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## EXECUTIVE SUMMARY

Six months after the publication of the *NHS Long Term Plan*, national and local implementation initiatives are well underway. The first new funding is being released, including through the new GP Contract. Primary Care Networks are being established. A range of specific service improvements are under development. An interim workforce strategy has been published.

This paper aims to contribute to the consideration of one aspect of these implementation plans: investment in provider and system enablers of service improvement at the neighbourhood level. It makes the case for investing additional resources in the Primary Care Networks so that they evolve into neighbourhood care 'integrators' in those areas where relationships between providers are already strong and the scope for reducing health inequalities is high. It also highlights the need to strengthen the service improvement capability and back-office systems of individual providers of primary and community care, and considers better ways to invest in such capacity.

### BACKGROUND - INVESTING IN LOCAL CARE

Over the last four years, Social Finance has supported social investment into around twenty projects and organisations which support the aims of the *Long Term Plan*. Our focus is preventative and community-based care, ranging from investment in large GP practices to a network of community organisations working to address loneliness.

This is a small and diverse sample, but a common theme across the investments is the critical importance of organisational and local system enablers of service improvement for enhancing health and wellbeing outcomes. Putting resources into better understanding the needs and experience of patients, good leadership, programme management, the effective application of analytical insight to service

development, a culture of adaption and good back-office systems and processes are the critical determinants of whether health and wellbeing improves. In our experience these factors can account for a greater than two-fold variation in outcomes for services with similar levels of front line funding. In other instances, were these enablers of integrated care are lacking, new front-line capacity has been significantly under-utilised.

The importance of these attributes is already widely recognised. However, putting social investment at risk and making returns dependent on the achievement of outcomes highlights their importance. Our conclusion is that the additional £4.5 billion per annum promised for expanding primary and community care by 2023/24 will fail to achieve its potential unless significantly more attention is given to investing in the enablers of service development and improvement.

## DEVELOPING ENABLERS OF SERVICE IMPROVEMENT AT NEIGHBOURHOOD LEVEL

This paper therefore considers two questions:

- i. What enablers of service improvement are typically required at the Primary Care Network (neighbourhood) level if local providers are to collectively deliver more integrated services and improve population health?
- ii. What greater capacity is typically required within individual providers of primary, community and preventative care?

For each, we consider the potential sources funding to strengthen these enablers of integrated care.

## DEVELOPING PRIMARY CARE NETWORKS INTO NEIGHBOURHOOD CARE INTEGRATORS

Social Finance has sought to estimate the resources which would be required for a typical Primary Care Network to enable major improvements in population health and care, rather than simply implement the minimum requirements of the *Long Term Plan* such as developing a multi-disciplinary primary care team. Drawing on international examples and emerging experience in England, we conclude that:

- i. For a typical Network to have the capacity to drive significant improvements in the personalisation care, population health and local system productivity (to become a neighbourhood care ‘integrator’) it would require a small team, including good clinical leadership, a full-time project manager and part time analytical and service development support. The Network would also require sustained access to high quality specialist advice on specific service developments and cross-cutting professional functions such as finance.
- ii. The cost of this capacity is likely to be around £250k per annum for the core team, and £100k in cash or in kind for specialist support.
- iii. Given that the new GP contract will typically only provide £100k per annum for the core Network team, there is a case for local commissioners to use some of the additional funding allocation for primary and community care to develop this neighbourhood capacity (and many are already diverting some existing resources). However, in a period of stretched resources this should usually be focused on areas where the scope for reducing health inequalities is greatest and provided only where existing provider relationships are strong and an excellent core team can be recruited.

## INVESTMENT IN THE ORGANISATIONAL CAPACITY OF PROVIDERS

Assessing the typical needs of primary, community and preventative care providers is difficult due to the variation in current organisational strength. There are many strong providers. However, there are also common needs among many to strengthen their capacity for service development and core back-office systems if they are to achieve the ambitions of the *Long Term Plan*. Based on Social Finance’s experience, we conclude:

- i. A typical primary care provider may require both non-recurrent investment of between £5-8 per patient, and the re-organising of community nursing of between £3-£7 per head of population in their service geography (£8-£15 per head of population in total). This excludes investment in major IT developments and would be higher for turning around struggling providers.

- ii. Investment requirements for developing more radically disruptive service and organisational models are much higher, with international examples of care start-ups spending tens of millions of pounds on such innovation.
- iii. It is important to principally enable investment in organisational capacity for improvement over the long term through better funding and incentives within service contracts. This includes ensuring that contracts have sufficient 'headroom' for investment and well-designed incentives for better outcomes and productivity.
- iv. Given the depleted reserves of many primary and community care providers, it may also be important to improve their access to low costs loans (potentially with a grant element).
- v. To fund new, 'disruptive' service delivery models, such as those testing the leading edge of digital delivery and radical changes in skills mix, it will still be important for the NHS to provide national innovation grants. However, there may be a role for socially motivated investors in supporting innovation within primary care delivery and elements of preventative care. NHS grant programmes could also benefit from taking a more explicit 'investment approach' to the management of such funding.

## CONCLUSION

Enabling service development and improvement within the primary, community and preventative care sectors and emerging Primary Care Networks is not simply a matter of funding. It also relies on leadership, training, fostering a culture of adaptation and innovation, and good incentives and governance. However, such capabilities are not cost free. We therefore propose that investing in them should be an important element of local and national funding plans.

By sharing some of Social Finance's experience, we hope to stimulate discussion about the level of investment required and best mechanisms for deploying and managing that investment. We hope that as the *Long Term Plan's* primary and community care ambitions are implemented, other funders and providers will also share more detailed information on the types of system and organisational investment they are making and the impact on health outcomes and service productivity.

# 1 Introduction – Investing in service improvement

Six months after publication of the *NHS Long Term Plan*,<sup>1</sup> providers, commissioners and partners are engaging in the detail of service development. At the national level, a new GP contract is in place, a raft of project work is in train on specific service improvement plans, and an interim strategy for the NHS workforce has been published.<sup>2</sup> Locally, providers and commissioners are developing more integrated approaches at neighbourhood, locality and ‘System’ levels, with the aim of providing more personalised services and improving population health.

This paper does not aim to summarise all these changes. They are well articulated elsewhere. Rather, we aim to share insights from Social Finance’s experience of investing in local care systems. In particular, we aim to highlight the importance of placing significant focus on developing organisational capacity for continuous service improvement alongside investment in front-line staff and the growth of specific services.

In this section, we therefore:

- Briefly outline our experience of some of the opportunities for improving care at the ‘neighbourhood’ level, particularly developing primary care, community nursing teams, local voluntary and community sector partners and the neighbourhood infrastructure for promoting collaboration between providers;
- Highlight the enablers of service improvement which are most important for translating these opportunities into improvements in health outcomes.

In the subsequent sections, we consider some of the implications for funding organisational development within Primary Care Networks and individual providers of primary, community and preventative care.

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1 NHS England, 2019, *The Long Term Plan*

2 See, for example, NHS England and BMA, 2019, *Investment and Evolution: A five-year framework for GP contract reform to implement the NHS Long Term Plan* and, NHS England, 2019, *Universal Personalised Care: Implementing the Comprehensive Offer*, NHS England, 2019, *Interim NHS People Plan*.

## 1.1 THE NEIGHBOURHOOD CARE ECOSYSTEM

One of the key features of the *Long Term Plan* is a commitment to significantly strengthen primary care and community nursing, and to work with partners to better prevent ill-health.

The vision of the *Plan* is both for individual providers to deliver better care, and for providers to more effectively collaborate as neighbourhood systems within a wider Integrated Care System (See Figure 1). This represents a significant agenda for change at the neighbourhood level.

### Primary care

For primary care, the next five years should involve a significant growth in scope and scale. More care is expected to shift from hospital to community settings, and more investment is planned on prevention.

**FIGURE 1: AN EFFECTIVE LOCAL CARE ECOSYSTEM**





The new GP contract promises £2.2 billion per annum in additional expenditure by 2023/24, as part of an overall commitment to at least an additional £4.5 billion in primary and community care. Alongside an aspiration for an additional 5,000 GPs, the wider clinical primary care team is anticipated to grow by 20,000 people. This represents a growth of two thirds from the 30,000 staff today.<sup>3</sup> Using these resources, providers are expected to implement a range of specific service improvements, further extend access and make better use of technology to engage with patients. GP practices are expected to collaborate through Primary Care Networks (covering a population of 30–50,000 patients) to deliver much of this growth and improvement in health outcomes.<sup>4</sup>

### Community nursing

Plans for community nursing are principally being developed locally rather than following a national blueprint. However, the *Long Term Plan* stipulates that configuring district nursing along Primary Care Network footprints ‘will now become the required norm.’<sup>5</sup> Further, the experience of other countries suggests that a renewal of generalist district nursing teams, to enhance the continuity and integration of care for those who are frail and/or living with complex needs, will be as important to delivering the ambitions of the *Plan* as the strengthening of primary care. (See Box 1 on Buurtzorg Nursing). Achieving this renewal will be challenging against a backdrop of a 11% decline in the overall community nursing workforce since 2010, including a 45% decline in district nursing, and high vacancy rates.<sup>6</sup>

Alongside stronger primary care and community nursing, an effective neighbourhood ecosystem of care clearly rests on better engagement with specialist services, social care and local partners to prevent and

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3 NHS Digital, 2019, *GP Practice Workforce Final 31 December 2018, Experimental Statistics*.

4 The total Primary Care Network contract funding nationally will reach around £1.8 billion pa by 2023/24, of which c. £1.24 billion will be new money. The £1.8 billion will include: £0.9 billion for 20,000 additional staff to develop multidisciplinary teams; £0.14 billion for the administration and leaderships of Networks; £0.47 billion (largely existing funding) for improved access; and up to £0.3 billion available as incentives linked improvements such as reducing unnecessary hospital admissions and better discharge from hospital.

5 NHS England, 2019, *The Long Term Plan*, page 14.

6 House of Commons Health Committee *The nursing workforce Second Report of Session 2017–19, January 2018*.

## BOX 1: BUURTZORG COMMUNITY NURSING

The Dutch Buurtzorg model of nurse-led relationship-based care has generated significant interest from the Royal College of Nursing, Health Education England (HEE) and others. The Secretary of State for Health in England has also expressed his support, and various community providers are exploring, and in some cases, piloting the model.

In the Netherlands, around 10,000 community nurses are currently working in Buurtzorg teams, caring for 100,000 patients a year; a remarkable rise since the first team was established in 2006. Nurses typically meet people's full range of needs across health and care, working with GPs as equal partners and only using specialists where absolutely necessary. The focus is on establishing relationships with patients. Teams are self-managing, organising staff rostering and other management tasks themselves and only drawing on a team coach when needed.

Not only has this led to better outcomes at lower costs compared to standard models of care in the Netherlands, but client satisfaction and staff commitment at Buurtzorg are also among the highest of any healthcare organisation in the country.<sup>7</sup> Relationships and trust between GPs and district nurses has also improved as GPs have observed the benefits of the model. Over time, Buurtzorg's overheads have fallen to just 8%: the central back office comprises of 45 staff and 22 coaches to support the 10,000 front line nurses.

Social Finance's experience of considering investment in these models of nursing suggests the approach has significant potential to make a transformative impact on care and health in the UK, in particular with respect to the recruitment, training and retention of nursing staff.

manage ill-health. This paper does not cover social care (given the forthcoming Green Paper) or specialist services. However, from the perspective of the neighbourhood system, it is important to highlight

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<sup>7</sup> See KPMG, 2015 De toegevoegde waarde van Buurtzorg t.o.v. andere aanbieders van thuiszorg [the added value of Buurtzorg compared to other providers of domiciliary care], and <https://www.buurtzorg.com/about-us/>

the contribution and collaboration expected by local partners that have a role in preventing ill-health and improving wellbeing.

### Community organisations and networks

The *Long Term Plan* highlights the recruitment of 1,000 social prescribing link workers, to help link patients with non-health support and advice. In turn, this rests on the presence of strong local community organisations and informal networks which provide social and cultural activities, physical exercise and foster the friendships and informal relationships of mutual support that are important determinants of health and wellbeing. Whilst not a sector the NHS has primary responsibility for, it's one in which the NHS has an important stake.<sup>8</sup>

### Employment and economic growth

The *Plan* also recognises the importance of employment and economic growth. With over 3.5 million people out of work due to a long-term health condition or disability, developing a more integrated approach between health and employment is important for patients' wellbeing and has a significant implication for the local economy and government expenditure. The cost to government alone exceeds £50 billion per annum.<sup>9,10</sup> This is an area where joining up between the health and employment sectors has often been poor in the past.<sup>11</sup>

### Better collaboration

There is an expectation that providers in neighbourhoods will better collaborate, both to integrate care around the needs of the individual patient and to more effectively allocate and monitor local resources to maximise population health improvement.

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8 For example, as has been highlighted in the last year by central government, activities which strengthen people's social relationships and sense of belonging, and help reduce loneliness, have an important long-term term impact on health. See Masi M *et al*, 2011, 'A Meta-Analysis of Interventions to Reduce Loneliness', *Personality and Social Psychology Review* 15(3).

9 See for example Van der Noordt M *et al*, 2014 'Health effects of employment: a systematic review of prospective studies' *Occupational and Environmental Medicine* 2014; 71. The Long Term Plan highlights the importance of links between health providers and employment support (see Annex 1 of the *Plan*).

10 Department for Work and Pensions, 2016, *Work, Health and Disability Green Paper Data Pack*.

11 For example, the *Fit for Work* telephone advice service was under-utilised and has recently been closed.

This capacity for collaboration and local system development is likely to evolve principally out of Primary Care Networks. At a minimum this will require overseeing the development of multi-disciplinary teams within primary care and specific service developments to enhance out of hospital care. However, the wider opportunity is to bring together local providers and staff to better allocate resources and continuously improve the services provided to patients.

## 1.2 SOCIAL FINANCE EXPERIENCE - THE IMPORTANCE OF INVESTING IN ORGANISATIONAL CAPACITY AT PROVIDER AND SYSTEM LEVEL

Over the last four years, Social Finance has been working in partnership with local health and social care systems to support the growth of preventative and community-based care. Using socially motivated external investment or public money, we have supported the development of around twenty organisations and programmes which aim to contribute to the objectives of the *Long Term Plan*. These include the development of large GP practices, emerging Primary Care Networks, community nursing, social prescribing and a range of more specialist services (see Box 2).

While these investments have been modest (between £0.5 – £1.5m each) and as a small sample are not necessarily representative, they have involved the considerable risk associated with the early stages of a programme or social enterprise. Many involve outcome-based contracts, and therefore the return on investment is dependent on achieving a pre-defined improvement in people's health and wellbeing and/or a reduction in the use of acute or other services.<sup>12</sup> Prior to investment, we have typically also undertaken due diligence on a range of other providers and drawn on national and international best practice.<sup>13</sup>

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12 These types of outcome-based contracts linked to investment are often described as Social Impact Bonds.

13 In addition to these direct investments, Social Finance undertakes advice to providers and commissioners on how to deploy their own funds for transformation – which in recent years has included working with New Models of Care Vanguard sites, Primary Care Home practices and providers of preventative and wellbeing services.

## BOX 2: INVESTING IN THE DEVELOPMENT OF PRIMARY AND COMMUNITY CARE

Social Finance is a not-for-profit social enterprise which seeks to work in partnership with others to develop and invest in better responses to social needs, particularly those faced by vulnerable groups. Over the last four years we have been exploring ways to support improvements in health and wellbeing through deploying socially-motivated investment and grants into preventative and community-based services.

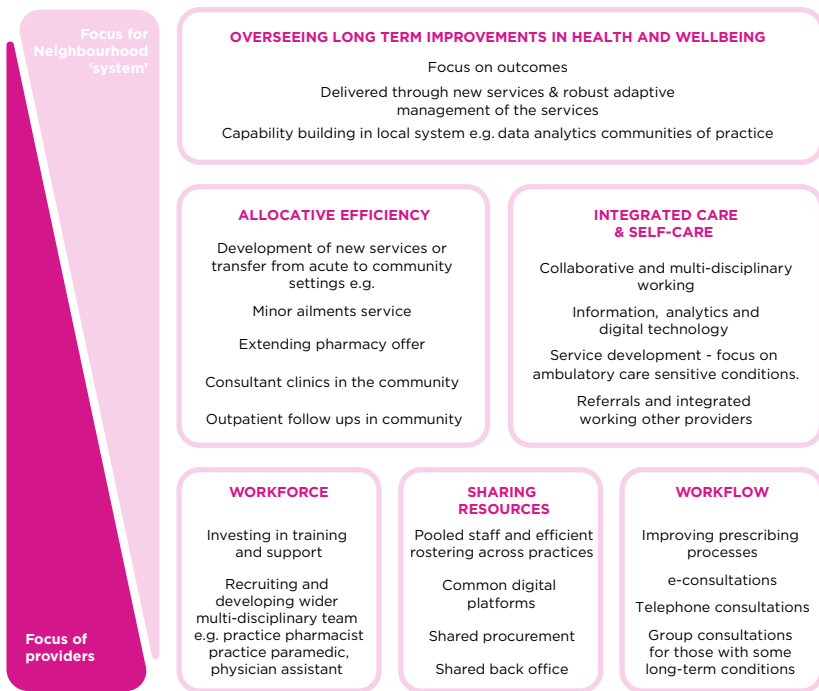
For example, investments made to date from the £12 million Care and Wellbeing Fund managed by Social Finance on behalf of MacMillan Cancer Support and Big Society Capital, include:

- **Primary Care** – an investment into Symphony Healthcare Services, a large, innovative primary care organisation in Somerset which arose from the Symphony Vanguard programme
- **Community Nursing** – a seed investment into SK Nurses, a social enterprise that aims to support the development of self-managing teams of district nurses
- **Social Prescribing** – developing *Reconnections*, a county-wide service for helping older people overcome chronic loneliness in Worcestershire
- **Community-based End of Life Care** – such as establishing the *Your Life Line* end of life care coordination and rapid response nursing service in Hillingdon

In addition, through specialist funds, Social Finance has invested in social care and integrated health and employment services.

The investments draw on funding from strongly socially motivated investors, usually charities or charitable foundations such as Macmillan Cancer Support and the Joseph Rowntree Foundation, together with public money from Big Society Capital. Investors are typically seeking to achieve a combination of direct impact on patients, the testing of system improvements and at least the repayment of their funding (ideally with a small return).

**FIGURE 2: TYPICAL INVESTMENT NEEDS IN A NEIGHBOURHOOD SYSTEM**



As Figure 2 sets out, Social Finance’s experience is that a range of developments are typically required at the local level; very much in line with the the *Long Term Plan* strategy.

A consistent finding from our experience is the need to ensure that an expansion in front-line workforce and service funding is accompanied by a comparable strengthening of organisational and local system capability for service improvement.<sup>14</sup>

Few in the health service would disagree that capability to manage service improvement is critical to the effective deployment of new front line-resources. Quality improvement and other approaches to building service and organisational capability have been given greater attention in recent years.<sup>15</sup>

14 The aim of this paper is not to seek to assess the investment need for front-line service developments, but rather to focus on this question of capability for improvement.

15 Such an emphasis on organisational capability is at the heart of a Quality Improvement Agenda. See, for example, The King’s Fund and Health Foundation, 2017, *Making the Case for Quality Improvement*.

Nevertheless, Social Finance's early investment experience has reinforced the importance of getting these features right to meet the ambitions of the *Long Term Plan* and to improve capability for service improvement in fragile providers of primary care, community and preventative services and nascent neighbourhood systems. We have also seen how, despite the interest in building capability for service improvement and widespread rhetoric, resources for these activities and functions are often very squeezed in the primary, community and preventative care sectors.

Typical enablers of organisational and system improvement include:

- Better understanding patient/service user needs and aspirations – as the foundation for developing better services;
- Quality of leadership and management – Social Finance now employs practitioners with coaching experience to work alongside the provision of investment, often to help middle leaders improve core management skills such as addressing under-performance in their teams;<sup>16</sup>
- Service redesign capability – having the capacity to engage in detailed collaborative development and to learn from others who have implemented similar services if required.
- Good project and programme management – many of our investments have required the recruitment or secondment of dedicated programme management support to work alongside line managers in the implementation of change because it is not available within providers;
- Applying analytics and insights – the challenge is often not the lack of data, but that organisations and systems are frequently not able to apply relevant information and insight to inform rapid service improvement and innovation.
- Continuous improvement approaches – such as routinely reviewing a proportion of all patient case files to inform service performance.

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<sup>16</sup> This emphasis does not necessarily mean increasing management cost per se. Plenty of effective organisations have flat structures, empower staff, make good use of enabling technology and achieve low long-term overheads, but they often require good oversight to reach this level.

- Relationships with other parts of the local system – for example in establishing the systems to improve referrals and collaboration between practitioners.
- Core administrative, finance and HR processes and systems – such as using simple digital tools to speed up workflow, improving Client Record Management systems and finance systems.

Of course, not every provider or local system needs such development. There are plenty of great examples of providers and local networks focused on effective implementation of change and continuous improvement. Nor are gaps in effective service improvement functions surprising, given that many primary care practices and care organisations are small and have been under enormous financial pressure.

Yet in the context of the *Long Term Plan*, we consider that it is crucial to emphasise the importance of addressing these challenges. The temptation is always to acknowledge the importance of these attributes, but to focus primarily on front line funding and staff numbers.

Given that Social Finance is making investments at risk, often with payments dependent on the achievement of outcomes,<sup>17</sup> the critical role of service improvement capability quickly becomes apparent. For example:

- In our ‘Reconnections’ social prescribing investment, which had a challenging start, spending an additional 20% of total resources specifically on more experienced management and greater service development activities (and initially cutting back on the number of front-line staff) has led to a sustained improvement in outcomes over time. The programme is achieving roughly 50% greater reductions in loneliness than at the start (see Box 6).<sup>18</sup>
- Even across four good providers of integrated health and employment support (Individual Placement and Support) with similar levels of resources, we have still found the outcomes

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<sup>17</sup> For example, some of the Social Finance investments involve contracts in which payments are only received if hospital admissions fall and others only if wellbeing outcomes improve.

<sup>18</sup> See Box 6. Average reductions in self-reported loneliness 18 months after referral, using the standard UCLA scale, have grown from around -0.8 pts among initial cohorts in 2016/17 to around -1.2 pts in 2018/19.



achieved can vary by more than two-fold, in significant part due to these factors.<sup>19</sup>

- In a number of investments, lack of local ‘system capability’ to enhance collaboration has, frustratingly, led to new front-line resources being under-utilised because of insufficient appropriate referrals have been received from GPs, social workers and others. Such under-utilisation of new services has cost our investors at least £1 million over the last four years.
- In many primary and community care organisations, improvements in core HR and financial management systems have been prerequisites for investing in specific service improvements, although the pressure is often to change the front-line services first.

Above all, we have found that improving health and financial outcomes rests far more on whether a practice and culture of continuous improvement is established, rather than the strength of the evidence informing the original investment case.

These are familiar stories. Similar points around service variation, the importance of good management and of systems joining up have been made for decades. However, as an investor seeking a combination of social impacts and a financial return, the long term costs of not investing in organisational and system capability are very tangible.

In the rest of this paper, we therefore draw on our experience to consider two questions:

- i. What enablers of service improvement are typically required at the Primary Care Network (neighbourhood) level if local providers are to collectively deliver more integrated services and improve population health? (Section 2)
- ii. What greater organisational capacity is typically required within individual providers of primary, community and preventative care? (Section 3).

For each, we consider the potential implications for funding.

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19 Benchmarking of four providers of Individual Placement and Support (IPS) investments in 2018/19 found employment outcomes (employment for at least six weeks) ranged from 0.5-1.2 per employment adviser between different providers, despite following the same programme and with similar levels of funding. It is important to note that although national comparisons are difficult, it is likely that all the programmes are relatively well performing. ‘Fidelity’ to the IPS model is also a specific factor alongside other elements of organisational capability.

## 2 Developing Primary Care Networks into Neighbourhood Integrators

Given that service development and improvement is often best overseen across a neighbourhood system, this section explores how such system development capability could be developed. In particular, we:

- Suggest that Primary Care Networks could have the potential to become neighbourhood 'integrators' of care, leading the drive to enhance population health and personalise services, rather than just overseeing the expansion of primary care;
- Estimate the resources which might be required to achieve such neighbourhood system capability as £150-£250k per annum above the core GP Contract funding;
- Consider potential sources of funding for such an enhanced Primary Care Network model and suggest that local commissioners focus additional funding on a small number of Networks where relationships are most advanced and the scope for reducing health inequalities is greatest.

### 2.1 PRIMARY CARE NETWORKS AS 'NEIGHBOURHOOD INTEGRATORS'

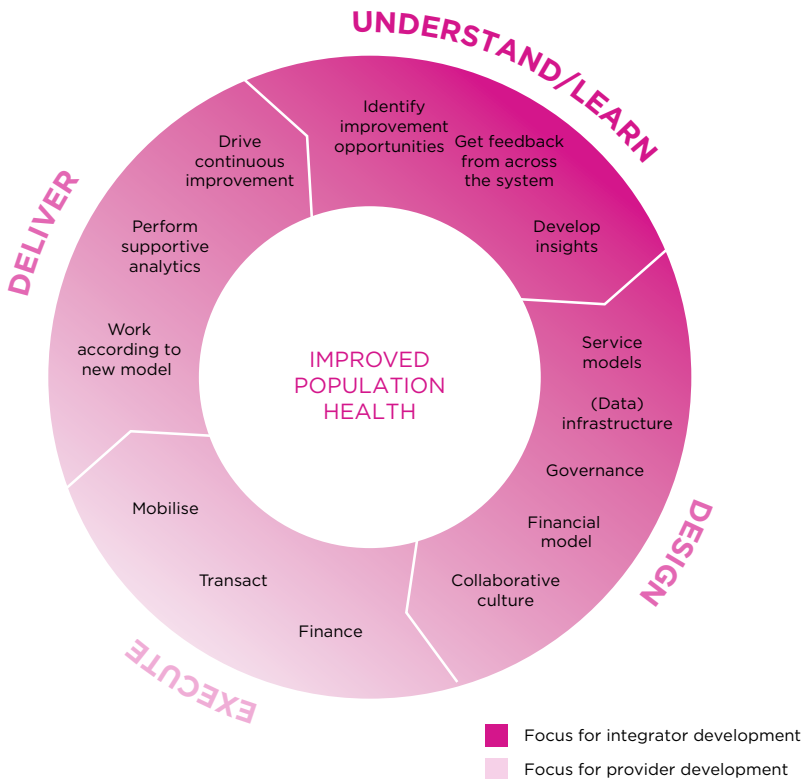
The development of emerging Primary Care Networks varies enormously between different parts of the country and often from one neighbourhood to another. Some Networks are nascent, while others already help plan and develop innovative services together.

In our view, strong Primary Care Networks have the potential to be the foundation of an NHS which provides better care, enables better health and makes better use of resources.<sup>20</sup> Whilst system integration needs to take place at many geographical levels, Primary Care Networks have

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20 This combination of aims and the concept of an 'integrator' to achieve these has been articulated by Don Berwick and others at the Institute for Healthcare Improvement over the last two decades. See, for example, Berwick D *et al*, 2007, 'The triple aim: care, health, and cost', *Health Affairs*, vol. 27 no. 3. More recently, some have proposed improving the work life of health care professionals as a fourth overarching aim. The 'integrator' concept – an organisation able to take a system view in how to achieve these aims – is more frequently promoted in relation to larger geographical areas including acute provision, such as the emerging Integrated Care Systems in England. However, as an approach it can be applied at any geographical level.

**FIGURE 3: CONTINUOUS IMPROVEMENT ACROSS A NEIGHBOURHOOD ECOSYSTEM**



an important potential role in enabling rapid and continuous service improvement around the needs of patients (see Figure 3).

We consider that the Primary Care Network is often the best building block for better care because:

- The Network level is small enough to bring front-line staff together, so that integration is more likely to be focused on practical collaboration around patient needs rather than organisational systems and structures.

- A Network is large enough for those working in a neighbourhood to also take an overview of needs, share resources and play a role in addressing the wider determinants of health.
- Unlike commissioning, and previous initiatives such as GP Fundholding and Practice Based Commissioning, the Network has the scope to focus on improving community based care rather than getting too absorbed by the challenges facing the delivery of acute care.

Social Finance has seen this potential for enabling service improvement in emerging Networks such as Newcastle Healthy Futures (see Box 3), in working with some of the leading Primary Care Home sites and in visiting international exemplars of local integrated care such as OptiMedis in Germany (See Box 4). OptiMedis, for example, has some of the best evidence in Europe for improving health outcomes and slowing the rise in overall health costs. It is helpful to consider such enhanced Network models as neighbourhood integrators.

## 2.2 RESOURCING NETWORKS TO BECOME INTEGRATORS

What resources would be required for Networks to play such a neighbourhood integrator role, with the capability to drive improvement in population health rather than simply oversee a limited set of service developments?

International experience suggests that such an approach can be relatively resource intensive. The OptiMedis model, for example, works in geographical localities of around the same size as a Primary Care Network. OptiMedis aims to invest EU3-EU5 million (£2.5-£4 million) in integrator capacity in each local area over the first three years (See Box 4). Although some of that is spent on non-health activities, much is assigned to analytics, coordination and continuous improvement.

The need in England is not the same as in Germany. GP Practices in Germany are more likely to be single-handed, and therefore rely more on the network/integrator. Nor do they benefit from the NHS infrastructure. As such, neighbourhood integrator resource needs in England should be lower.

### BOX 3: NEWCASTLE HEALTHY FUTURES

Newcastle Healthy Futures is a partnership between three GP practices, two charities focused on supporting vulnerable groups and communities, the University of Newcastle and Social Finance's Care and Wellbeing Fund. It is at the heart of an emerging Primary Care Network, with a strong focus on improving the overall wellbeing and health of residents of one of the most deprived parts of the UK, in the west end of Newcastle.

The practices have already been collaborating for a number of years and are at the forefront of social prescribing, helping to develop and implement the Ways to Wellness Social Prescribing programme across the West of Newcastle. With the additional partners they are testing a variety of other ways to strengthen local communities and improve outcomes for residents including:

- Recruiting a vocational rehabilitation specialist to work alongside GPs to support those at risk of falling out of work due to ill-health
- The development of a community hub building, where a variety of health related and wider preventative activities can take place
- More intensive personal support for particularly vulnerable groups, such as those who are homeless

With support from the Health Foundation, a dedicated manager has been recruited to deepen collaboration and continuous improvement. A separate Community Interest Company is being formed. It represents the type of Primary Care Network which could benefit from being part of a programme to become a neighbourhood care integrator.

However, Social Finance's due diligence and research among emerging Networks indicates that many feel under-resourced to properly oversee population health improvement rather than *ad hoc* service initiatives.<sup>21</sup>

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21 This analysis draws on interviews and engagement with around a dozen emerging locality networks and groups undertaken in 2018.

## BOX 4: OPTIMEDIS LOCAL INTEGRATED CARE

The OptiMedis local integrated care model in Kinzigtal, southern Germany, is widely regarded as one of the most successful models of local integrated care in Europe. Over ten years, patients supported by OptiMedis in Kinzigtal have seen healthy life expectancy rise by over a year and costs are 7% lower compared to benchmarked population groups.<sup>21</sup> Staff retention and morale has improved, and patient satisfaction is very high. OptiMedis are now expanding to other areas, such as Hamburg, and undertaking some collaboration in the UK.<sup>22</sup>

At the heart of the model is a local 'integrator' team that provides analytics, planning, the sharing of best practice and targeted developments of (usually non-clinical) services to enhance health and wellbeing. This is a long-term task. In Kinzigtal, the development and impacts of strong networks of health professionals, strengthened community activities and the use of data science to support service prioritisation and adaptation grew progressively over many years.

The OptiMedis central team benefited over the first five years from an initial c.€4 million (£3.5 million) grant in Kinzigtal, covering a local primary care network of 30,000 patients, in addition to the core health revenue funding. When considering expansion, OptiMedis suggest €3-5 million start-up investment spread over the first three years per local area for local management, technology, care plans, integration architecture and support for additional activities. Although they suggest that there would be some economies of scale in developing such a model in many areas simultaneously, they estimate these to only be around 20% because each local area will need a small team.

Our assessment suggests that Primary Care Networks will typically need the following capacity and capability if they are to act as neighbourhood care integrators:

- Clinical lead, usually a senior local GP (part time)

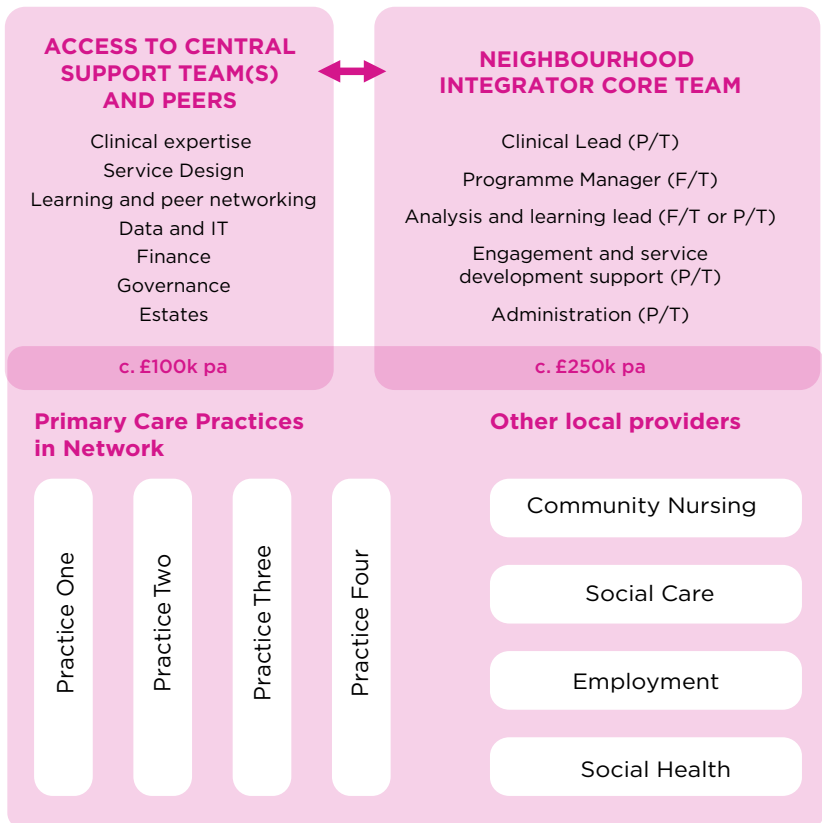
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22 Pimperl *et al*, 2017, *Case Study: Gesundes Kinzigtal Germany*. Duke Margolis Center for Health Policy and The Commonwealth Fund.

23 In the UK, OPTIMEDIS-COBIC is seeking to support health systems to develop the model see [OptiMedis-cobic.co.uk](http://OptiMedis-cobic.co.uk)

- Programme manager (full time)
- Service development support to facilitate service design and implementation (part time)
- Analytical support capable of producing influential, actionable analysis that goes beyond access to a standard informatics system (part time)
- Good administrative support

**FIGURE 4: TYPICAL RESOURCES FOR A NEIGHBOURHOOD INTEGRATOR**



- Access to additional expert support when required, such as service design, clinical pathway improvement, data analytics, finance, estates
- Access to good peer support, evaluation and benchmarking, to allow local leaders to properly learn from others.

We consider that this level of capacity will typically cost around £250,000 a year for the core team and £100,000 a year (in cash or kind) for drawing on central/specialist resources.<sup>24</sup> To put this in context, it is less than a third of the OptiMedis costs. It represents around £7 per head of patient list, compared to around £22 per head of population that CCGs currently receive to cover their administrative functions. The recent NHS New Models of Care Vanguards received around £15 per head (from which they often also funded some non-core service development).

## 2.3 DISCUSSION – POTENTIAL SOURCES OF FUNDING

The new GP Contract framework provides some resources. Central funding for a typical Primary Care Network will support a part-time clinical director, part-time programme manager and some administration support. A Network supporting 50,000 patients will receive around £100,000 per annum (£2 per head of population).

This central funding significantly exceeds previous programmes. Leading Primary Care Homes, for example, received around £40,000 as a one-off payment from NHS England.<sup>25</sup> Nevertheless, finding the additional £150–£250k per annum locally is likely to be challenging.

Some resources may be already allocated to locality development and could be merged. Some might be freed up by merging CCGs, although commissioners are already scheduled to make significant savings in their administrative budgets. Some of the central support may come from NHS wide analytics and digital programmes. The NHS is also

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<sup>24</sup> Calculation based on typical salaries. Where emerging Networks are rooted in existing GP large practices and federations, some of the leads that we interviewed highlighted the scope for economies of scale with this established infrastructure.

<sup>25</sup> See Kumpunen S *et al*, 2017, *Primary Care Home: Evaluating a new model of primary care*, Nuffield Trust.



currently seeking to support 14 Primary Care Networks to become 'accelerator' sites, with access to an additional £200k each.<sup>26</sup>

However, local areas would generally need to spend a proportion of their new local allocations on core Network capacity if they wish some or all of these to evolve into neighbourhood integrators.

Would this represent value for money in the current environment of multiple demands on limited resources? Commissioners may consider that an alternative is to keep Networks' capacity very 'light' and locate most of the development, analytics and improvement functions at a 'locality' or Integrated Care System level.

Social Finance's assessment is that a neighbourhood integrator model has the *potential* for significant benefits. As we outlined in the opening section, a neighbourhood model has potential advantages compared to traditional commissioning structures and 'integrators' which act across larger geographical units. Drawing on our experience of the importance of service improvement capability, a detailed study in one primary care home area and in one Vanguard site, and literature reviews on specific services, we have concluded that local investment could represent value for money, but acknowledge that there is still uncertainty around the investment case.

In summary:

- As highlighted in the previous section and examples such as OptiMedis, there is good evidence that the quality of care could be improved by having a good, locally embedded capacity for continuous improvement across the system;
- Like all integrated care initiatives (at various levels) there is reasonable evidence about the impact on people's health and satisfaction, but less certainty over the impact of acute health use/costs, partly because good local services can highlight unmet demand. It is therefore important to ensure that care co-ordination leads more allocative efficiency (moving people to more cost-effective interventions) and providers identify any opportunities for short term efficiency gains as well as long-term demand reduction;

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<sup>26</sup> See <https://www.healthcareleadernews.com/nhs-england-to-offer-up-to-200k-per-selected-network-accelerator-site/> accessed 6<sup>th</sup> June 2019.

- Realising health and financial benefits rests on local providers fully engaging in the approach, and in the long-term from capturing economic as well as health service benefits;
- The availability of an excellent clinical lead and programme manager should be a requisite for any funding; without such leadership a neighbourhood integrator is unlikely to improve outcomes.

In the current funding environment, we therefore consider that investment in such a neighbourhood integrator capacity is most likely to be justified in cases where:

- i. There are already strong relationships and commitment across primary, community care and wider local services, largely good providers and the scope to hire a high quality and entrepreneurial team;
- ii. There is also significant scope to reduce health inequalities i.e. in more deprived areas.

An Integrated Care System/Sustainability and Transformation Partnership (STP) could identify a small number of Networks to pioneer such an 'enhanced' neighbourhood integrator model. A varied local approach across an STP clearly has some complexities and may not be appropriate in every area. However, an initial cohort of enhanced Networks could spread learning to neighbouring Networks if and when the model is proven and those other Networks develop their relationships.

Finally, we consider that it will be important to consider the interaction between any additional neighbourhood integrator funding and the Investment and Impact Fund within the new Primary Care Network contract. This has the scope to provide around £300,000 pa per Network by 2023/24, linked to achievements in reducing acute service use and prescribing spend. It would probably be appropriate for a proportion of revenue earned from this Fund to support ongoing neighbourhood integrator costs, given that the additional capability from such a team should help the Network achieve the Fund targets.

## 3 Investment in the organisational capacity of providers

This Section considers the second element of local capacity development; that which is best located in providers. In particular, we:

- Estimate the one-off investment required to strengthen the capacity of typical primary and community providers to meet the *Long Term Plan* ambitions as £8-£15 per head of population covered, excluding significant digital investment (based on a small number of examples and therefore subject to uncertainty).
- Highlight the much higher organisational investment needs for developing more radical, disruptive new models of service delivery.
- Consider the options for incentivising and enabling this investment, recommending that well-designed contracts and access to soft loans are the best enablers of investment for general organisational capability development, but that grant programmes which draw upon investment approaches are still required for radical innovation.

### 3.1 INVESTING IN INCREMENTAL IMPROVEMENTS IN PROVIDER CAPACITY

Like emerging Primary Care Networks, the organisational strength of local providers varies enormously.

For example, as the 2018 Carter Review of Community and Mental Health services highlights, some community nursing services have made big strides in the use of digital technologies to improve productivity, while others have seen very little progress.<sup>27</sup> Some have clarified and simplified the roles of different community services, but others still risk duplication or fail to join up services.

Likewise, some GP practices have undergone very significant organisational change – for example through the merger of GPs into much larger practices. Others have pioneered some of the approaches

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<sup>27</sup> NHS Improvement, 2018, *Lord Carter's review into unwarranted variations in mental health and community health services*. NHS Improvement.

advocated in the *Long Term Plan*.<sup>28</sup> But for many, the front-line pressure on demand and challenges of recruitment have weakened their capacity to develop and improve the way that they work over the last five years.

As highlighted in Section 2, some of the common gaps in providers' organisational capacity include:

- Service development capability. For example, the King's Fund has highlighted Primary Care often 'has less access to the management skills required, such as organisational development intervention, improvement expertise and experience.'<sup>29</sup>
- Core organisational systems and processes, including in HR and finance systems, core IT and patient record systems and new channels of communicating with patients. The anticipated growth in multi-disciplinary staff and commitments to digital access will make such capability more important.

Given the variability in the existing capacity of providers and in local needs, quantifying the cost of such developments is inherently difficult.<sup>30</sup> Social Finance only has a small number of data points to draw upon. However, based on our experience to date, we tentatively estimate that the one-off investment required to help implement the commitments in the *Long Term Plan* may typically involve:

- GP practices investing around £5–8 per patient in developing core organisational capacity *in addition to any national programmes for digitisation*. This might be used to fund short-term management capacity to plan the development of the extended workforce, investment in better back-office systems and some training and support. Turning around struggling or failing practices can involve much higher costs.
- The re-organisation of community nursing services into Network based local teams can involve transition costs of around £3–£7 per head of population, *again excluding major IT developments*. That

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28 Changes have sometimes been helped by the £1 billion Primary Care Infrastructure Fund, to support the long-term project of moving practices into more appropriate accommodation.

29 Baird B *et al*, 2018, *Innovative Models of General Practice*, The King's Fund.

30 The lack of public transparency around detailed costs within GP practices and NHS community trusts makes an accurate assessment particularly challenging.

might be required to support service re-design, the development of local systems and the potential staff restructuring costs.

Taken together, this suggests that non-recurrent organisational development costs for providers might range from £8–£15 per head of population over the next five years (£400k–£750k of one-off/non recurrent spend per Primary Care Network area, although typically providers will cover different geographies).

### 3.2 INVESTING IN MORE RADICAL ORGANISATIONAL INNOVATION

It is important to highlight that such relatively modest non-recurrent investment would only support developing the core capacity of providers for implementing the *Long Term Plan* objectives and playing a role in the continuous improvement of services.

In addition, the NHS needs to consider whether to seek to enable investment in a further wave of developing and testing more radical service and organisational changes, such as testing an acceleration in digitally delivered care or very different workforce compositions.

Here, the lesson from around the world is that much more significant investment in new organisational structures is required in the first instance, potentially delivering lower-costs models in the long-term.

Box 5 highlights the example of Iora primary care practices in the US. Iora is a model which has attracted attention in the UK.<sup>31</sup> They are developing more proactive care models, particularly a much greater use of health coaches, and are significantly investing in digital systems to help plan and manage care. Reaching an initial 80,000 patients involved investing \$125 million dollars (around £1,100 per patient, magnitudes higher than the £15 per patient per head average expenditure on New Models of Care Vanguard highlighted in Section 2). Clearly, launching a start-up involves significant development costs, such as investment in proprietary IT systems and initial operating losses. However, it highlights that we need to be wary of believing that England can test radically different delivery models without deploying significant investment.

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31 See for example, Baird B *et al*, 2018, *Innovative Models of General Practice*, The King's Fund.

## BOX 5: INVESTING IN SIGNIFICANT SERVICE AND ORGANISATIONAL INNOVATION - IORA

The Iora primary care practices in parts of the US are seeking a radical shift in the balance between primary and acute care. They are focused on making significant use of non-clinical 'health coaches' to support a greater range of people's wellbeing and emotional needs, alongside one GP per 1,000 population. Impact from the first dozen or so practices is very promising; hospitalisation is about a third lower than the population-adjusted average and patient satisfaction is high.<sup>32</sup>

There are obviously differences between the US and UK contexts, and we start from a more comprehensive model of primary care and a lower cost system overall. However, it is still instructive that the Iora model involves not only significantly greater recurrent expenditure on primary care (shifting resources from hospital to the community) but also much higher organisational investment than any we are aware of in primary care in England.

Iora has raised around \$125 million to establish 24 practices, covering fewer than 100,000 patients. Although it is likely that some has been used to support initial operating losses, much has been invested in underlying organisational infrastructure. A further \$100 million was raised in 2018 to support further expansion.<sup>33</sup>

Even working within modest preventative care projects, Social Finance has found innovation requiring a much greater investment in core capability than local commissioners are comfortable supporting (See Box 6 on Reconnections). Additional overheads for an innovative programme can easily be double or treble the management overheads required for 'business as usual'.

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32 Commonwealth Fund <https://www.commonwealthfund.org/publications/newsletter-article/2016/mar/focus-redesigning-primary-care-those-who-need-it-most>

33 Published interview with Rushika Fernandopulle, MD, co-founder and CEO of Iora Health 18 June 2018 <https://www.healthleadersmedia.com/clinical-care/iora-health-looks-kick-industry-behind>

## BOX 6: RECONNECTIONS - EFFECTIVE IMPLEMENTATION OF SOCIAL PRESCRIBING FOR THOSE WITH COMPLEX NEEDS

Reconnections provides personalised support for chronically lonely older people in Worcestershire. Reconnections is delivered by a small partnership of community organisations, led by Age UK Herefordshire and Worcestershire. The service is funded through a Social Impact Bond, in which socially motivated investors cover up front costs, and only receive their money back from the local health and care system if and when outcomes improve (in Reconnections case, a reduction in loneliness).

Since launching in summer 2015, around 2,500 older people have been referred to the service and over 1,400 received personalised support to help them re-engage with others and activities of their choice. It complements social prescribing link workers, enabling people with more complex needs and suffering from chronic loneliness to receive support from a volunteer or case worker for 6 to 9 months. To date, impacts have exceeded expectations, with self-reported loneliness falling by 1.4 points on the standard measurement scale against an expectation of a 0.8 point reduction based on the benchmark from other areas.

However, developing Reconnections as a new service required significantly greater service development and adaptation capacity than initially envisaged. Investors and grant makers have committed around £300,000 of non-recurrent funding in service development and innovation over the first four years, around a 20% supplement to core delivery costs.

## 3.3 DISCUSSION - ENABLING ORGANISATIONAL CAPACITY BUILDING

How should funders respond to this need for investment in organisational capacity and capability for service improvement? There are instances where separate national funding and development programmes are appropriate, for example around some digital programmes and management training. There will also be instances where one-off funding is necessary, such as in the turnaround of a GP practice at risk of closure.

However, the track record of national organisational capacity building and development programmes is mixed. For example, the £150 million ChangeUp capacity building programme for the voluntary and community sector, which ended a decade ago, had an uncertain impact on front line delivery quality.<sup>34</sup> At worst, centrally funded capability building programmes can be perceived as a ‘free good’ and do not lead to actual changes in organisational processes, leadership or culture.

### **A systemic approach to enabling and incentivising investment in organisational capability**

Therefore, it is usually preferable to take a systemic approach to enabling and incentivising investment in organisational capacity so that it is clearly ‘owned’ by providers themselves. That is the model the NHS has generally sought to follow in theory, but has found difficult to always implement in a period of very tight resources. Elements of this approach include:

- Allowing *sufficient headroom in contracts* to allow investment in organisational capability – some contracts over the last few years have unsustainably squeezed management costs and assumed zero margin for long-term investment in systems and processes.
- Contracts with *sufficient length to repay investment in productivity improvements*. Social Finance has found that organisational capacity investments can take five to seven years to be fully repaid from productivity gains generated.
- Providers are *incentivised to achieve overall improvements in patient care and health outcomes over the long term*. It is through such incentives for delivering quality services and impact that organisations prioritise expenditure on measures to support continuous improvement. The new Investment and Impact Fund within the GP Contract could be a helpful incentive in this regard if the payment metrics are well designed.
- Some *additional incentives for good management and organisational systems within the assurance and regulatory process*. The CQC inspection framework and GP contract requirements around clinical governance already provide some incentives for good

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34 The formal evaluation portrays a mixed picture, with some positive indications around the growth of local ‘infrastructure’ organisations, but no clear correlation with the growth of front line delivery. See Third Sector Research Centre, 2009, *Evaluation of ChangeUp 2004-2008*.



systems and continuous improvement, but there may be opportunities to improve these incentives.

- Ensure greater *benchmarking of productivity*. The lack of transparency on costs, outputs and outcomes in much of the local care sector means organisations struggle to understand their scope for improvement and therefore probably under- or wrongly invest in capability to raise their productivity.

In addition, given the very low reserves or deficits in much of the primary and community care sector, our view is that easier access to low-cost loan capital for organisational development would be helpful. One question, therefore, is whether the NHS/Department of Health and Social Care should consider adapting its loan arrangements, and potentially to also include independent providers of primary and community care. This is a complex field. NHS Trusts can already borrow for technology and other projects to improve productivity. There are also specialist lenders to GP practices. However, it could be that the current Department of Health and Social Care model could be made simpler and more advantageous for smaller sized loans aimed at improving productivity through organisational capacity and capability improvements. This might involve a mixture of grant and loan finance or a zero percent loan scheme for GP practices.<sup>35</sup>

Socially motivated investors might also have a role in supporting social enterprises and potentially independent primary care practices more widely. For example, Social Finance has provided loans to primary care providers and the community sector which base a return on future revenues, taking more risk than traditional lenders.

### **Funding more radical organisational innovation**

Finally, reflecting on the need for investment in more radical organisational innovation in delivery models, our conclusion is that a carefully managed separate programme of NHS grant funding is likely to remain the most important source of funding in this field.

There is a role for social investors, and fully commercial investors, in backing independent providers develop very different delivery models, particularly where there are well-functioning markets and a need for non-NHS providers. Social Finance, for example, is exploring joint

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<sup>35</sup> Such loans would need to comply with State Aid requirements.

ventures with the NHS to support new models of community nursing delivery and the introduction of tele-health. There is potentially value in socially aligned external capital to better support major consolidation and organisational innovation within primary care.<sup>36</sup> Some preventative services are best managed at arms-length from the NHS.

Yet the development of integrated care and the weakening of the purchaser-provider split, for goods reasons, makes external investment more challenging. If the NHS wished to involve more commercial providers and venture capital centrally in transforming primary and community care (and there are good reasons not to), in our experience developing contracts to fairly reflect the risks and rewards from investing in radical innovation is technically very challenging.<sup>37</sup>

As a consequence, if the UK health service is to test models such as Iora, more disruptive models of community nursing provision or innovative preventative programmes, some form of national innovation grants are likely to be required. But such a programme could better draw on the principles of commercial investment to drive discipline in resource use. Elements might include:

- An investment fund managed at arms-length from NHS England, even if all or most funding comes from NHS England;
- An exploration of partnerships with charities and potentially socially motivated investors, in part to provide greater independence and additional perspectives on investment decisions (Social Finance has tested models of 50:50 investment with CCGs in innovative services);
- The scope to provide loans, equity or repayable grants as well as just traditional grants;

More hands-on support and challenge into new ventures and projects, such as ensuring director representation from the funding body on the board of any organisations receiving such investment and greater technical support.

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36 Such investment would need to comply with the rules around the ownership of GP practices and prohibition of the sale of 'goodwill' in GP Practices.

37 The recent experiences of contracting GP at Hand or the acquisition of primary care practices and community nursing contracts by Virgin Care exemplify some of these challenges.

## 4 Conclusion

Many of the themes highlighted in this paper are acknowledged in the *Long Term Plan*. Organisations such as the Health Foundation, as well as NHS Improvement, have long reflected the importance of the organisational and system capacity for service improvement. We are conscious that Social Finance's direct engagement with twenty or so projects over the last four years represents a limited sample.

However, it is also clear that many primary care, community nursing and preventative service providers have organisational frailties, and collaboration in many neighbourhoods is still in its early stages. Our fear is that the focus of implementing the *Long Term Plan* will gravitate towards the delivery of a pressing workforce, patient access and service implementation targets in the short term, and that investing in the capability for continuous improvement will be relatively marginal. In our view, there are risks that Primary Care Networks will not have the capacity to drive population health improvements at neighbourhood level. There are also risks that either providers struggle to deliver quality services or that poorly designed grant programmes do not embed long term improvements in organisational capability.

Promoting continuous service improvement at neighbourhood level is not just about resources. It requires clinical, managerial and political leadership across the NHS, fostering a culture of openness and ambition, providing training and support, and improving governance and incentives. But nor is the capacity for service improvement cost free. By sharing our estimates of the potential costs of developing organisational capability at the neighbourhood and provider level, and reflections on the right sources of funding and incentives for investment in these capabilities, we aim to stimulate discussion at local and national level about the provision and management of the resources required.

Our hope is that this helps local and national decision makers. As importantly, we hope that over the coming years primary and community care providers, Primary Care Networks and funders provide greater transparency around their investments. It would be useful to show information on expenditure, capacity and the impact on

outcomes and service productivity,<sup>38</sup> That will help allow better analysis and investment decisions in the future. Given the challenge of effectively implementing the *Long Term Plan* at neighbourhood level, we consider that addressing these needs will be a critical element of raising health outcomes, alongside addressing the immediate workforce and funding challenges.

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<sup>38</sup> NHS Benchmarking (<https://www.nhsbenchmarking.nhs.uk/>) does run benchmarking for NHS community trusts and is developing tools for Integrated Care Systems. We are not aware of plans for extending this to Primary Care Networks or a wider range of primary and preventative care providers.



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