2021/22 onwards
• Structured Medicines Review and Optimisation • Enhanced Health in Care Homes	• Anticipatory care requirements [for high need typically multi-morbidity patients, jointly with community care] • Personalised Care • Supporting Early Cancer diagnosis	• CVD Prevention and Diagnosis • Tackling Neighbourhood Inequalities

The Public Voice

Network Contract DES Specification 2019-20

Network Contract DES Specification 2019-20

4.4.4 Patient engagement

a. GP member practices within the PCN will have requirements relating to patient engagement under their primary medical services contracts. The PCN will therefore be expected to reflect those requirements by engaging, liaising and communicating with their collective registered population in the most appropriate way, informing and/or involving them in developing new services and changes related to service delivery. This includes engaging with a range of communities, including ‘seldom heard’ groups.

b. The PCN will be required to provide reasonable support and assistance to the commissioner in the performance of its duties to engage patients in the provision of and/or reconfiguration of services where applicable to the registered population.

Population testing

Women carrying mutations (alterations) in the BRCA genes are at higher risk of both ovarian (17 - 44%) and breast cancers (69 - 72%) (see slides)

Testing for the BRCA gene mutations to identify people at risk, offers women the opportunity to take preventative measures - and save lives. This can either be by increased screening (MRI/Mammograms) to prevent breast cancer and surgery to remove ovaries, to prevent ovarian cancer

Medication (chemo-prevention) can also reduce certain types of cancer.

Testing for these mutations in clinical practice today is currently restricted by criteria based on family history of cancer. However, 50% of people carrying these mutations do not fulfil current testing criteria and so are not identified by the current system

Why do we need to wait for people to get cancer, to be able to identify others whom we can prevent cancer?

The current system is plagued by restricted access and underutilisation of genetic testing

Offering the alternative of unrestricted testing for everyone (population testing) can overcome these limitations and prevent many more cancers, then the current policy

Technological advances and falling costs has now made it possible to offer routine population testing. Research shows it will identify over double the number of people at risk (half are missed by current system) and that this approach is feasible, acceptable, results in reduced anxiety and does not detrimentally affect quality of life, compared to the current system of testing

Economic analysis shows that such an approach is cost effective for the NHS. There are few interventions in medicine that can save both lives and money. Population based BRCA testing is one of them

The UK should be the first health system world-wide to use population genomics for cancer prevention. Population based testing in the Jewish population offers the opportunity to do this (see slides)

Dates for next year - 2020

Tues Jan 21st

Thurs Apr 23rd

Tues July 21st

Thurs Oct 22nd