Threats and opportunities from the current challenges facing general practice

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What are the challenges and threats facing General Practice

Day to day workload is unmanageable	Workforce numbers are insufficient	Staff morale is low	Changes in staff career aspirations
Poor IT and Estate infrastructure	Misaligned payment mechanisms with deprived areas hit harder	Immature system integration creating inefficiency and ‘gridlock’	Greater health inequalities and poorer health outcomes
Worsening offer to patients with contractual focus on access over continuity	Negative portrayal in the media	Loss of public confidence	Increasing demand, Covid legacy and keeping secondary care back log safe

Opportunities from the challenges facing General Practice

A new model of care is now inevitable

ICS architecture facilitates devolution and system wide join up

Opportunity to redesign patient pathways using a one system, one team, one mission approach

A new mesolayer of services that sits between hospitals and community

Services based on population health data insights

Area wide workforce planning, interoperable technology and estates planning

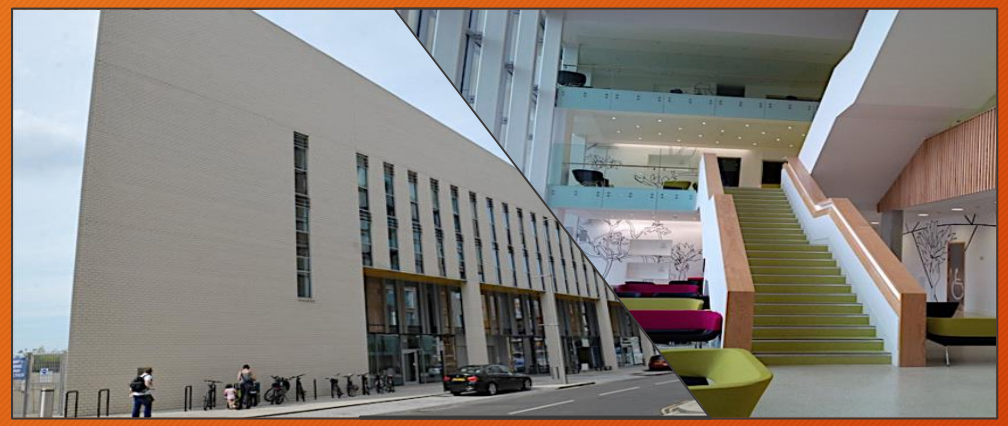
Automation to reduce the administrative burden on practices

…But you knew all that…! We need some fresh ideas

Just three examples:

1. Imagine if we thought differently about how we funded estate
2. Imagine if we aligned financial drivers across primary and secondary care
3. Imagine if we optimised the use of technology that already exists

Imagine we didn't build *40 new hospitals…*



We could build a national network of community-based anchor institutions focused on health and well being encompassing horizontal and vertically integrated services to redefine what primary care means

General Practice

- GPs
- Practice Nursing
- Paramedics
- Clinical pharmacists
- Physician Associates
- Physiotherapists
- Paramedics
- Mental Health Therapy
- Care Coordinators
- Health Trainers
- Social prescribing
- Digital Leads

Horizontal Integration

- Dentistry and Pharmacy
- Optometry and Audiology
- Community Nursing
- MSK services
- Mental Health
- Substance Misuse
- Minor Surgery
- GP Access Hub
- eHub MDT workforce
- Urgent Care
- Home Visiting
- Voluntary Sector
- Community resource space

Vertical Integration

- Speciality Outpatients
- Diagnostics
- On site laboratory
- Midwifery
- Minor procedures
- Specialist nurse teams
- Anticoagulation
- Virtual Ward Team
- Intermediate care beds
- Teaching facilities
- Staff welfare space

…but imagine how much more we could do if the overall system savings from a full health economic analysis could also be considered?

Imagine if we aligned financial drivers across primary and secondary care

Commissioner Costs

GP Funding
- Weighted Capitation
- QOF and Local Enhances Services
- PCN Enhanced Services
- Investment Impact Fund
- Rent, Rates and IT costs

NHS Costs instigated from General Practice
- Investigations ordered
- Prescribing costs
- Referrals
- A&E Attendances
- Hospital Admissions

Secondary Care Funding
- Block contracts
- Payment by results
- Estate and IT costs
- Able to retain private income

Hypothesis: If GP practices working together through PCNs could share in some of the gains created from them working collectively to reduce commissioner expenditure, they would be more motivated to contain unnecessary costs (investigations, prescriptions, low value referrals and admissions). This would recycle monies back into an ever-enriching version of the primary care offer, thereby strengthening upstream care. Not fund holding but gain sharing.

Imagine if we optimised the use of technology that already exists

First a thought experiment:

What if I said you have to create a 30% increase in NHS productivity today, with no extra resource? Well, how many people “touch the NHS” each day, and where?

- 1.5 M visit a pharmacist each day
- 1.3 M have a GP Practice appointment each working day
- 0.3 M attend an outpatient or test appointment each day
- 78 K attend A&E or Urgent Treatment Centres each day
- 20 K calls to 111 each day
- Add the bits and pieces e.g., docs, scripts, results, GUM clinics

So, there are over 3 million “touchpoints with the NHS” each day

I believe at least 30% or 1M patients in the NHS today are sitting in the wrong waiting room or are in the wrong queue for a test or an appointment

Don’t believe me yet? Well let’s ask the audience

- Ask GPs - how many people seeing them could have been dealt with using a simpler method e.g., an allied health professional, a community pharmacy or even self-care?
- Ask Specialists - how many people in their outpatients needed their outpatient appointment?
- Ask A&E consultants - what proportion of patients attending shouldn’t be there?

They will all say at least 30% of patients are in the wrong queue or waiting room.
This equates to millions of patient journeys and potentially billions of NHS pounds.

So, IF at least 30% of patient contacts are low or even no value what do we do with that information? The key to extracting the efficiency opportunity for the NHS is getting better at directing each case to the right resource in accordance with each patient’s need. The key to this is getting better at understanding the problem upfront and routing patients accordingly. So how do we do this?

Imagine we could…

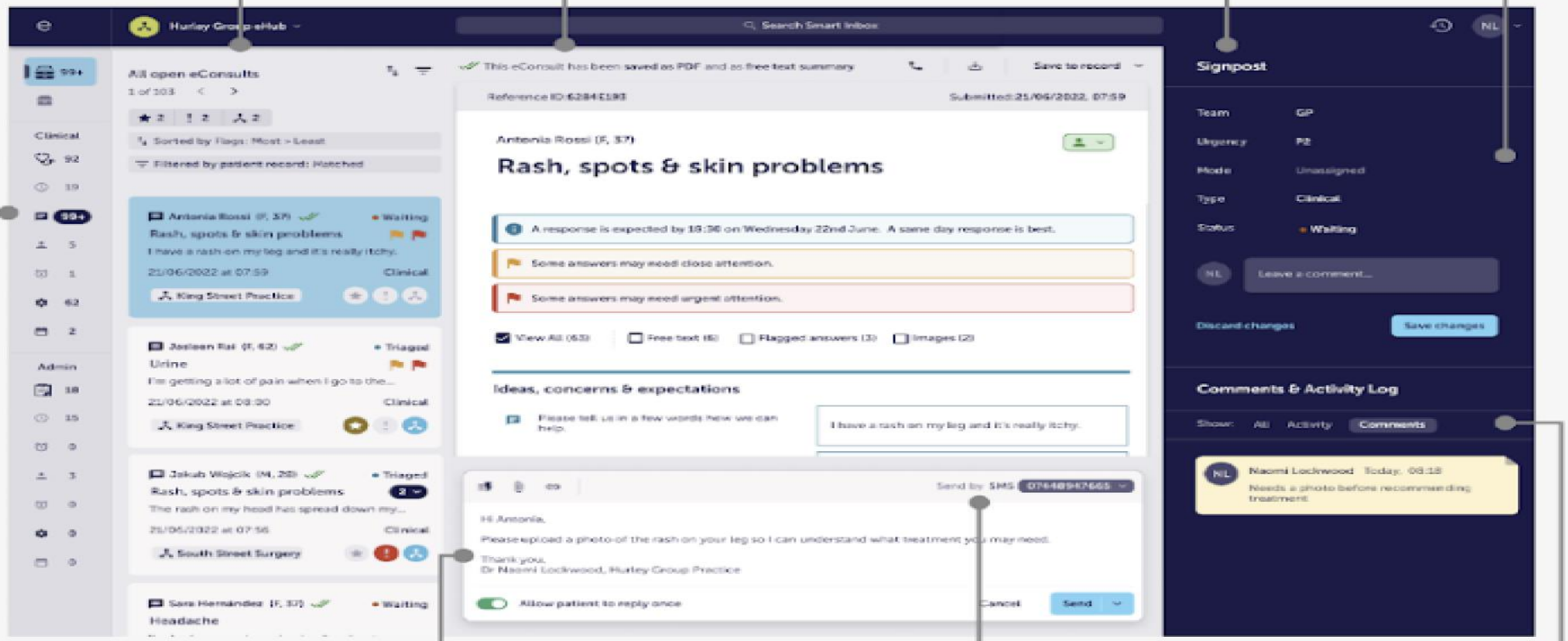
- Ask patients to give us a comprehensive history upfront, specific to their issue, by phone or online and that history was automatically summarised so staff could direct patients to the right resource first time
- Imagine that eventually instead of staff triaging cases, AI does this using neurolinguistic programming and machine learning to create accurate triage decisions in milliseconds, saving clinicians thousands of hours
- Imagine this could eventually be supplemented with biometrics from devices and Apps
- Surface key contextual information from the EHR to assist with rapid case processing
- Supply staff with a slick range of outbound tools to efficiently close each case e.g., SMS, email, click to call/video, pre-canned responses, patient resources (links, videos, Apps)
- Do this for general practice, urgent care and outpatients, and eventually seamlessly between them, replacing “referrals” with “case assignment” according to need, regardless of patient entry point
- Become proactive in the management of long-term conditions by sending patients condition based questionnaires about their condition, so we can see who needs seeing rather than everyone, every year

Filter and sort your queue

See the information to help you triage

Prioritise, allocate and signpost to other roles in seconds

Save and auto-code data to the patient's record



Customise your demand view

Create and preview custom response templates

Communicate seamlessly using any channel

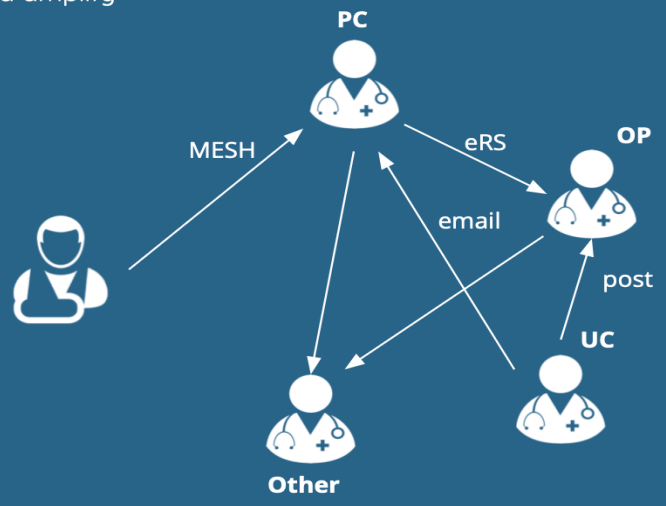
Collaborate better, at any scale

How the smart inbox makes a fosters integration

Everyone will be working from the ‘same’ smart-inbox - so redirection = re-assignment

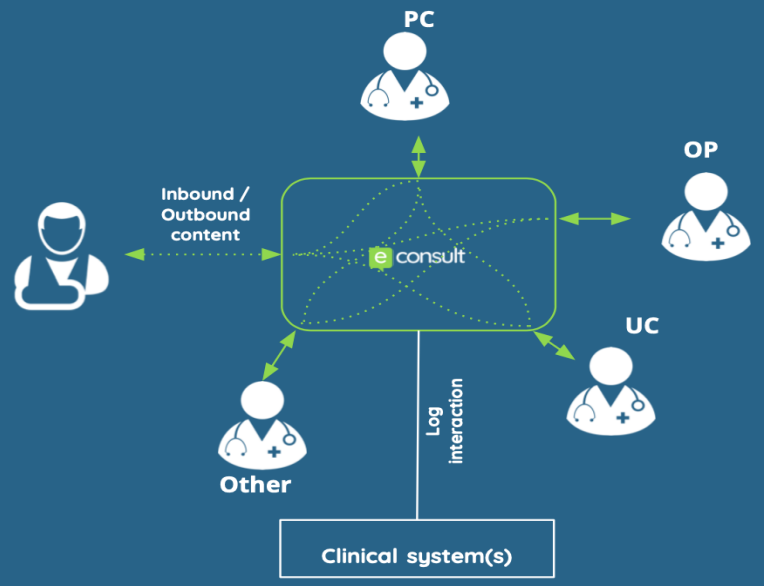
Not this 👎

Isolated interactions out of our ability to see and amplify



This 🚀

Fostering *network effect* by powering all interactions on our platform



Imagine we used interoperable technology effectively to triage out the 30% of low value interactions, across and between general practice, urgent care and outpatients?

Reasons to be hopeful?

- It is true that general practice can't go back, but whether we become a hollow shell of an offer, or a turbocharged enriched connected offer is unclear
- My hope is that a version of what I am proposing on estates, payment reform and technology will come true
- This is not to sideline the values and soul of what general practice is… rather it is an attempt to protect general practice from being swamped by popularist politicians offering the public an 'all you can eat' general practice to 'Darren with his dandruff'

Thank you for listening

Any questions?