DEVELOPING SUSTAINABLE PRIMARY CARE

Challenges facing general practice are increasing. This comes at a time of increased patient need, high demand for services and growing challenges in retaining and recruiting clinical team members. Day-to-day challenges also limit the ability of general practices to clearly plan for a sustainable future.

PCC has been supporting practices to prepare for the future by looking at ways they can become more sustainable. Our work has identified two main requirements for support:

- The need to ensure practices are well run, claiming appropriately and considering how the practice, as a whole, could work smarter.
- Planning for the future – how a practice will need to change in the next three to five years and how steps towards this can start now, to achieve early wins and boost morale.

General practices are responding to the increasing demands they face in several ways. Some are merging with other like-minded practices or working with other partners in the health economy. Others are collaborating to share back office or clinical skills to enable them to manage patients and workloads more effectively. This includes signposting to other local services.

PCC helps practices to manage these changes with:
- Project management support for mergers
- Experienced practice business management support to mentor and develop practice managers
- Signposting and reception staff training
- Premises strategy and relocations advice.

We also work with groups of practices to develop collaborative models and facilitation to encourage a clear vision and viable business plan.

Much of this support has been funded by NHS England or CCGs under the General Practice Resilience Programme, part of the GP Forward View.

If you would like to discuss how PCC can support your practices, contact enquiries@pcc-cic.org.uk
Super-partnership seeks to think big while acting local

“Are we too big? I would say no because we do not manage our practices: we support our practices to manage themselves. We avoid being centrally driven as the NHS has had enough of that. Coming from the acute sector where trusts run on a corporate model we know that you need accountability at the front line. In general practice you have that and it is very important you do not lose it.”

Talking at PCC’s recent Going with the Grain event, Newbold said: “We have a single board with a single purpose but not a single way of doing things. The word practice is no longer synonymous with partnership but this is still a partnership and not a corporation.”

This ethos is enshrined in the partnership deed.

With some 680 practice staff transferring under TUPE to the new super-partnership and an annual income of more than £40million, Newbold recognises that some might suggest his organisation is too big for general practice.

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The seven GP board members were elected by the partners after each submitted a 300 word manifesto.

“The GPs on the board are firsts amongst equals. They are there as leaders rather than managers. You don’t need management expertise to be on the board because they hired that in.

“Working as a board member is completely different to taking part in a practice team meeting as you are spending resources that are not yours.”

The important thing, he said, is for the board to communicate effectively with its GP members and to prioritise that representative role. It does this partly through regular partners’ meetings and locality gathering but Newbold admits that the organisation needs to continually think about how it reaches and informs busy GPs.

OHP achieves efficiencies by delivering functions such as finance and payroll centrally. Savings on accounting costs alone ensure that practices recoup almost half the £2 a patient subscription fee, Newbold says.

Among the other benefits of membership are OHP’s banks of locums and other healthcare professionals, central procurement, monthly payroll services and benchmarking reports.

The latter will be accompanied by regular dashboard reports that have taken on new significance now that OHP is to be registered as a provider with the Care Quality Commission effectively replacing individual practice registrations.

Newbold says: “We sit between the practices and the CQC. The practices will now be registered locations that we monitor. That means they will not be directly inspected as often, and we can generate an ethos of quality improvement through peer advice and support.”

Equally important, Newbold suggests, is the visible presence and voice that the super-partnership has belatedly given GPs in the development of sustainability and transformation plans (STP).

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The structure also increases the scope for local primary care providers to deliver new services – including through eventually evolving into some form of multispecialty community provider (MCP). The super-partnership’s central team is charged with growing the organisation by bidding for new contracts.

Newbold says there is an opportunity for the organisation to commission its own out-of-hospital services.

Early thinking around the possible MCP development includes discussion around a separate vehicle involving community, acute and mental health partners. First steps towards that goal could include ‘wrapping’ services such as physiotherapy and district nursing around practices.

However, Newbold insists that the partnership will remain intact and continue to be based on the GMS contract.

He says: “OHP demonstrates that independent general practice is viable, sustainable and able to contribute effectively to delivering the modern NHS. The partnership model of GP practices can deliver the transformation agenda.”

PCC can advise on all aspects of collaboration in general practice, from agreeing a shared mission to working through the legal detail and writing a business plan.

Contact enquiries@pcc-cic.org.uk for more information.
Cheshire takes its own steps to primary care at scale

The Cheshire Local Medical Committee and PCC recently brought together local GPs and practice managers to consider how to make a reality of NHS England’s vision of primary care at scale.

The half-day session was intended to outline a sensible step-by-step approach to delivering on the clear direction of travel coming from the centre. This was outlined in the Next Steps on the Five Year Forward View and the GP Forward View documents.

Speakers noted during their presentations and workshops that there are significant challenges in achieving the aims of collaboration and integrating care to move resources from the acute sector into the community.

They highlighted how some recent responses – including in some cases the rise of GP federations – have not been universally successful.

We outline below some of the pitfalls and possible ways of navigating around them.

That includes considering:

- A clear vision of the purpose of collaboration focused on the genuine reasons for doing it, as distinct from external pressures from the CCG and others
- The appropriate level at which to collaborate – eg a cluster of practices, a clinical commissioning group or a sustainability and transformation plan footprint
- The right organisational form – which does not necessarily have to be a new legal structure.

In her opening remarks, PCC chief executive Helen Northall emphasised the need for clear heads and a clear vision.

And that starts with agreeing the purpose of collaboration or local new models of care.

Several speakers pointed out that not all collaborations require a new legal form. Additionally, often the right organisational form only becomes clear once the purpose has been agreed.

Mike Smith, London GP and chief executive of Haverstock Healthcare, urged GPs and their management teams to consider:

- What is the exact purpose that your collaboration has formed to address?
- Is this a purpose that is shared by everyone in the collaboration?

What do we want to achieve?

When a direction of travel seems logical and is the clear wish of those who hold the purse strings in Westminster and Whitehall it is easy to rush to arms.

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- What is the exact purpose that your collaboration has formed to address?
- Is this a purpose that is shared by everyone in the collaboration?

How have you captured this and how will you hold everyone to account for this?

Having almost accidentally prototyped the GP federation model nearly a decade ago, Smith said that too many federations are now struggling or even “going bust” because they were formed for the wrong reasons. These, he suggested, had included “to finally make some money”, being given cash by the CCG to form a federation and “because everyone else was doing it”. Another federation trailblazer and GP, Dr Phil Yates, noted that by collaborating practices were following a trend for larger provider organisations - citing the example of out-of-hours services in his home area of Gloucestershire where large scale collaboration between providers has developed. He questioned whether the merger of two practices each with a list size of 5,000 delivered the economies of scale that were being sought by NHS England and ministers.

“We have got to reverse the flow of cash that has been sucked into acute care by payment-by-results over the last 15 years and move resources into the community. The government is certainly thinking about practices joining local care networks or similar but you shouldn’t jump into bigger organisations until you can get the cash to go with the new ways of working.

“You need not just to look at the sort of contracts federations have been going for but at core general practice work. Discussions about the primary care home (PCH) model have touched on gainshare. If we are going to step up and do more, that needs to be recognised somehow but I have not heard how.”

Other drivers, he suggested, include the “prohibitive” contracting costs for small organisations and the inevitably restricted legal, finance and strategic expertise in primary care.

A longer version of this article is at: http://bit.ly/2rkl5Z2

For information about PCC’s support for primary care development, contact enquiries@pcc-cic.org.uk
Wolverhampton practices team up for workforce and pathway redesign

Wolverhampton Total Health, a partnership of eight practices, has adopted a creative approach to its primary care home (PCH) test site.

The practices were spurred into action by a looming GP recruitment and retention crisis against the backdrop of high levels of deprivation and associated unhealthy lifestyles such as smoking and poor diet.

Dr Gill Pickavance, GP and Wolverhampton Total Health Limited’s chair, says PCH test site status provided an opportunity to improve collaboration and integration and to shape new clinical pathways.

Addressing a recent PCC event, Pickavance said:

“We were working in silos and this was a chance for us to get to know our colleagues a bit more and to work together with the clinical commissioning group to shape commissioning. It was seeing what we could do. The population we covered was small enough for people to know each other and to know their patients and their problems. We had always done things like peer group analysis of referral patterns but with PCH we are going into meetings thinking we can change something.”

One major outcome is three new clinical pathways effective from this month (April) with planning for another three underway.

Pickavance explains: “We try to identify who in the PCH has the expertise we can use. We’re sharing resources such as GPs with a special interest across practices. We’re also able to share a counsellor or social prescriber.”

Freeing up time for GPs to have longer consultations with patients with complex needs is, as with all the PCH sites, a key priority.

In Wolverhampton, Pickavance and her colleagues are reshaping the workforce by recruiting more physician's assistants, pharmacists, advanced nurse practitioners and health care assistants. When news broke that the eight practices would share back office functions some staff were understandably worried about their jobs. However, their concern proved unfounded.

“What we have done is provide them with more training and identified talents amongst the staff and partners. Recognising that we will not have as many GPs in the future means that we have to maximise our use of current resources and diversify the workforce.

“Reception staff, for example, have been trained to signpost people to voluntary services, the PCH is working closely with pharmacies and we’ve introduced social prescribing.”

This focus on wellbeing is a central part of the PCH’s platform locally, Pickavance says.

“If you are making people feel better because they are less lonely, for example, they tend not to go to hospital or need to come to your clinic. People who are happier in their own homes by adjusting their physical and social environment are less likely to fall over and risk breaking their hips. We're trying to move away from being so reactive. The people we want to reach are not necessarily the very sick but those at risk of being very sick.”

“We’re coordinating primary and secondary services and blurring the lines between the two. We are providing more care and diagnostics in the community but we need to be careful not to undersell ourselves – just because we can move it out to general practice it doesn’t mean the care will be cheaper, although it will improve access by making it more accessible. Often the biggest barrier to achieving that is lack of space in the practice and we are working with our CCG to develop premises to suit this transformation.”

Several of the PCH practices took part in the extended hours opening pilot over the Christmas and New Year period and on through to the end of February to help relieve winter pressures. Pickavance says the pilot also allowed the practices to test out the compatibility of their linked IT systems.

See also related article on PCH set-up costs at: http://bit.ly/2rbNBR

For information about PCC’s support for primary care development, contact enquiries@pcc-cic.org.uk
Hampshire practice integrates to grow with its community

Like many communities that grew rapidly in the late sixties and early seventies, Yateley in North East Hampshire faces a demographic challenge beyond even that confronting the rest of the nation.

Many of the young parents who arrived with their families back then are now either over 75 or soon will be.

The Oakley Health Group is a practice formed of a merger between two existing practices. With a third set to join the group and new homes going up in the area, the combined practice list is expected to reach 30,000 over the next year or two.

The practice’s business development manager, Jennifer Taylor, says that when planning started three years ago, the practices could see that growing pressures of demand and GP recruitment meant redesigning local primary care from scratch.

Taylor says one of the key innovations has been the separation of routine and urgent practice appointments. “With patients seeking urgent same day appointments, GPs were never sure what their working day was going to look like. Having to squeeze people in to the day also meant they often could not dedicate enough time to patients with complex needs. We also had patients going to A&E because they couldn’t get an appointment with a GP quickly enough.”

The practice’s response was to adapt part of its sprawling premises into an urgent care centre for patients who need to see a GP on the same day. Around 80 patients a day are seen by GPs and nurses working in the centre – on a booked appointment rather than a walk-in basis. This frees up additional time for GPs to support patients with chronic or complex health problems while also building in greater certainty to their working day.

It is one factor in a 5% reduction in A&E attendances by Oakley Health Group patients compared to a 3% fall across the CCG.

The practice’s 17 GPs, seven practice nurses and five health care assistants are supplemented by a range of professionals delivering integrated care with an emphasis on prevention and self-care. Two orthopaedic practitioners are provided by the local acute trust, Frimley Health NHS Foundation Trust. Patients with musculoskeletal problems can make an appointment with an orthopaedic practitioner from the hospital who provides clinics at the practice.

Taylor says: “Patients book directly with the orthopaedic practitioner and it’s better for the patients because they often had several appointments with the GP and physio before those that needed a referral to an orthopaedic specialist finally got one. The practitioner can book patients directly into the consultant if necessary as well as referring them for physiotherapy.

“We’ve cut orthopaedic referrals to secondary care by 30%. It’s a good example of a service that can pay for itself.”

That latter point also applies to another innovative appointment – a paramedic working with the practice full time. Formerly an employee of the local ambulance trust, he spends time in the practice’s urgent care centre but works extensively with the hospital discharge team and supporting patients who have been recently discharged.

The paramedic also cares for patients from other practices and is employed by the GP federation that covers four of the CCG’s five localities.

Taylor says: “We believe that by reducing the numbers of hospital admissions, the service will be self-sustaining.”

Practice and community nurses and nurse specialists see hundreds of patients a week for services ranging from asthma, diabetes and cardiac care reviews to cancer, end of life care, Parkinson’s disease and catheter care.

Taylor said: “The nurses like it because they have GPs on hand if they want to talk about a patient’s medication but the GPs can also talk to a nurse specialist about a particular patient.”

With a community matron, midwives, a dietitian, a mental health professional and adult care social worker also part of the team the practice is a byword for integration.

That is reinforced by siting “help hub” call handlers next to the integrated team desks. They handle an average of 700 calls a day – booking appointments but also signposting to appropriate services and checking with members of the integrated team in the adjoining room.

Taylor concluded: “Demand is increasing but there is not a bottomless pit of money to support this. We must use the resources we have in more innovative ways to provide excellent patient care.”

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GP feds trailblazer urges colleagues to get their heads down and deliver change

GPs need to stop behaving like meerkats and start thinking about how they and their local partners can deliver primary care at scale and new models of care, according to Mike Smith, a federation trailblazer and board member of the National Association of Primary Care (NAPC).

Smith is a founder member of Haverstock Healthcare, a federation of GPs in Camden, north London that was formed nearly a decade ago.

Addressing a recent PCC event in Leeds, Smith used the example of the federation’s urgent care centre to illustrate what GPs could do together.

Based in a local acute trust’s A&E department and staffed by two GPs, a nurse and an admin person, the centre redirects up to 30% of patients back to the community. They redirect or treat 44% of all the patients arriving at A&E while the centre is open. The centre’s team has also helped 4,000 people to register with a GP practice.

The facility helped the trust’s A&E department move from the bottom five in terms of waiting times in London to the top five within 12 months.

As a leading NAPC evangelist for the primary care home (PCH) model, Smith said: “The 30,000-50,000 population served by the PCH test sites is big enough to get economies of scale and small enough to build trust between practices and to get teams working together. It also often reflects council wards and the nuances of a local area that can make it easier to build philosophical alignment between practices.”

The model is ideal for ensuring GP leadership of primary care at scale, he said.

“When organisations such as acute hospitals or community trusts try PCH-type care they only do it in bits: they don’t have it led by expert, geographically and philosophically aligned GPs and practices.”

GPs, Smith suggested, are too independently-minded to be part of a huge collective.

“Someone said to me that GPs are like Welsh hill farmers: we know our hills and we know our flock.”

He suggested that GPs should be thinking more creatively about their future given the threats to existing PMS and GMS contracts. Too many, he said, are looking to the federation model simply because it is in vogue.

“Is there really a shared vision on why we are doing this? GPs are like meerkats – looking up at what is happening and then running in the same direction.”

Referring to those practices hoping to be involved in multispecialty provider contracts (MCPs), he said: “It’s really important we get realistic about MCP contracts. That looks scarly distant for many GPs.”

Workshops promise to get boards up to speed on conflicts of interest

NHS England now require all governing body members to undergo on line training in respect of conflicts of interest.

It is our view that there are no handbooks, rules or algorithms that can be universally followed to give the “right” answers. Managing conflicts, to ensure that organisations make the best possible decisions, is a discipline founded in judgements and balance of risk. Therefore, whilst online training is great as a cost-effective introduction and for awareness raising, the greatest value comes from discussion and talking through scenarios with colleagues.

There are no substitutes for face to face workshops.

In this workshop, the board members work together to discuss potential issues. They develop, for themselves, a common language and range of perspectives with which to identify and resolve real issues locally when they arise. The standard workshop takes three hours and is approximately two thirds discussion based. Boards that take part are able to identify potential concerns, have an understanding of how to collectively approach and issue and have greater confidence in their local arrangements when making and taking decisions. The workshop, which is delivered on site at the organisation’s offices, can be adapted to address live local scenarios for a small additional cost. To make the workshop even more cost-effective, it can be shared by two or more similar organisations up to a total of 45 participants.

To find out more or to book a session for your CCG, email enquiries@pcc-cic.org.uk with the subject line “COI training”.

“...
In St Austell, home to the Eden Project, new life for general practice has emerged from fairly unpromising soil.

The town’s practices began working collaboratively in 2014 but swiftly realised they had enough in common to merge in May 2015 – producing a practice serving 32,000 people. The new practice, which also absorbed patients from a failed practice that was forced to close, became a rapid test site for the primary care home (PCH) model.

Dr Stewart Smith, a local GP, told a PCC event in Leeds that the merger took place against a challenging background.

“St Austell is a relatively urban area for Cornwall with high levels of deprivation and we needed a sustainable model of general practice that would support preventative medicine, and integration with other providers and with our community. There were problems with recruiting and retaining GPs and other workforce pressures.”

He said that with its target population of 30,000 to 50,000 the PCH model is built on a manageable workforce of 100 to 150 – “the right size to scale and the right size to care”.

As well as separating planned and acute primary care and developing a centralised call handling hub, Smith and his colleagues have concentrated on four key areas:

- Community services integration
- Social prescribing
- Multi-disciplinary team working, education and workforce planning
- Working towards a population-based model – most likely as a multi-specialty community provider (MCP).

Smith said: “We used some of the seed funding we got from NAPC’s PCH programme to employ a social prescribing navigator. She has mapped and quality assured physical activity providers in our community. We refer anyone we think can benefit from physical activity – with very few exclusion criteria. We can find physical activity programmes for everybody and have shown statistically significant reduction in obesity as well as wellbeing score increases for 94% of participants.”

The team has also built a strong relationship with the Eden Project which hosts many walks and other activities. While they face challenges to secure ongoing funding, the practice is already expanding the programme to cover areas such as nutrition, befriending, cultural activities and carer support.

Such work also helps promote integration, Smith said, an ambition helped by the appointment of a nurse facilitator. She acts as integration lead for community work. The integration push includes a review of hospital discharge arrangements and a home visiting service by an advance nurse practitioner that has reduced GP home visits by 30%.

“Community integration with other health and social care providers is fundamental to reducing GP workload, avoiding duplication and improving quality for patients,” Smith and his colleagues also see staff morale and job satisfaction as a key plank of improving care and the efficiency of care.

“We conduct six monthly staff surveys that are a great way of assessing how the organisation feels and letting staff know we are listening – we want to increase joy and a sense of ownership for the workforce.”

Smith is in no doubt that the practice merger and PCH experience has had that effect on the leadership.

“We’re now working closely with our CCG and with other providers and have started to pull together towards a whole population healthcare model. This has been an overwhelmingly positive experience for us – we’ve moved so far since fearing for the future of general practice in St Austell.”

“Community integration with other health and social care providers is fundamental to reducing GP workload, avoiding duplication and improving quality for patients,”
Pharmacist saves a GP a day

While working as a CCG pharmacist brought its own rewards, Yaksheeta Dave realised she missed the direct contact with patients she previously had as a community and hospital pharmacist.

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When the NHS England clinical pharmacist in general practice pilot began in April 2016, Dave was already working as a GP pharmacist at two practices as part of a pilot organised by the practices themselves. One of those was Hillview Surgery, where she is now the full time clinical pharmacist.

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If her work triaging patients goes well the practice could reduce the use of locum GPs.

Dave sees frequent contact with patients as a vital part of the practice pharmacist’s role, but warns that it may not be for everybody.

“That does come with experience but it also depends on your personality. There are lots of things that make up a consultation and there is a lot of training on patient consultations through the programme, but if you are not the sort of pharmacist who relishes patient contact then maybe you should think carefully about whether the role would suit you.

“I’ve also got the certificate and diploma in pharmacy practice which are general qualifications and in this role we are generalists. However, I do think that my experience in community and hospital pharmacy and also as a CCG pharmacist have really helped me in my current role “

Peterborough practice pharmacists proving their worth

Having appointed a clinical pharmacist before the launch of NHS England’s pilot programme, Cambridgeshire GP Dr Amrit Takhar has been buoyed by the impact and the potential for further development.

Wansford surgery has already appointed a second pharmacist – this time directly through the pilot programme.

“When we made the first appointment 18 months ago we were not sure what they would do but knew we could use their skillset to replace work currently undertaken by GPs. One measure of the success of this is that I now leave the practice at 6.30pm rather than 7.30pm knowing that all the day’s medication queries have been handled properly and appropriately.”

Both the clinical pharmacists are attending university and taking part in other training through the NHS the NHS England programme to become independent prescribers.

Takhar says: “We saw that we needed a second pharmacist – not least to provide cover as we really noticed when the pharmacist wasn’t there. We believed in clinical pharmacy in the GP practice anyway before the NHS England programme started.

“They have certainly reduced GP workload and that is how we will fund them. Their biggest impact has been through reconciling medicines of patients who have been discharged from hospital or whose medications have been changed by a consultant after an outpatient appointment. They deal with around 50 such hospital letters per day. The pharmacists contact the patient proactively which makes the patients feel better and helps them get to know the pharmacists so they can contact them about medicines rather than their GP.”

Although the senior clinical pharmacist only works 0.6 of a week, in a typical month he and his pharmacy colleague conduct around 200 telephone or face-to-face consultations and perform around 20 complex medicine use reviews.

Like other practices, the Wansford Surgery near Peterborough receives daily medication queries from community pharmacists, nursing homes and patients. Most of these, Takhar says, are now dealt with by the clinical pharmacists.

The practice, which has ambitious development plans including establishing a second practice with sheltered and extra care housing on-site, also has a contract to provide GP time to a 105 bed nursing home for people with severe brain injuries. Takhar says the pharmacists have come into their own in supporting the nursing home staff – issuing an average of ten items per month for each of the patients.

“These patients have very complex needs with many on PEG feeds. Although we are contracted to provide GP care on site, as GPs we used to spend another ten hours a week dealing with daily calls about medication. The patients have around 950 prescriptions per month. The pharmacists have effectively removed that time from our workload by proactively calling the home each day.”

Two of the practice’s six GPs are mentoring the pharmacists as they develop the skills and knowledge they need for independent prescribing. In time, Takhar says, they will run their own clinics under supervision, with pharmacist-led hypertension and diabetes clinics already being developed.

Takhar says: “GPs see clinical pharmacists as an expensive employee but GPs are even more expensive so it is obviously a practical approach as long as they are not doing things that other staff could do. We plan to build some surplus capacity then we could look at making our pharmacists available to other practices.”

For Takhar, it is important that the pharmacists are supported by the right structure and culture within a practice.

“We try to create a culture around development and we have a particular approach that maybe others don’t have. It’s not just about developing the practice leadership but all the team. We look to embed professionals – such as a mental health nurse – in primary care where the public can access them because they have different skillsets to the GPs. That culture means the pharmacists have fitted in well to the team.”

They will also be involved in a clinical trial for a new psoriasis treatment that the practice is participating in.

He says that PCC facilitator Janice Steed has played a valuable role in helping the practice and the professionals involved define the role and the most appropriate functions.
Norfolk prescribes more practice pharmacists

Word is spreading across Norfolk of the impact clinical pharmacists are having in GP practices.

When John Higgins began work as senior clinical pharmacist at the Norwich Practices Health Centre in Norwich in March 2016 he assumed supervisory responsibilities for two colleagues at neighbouring practices. They have recently secured independent prescriber status but up to seven more of the 23 practices in Norwich Clinical Commissioning Group are now seeking funding to join the NHS England pilot programme. He expects to be involved in the development of some of those pharmacists.

Higgins, who became an independent prescriber around five years ago, has had a varied career in community pharmacy and as head of pharmacy for Norfolk prisons. He feels his latest role will be for the long-term.

“It’s a very interesting and varied role that gives you plenty of contact with patients and means you can make a difference to the care of people with long term conditions in particular.”

Higgins also reviews the medicines changes outlined in hospital discharge letters and contacts newly-discharged patients.

“Often patients will have a lot of new medications so we see if they have any queries and they welcome that.”

Another piece of proactive work Higgins has initiated is inviting people on ten or more medications for a half hour consultation.

“We know our hospitals are very full and people with ten or more medications are three times more likely to be admitted to hospital. They are delighted to come in when you offer a half hour appointment. Patients leave with a greater understanding of their medication and where appropriate I can increase medicine optimisation and address any worries.”

He also typically has eight 15 to 30 minute face-to-face appointments with patients each day – mostly people with long term conditions.

“GPs in the practice have reported a significant increase in their daily workload when I’m not present at the practice,” Higgins says.

The GPs are also able to see more patients each day as a result of the clinical pharmacist dealing with so many of the prescription queries.

Working full-time at just one practice and being an independent prescriber are both advantages in his new role, Higgins believes.

“Being an independent prescriber has the benefit that I don’t need to interrupt the GPs to sign my prescriptions when I have seen the patients. I know that some pharmacists are working across two or more practices but being fulltime at one helps you embed into the team and you can take care of any queries from colleagues quickly.”

That has also helped Higgins’ new colleagues understand his role and the skills and expertise he brings to the practice.

“There is a bit of an education role in terms of making colleagues aware of your skills and expertise. Their only contact with pharmacists previously was often a brief telephone call to sort out a query. Some staff felt threatened and were not sure exactly what I would be doing and you need to show the GPs that they can be confident about you being involved in a patient’s care.”

With his practice playing a leading role in the NHS England programme locally, Higgins is sure he is part of the future.

“In five years’ time every practice will have a pharmacist. It will be just like the move to appoint practice nurses that started 25 years ago – now every practice has at least one. The pilot programme started in response to the problem in recruiting GPs and that has got worse over the last two years – as has the recruitment of practice nurses and nurse practitioners.”
New contracting models demand better data

From the child hiding an “unhelpful” school report to the smartest guys in the room at Enron playing fast and loose with the figures, the temptation to massage the data is ingrained in human nature.

We are entering a new era in which organisations work together to solve problems and deliver outcomes – rather than focusing on factory-like output figures. Population based accountable care systems promise to erode unhelpful distinctions between commissioning and provision, underpinned by new types of contract that encourage teamwork and discourage finger-pointing.

Linda Hutchinson, director of LH Alliances, a consultancy specialising in alliance contracting, certainly thinks so.

“We are moving from performance management being a hierarchical and transactional arrangement. That approach is dominated by performance management meetings and contract management meetings that just look at outputs and tend to be quite ‘them and-us’ and a bit adversarial.

“An alliance contract should create the environment where each organisation’s success is tied in with that of the others. If one partner in an alliance contract is struggling and they have to cancel appointments or procedures at the last minute I would hope they would be talking to other partners locally and saying that they need help.”

Open-book accounting is a core principle of such approaches but Hutchinson points out that this still relies on honest book-keeping.

But Hutchinson agrees that the greater user voice inherent in many of the new models should help expose irregularities. “It’s so obvious that when people say the service was quick, approachable and personalised then it almost does not matter what the provider says.”

Capsticks partner Robert McGough suggests that the increasing importance attached to different forms of patient reported outcomes could make it more difficult for providers tempted to distort performance and quality data: “Outcomes are changing with more emphasis on patient reported measures.

“Even under the NHS standard contract a commissioner has the right to review data and that becomes more important when you are looking at the whole population models which are becoming more common. It is incumbent on commissioners and other providers to validate that. Place based alliances rely on relationships between providers and changing the dynamic because they are no longer working in silos.

“But whatever system you have if someone is not reporting information correctly then you are looking at it being picked up at an audit or through contract management reviews identifying unusual patterns or changes in performance without clear rationale. It could also arise from a whistle-blower reporting a problem.

For example, I have heard of night-shift staff allegedly being asked to fill in patient questionnaires when they had down time.

“However, performance in many outcomes areas such as clinical performance and quality will have knock-on effects across other parts of the system so this may also highlight unusual data to the other providers and to the commissioners.”

Whatever contracting approach they take, however, commissioners will clearly still need to manage their contracts efficiently and quality assure performance.

“We are moving from performance management being a hierarchical and transactional arrangement. That approach is dominated by performance management meetings and contract management meetings that just look at outputs and tend to be quite ‘them and-us’ and a bit adversarial.”
Why the message of the GP Forward View may not be getting through  

By David Colin-Thomé

General practice over the last few years, despite continuing to provide over 80% of all the clinical consultations in the NHS, has seen its workload hugely increased and its actual share of NHS finances reduced. Announcing the GP Forward View in 2016, Simon Stevens, chief executive since April 2014 of NHS England, said he was “openly acknowledging” the problems and acting on them.

“The foundation of NHS care will remain list-based primary care”

(NHS England Five Year Forward View, 2014)

We have a GP service which optimally needs to deliver on first point of contact care, continuous person and family focused care, care for all common health needs, management of chronic disease, referral and coordination of specialist care, care of the health of the population as well as the individual (Chambers and Colin-Thomé: Doctors Managing in Primary Care – International Focus 2008).

General practice is commendably still the most popular and the clinical service most highly ranked by the Care Quality Commission. This is despite increasing pressure and stresses that threaten its sustainability.

All practices small or large, rural or urban, successful or vulnerable need to deliver on that range of services. They may deliver by working either singly or by cooperating with other practices.

If a multi-practice, each practice may by agreement only deliver some of these services themselves, with the proviso their patients will receive the full range facilitated or provided by the larger organisation.

The current programme to introduce pharmacists into general practice to help with the increasingly pressurised service, needs similarly to be cognisant of local needs and match them with pharmacists with the appropriate skill to meet those needs. It may be appropriate for the pharmacist to be employed at the larger GP organisation level and make them available for individual practices.

Other staff needed in general practice, such as physiotherapists, could be similarly employed. Variation in funding to and by practices will need to be decided locally. The role of the larger GP organisation has become enormously significant in the modern context.

General medical practice’s heritage, strength and popularity with its patients have been earned by being local to its community and offering continuity of care. These virtues must be preserved and to fulfil the potential of general practice as a local provider and as a service that can shape and transform the NHS, it must be concomitantly small and large – small as an essential element of local social capital and large to be of strategic importance. The ongoing relationship between the practice and the larger GP or broader primary care organisation is fundamental.

NHS England is completely committed to major support for general practice but to avoid confusion, duplication and yet enhance support, a rationalisation of various national programmes is essential.

The aims of these programmes are all worthwhile and pulling in broadly the same direction, but the existence of multiple programmes with separate funding arrangements is likely to induce piecemeal and siloed working.

How do these services aimed at individual practices relate to the larger organisations to which an estimated three-quarters of English general practices belong?

GP federations and the primary care home sites see developing, enthusing and enhancing local general practice as an essential part of their broader provider responsibility. Could these larger organisations be the optimal focus for GP support and where all support programmes are synergised?

There is an apparent disconnect between the vision and operational reality of the GP Forward View, which was expressed in recent complaints by GP professional bodies that funding does not appear to be reaching the service.

This is a pity because the GP Forward View promotes a vision many GPs would sign up to: individual practice working as part of a larger local organisation – a partnership of two equals. Both clinically led, population responsible, patient and community focused but with differing attributes that together can greatly enhance the offer to patients, public and the NHS.

Professor David Colin-Thomé is chair of PCC, a former national director of primary care with the Department of Health and honorary visiting professor at Manchester Business School.