WHY SHOULD STPS WORRY ABOUT PRIMARY CARE?

By Helen Northall

Sustainability and transformation partnerships (STPs) have a tough job to do – focused on making the books balance, hamstrung by provider deficits, trying to make an unsustainable system sustainable.

Yet the majority of patient contacts and opportunity for upstream intervention is in primary care, most obviously general practice but also community pharmacies, dentists and optometrists.

The BMA recently highlighted that one in ten GP practices are financially unsustainable. Behind the well-known GP shortage are other worrying workforce gaps affecting practice nurses and practice managers. Community pharmacy is facing severe budget restrictions. Without these gatekeepers, the pressure on acute services will only grow. So what can STPs do to support primary care services?

To start with primary care needs to save itself. Figures from a study cited in the GP Forward View suggest that between 25% and 30% of GP consultations are avoidable. Use of effective signposting and care navigation could help to reduce this number, by steering patients to other more appropriate services and encouraging them to make use of resources in the community and supporting them to self-care.

Primary care at scale is a key part of the NHS response to crises in both finances and GP recruitment and retention.

PCC has supported practices and CCGs facing a range of those pressures or changed circumstances. Working in commissioning and primary care for many years, our associates can communicate effectively with both commissioners and providers. PCC adviser Charlotte Goodson says a range of local circumstances can trigger merger decisions.

“Many areas are finding it very difficult to recruit and retain GPs and the number of doctors retiring from general practice is unprecedented. We’ve worked with several practices that began thinking about merging when one or more partners announced they planned to retire early – partly because of contract changes. Sudden retirements for ill-health or other reasons can hit almost any practice. Partners today often earn little more than salaried GPs but have massive additional responsibilities in areas such as employment, premises and care quality.”

Those responsibilities are complicated by the difficulties recruiting salaried colleagues and other practice staff, ever-rising demand and changes in the funding formula for primary medical services contracts.

However, Goodson notes that clinical commissioning groups (CCGs) are also taking a keen interest in the quality and flexibility of the services practices deliver as they seek to shift more care and services from hospitals into the community.

“As we’ve seen with the rise of federations and primary care home structures, there’s widespread recognition that we need a new primary care organisational model predominantly based on practices coming together.”

PCC associate Frances O’Sullivan recently supported two practices in north Warwickshire to merge, creating the largest practice in the area.

“The practice managers appreciated that I spoke their language as well as that of the commissioner so I could clarify issues quickly. We can act as the interface or honest broker between the practices and the commissioner. For example, I was quite clear about the reasons for requesting additional funding from NHS England for a specific piece of work relating to the merger which was proving unexpectedly difficult to resolve.”

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How to get practice mergers right first time

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How to get practice mergers right first time  continued from page 1

Jenni Northcote, chief strategy and primary care officer with NHS Warwickshire North Clinical Commissioning Group, says: “Having an identified project manager gave a focus to the work and Frances was able to co-ordinate the actions in the project plan. She also arranged weekly tele-conferences – and identified people from key agencies who it was useful to have joining in particular calls. I think Frances’s primary care management experience was crucial.”

Practice manager Elizabeth Gilbey says: “Although the practice had been proactively holding weekly planning meetings, Frances was invaluable in highlighting areas and risks that needed action. She identified key people within NHS England and PCSE and generally kept the momentum going when we were juggling so many tasks.

She cautions that it’s easy to underestimate the work-load of the practice manager of the practice that is losing its individual identity in the merger.

“They have to keep the practice running each day while ultimately closing a business, planning the logistics of the physical merge and trying to keep staff morale upbeat throughout the TUPE process.”

O’Sullivan agrees about the need for the softer form of support during what can be a stressful process: “It can be important just to provide encouragement and emotional support for practice managers feeling overwhelmed by the demands of the merger process while still doing the day job.”

PCC support for practices negotiating mergers typically includes:

• Project management
• Capacity and expertise
• Providing structured plans and reporting mechanisms
• Acting as the interface between all the parties involved
• Providing reassurance to the commissioners about the process being followed.

Goodson says that an outside perspective such as that provided by PCC can also act as a catalyst to kick-start the merger process.

“In one area in the East of England three practices had been talking about merger for a while as recruiting new partners was proving difficult especially with the squeeze on practice finances. The premises are reaching capacity and the pressure on the partners as the business owners is spiralling. It got to the point where they could carry on talking about merger as an interesting philosophical exercise or they could take practical action to move the merger along.

We’re practical people with a practical approach.

“Their early discussions led them to realise that they had very similar views around the type and quality of services they wanted to provide. I have provided one day a week project management support to them and I’m now handing over to a project manager who can work four days a week over the next eight months up to the merger.”

LESSTONS FROM THE COALFACE

Here are just a few of the 60 or so issues around mergers that practices and CCGs need to think about:

• The parties need to understand the reasons for the merger, the complexity of the task and allow sufficient time to both plan and execute the project plan
• They should factor in possible delayed responses from other organisations such as NHS Property Services, the Care Quality Commission and IT providers. Communicate with these groups early on
• Find out at the start what funding the commissioner can provide to support the merger – this could cover project management fees and the cost of integrating or upgrading IT systems
• Complications can arise if any partners are retiring as they may prioritise their own interests over those of a merged practice that they have no stake in. This can be a particular issue if partners own some of the premises
• Allow a number of months to update the partnership agreement as the format of new agreements will be comprehensive and run to hundreds of pages
• Keep patient participation groups informed and involved
• Seek third party advice on the TUPE process to reduce any risks around the transfer of staff.

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By freeing some headspace in GP practices, it may be possible for primary care to be strengthened and supported by the STP to take on more, and support trusts at their pressure points.

Practices working at scale could combine extended hours, out of hours or urgent care provision with some of the routine services that could take the pressure off trusts at a local level. Bringing staff from trusts into primary care, and getting community service support aligned and working closely with GPs is vital to help keep vulnerable people out of hospital. This level of local co-ordination could also relieve the problem of delayed transfers of care by providing suitable services to support patients when they are discharged from hospital.

Primary care has a vital role as the care navigator to enable this to happen. STP leaders can encourage and enable these developments by:

• Ensuring primary care is supported to become more resilient and sustainable for the future
• Having a coherent strategy for primary care supported as part of the wider estates strategy
• Encouraging, investing and supporting at scale working led by primary care
• Enabling the links to be made at a neighbourhood level so that services can really meet the needs of the local people
Even well run practices need to improve their resilience

Resilience is the umbrella term for the period in which the NHS was founded three years after the end of the Second World War.

PCC has worked with hundreds of practices to help them get fit for the future. We’ve also conducted half day or day-long sessions at the request of clinical commissioning groups in which we bring together all the local practices to discuss issues as diverse as premises, establishing a GP federation, new models of care, contracting and funding streams.

Our work is supported by NHS England and can ensure GPs and practice managers have the knowledge to make the most of the initiatives – and new funding – set out in the GP Forward View. With the forward view identifying more than 80 funding streams there is certainly room for investing a little time in finding a way through the maze.

Added to that, most practices – no matter how well-run and efficient they are – would be in danger of falling into NHS England’s “vulnerable” category if even one partner was to unexpectedly retire, die or simply decide to move on.

Our experience with a practice in the south-east with a list size of 12,000, which NHS England saw as vulnerable, is typical of the support we provide as part of the resilience programme.

We are currently working with local health systems to:

- Work through the detail of how GP practices can integrate into a multi-speciality provider (MCP) or accountable care organisation (ACO)
- Develop GP federations/ neighbourhoods to work together and link to an MCP
- Provide detailed knowledge on primary care to a whole health economy as they move towards an accountable care system

One of our team of advisers – an experienced former practice manager – then worked with the practice in stage three to develop a tailored package of support from PCC to improve the practice’s resilience.

Deare says: “That third stage involved a more strategic plan looking at longer term sustainability of the practice. It includes three members of the management team attending a national PCC course in negotiation skills as part of developing the leadership skills needed to encourage changes in patient and staff behaviour and to support the business planning that is needed.”

Other PCC support for the practice includes:

- A session with an experienced practice manager associate to develop a strategic business plan for the next five years, building on a SWOT (strengths, weaknesses, opportunities and threats) analysis, with a focus on succession planning
- Another session to develop the financial review mechanisms that ensured effective monitoring of financial performance
- A question and answer session with our premises expert to assess the options for ensuring the premises meet patients’ future care needs
- A coaching session on how to use the PDSA (plan-do-study-act) quality improvement tool, to make small, incremental changes that make a big difference.

For information about support for resilience or practice mergers contact enquiries@pcc-cic.org.uk with “GP practice support” in the subject line.
A specialist older people’s nurse wasted little time in proving her worth to a Gateshead practice seeking to improve services for the frail elderly and reduce their use of unplanned care.

The nurse was initially seconded from the South Tyneside NHS Foundation Trust to the Oxford Terrace and Rawling Road Medical Group in 2013 but her impact meant the practice quickly turned the role into a substantive post.

Using the comprehensive geriatric assessment approach, she initially developed comprehensive care plans for 94 housebound patients with an average age of 85.

Within nine months, emergency department visits by the cohort had fallen from 66 to 30. Unplanned hospital admissions more than halved during the same period – falling from 63 to 29.

These figures reversed a seemingly inexorable upward trend in emergency attendances and unplanned admissions.

Also importantly for the practice, the number of house calls by GPs fell by more than 80% - from 318 to 63.

Practice manager Sheinaz Stansfield says: “We had the test period with the older people’s nurse for six months and with those results it did not take much to convince the practice partners that we need to be doing this ourselves because we are saving appointments and money and improving patient care.”

Stansfield says that given her expertise it was inevitable the nurse specialist would act as a clinical leader as colleagues, patients and carers worked together to develop multi-disciplinary approaches to personalised care.

The benefits go further than savings in hospital resources and GP time. With the care plans accessible to other professionals in partner organisations, care is more integrated.

Stansfield says the practice and its team have benefited from the new opportunities for peer support, networking and multi-disciplinary working.

Practice staff are also working more closely with a community matron who, while still employed by the community trust, is directly linked to the practice – making her more visible and available. As the care plans of housebound patients seen by the nurse specialist have been entrenched and started to produce results, the community matron works more closely with those patients as a case manager to reduce duplication of care.

This has enabled the nurse specialist to take on a steady stream of new patients.

The practice identified the first cohort of patients with multiple comorbidities and at high risk of unplanned hospital admission for the nurse specialist to work with by using a risk stratification tool. Around 100 of those were older people who were housebound but did not meet the criteria for access to community matrons.

The practice’s GPs and nurse practitioner referred around 60% of the patients to the new service while around a quarter were identified through proactive searching of data such as house calls records. The rest were encouraged to self-refer by other health professionals.

Stansfield argues that this proactive case management approach results in much better care and support for patients and carers than the reactive annual review that GPs are paid to conduct for each patient under the quality and outcomes framework (QOF).
We are the champions – when engagement is more than a tick in the box

Patient engagement has moved from being a tick box exercise based on surveys to playing a key role in addressing the pressures on primary care at one Gateshead practice.

The Oxford Terrace and Rawling Medical Group in Central Gateshead has won awards for its comprehensive approach. It stretches from care navigators through to extensive use of signposting and social prescribing and a key role for volunteer “practice champions” whose scope goes well beyond chatting to patients in the waiting area.

The practice has also seen significant results from an engagement programme that empowers young people with type one diabetes while reducing their emergency department attendance and hospital admissions.

The practice manager, Sheinaz Stansfield, says: “You have to reach out to patients – think differently to do things differently.”

She urges practices to seek funding available from CCGs to develop new roles and approaches to working with patients. She says they should also build relationships with the third sector, both because it offers services that can alleviate the pressure on general practice and because they can help train practice staff in listening, communication and signposting skills.

“People do want to work with us to make things better,” she said.

A recruitment exercise for practice champions resulted in a diverse group of 19 people. This included nine people with mental health problems – most of whom regularly booked GP appointments.

The champions now run a neighbouring third sector “clubhouse” which provides activities such as cooking classes for people with diabetes and a “knit and natter” group.

“The people with mental health problems support each other and because of that – plus the fact they are so busy running the centre – they have far fewer GP appointments,” Stansfield says.

The original network of 19 practice champions has grown to 39 – with the training of the second wave funded by a £2,000 prize the scheme won.

Stansfield emphasises they play a much greater role than that of the volunteers of old – too many of whom were used just to teach patients how to use a touch arrival screen or to help them roll up a sleeve for a flu jab.

“We’re creating a social movement. They are ambassadors for the practice and they advocate for the under-represented. They lead patient engagement activities such as sitting in the waiting room gathering soft intelligence – which is so important when redesigning services.”

Newcastle, Durham and Gateshead offered no support for self-help. Young people wanted to continue in the care of the clinicians who had worked with them as children.

However, the engagement with this group also highlighted the need for:

- More informative leaflets and reading material outside clinics – including clearer information about alcohol and sexual health
- Better diabetes education for secondary school and college teachers – including what to do in an emergency
- Better use of technology – with greater access to insulin pumps and continuous glucose monitoring
- Texting with nurses
- Supported self-help though peer mentoring and social activities resulting in self-help education.

The interaction with the young people led to a successful bid for £42,000 which has funded the creation of self-help groups in Durham and Newcastle – as well as Gateshead.
Confidence and trust enabled Wakefield GP federations to work together

PCC has equipped primary care leaders in Wakefield with the skills and confidence to collaborate at scale.

At the start of the year NHS Wakefield Clinical Commissioning Group (CCG) awarded PCC a contract to deliver a Confident Leader programme for the leaders and key representatives of the five GP federations in the town alongside some tailored consultancy support.

“ I have done a lot of development programmes and this has been by far the best,” Kate Brentley, managing director, Conexus

The programme was aimed at equipping federation leaders with the skills to build their own organisations and to create a new over-arching confederation, Conexus. An important factor in achieving that latter aim was building trust between the five federations.

Kate Brentley, managing director of Conexus, explains: “There was a willingness to work together but also a slight undercurrent of mistrust. The PCC sessions helped bring us out of that as they facilitated trust between the federations and really made it possible to establish the confederation and for the CCG to award one extended hours contract across Wakefield.”

Melanie Brown, commissioning director for integrated care at Wakefield CCG, adds: “Wakefield has five general practice federations; some had recently evolved and the federations had identified to the CCG that they wanted to access organisational development support to aid their development. They also recognised that communication across the federations wasn’t as effective as it could be. PCC brought them together and energised them to develop a new model and to strengthen the role of GPs by giving them a unified and strong voice.

“NHS England funding had enabled some leadership development in one federation but it became clear that we needed more organisation development support for talented GP leaders who were taking on new responsibilities and for others within the federations.”

The process of coming together was kick-started by Dr Mike Smith, former chief executive of Haverstock Healthcare, an early GP federation.

Brentley says: “That first seminar was really interesting: it was a stick of dynamite and PCC obviously did that for a reason because Mike Smith has a quite forceful presentational style. It got people talking and galvanised the group into thinking ‘we don’t want that model so we had better start thinking of an alternative’.

“It was typical of the whole programme which was so much more practical than other conferences or events I’ve attended. You were given the theory then asked to think what you should do as a result. You could discuss in a safe, open space what the theory meant on the ground in Wakefield. I have done a lot of different development programmes and this has been by far the best.”

A session around building a successful business let participants assess issues such as costing of services, the dangers over-diversifying and the time-lag between delivering services and receiving payment.

Other early workshops included a “getting to know you session” where participants scoped the population sizes for different services and a governance session where it was quickly agreed responsibility would most efficiently and effectively lie at confederation level.

With this early work stimulating creative thinking and highlighting both new challenges and new opportunities, PCC tweaked the planned support programme to allow sessions increasingly focused on the development of the confederation, Conexus.
One session featured Manchester LMC chief executive Dr Tracey Vell, who has been involved in national negotiations around the MCP contract, and Dr Steve Kell, who has developed the Primary Care Home model in Nottinghamshire. This allowed participants to consider how the confederation might work as part of a bigger care organisation, while allowing individual neighbourhoods to maintain their identity and develop locally tailored services.

Later sessions included:
• A lawyer-led analysis of the current multispecialty community provider contract (MCP) – including discussion of the myths around it and its impact on GMS contract-holders
• Business planning to support the development of the federations and the new confederation
• Communication and engagement with practices through understanding negotiation, influencing and meeting management strategies.

Brentley says: “I liked the flexibility of the programme. PCC adapted as we changed our thinking. The management consultant who delivered the business planning session was great and he is going to appraise our business plan as well. That is typical of the supportive approach that PCC took – the advice and support between sessions were as helpful to me as the sessions themselves.”

This learning and support around business development, Brentley suggests, is crucial in the fast-changing and challenging world of primary care in 2017.

She says: “The whole concept of new models of care and the MCP contract is such an unknown. The private and public sectors work very differently but we’re all going to have to be more commercially savvy and open to new ideas. I’m not sure the rigour and structure of public services has the flexibility at present to modify and adapt as quickly as the ask from central government. There is also a real need to develop the skills and understanding of those working in these evolving accountable care organisations and MCPs for change to be truly effective.

“The LMC has been quite concerned about primary care signing up to the MCP. Dr Vell was brilliant around those issues and it always helps to have GPs talking to GPs.”

PCC chief executive Helen Northall, who developed the programme and facilitated the sessions, says: “The action learning programme worked well because it gave the primary care leaders the headspace to talk together and work out their next steps while being challenged and supported by experts. We got excellent feedback and I think that was because there was real transfer of knowledge, skills and capability which often doesn’t happen with traditional consultancy.”

Dr Ann Carroll, chair of the new model of care board at Wakefield, says: “I would recommend the [Confident Leader] programme – [it was] sensible practical and relevant, with a good range of expert speakers.”

Support for sustainable primary care

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:
• Ensuring practices are well run, which includes looking at whether they are claiming appropriately and considering how the practice as a whole could work smarter
• Planning for the future – looking at how a practice will need to change in the next three to five years and what steps can be taken 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 local provider organisations. 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, including some of the complex issues dispensing practices may face.

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 with “practice support” in the subject line.

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Ealing pharmacist eases GP workload


Armed with 27 years’ experience as a community pharmacist, Shah embraced the new challenges.

“It has been really positive and it’s absolutely fantastic that the role sits across both GPs and nurses and helps pull the team together.

“The long period I had working with patients in the community allowed me to come in and start working straight away. I did a return to independent prescribing course to refresh those skills.”

Shah has had to curb her enthusiasm in one respect: working in three different practices, sometimes for as little as half a day a week was not practical. She now works full-time at the Gordon House surgery in Ealing.

Shah says: “It is more efficient to work full-time in one practice because you cut out the travelling time. On a full day at Gordon House I sometimes do home visits and just have more time for patient care.”

The bulk of Shah’s work on a typical day includes sorting out medication queries in telephone consultations, conducting medicine reviews in ten minute face-to-face appointments, monitoring some patients where appropriate, signing repeat prescriptions and dealing with medicine changes set out in hospital discharge or outpatient letters. Her medication reviews in clinics include patients with diabetes (she is doing the MERIT diabetes qualification), asthma, chronic obstructive pulmonary disease, depression and hypertension.

This core work has had a significant impact on GP workload and produced savings in the prescribing budget.

Shah explains: “Because I do all the medicine queries it does free up a considerable amount of GP time to deal with the most urgent cases. I deal with one or two patients with medicines queries from the emergency list each session but that part of the work is still a learning exercise. I also get patients whose blood test results show they need prescriptions for things like vitamin D.

“The practice has saved a few GP sessions by making the best use of my skills and that is what we’ll be trying out further.”

She has also brought about changes in how the practice meets its quality and outcomes framework (QOF) targets. Each month she checks paperwork to ensure that specific groups of patients whose care is linked to QOF measurements have had the required reviews or received the appropriate referrals. She is doing this in the following QOF areas:

- Emergency hormonal contraception and advice
- Cancer review within six months of diagnosis
- Dementia tested within date range of diagnosis
- Review within 56 days of being diagnosed with depression
- Stroke/TIA referred for further investigation
- Diabetes patients referred to structured education programme
- Heart failure confirmed by echocardiogram.

Her two GP mentors provide learning sessions in areas where the partners see Shah playing an enhanced role – with chronic pain the latest condition in which she has had received training.

Practice manager Furiha Chaudry says: “We have found the role truly invaluable, and as Shelina grows her confidence in a GP setting, so do her competencies. We are supportive of her training needs and her commitment to a high number of training days which we find have helped us provide better care to our patients.”

Much of the prescribing savings have come during medicine reviews when Shah has been able to move patients from branded to generic medication. However, perhaps the most spectacular example involved a patient requiring daily doses of the relatively humble sodium bicarbonate. By amending the size of the packages prescribed for the patient, Shah reduced the annual cost by some £4,300.

Her asthma audits have also produced significant savings by moving patients from high-cost inhalers and using placebo inhalers to train patients in their use.

With such results behind her it must seem a long time ago that she was dealing with the perhaps understandable teething problems that new ways of working will always bring.

“There was some uncertainty as this was a new thing for the surgery. I was in a new role in a new environment and there was an issue of educating the reception team. Angela Moon (the PCC facilitator supporting the NHS England pilots in west London) helped us to develop guidelines and we had a meeting to make sure that reception staff knew which patients could be booked in to see me.

“Most patients are happy to come to see me for medicine reviews because they understand that frees up GPs to do the acute work. The feedback certainly suggests they are happy.”

Shah sees communication as the key to building up the role.

“In any practice there needs to be a change environment but communication is so important. GPs have to delegate tasks but I’ve been very lucky here. The pharmacist also needs to communicate back to the GPs and to managers the outcomes of tasks and feedback.”

PCC provides individual development support to all the practices involved in the clinical pharmacists in general practice programme, facilitating discussion, business planning, staff and patient communications, and process and culture change to ensure that the clinical pharmacist role is successfully embedded.
While working across two Hull practices keeps her busy, clinical pharmacist Emma Hewitt says that having the time to spend with patients with complex needs or worries is a key element of the role she started last year.

After a decade in community pharmacy and three years working as a medicines management pharmacist with clinical commissioning groups, Hewitt is relishing the new challenge.

She enjoys having the opportunity to spend as much time with a patient as they need rather than being tied to ten-minute appointments.

Recently, for example, she worked with a person with learning disabilities who had complained to the practice manager after feeling that a GP had not explained a prescription change. He was also unhappy with the GP’s attitude towards him.

“I telephoned the patient initially and was able to reassure him about the correct dose of the drug from the most recent hospital letter and offered him an appointment to come in and see me for a full medication review.

“When he came in I was able to see that he had been given the medication from two pharmacies in different packaging so I explained that it was the same medication.

“During the consultation I discovered that the community pharmacy dispenses his medicine in a monitored dosage system so I telephoned the pharmacy while the patient was with me to arrange to have this new medication added to his weekly prescriptions. The patient didn’t really know what all the medications were for so I explained that and at the end of the consultation he said his mind was at rest.”

This was the first of several contacts with the patient and his wife to support him over a six week period. Hewitt identified a potential issue when processing a clinic letter for the patient which requested a complex dose titration of a medicine.

She worked in close collaboration with the community pharmacy to ensure the patient received the best possible care.

“I had continuity with that patient and the luxury of time so I could prevent problems arising.”

Her work with that patient alone probably avoided several GP appointments.

Hewitt has largely enjoyed a positive response from patients at the two weekly clinics she runs at each of the practices. As well as conducting medicine reviews, she holds hypertension clinics.

“Some patients coming for medicine reviews were initially dubious because they felt it was a waste of time but because I could take the time to talk things through, give specialist advice on medicines and give them opportunities for questions they recognised the value and gave positive feedback.”

The biggest challenge she has found is the novelty of the role – and she sees good communication as the solution to that.

“Initially there was a challenge involved in creating a new role and integrating yourself into the team. But it wasn’t a hideous challenge – the GPs were keen. You have to make sure you are accessible and visible and that the practice team understands your role. To some extent you grow the role yourself.”

For Hewitt, that role includes reviewing discharge and outpatient letters as well as handling all medicine-related inquiries. This reduces GP workload and her presence gives them access to prescribing support.

“With the two practices I am kept fully occupied and from my point of view full-time in one practice would perhaps be ideal. With my experience as a medicines management pharmacist I would like to have more time to contribute to the education of the practice team and also to influence prescribing to ensure it is in line with local and national guidelines.”
Cost savings and better care as North Tyneside acts on variation

Steps to address unwarranted variation in clinical pathways and spending highlighted by NHS RightCare data need to be mainstreamed and not seen as an add-on, according to Christine Briggs, deputy chief executive at NHS South Tyneside Clinical Commissioning Group (CCG).

The CCG aimed to deliver significant savings and improved patient care when it revamped care pathways to address variations in spending on respiratory, cancer and cardiovascular services. This year the CCG is reviewing further opportunities in gastroenterology, musculoskeletal and diabetes pathways.

Briggs said: “Right care is an indicator that you are different and a starting point for discussion. Local demographics can explain some of the variation – some variation might be warranted. For example, our rate of chronic obstructive pulmonary disease (COPD) is 35% higher than our ten comparator CCGs but we still looked at our respiratory spending and services.

“You must resist the temptation to just deny the data,” she said.

In deciding which pathways to redesign, the CCG considered the RightCare data alongside statistics provided by the local authority, the acute trust and other partners.

They chose COPD/respiratory services and cardiovascular services as these offered the greatest potential savings while cancer services offered opportunities to improve care.

“We adopted a formal structure in the CCG with a multi-agency steering group for each of the three pathways. The respiratory steering group, for example, had representation from the foundation trust, public health, community teams and the local authority – as well as a patient representative.

“We had a standardised workplan for each of the three and they fed into the CCG delivery plan that we monitor regularly.”

The steering group for each stream researched best practice to identify potential interventions and opportunities and did baseline mapping of existing pathways.

The steering groups were responsible for the on-going review of data.

Securing buy-in from the foundation trust at the clinical and managerial levels and having strong clinical leadership across the system were essential elements of the programme, Briggs suggested.

“Relationship building did take a lot of time but we are in a really positive place on that now,” she said.

The redesigned COPD pathway is budgeted to save £555,000 with a new pulmonary rehabilitation service expected to avoid around 200 hospital admissions. The new respiratory pathway, including a self-management pilot, was launched at a GP education session.

The cancer group’s work has resulted in a new lung cancer screening pilot but Briggs said that the CCG is prioritising care improvement rather than savings in this area.

The new heart failure pathway includes a single point of access referral form and the provision of pulse-checking kits to practices to help with atrial fibrillation identification.

Phone triage helps Hampshire MCP to avert local GP crisis

A string of GP departures and retirements which left some practices facing potential bankruptcy and others managing up to 12,000 patients with just two doctors forced the multi-specialty care provider (MCP) in south Hampshire to rethink the way it provided GP services.

GP and clinical lead for the Better Local Care MCP, Donal Collins, said: “Changing cultures is the big issue for us. We had to get people to think in a different way. We had to accept that there were no more GPs coming so we needed to work together.

“We had to focus on which patients the GPs need to see and what work can be done by others and then build the team around the GPs.”

Now an accelerator site for NHS England’s vanguard programme, Better Local Care believes the development of a same day access and telephone triage service covering four practices made a big difference.

The service helps to separate urgent care from routine care. It handled 41,500 calls in 12 months – only 36% of which resulted in a face-to-face appointment with a health professional. Just a quarter of those – or 9% of the total – needed to see a GP face to face.

The other patients are instead seeing professionals from an extended primary care workforce – including physiotherapists, a paediatric nurse practitioner, a pharmacist and a nurse practitioner.

Some of these additional professionals are not employed directly by the practice, helping to ‘de-risk’ the business of general practice for GPs, Collins says.

Addressing a conference session in June, Collins said changes in practice skill mix and access were not sufficient by themselves to meet the challenges facing the local health economy.

“All of that is a good foundation but if you just have that, it won’t be enough. The hospitals are saying to us that we tend to get patients to them at 6pm after conducting home visits at lunchtime. That means they can’t turn the patients around that day to avoid an overnight
New kind of reality show improves health in care homes

Holistic assessment is not always associated with fun but that is the approach Wakefield’s enhanced care homes vanguard is taking.

The vanguard is supporting staff and residents in care homes and supported living schemes.

Addressing a session at the recent HealthplusCare event, the vanguard’s senior project manager, Lesley Carver, said: “We have been following NHS England’s enhanced health and care homes framework but holistic assessment is the USP of our vanguard.”

However, the team has been imaginative in developing those assessments – including using video diaries that not only give insights into what residents enjoy and what is important to them but also, according to Carver, “make them feel the star of the show”.

“We call the video concept ‘pull up a chair’. It was developed by Age UK and it’s about listening to the residents – finding out what it was like at home and what would make a difference in their lives. We use the LEAF tool to assess quality of life as it’s not just about bingo and bowls.”

They have also introduced dementia mapping which involves assessing a group of residents as they undertake daily activities over several hours.

“That allows us to identify the challenges that each resident faces, mapping social and physical surroundings affecting the person in a positive or negative way,” Carver explains.

The enhanced care home vanguard sites aim to tackle loneliness and fragmented care, by joining up services for older people in supported living schemes and care homes.

As well as identifying health care needs and new ways of meeting them, the Wakefield assessment process has improved general wellbeing by organising more activities in the home and excursions outside it.

“We get to know the residents in a truly person-centred way,” Carver says.

Recognising that care homes cannot provide everything a person needs to improve their health and wellbeing, the assessment results shape the strong relationships that the vanguard and care homes have built with community anchors. Community anchors are centres offering a variety of clubs, classes, and events aimed at helping older people improve their health and wellbeing.

There has been a dramatic impact on demand for health care services from residents of the first 15 care homes involved. The first 12 months saw falls of 13% for emergency admissions, 6% for A&E admissions and 5% for ambulance callouts.

Carver said this was against a background of increased activity across all three measures for the general population.

More people who have had holistic assessments are dying in their preferred place of care – a recognised indicator of the quality of end of life care.

The vanguard has now grown to cover 27 care homes and six extra-care facilities.

Carver says the latter accommodation, while maintaining older people’s independence, brings its own challenges for residents.

“We are working with a supported living scheme with 27 one bedroom flats to slow down progression into residential care. Residents do have their own front door but many are socially isolated so we did ‘pull up a chair’ and ‘portrait of a life’.”

The vanguard is built around a new multi-disciplinary care home support team which includes a general nurse, a mental health nurse and a physiotherapist. The team meets each week to develop personally tailored care plans for the older people they are working with.

It has helped build confidence in care home staff through ad-hoc training sessions and advice.

The vanguard has also been working to ensure that each care home is served by a named GP practice by the end of 2017.
No premises, no transformation

Sorting out GP premises is among the least headline-grabbing but most important of issues. Without safe, modern premises able to meet rising demand and the needs of a changing general practice workforce, transformation could grind to a halt.

In 2015, after the announcement of a £1bn fund to upgrade primary care premises and infrastructure, we wrote about the opportunity to start work on the physical environment on which the success of many transformation plans will ultimately depend. Two years on, and halfway through the life of the fund, very little has changed.

That’s the view of Bill May, one of PCC’s experts on premises, who regularly advises commissioners and providers on primary care premises and estates strategy.

“We give participants scenarios and questions so that in groups and together they can work through the quirks of the system. Some of the issues can tend to be quite dry and technical but the scenarios help bring them to life.”

Responsibility for premises has been delegated from NHS England to CCGs under co-commissioning arrangements. May concedes that with continuing pressure on commissioners and a shortage of expertise in the system, CCGs often don’t know where to turn for advice.

“We have advised on those contracting issues for 14 years so we’ve got the corporate history and memory that a lot of CCGs are light on. Practices and CCGs sometimes aren’t always finding from their NHS England regional teams quite the type and level of support on specific issues that they need.”

With commissioners and providers short both of time and expertise in the often convoluted and confusing rules surrounding premises, May worries that important decisions are being deferred.

“The rules and regulations are out of sync with the real world that commissioners and practices are facing. We are asking commissioners and practices to drive change but the regulatory environment makes that difficult. Faced with other pressing priorities many are just putting it off.”

On the upside, May says that with full delegation CCGs have many more powers around contracting than they sometimes realise.

“CCGs think they have to keep going back to NHS England but they can decide on most things. There is flexibility there in terms of new service provision by super-partnerships, federations or even foundation trusts running primary care services.”

More CCGs are also seeking sessions specifically around practice premises, not as an isolated topic but as part of wider discussions about commissioning strategy, new care models and effective decision-making.

Demand for advice on premises is driven by operational considerations such as a rise in retirement rates of GP partners, many of whom own or have a share in the practice premises, and more rigorous building inspections to ensure compliance with quality standards.

CCGs and developers looking for practices to take long leases on new premises are finding GP partners increasingly wary of signing up, May suggests.

“GP partners are looking for some flexibility in leases because some are approaching retirement and the days of just finding a new partner to sell to are behind us”

May has sympathy with commissioners because they need to get to grips with the legal and regulatory detail that underpins these operational issues – and they need to find answers to the day to day problems practices are bringing to them.

But he worries that commissioners are drowning in the detail and losing sight of the bigger picture.

“In our sessions where we help CCGs turn their estates strategies into reality we do point out some of the advantages of a practice having modern, well-planned premises. That includes that it can help in recruiting GPs and other health professionals.

“The Five Year Forward View makes sweeping assumptions about the ability of community services – with general practice at their centre – coping with more and more out-of-hospital care. That can’t be done without flexible modern amenities to accommodate rising numbers of patients and multi-disciplinary teams caring for them.

“Premises should be a top strategic priority for commissioners. If it isn’t then much of the other efforts going in to support general practice to be fit for the future will be in vain.”

For more information on support for local premises plans, from strategy to operational detail, contact enquiries@pcc-cic.org.uk with “premises” in the subject line.

“The tragedy is that without clarity on the rules and a clear premises strategy in each area, any money available will continue to go to those who shout loudest”