October 2016

PSNC Briefing 050/16: Integrated primary and acute care systems (PACS) – Describing the care model and the business model

In January 2015, the NHS invited individual organisations and partnerships, including those with the voluntary sector to apply to become vanguard sites for the New Models of Care Programme, one of the first steps towards delivering the NHS Five Year Forward View (5YFV) and supporting improvement and integration of services.

One of the vanguard types is the integrated primary and acute care system (PACS), which aims to join up primary care, hospital, community, mental health and social care services to improve the health and wellbeing of the whole population.

This PSNC Briefing summarises NHS England's document, *Integrated primary and acute care systems (PACS) - Describing the care model and the business model*, which describes a framework covering the core elements of the population-based accountable care model and the options for commissioning and providing a PACS. It will be of particular interest to LPC members who have PACS being developed in their area.

1. Introduction and summary

Two population-based new care models are central to delivering the vision of the NHS 5YFV: PACSs and MCPs. The MCP framework is covered in more detail in PSNC Briefing 045/16: An introduction to multispecialty community providers (MCPs) and the emerging contract framework.

Currently, PACS and MCP vanguards cover about 8% of England; since nearly all the Sustainability and Transformation plans (STPs) involve population-based accountable care models of this kind, NHS England wants national coverage to grow to 25% in 2017, and to 50% by 2020. Funding will be made available to support new sites from 2017/18 to achieve this growth, where the implementation of a PACS or an MCP model is clearly demonstrated.

Like an MCP, a PACS is a population-based care model based on the GP registered list. A PACS aims to improve the physical, mental and social health and wellbeing of its local population and reduce inequalities. It can only succeed with general practice at its core. A PACS brings together health and care providers with shared goals and incentives, so that they can focus on what is best for the local population. The current fragmented and complex contracting, funding and governance systems within the NHS, and between NHS and social care, frustrate a focus on population health. Joining up services in a PACS allows better decision-making and more sustainable use of resources, with a greater focus on prevention and integrated community-based care, and less reliance on hospital care.

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2. Illustrating the PACS care model: the core elements of a population-based accountable care model

How can a PACS be developed?

It may take several years for a PACS to reach full maturity and effectiveness. Based on the learning from the vanguards, five tasks are essential for success:

1. Build collaborative system leadership and relationships around a shared local vision for the population
2. Develop a system-wide governance and programme structure to drive the change
3. Carry out detailed work to design the care model, financial model and business model
4. Develop and implement the care model in a way that allows it to adapt and scale
5. Develop and implement appropriate changes to contacting, payment and organisational form to support delivery

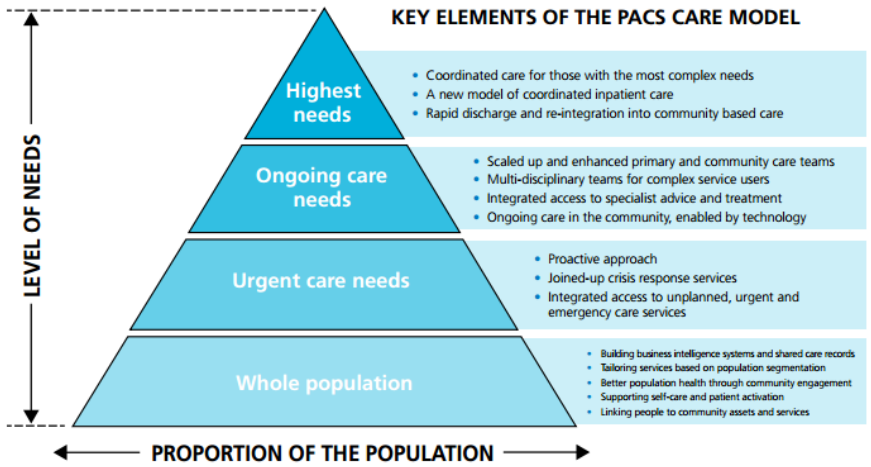
The core elements of the PACS care model

PACS will increasingly form a common, identifiable model as they implement this framework in a systematic way, ensuring both the depth and the breadth of its components are implemented. NHS England is developing an 'implementation matrix' for each new care model.

All PACS build upon two key enablers: staff and technology. PACS empower a wide range of staff to work in different ways by creating new multi-disciplinary teams, redesigning more rewarding jobs and implementing new professional roles.

Wherever they emerge, PACS will not exist in isolation but will need strong relationships with other providers and services. For example, the acute hospital trust in a PACS may join a hospital group or other acute care collaboration (ACC) to support sustainability of acute services over a bigger geography.

As with the MCP, the PACS care model operates on four levels of population need. The PACS care model bears many similarities to the MCP model, but the wider scope of the PACS model has distinctive implications, in particular for hospital services.



Source: NHS England - Integrated primary and acute care systems (PACS) - Describing the care model and the business model

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A) Whole population - prevention and population health management

First, a PACS needs the data, systems and capabilities that give it deep understanding of its population - including skills and expertise that have traditionally been found in commissioning. This will enable a PACS to plan services and allocate resources by segmenting service users based on their demographics and needs. This should include planning services that are accessible for people with different protected characteristics and those who experience health inequalities.

Second, a PACS needs to apply effective approaches to prevention, public health and self-care that unlock the power and potential of communities to reshape the relationship between service users and health and care services.

Building shared care records and business intelligence systems

A PACS will need connected, real-time data sets for all health and care services, accessible in all care settings and to patients and service users. These will be the foundation for the whole population health model.

At an individual level, consent-based shared care records help professionals deliver safe, personalised care. Integrated data sets drawn from shared records need to be complemented by business intelligence systems that analyse health and care needs at the population level to inform the design and delivery of services.

Tailoring services based on population segmentation

These business intelligence systems support new service design through patient segmentation; this approach can also help develop tailored preventative services.

Better population health through community engagement

Both PACS and MCPs will only be successful if they build new, stronger relationships with their local population, using the six principles for effective local engagement:

Source: NHS England - Integrated primary and acute care systems (PACS) - Describing the care model and the business model

Supporting self-care and patient activation

A PACS will improve patient activation through approaches such as health coaching, self-management and education that build knowledge and raise citizens' awareness, skills and confidence.

Linking people to community assets and other public services

Clinical services alone have a limited impact on broader health and wellbeing. A range of other social and economic determinants, including good housing, financial stability and strong social networks, have much greater impact. PACS

vanguards can help connect people to sources of community support and public services including schools, housing associations, job centres, and youth justice and probation services.

B) Urgent care needs - integrated access and crisis response teams

A PACS will focus on predicting and preventing the need for emergency or unplanned intervention. When crises do occur, community-based rapid response services will help avoid the situation getting worse. A single front door will make access to urgent care seamless. The traditional A&E department will be much more closely integrated with services in the wider system, with people only attending hospital when their needs cannot be met through a community response.

A proactive approach to urgent care

When a PACS is fully developed the need for emergency or unplanned responses should be much reduced. Stronger, more resilient communities, good care planning and expert multidisciplinary case management should ensure that potential problems are identified and addressed well before the need for a 'blue light' response.

Joined-up crisis response services

When urgent care is needed, a PACS will provide community-based alternatives to avoid unnecessary attendances at A&E. The scale of a PACS offers the prospect of more sustainable primary care out-of-hours services. New workforce models may help sustain these services, for example by providing multi-disciplinary crisis response and 'hospital at home' services. Co-located hubs may also provide simplified access to integrated primary, community and social care urgent and emergency services.

PACSs will all operate as part of a system where the following eight urgent care commissioning standards are met:

Patients can make a single call to get an appointment out-of-hours (OOH)	Data can be sent between providers	The capacity for NHS 111 and OOH appointments is jointly planned	The summary care record is available in the clinical hub and elsewhere
Care plans and patient notes are shared between providers	The system can make appointments to in-hours general practice	There is joint governance across local urgent and emergency care providers	There is a clinical hub containing (physically or virtually) GPs and other health care professionals

C) Ongoing care needs - enhanced primary and community care

A PACS will use its workforce and technology flexibly. Specialist care will be linked with generalists for the better management of chronic conditions. Mental health professionals will be embedded in physical health teams, and vice versa, to ensure that the wellbeing of people with long term conditions is addressed and that the inequalities in physical health outcomes for people with mental health conditions are reduced.

Scaled up and enhanced primary and community care teams

Integrated primary and community-based care is core to the PACS model. It must always include a resilient model of general practice, with enhanced input from a range of other services. Teams will need greater input from pharmacists, social workers and mental health professionals, and hospital consultants among others, to better manage complex needs. As new teams move into community-based settings, teams will need to change and a systematic and standardised community services model will need to be developed, supported by technology.

PACSs will also be well placed to deliver improvements in access to general practice as described in the General Practice Forward View. A fully-fledged PACS should offer patients the choice of electronic appointments and prescriptions, and greater support for self-care, for example, through the use of health apps and telecare.

Multi-disciplinary teams for service users with complex needs

Integrated multi-disciplinary teams (MDTs), each serving neighbourhoods of around 30,000-50,000 people, are central to the PACS and MCP model. These MDTs will 'wrap around' GPs as the holders of the registered population list. The teams will target those people who are at greatest risk of developing complex needs as well as those who already need high levels of support.

Effective MDTs will include GPs, practice nurses, district nurses, social workers, acute consultants (such as geriatricians) and mental health and voluntary sector expertise. They will identify cases from the registered list and meet regularly to review them. Between these meetings there should be mechanisms for the teams to discuss cases in real time and to access advice and support from each other to avert crises.

Each team member will thereby become more efficient, with less duplication of assessments and fewer contacts for patients. The scale of a PACS should allow for efficient procurement of mobile devices and technology to support this.

Integrated access to specialist advice and treatment

A PACS will integrate specialist doctors and nurses into neighbourhood care teams to deliver a new way of accessing advice and treatment in the community. Clinicians and service users will be able to design pathways of care that are based around blending clinical skills, shared decision making and agreeing shared outcomes, minimising wasted time and resources.

In practice, this will mean that diagnostic tests will be carried out in the community where feasible. Decisions about treatment options will involve the user and their carer/family when appropriate. Elective surgery will increasingly take place as a community-based or outpatient procedure. Pre-operative discussions for hospital procedures needn't be in the hospital; admission can be on the day of the procedure. Rapid discharge will be combined with community-based therapy, with rehabilitation and social care teams supporting recovery.

Ongoing care in the community, enabled by technology

Using learning from systems where physicians now handle patients via telehealth and in person, PACSs will explore how these new processes can be implemented at scale. PACSs are already testing how a variety of telehealth solutions can enable GPs and users to seek advice from specialists whilst in a GP practice consulting room.

D) Highest care needs - coordinated community-based and inpatient care

In a PACS, incentives will be aligned towards prevention. People with the most complex needs, and their carers, need expert advice on treatment options, ongoing support to manage their wellbeing, and practical help to enable them to remain independent. Social care integration is crucial in providing expert assessment and access to equipment alongside clinical care. PACSs will work to minimise admissions to hospital and care homes.

Where hospital admission is necessary, PACSs will provide high-quality inpatient services, with care coordinated with the wider system, to return people to good health. In many cases PACSs may identify people with high care needs but low clinical complexity, and provide care and support services in the community to help them live as independently as possible.

Better care for patients with complex needs and high costs

For high cost patients with multiple long term conditions, and complex needs, the unique link between primary, community, social and hospital care within a PACS gives the opportunity to develop an approach that blends the generalist and specialist skills around the needs of the patient. For example, a PACS will develop clinical roles which specialise in complexity and follow the patient between hospital and community settings - the 'extensivist' model.

A new model of coordinated inpatient care

Within a PACS, hospital inpatient care will be for those with the most serious care needs; all other care will be in the community. For services such as end of life or maternity care, where the place is critical to a good experience, high quality inpatient services will be part of a wider community- and home-based offer.

Inpatient care will be co-ordinated and connected with GPs, social care, community services, carers and families, with easy in-reach for community support. This will improve care coordination, reduce the risk from multiple hand-offs, and ensure smooth admission and discharge. Practically, this could mean joint ward rounds between the enhanced primary care team (GPs, nurses, social workers and therapists) and hospital clinical staff, to review patients on their case load when they have been admitted.

Regular review will ensure that even when acutely ill, patients receive care and support from teams who know them and their condition well. This will enable early supported discharge back into the integrated community multidisciplinary team when appropriate. GPs will be able to discharge patients or 'step down' services when appropriate. Further rehabilitation and recovery will be provided in the community.

Rapid discharge and re-integration into community based care

Patients will be fully involved in their discharge planning even before admission. A PACS will enable local services to work together to deliver a smooth transition between inpatient and community settings, implementing the best practice already set out.

3. The PACS business model: options for commissioning and providing a PACS

Changing the care model is the most critical task for developing a PACS. Achieving this change requires effective system leadership and strong relationships and trust between the various partners. It needs an agreed vision and a shared understanding of the new care model and each partner's role in it as well as a strong financial case backed by evaluation and learning mechanisms.

A PACS will need to be formally commissioned so that money flows and contracts support the goals of the care model. Providers will also need to consider new organisational structures to support their staff to achieve the goals of a PACS.

Who commissions a PACS and what is their role?

Commissioning a PACS will require NHS and local authority commissioners to work closely together and agree robust and sustainable collaborative commissioning arrangements. NHS England expects PACSs to explore expanded collaborative commissioning models that bring together funding for NHS and social care services that have historically been funded separately.

Commissioners will retain a strategic role, which would likely include setting contract outcomes, managing the procurement process, overseeing the PACS delivery against the contract, and ensuring service user voice and choice are maintained. The PACS provider, meanwhile, would have the freedom to define the detailed service model, determining how providers (including sub-contractors) would work together to deliver this and defining the operating and governance model across the PACS.

What are the contractual models for a PACS?

As for MCPs, there are three broad versions of contracting for a PACS emerging; all three are voluntary options and local areas will need to make the choice that best meets their needs:

1. A virtual PACS

In a 'virtual PACS', providers of services within the scope of the PACS care model and (if required) their commissioners

would enter into 'alliance arrangements'. An alliance agreement could establish a shared vision, ways of working and the role of each provider in the PACS. This type of arrangement is a pragmatic step forward and is the least disruptive. It is the weakest form of a PACS in terms of its rights to create and manage integrated provision, and its ability to deploy resources flexibly.

2. A partially integrated PACS

This is a step beyond an alliance approach in which commissioners re-procure, under a single contract, all services that would be in the scope of a fully-fledged PACS except for core primary medical services. The resulting contract could include some aspects of local Enhanced primary care services.

3. A fully integrated PACS.

Here the PACS holds a single whole population budget for the full range of services in scope including primary medical services. It best reflects the logic of the new care model with the greatest freedom to redesign care and workforce roles

What organisational form might a PACS provider take?

A PACS will need to be a formal legal entity, or group of entities acting together, that is capable of bearing the financial risk, and which has clear governance and accountability arrangements in place for both clinical quality and finance. The robustness of this organisational form will be assessed as part of the new 'joint assurance' process being developed by NHS England and NHS Improvement. It is quite likely that many existing organisations that deliver parts of the proposed PACS model will be unable in isolation to be credible holders of a fully integrated PACS contract, and they will need instead to forge a new entity.

The precise form of legal entity of a PACS will be for local determination. This entity may, of course, sub-contract elements of the services to existing or new providers. If it is a single organisation it is equally conceivable it could be a new entity as it could be an existing NHS entity

How can GPs relate to a PACS?

NHS England is clear that general practice must be at the heart of the PACS model, as with the MCP model. The PACS model opens up the prospect of a wider set of options for how GPs and other clinicians could relate to the NHS.

What will a PACS contract comprise?

Like an MCP but with a wider scope, a PACS will deliver services that are currently commissioned through both primary medical services contracts as well as any local authority services that are determined to be in scope.

If you have queries on this PSNC Briefing or you require more information please contact Zainab Al-Kharsan, Service Development Pharmacist.