Completed evidence forms

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EE01 The Vitality Partnership

Organisational Information

Name of organisation	The Vitality Partnership	Contact Number	07850914355
Address	Osborn House 55 Terrace Road B19 1BP	Email	Will.murdoch@nhs.net
Contact Person Name and Position	Dr Will Murdoch (Partner)	Number of attached evidence documents	none

Outline below the evidence that you would like the Commission to consider.

The Vitality Partnership has been developing a service model for local people and its staff for 5 years. It has been crystallised by being awarded a Prime Ministers Challenge Fund award in Wave 1 (and several bids being considered for wave 2).

As part of this bid we have been examining how we can make patient access faster and easier and improve patient continuity whilst decreasing acute hospital activity. We have done this through a number of routes including centralising call handling and opening wider channels of access (a smartphone app & Skype) to supplement the traditional models of access. As part of this bid we have also developed a suite of self help films which are available through our new website. We are in the process of developing a long term conditions focus, using technology as a sharing platform between clinicians and patients/families/carers.

Diabetes is our first LTC to be developed and this will be further supported by the development of a 'diabetes hub' which we will develop to take over the routine care of diabetes for our whole registered population. We aim to follow this with other LTC pathways.

We have always been a part of education and training for clinical and non-clinical staff.

For our clinical staff, we have an agreed salaried GP career scheme to suit the needs of different clinicians. Through this we have been able to develop secondary care services in primary care, supported by secondary care clinicians. Our most advanced services are dermatology and rheumatology. We also provide ENT, gynaecology and urology, all delivered by our own doctors and nurses.

We have been early adopters of primary care nurse training and have a regular undergraduate placements from Birmingham City University. We also teach a wide range of undergraduate students for medicine and are soon to embark on PA training.

Amongst our group we have 5 training practices for GP speciality training and many more trainers. Several of our sites also take Foundation Year 2 trainees, including from the military.

Our non-clinical workforce is developing, albeit at a less rapid pace. For some time we have offered training to our reception teams to devlelop them in phlebotomoy and ultimately to develop some as HCSWs through an NVQ3 in Health and Social Care. We also have several sites supported by apprentices, currently from Birmingham Metopolitan College.

It is easy as leaders within an organisation to overlook the needs of ourselves however we are proactive in offering 1:1 coaching to each other. Several partners are in leadership roles across the system and one partner is currently a participant on the Nye Bevan programme for the NHS Leadership Academy. Clinical needs are also addressed and most of the partners have developed a clear clinical interest and are developing a service model around their expertise.

As an overall organisation, we are currently reviewing the role of the primary care medical home (PCMH) having previously sent a delegation to New Zealand and are in the process of applying to be a Vanguard site.

EE02 Sentinel Healthcare South West CIC

Organisational Information

Name of organisation	Sentinel Healthcare SouthWest Community Interest Company	Contact Number	07957 597 094
Address	c/o Express Diagnostics & Treatment Se Research Way, Plymouth, PL6 8BU	Email	roland.gude@nhs.net
Contact Person Name and Position	Roland Gude Strategic Manager	Number of attached evidence documents	

Outline below the evidence that you would like the Commission to consider.

The GP provider network across the Peninsula is developing at a fast pace. Sentinel is in the welcome position of having been around for seven years and our sisters organisations have been developing over that time and have recently formed SHED [K] (see below) to ensure there is a collaborative approach to delivering services in a more systematic way that helps to support and learning of our GP colleagues.

Link to Sentinel Learning - http://www.sentinelhealthcare.co.uk/practice-education-via-Sentinel-Learning

and the Nursing forum

http://www.sentinelhealthcare.co.uk/Practice-Nurse-HCA-Forum

Currently Sentinel, Haytor, Exeter Primary Care, Devon Health and Kernow all play a role in developing and delivering services in a different format. The commissioning decisions to move services out of hospitals and into interface community services is an extremely important long term future strategy. The cost savings will be significant in addition to care closer to home.

We are aware of the current situation with GP recruitment and the finite resource that comes with GPs. We want to develop a GPwSI/Allied Helath Professional training school to encourage more GPwSIs into this fiel reflect the development of the GP federation model.

In its simplest form we want to be able to support GPs and Allied Health Professionals to encourage and support the accreditation process to be able to provide backfill and support to release the burden of becoming a specialist. We are working with CCGs with regards to this and with the support of HESW the system could really start to develop effectively.

Moving services out of a hospital setting is a direction of travel for commissioners but without the support to enable primary care to develop there is a risk the process will stall because of time pressures and difficulties in becoming accredited.

We are on the cusp of technological revolution with information technology and we have been working with remote management system over the last two years to enhance the use of GPwSIs providing treatment and assessment to GP federations.

Our links with organisations such as the Local Pharmacy Network and the wider primary care community (Dentistry, Opthalmology and Pharmacy) put us at the fore front of workforce planning for the future and we would welcome to poortunity to discuss this further with you.

EE03 The Old School Surgery/ Old School Pharmacy

Organisational Information

Name of organisatio	The Old School Surgery/Old School Pharmacy	Contact Number	01179651114
Address	The Old School Surgery Manor Road Fishponds Bristol BS16 2JD	Email	oldschoolpharmacy@nhs.net
Contact Person Name and Position	Jonathan Campbell	Number of attached evider documents	**4**

Outline below the evidence that you would like the Commission to consider.

The GMS general practice and on-site pharmacy situated at The Old School Surgery in Bristol run a fully integrated service that benefits both patients and staff by allowing the GP's to focus on what they are trained to do – namely make new diagnoses and manage complex medical problems.

Despite a rising list size (now at 16,500 patients) and the widespread problems with recruitment and managing the rising demand for services inherent in primary care at present the practice continues to achieve excellent QoF scores, high scores in the friends and family test (93% in the last month), and remains a place were the patient is at the centre of everything we do.

Much of this is achieved by directing many problems through the pharmacy which runs a minor ailment scheme, is the source of much of our smoking cessation service, is first point of call for EHC, supports manyvulnerable patients with Long Term Conditions and offers many other services that are detailed on the attached documentation.

The model works because of the mutual respect held between the professionals working together and because the practice was able to embrace an innovative idea to allow it to focus on the job that it was bes able to deliver.

The practice and pharmacy are piloting an exciting project to host a pre-registration pharmacist from September 2105 and has just received a small grant to introduce near patient CRP testing in the pharmacyto better advise patients on whether a GP appointment is necessary for respiratory tract infections.

The barrier to implementing this across the wider NHS is a lack of understanding and respect between

GP's and pharmacists and the current business model and contract that governs pharmacy.

Neither of these are insurmountable and require frank and in depth discussion between the two Professional bodies, NHS England and the Department of Health.

The RCGP and Royal Pharmaceutical society have just released a joint statement and are commited to closer working between the professions and the 5YFV looks as if it may further encourage integration between community providers.

In many ways pharmacists could be seen as the future saviours of general practice and should allow primary care in the NHS to survive. We need to encourage joint initiatives and closer working between the two.

EE04 HENWL

Organisational Information

Name of organisation	HENWL	Contact Number	07867142910
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Contact Person Name and Position	Dr A Tate Speciality Training Lead	Number of attached evidence documents	

Outline below the evidence that you would like the Commission to consider.

Whole Systems integrated Care Pilots

These are being piloted across a number of sites across NW London. I am most familiar with those in Brent, being piloted in Harness and Kilburn Networks.

They are based on evidence from Kings Fund documents on integrated care.

The scheme is currently in transition from a meeting based model of ICP to a participatory work based learning in WSIC.

The scheme in Brent is based on a number of principles, being inter-professional rather than multi-professional

1) Blurring of professional spheres of action – this is so that no patient falls between professional groups
2) Professional conversations with the whole systems team rather than referrals between teams
3) Proactive and reaction care
4) Single point of contact
5) Using voluntary sector and care coordinators to promote self efficacy
6) Over 65s with one or more long term conditions

The model of care is of a core team comprising GPs, social care, community services, plus or minus specilaist nurses and doctors. There are links between these core members and their wider communities of practice ; and between the core team and the co-opted team member such as local trusts.

The major model of care challenges have been

1) The role of GPs – patients wish to stay with their home practice and GP practices do not wish to lose their patients; however the working week of GPs does not lend itself to involvement in meeting rest of the team once or twice per day. Options considered are GPs having a rota; using GPSI or COTE specialists for those needing intensive and rapid response reactive care; or setting up a separate organisation
   for these patients to register with (this is unliley to be supported)
2) Cross border issues – ensuring all regsitred patients have access to services
3) Data sharing
4) Budgeting

Imperial planned care

There have been some innovative approaches taken at imperial in managing outpatient referrals between primary and secondary care. The planned care board is working on pathway redesign and methods for sharing learning between the two sectors. This involves Imperial Darzi fellows, consultants, GPs, GP trainees.

Highlights include an email and telephone advice line for most specialities,and outreach clinics. Paediatrics and urology have been particualrly proactive in these. The model is that consultants visit a practice once per month. They may review all 2 week referrals for suitabiity and outcome. They may then discuss problem patients with the primary care team, before undertaking joint clinics with GPs.

It is hoped that these can be mutually educational and may lead to wider dissemination of learning.

The problems have been :

1) Coverage not all practices can directly engage
2) Commissioning arrangements have been unclear
3) No formal ways of disseminating knowledge

EE06 Sentinel Healthcare SouthWest CIC

Organisational Information

Name of organisation		Contact Number	
Address		Email	
Contact Person Name and Position		Number of attached evidence documents	

Outline below the evidence that you would like the Commission to consider.

The GP provider network across the Peninsula is developing at a fast pace. Sentinel is in the welcome position of having been around for seven years and our sisters organisations have been developing over that time and have recently formed SHED [K] (see below) to ensure there is a collaborative approach to delivering services in a more systematic way that helps to support and learning of our GP colleagues.

Link to Sentinel Learning - http://www.sentinelhealthcare.co.uk/practice-education-via-Sentinel-Learning

and the Nursing forum

http://www.sentinelhealthcare.co.uk/Practice-Nurse-HCA-Forum

Currently Sentinel, Haytor, Exeter Primary Care, Devon Health and Kernow all play a role in developing and delivering services in a different format. The commissioning decisions to move services out of hospitals and into interface community services is an extremely important long term future strategy. The cost savings will be significant in addition to care closer to home.

We are aware of the current situation with GP recruitment and the finite resource that comes with GPs. We want to develop a GPwSI/Allied Helath Professional training school to encourage more GPwSIs into this field to reflect the development of the GP federation model.

In its simplest form we want to be able to support GPs and Allied Health Professionals to encourage and support the accreditation process to be able to provide backfill and support to release the burden of becoming a specialist. We are working with CCGs with regards to this and with the support of HESW the system could really start to develop effectively.

Moving services out of a hospital setting is a direction of travel for commissioners but without the support to enable primary care to develop there is a risk the process will stall because of time pressures and difficulties in becoming accredited.

We are on the cusp of technological revolution with information technology and we have been working with remote management system over the last two years to enhance the use of GPwSIs providing treatment and assessment to GP federations.

Our links with organisations such as the Local Pharmacy Network and the wider primary care community (Dentistry, Opthalmology and Pharmacy) put us at the fore front of workforce planning for the future and we would welcome to poortunity to discuss this further with you.

EE07 Nottingham City Care

Organisational Information

Name of organisation	**CityCare**	Contact Number	07738755208
Address	1 Standard Court Park Row Nottingham NG1 6GN	Email	Stephen.upton@nottinghamcitycare.nhs.uk
Contact Person Name and Position	Steve Upton Assistant Director, Urgent Care & Transformation	Number of attached Evidence documents	In addition to supportive evidence attached Within the email is Link to holistic worker short film

Outline below the evidence that you would like the Commission to consider.

This new model of working was born from the front line, by staff delivering face to face care everyday to our m
Vulnerable citizens. I have submitted the article that the HSJ published on this new way of working in its Feb 20
Edition as I believe that this provides a good background and the evidence that has emerged around how impo
Working in this way has become. This model is one we are now using to educate our whole workforce to maxi
Our resources and start to approach the challenges we face in a different way. We firmly believe that any prim
Provider can apply this model. All it takes is engagement with the workforce capitising on their
inherent desire to care
For people and do good.

Integration within our workforces fingertips

Nottingham CityCare Partnership is a social enterprise delivering community health care. It has introduced a new approach to working. Qualified nurses, social workers, occupational therapists and physiotherapists are all trained in each other's discipline up to the level of a general assistant practitioner. This may sound simple, but is in fact ground breaking, and makes such sense to a person in crisis. In practice it means, for example, a nurse can visit to undertake a full nursing assessment, and whilst she's there, sort out basic occupational therapy issues like equipment to get in and out of bed or to cook safely in the kitchen. Similarly a physiotherapist could teach an exercise programme and do a basic tissue viability assessment at the same time. We call this the holistic worker model, and this is used within CityCare's Urgent Care Service.

The service is commissioned by Nottingham Clinical Commissioning Group. In 2009 a pilot was established to redesign an existing Intermediate Care team into a new Crisis Response service. The challenges in meeting the needs of Nottingham City's older population were considerable. The City's population included 39, 200 over 65's registered with General Practices in its boundary. 18,200 of these were living with one or more Long Term Conditions. 11,182 of the 38708 emergency admissions in 2008-9 were for patients over 65 and out of these 7198 had a hospital stay of over 2 days

The new team aimed to provide an immediate response when a health and/or social care emergency in the community happened, with the aim of preventing admissions to hospitals or care homes. The service would assess the situation, provide immediate interventions, and ensure arrangements for follow-up health and social care support were in place. The response time was a maximum of 2 hours, and the transfer to services for on-going support was 48 hours.

The initial team had a limited number of qualified professional staff. The health component consisted of a nurse, a physiotherapist, and an occupational therapist. The local authority provided a community care officer to address social care needs. A number of health and social care support staff worked alongside the professional staff as part of the wider team. When the pilot started to receive referrals the challenge of preparing for the unexpected became apparent. It became clear that each crisis was different, and required a tailored response. Staff became increasingly anxious regarding their individual ability to respond to the wide range of situations they were experiencing. In addition, the service struggled to provide the right clinician at the right time to meet the individual or family's presenting emergency. For example, someone experiencing a health care crisis relating to nursing needs would have their initial assessment by a different professional if the nurse in the team was already busy responding to another situation.

The team had also begun to notice a pattern. Most people had multi-faceted health and social care issues rather than single straightforward clinical or social problem. Each single need at assessment tended to be at a lower level than originally expected - it was the *combination of needs and the resultant dynamics* in the home that created the crisis.

The demand on the limited pool of expertise, coupled with concerns of the individuals regarding the limits of their abilities regarding the spectrum of presenting needs, led to a new idea. Radical change was the only way to meet the needs of the people using the service. The holistic practitioner model was created.

Steve Upton, responsible for developing the pilot and a social worker by profession, found himself managing a predominantly health care team. Steve understood the differences between the social and health models of care, and he knew that they could clash as well as complement each other. He figured that the key would be to establish a deep mutual understanding between team members, and a high level of trust in each other's opinions and training. Steve says

> "It didn't seem too great a leap of faith to me to try and take this one step further and actually give each member of the team each other's skills. My vision was to take the theory of mutual understanding across professions to a practical, skills based application".

Steve and his team decided to establish a workforce development approach which would give each individual a basic grounding across the professions of their colleagues. The national assistant practitioner competency framework offered a set of core skills. The "Skills for Health" website helped establish a framework to introduce the national core competencies combined with a set of discipline specific skills. The whole team took part in the design, each identifying skills that they would teach to their colleagues.

The next step was to develop a training framework which included occupational therapy, physiotherapy, nursing and social work. Core elements from each profession's National Competency Framework up to a band 4 level were included. No one would be expected to perform degree qualification level activity outside of their own discipline. Team members delivered the training, and trainees were assessed for theoretical understanding and practical safety. Finally, each professional assessed their colleagues' competence to practice core skills within his or her own discipline; this was seen as the most important factor.

This new way of working was not easy at first. There were concerns around professional identity and a worry about becoming too "generic". These initial worries have given way to a hugely positive impact on the team, especially in terms of the responsiveness of care. All agree that their individual confidence levels have improved since being practically equipped to manage unexpected situations and respond to the complexity of most crises. The original fear that there would be a "watering-down" has been negated. Rather a deeper understanding of each other's profession and contribution has led to a greater valuing of skills.

Whilst the primary intention of the innovation was not to release resources, in practice this has happened. More can be done in a single visit, and less time is taken in referring between disciplines. Steve says

> "all the background activity everyone complains so much about is reduced – that time is spent in face to face contact, releasing time to care".

For years, people have told health and social care providers that too many people are involved in their care. If this holistic style of working was widened beyond Urgent Care, it would reduce the number of different professionals going into people's homes. It would allow relationships to develop and a greater understanding of what is important ***to*** the person rather than just what is important ***for*** them. CityCare is exploring the development of this model in consultation with the Nottingham City Council as part of its integrated care programme.

What evidence do we have regarding the success of the new approach? Certainly team members have reported greater job satisfaction as they now feel more prepared to take on daily challenges and to do more for each person they work with. The nurse, when asked what it was like to be "the nurse" in the team, said "You should have asked me that on Monday when I was mainly being a Nurse, today I have spent the morning being a social worker, and the afternoon as a physiotherapist." She says she never wants to go back to her previous way of working – she now has more freedom to help, which was why she became a nurse in the first place. When the team was developing its approach it developed its own mantra:

> "If I knew how to do what you can do, I could do my job better"

This has certainly been born out by the evidence of the opinions of team members.

Health and Social Care integration is now the next step to improve our service delivery across England. Steve says:

> "Truly integrated working takes place through the fingertips of our workforce. It is our dedicated, hardworking, committed and compassionate staff that have the power to make the citizens experience of health and social care a radically different one. Let's provide them with the support to be multi-skilled, holistic practitioners and change the way in which we deliver care to our communities. My plea to all organisations is to recognise that the integration of skills and knowledge needs to be given prominence, alongside any integration of institutions and structures."

Finally Steve brings his training as a social worker to bear.

> "In short let's start to deliver health care through the lens of the social care model. Let's combine the very best of what we offer through each precious moment that passes by every day when we care for people who need help. It is within these moments that the power to revolutionise the care we offer older people lies"

Since the implementation of this way of working we have been working to expand this to other teams within our organisation. Our ambitious plans to educate all our workforce in this model will enable us to make better use of our resource, skills and expertise to meet the growing demands of an older population.

Please follow the link below to view a short film produced by the staff who have been practicing using the

holistic Worker model

https://vimeo.com/99636106 Password: holistic

EE08 Gaywood House Surgery

Organisational Information

Name of organisation	**Gaywood House Surgery**	**Contact Number**	**0117 953 1294**
Address	**Gaywood House, North Street Bedminster, Bristol, BS3 3AZ**	**Email**	**Brent.stephen@ Gp-L81057.nhs.uk**
Contact Person Name and Position	**Brent Stephen Practice Manager**	**Number of attached evidence documents**	**2**

Outline below the evidence that you would like the Commission to consider.

Attached are two documents for consideration. Unfortunately we were only made aware of your piece of work with hours to run to the deadline for submission. If our application is of interest then of course we will submit more detailed and appropriate documents. The presentation is used as an internal document to talk to staff and other interested practices. The business case is a document we are preparing for our local Area Team in NHS England.

We accept that we are at an early stage in this process, but believe that by April 2015 we will be in a position where Bedminster Medical Group is created. As we develop workforce issues will be at to fore of our thinking and therefore believe that the Commission could a) support us and b) use us as a learning latform to help other budding federations.

EE09 Devon LPC

Organisational Information

Name of organisation	Devon LPC / Sentinel /SWAHSN	Contact Number	01392 834022 07739 806995
Address	Devon Local Pharmaceutical Committe Deer Park Business Centre Haldon Hill Kennford Exeter Devon EX6 7XX	Email	Dbearman1@aol.com
Contact Person Name and Position	David Bearman Chairman	Number of attached evidence documents	0

Outline below the evidence that you would like the Commission to consider.

The workforce pressures on practices and the recently changing contractural environment has brought about a significant shift in relationships. As a consequence a number of changes to working practices have been/ are being developed to ensure a sustainable solution in primary care and to enhance patient outcomes.

The key areas of change have been the result of the changing local relationships between community pharmacy and general practice with the emergence of a collaborative model of joint working some examples which may be of interest interest are:

A joint model of service development :

Community Pharmacy has worked with the GP provider bodies across Devon to ensure that when service opportunities arise practices and Community Pharmacy respond in an approach that maximises impact on outcomes while ensuring provision is efficiently delivered. A Joint approach to weight management is in operation utilising the devon doctors telephone referral hub as the access point for patients. This approach is being further developed with sentinel the GP provider body in West Devon where responding to the difficulties in capacity in practices to invite and deliver healthchecks and the national / local issues in reaching sustainable levels of delivered checks. Rather than just adding further provision through community pharmacy we are establishing an approach in which Practices still try and maximise the checks that they provide and then the system follows an escalation route with patients who fail to attend being invited to pharmacy and potentially interventions at prescription collection and at these points checks are provided. If activity levels still are not reached further escalation to in store marketing and interventions occurs. Finally an outreach service providing checks in the workplace were resources are deployed from practices and pharmacies. This activity being coordinated through the GP provider body.

This approach aims to maximise the impact on population while minimising the cost to commissioners and to use resources across the organisations effectively.

A joint approach to resource management and GP and nurse resource shortages :

Locally we are experiencing a substantial shortage of GPs and nurses with predicted levels of retirements set to exacerbate this situation. As a consequence a team has been established across the peninsula to examine potential solutions. Hosted by the AHSN this has bought together the LMC, LPC, Universities, CCGs, HESW to

investigate potential solutions. A number of work themes have emerged, recruitment from overseas, a study of leavers and potential leavers to understand the drivers, engagement activities to encourage people to stay on and return and work with pharmacy to understand the potential to provide resource. This later worktheme has gained significant traction.

Locally the prime ministers challenge fund has been used to support the piloting of pharmacists in practice, the feedback has been strong and as a consequence a number of other practices have begun embarking on employing pharmacists outside the challenge fund. The work has evolved providing input into HESW tender exercise for pre registration and post graduate education, and an additional programme to create more pharmacist prescribers being provided this year in march. The intent is to provide a cohort of pharmacy prescribers to provide resource in practices and joint roles between practices, community pharmacy and acute trusts this will provide a number of potential future benefits:

- The management of long term conditions in the community while ensuring continuity of care.
- The provision of minor ailents and injuries in the community setting at a highler level of acuity by sharing A&E prescribing pharmacists between the community and the A&E.
- The joint focus on medicines optimisation across sectors, minimising medicines costs and improving outcomes.

The level of interest is high and growing with providers and we antcipate significant movement in this direction in the near term.

A collaborative use of Community pharmacy services to impact practive demand and activity:

With the emergence of federations the opportunity to create a new way of working with community pharmacy is evolving. This is due to the fact that historically community pharmacies served a number of practices and as such one to one relationships did not exist. With federations dominating a locality this situation changes, and allows discussions on changing core processes and ways of working. This change is further facilitated by the introduction of pharmacists into practice that has been previously mentioned as one of the key barriers to change has been a level of mistrust in delivery. The introduction of pharmacists/ prescribing pharmacists into this environment has provided an ability to provide some assurance of delivery and that in pharmacy protocols align to practice perspectives of quality. In this way we are effectively leveraging the resource gains to practices of the introduction of pharmacies by effectively creating a network of community pharmacies providing extension services of the practice. Some early areas of investigation of this work are.

- The referral of patients on new medicines to community pharmacy and the assurance of delivery meaning that no follow up was required in practice.
- The use of an extended MUR in respiratory taking the place of respiratory interventions in practice
- The referral of minor ailments such as UTIs, Impetigo, Nappy rash, Oral thrush to the community pharmacy being triaged through the GP / front desk as appropriate.

The future extention of this if successful is likely to involve long term condition management and monitoring proceedures but this is effectively the begining of a reframing of the primary care system considering the broader system assests and how to deploy them to maximise impact on population health.

EE010 Northumbria Healthcare

Organisational Information

Name of organisation	Northumbria Healthcare NHS Foundation Trust	Contact Number	01912932729
Address	North Tyneside Hospital Rake Lane North Shields NE29 8NH	Email	Wasim.baqir@nhs.net
Contact Person Name and Position	Wasim Baqir Research and Development Pharrmacist	Number of attached evidence documents	

Outline below the evidence that you would like the Commission to consider.

Pharmacist prescribing can happen at scale and is safe.

Objectives Suitably qualified pharmacists in the UK are able to prescribe all medicines. While doctors' prescribing errors are well documented, there is little information on the rate and nature of pharmacists' prescribing errors. Our aim was to measure the prevalence of prescribing errors by pharmacists.

Methods Prescribing by pharmacists,for inpatients admitted to three hospitals in North East England was studied. Part one measured the extent of prescribing by pharmacists as a proportion of all prescribing on a single day. The number of medication orders, reason for prescribing and therapeutic category were ollected by the researcher (OC).

In part two, pharmacist prescribing was reviewed for safety and accuracy by ward-based clinical pharmacists over 10 days; errors were documented and categorised as per EQUIP study.

Results Part 1: Pharmacists prescribed one or more medication orders for 182 (39.8%) of 457 patients, accounting for 12.9% (680 from 5274) of all medication orders prescribed on a single census day. Pharmacists prescribed medicines from 12 out of 15 British National Formulary categories (no prescribing of drugs used in malignancy, immunology and anaesthetics). Part 2: 1415 pharmacist-prescribed medication orders were checked by clinical pharmacists, with four errors (0.3%) reported.

Conclusions This study suggests that prescribing pharmacists can provide a valuable role in safely prescribing for a broad range of inpatients in UK general hospitals.

Published in The European Journal of Hospital Pharmacy:
http://ejhp.bmj.com/content/early/2014/09/04/ejhpharm-2014-000486.abstract

EE011 Northumbria Shine

Organisational Information

Name of organisation	Northumbria Healthcare NHS Foundation Trust	Contact Number	01912932729
Address	North Tyneside Hospital Rake Lane North Shields NE29 8NH	Email	Wasim.baqir@nhs.net
Contact Person Name and Position	Wasim Baqir Research and Development Pharrmacist	Number of attached evidence documents	

Outline below the evidence that you would like the Commission to consider.

The Shine Care Home Project.

Prescribing pharmacists can improve quality and reduce costs through complex medication reviews within a shared decision making framework.

Residents in care homes are more likely to be prescribed multiple medicines yet often have little involvement in these prescribing decisions. Reviewing and stopping inappropriate medicines is not currently adopted across the health economy. This Health Foundation funded Shine project developed a pragmatic approach to optimising medicines in care homes while involving all residents in decision making.

The pharmacist undertook a detailed medication review using primary care records. The results were discussed at a multidisciplinary team (MDT) meeting involving the care home nurse and the resident's general practitioner (GP), with input from the local psychiatry of old age service (POAS) where appropriate. Suggestions for medicines which should be stopped, changed or started, and other interventions (eg monitoring) were discussed with the resident and/or their family.

Over 12 months 422 residents were reviewed, and 1346 interventions were made in 91% of residents reviewed with 15 different types of interventions. The most common intervention (52.3%) was to stop medicines; 704 medicines stopped in 298 residents (70.6%). On average, 1.7 medicines were stopped for every resident reviewed (range zero to nine medicines; SD=1.7), with a 17.4% reduction in medicines prescribed (3602 medicines prescribed before and 2975 after review). The main reasons for stopping medicines were: no current indication (401 medicines; 57%), resident not wanting medicine after risks and benefits were explained (120 medicines; 17%), and safety concerns (42 medicines; 6%).
The net annualised savings against the medicines budget were £77,703 or £184 per person reviewed. The cost of delivering the intervention was £32,670 (pharmacist, GP, POAS consultant, and care home nurse time) for 422 residents; for every £1 invested, £2.38 could be released from the medicines budget.

This project demonstrated that a multidisciplinary medication review with a pharmacist, doctor, and care home nurse can safely reduce inappropriate medication in elderly care home residents.

The full project report can be downloaded here: http://www.health.org.uk/areas-of-work/programmes/shine-twelve/related-projects/northumbria-healthcare-nhs-foundation-trust/learning/ and publication from the the project is available at BMJ Quality: http://qir.bmj.com/content/3/1/u203261.w2538.abstract

EE12 Innovation in Health and Wellbeing lead by Jhoots Pharmacy

Organisational Information

Name of organisation	Innovation In Health and Wellbeing Lead by Jhoots Pharmacy	Contact Number	0121 526 5555
Address	Jhoots Group, 43-45 Church St, Darlaston WS10 8DU	Email	manjitjhooty@jhoots.co.uk
Contact Person Name and Position	Manjit Jhooty – Managing Director	Number of attach evidence documents	

Outline below the evidence that you would like the Commission to consider.

Innovation in Health and Wellbeing Limited (IHWB) is a West Midlands based Social Enterprise made up of a group of high profile public, private, and community organisations which have successfully come together as an integrated team to:

Collaborate on raising the awareness of the problems arising from obesity, and promote the effectiveness of creating regulated, licensed, and validated Weight Management Advisors.

IHWB operates as a Strategic Centre of Excellence, and is currently developing a training scheme which it hopes will create hundreds of licensed weight-loss experts to work with obese people in the community. The training scheme is focused on an evidence-based, weight management programme including dietary advice, physical activity, and psychological support - a programme that is continually evaluated and audited to ensure best practice.
IHWB is bringing a more professional and effective approach to weight management through the enthusiastic commitment of its 'team' members. For example, there are a number of key reasons why Housing Associations are likely to support weight management initiatives being put forward by IHWB.

- *Vision*

To promote health improvement in Walsall
To create an income stream for IHWB that could be redistributed in the Walsall community

- *Product*

To write and deliver an accredited weight management qualification
Develop a virtual technical advice web site to provide personal development for those involved in weight management

- *The Model*

Pharmacy Assistants delivering weight management in the community in chemists
Unemployed - providing employment either as individual sole traders or in care settings
Community Champions delivering weight management in the community

Central Government is keen that Housing Associations play a more strategic role in the Health Promotion and the Worklessness agenda and in Walsall there is a borough wide Health and Housing Steering Committee wilh a Health and Housing Strategy which has been endorsed and recognised as good practice by the NHS nationally.

Over the next 12-18 months IHWB will continue to demonstrate how its 'integrated' model and approach to the obesity problem is:

1. An effective way of working, and of managing the delivery of weight management programmes
2. Effective in improving the professionalism and accountability of the deliverers of weight management services
3. Cost effective
4. Effective in improving the health and wellbeing of its targeted customers

A key focus of IHWB's current activities is identifying where funding is available (for example some £210m through the Clinical Commissioning Groups), how it is being spent, and how effectively the services are being delivered.

This is being compared with how a co-ordinated approach by IHWB can bring greater efficiencies, reduced overall costs to the health service. and a more professional – and licensed and accountable - delivery of weight management services.

A key element of this will be for IHWB to appoint its own 'Executive Team' to take the responsibility for implementing the delivery of the agreed weight management initiatives, and for it to build on its growing reputation as an 'Exemplar' organisation.

Andrew Hartland and Manjit Jhooty
Board Members
Innovation in Health and Wellbeing Limited

EE13 Harrogate and Rural District CCU

Organisational Information

Name of organisation	Harrogate and Rural District Clinical Commissioning Unit	Contact Number	01423 799300
Address	1 Grimbald Craf Court, St James Business Park Knaresborough HG5 8QB	Email	Jane.baxter1@nhs.net
Contact Person Name and Position	Jane Baxter Head of Commissioning	Number of attached evidence documents	Two

Outline below the evidence that you would like the Commission to consider.

Harrogate Model of Care:

Objective to develop and deliver a comprehensive out of hospital model where:

- Prevention, self care and independence are promoted
- When people need care, their needs take precedence over organisational boundaries, and people are cared

  for as close to home as possible
- Local health and social care system is clinically and financially sustainable for the future anticipated demands.

Each hub will integrate primary and community teams including GPs, Community nursing, adult social care, OT, physiotherapy, mental health and voluntary sector. In Harrogate a central hub offering access 24/7, with a number of smaller rural hubs offering advice, access and care on an extended basis, including NHS services from 8-8, 7 days a week.

Attachment : Vanguard Application – awaiting feedback as of 11 February 2015.

Making integrated our of hospital care a reality in the Harrogate and Rural District :

To develop a primary care led responsive, integrated model of care for those patients identified by validated risk stratification, as being at greatest risk of unplanned hospital admission.

The new service will run from 6.30-8pm Monday to Friday and initially on Saturday and Sunday 10am-4pm.

It will be community based model, focused around enhanced local GP service provision working as part of the a Primary/Community collaborative and supported by community nursing teams, with the aim of responding to medical need and where appropriate coordinating integarted care for this group outside standard working hours to manage the patient outside of the hospital.

Attachment : Prime Minister's Challenge Fund : Improving Access to General Practice – Yorkshire Health Netwo

- Awaiting feedback as of 11 February 2015.

EE14 Central Manchester CCG

Organisational Information

Name of organisation	Central Manchester Clinical Commissioning Group	Contact Number	07507 22 78 44
Address	2nd Floor Right Wing, Parkway 3, Parkway Business Centre, Princess Road, Manchester, M14 7LU	Email	Angela.beacon@nhs.net
Contact Person Name and Position	Angela Beacon – Project Manager	Number of attached evidence documents	2

Outline below the evidence that you would like the Commission to consider.

The evidence attached relates to the development of one aspect of integrated working in central Manchester. The model for the Practice Integrated Care Teams which will be described recognises the importance of bringing together a range of health and social care professionals (with primary care as central to this) to work together to meet the needs of some of the most vulnerable members of our communities.

The attached documents provide the detail around this work, and include as follows :

1. A report published by the Royal College of General Practice and the College of Social Work, in which
   the work taking place in central Manchester has been evidenced as a case study

2. A case study article due to be published shortly in the Journal of Integrated Care, which considers the integrated work which has taken place. This details both a summary of the model and findings
   of the models' evaluation, including factors for success and barriers experienced.

The work that has taken place within this project will now be built on further by a programme of work which will see the development of a city wide approach to integrated health and social care, and as such is supporting further nnovation around approaches to integration.

EE15 North Lincolnshire CCG

Organisational Information

Name of organisation	North Lincolnshire CCG	Contact Number	01652 251011
Address	Health Place, Wrawby Road, BRIGG, DN20 8GS	Email	peter.lequelenec@nhs.net
Contact Person Name and Position	Peter LeQuelenec, Business Manager Dr Andy Lee Partner of West Common Lane Teaching Practice	Number of attached evidence documents	

Outline below the evidence that you would like the Commission to consider.

Primary Care Model operated at West Common Lane Teaching Practice

This model contains elements that are common in many practices but it is the way those elements are combined and the key strategic principles underpinning them which produce the exceptional results.

The three key principles are to maximise evidence based practice, patient access and quality of work for staff. If any of these deteriorates, the others are compromised and as a result, patient experience and both clinical and financial outcomes suffer.

The practice pioneered the development of nurse practitioner roles in North Lincolnshire from 2001 as part of a PMS pilot with one other practice. Together 5 NPs were recruited and trained, of which two roles have continued with this practice. They have undertaken unfiltered general consulting, prescribing and home based long term condition care for housebound patients. This allowed the GPs to concentrate more of their time on managing more complex cases whilst still being available on a consultancy basis to support the NPs as needed. This devolution and differentiation of care being provided by staff with varied training and skills has been extended, with the NPs able to provide consultancy to the practice nurses at times and the practice nurses taking on more routine monitoring of long term conditions for patients who can access the medical centre. The practice nurses, in turn, have provided support for a health care assistant who has taken over provision of historic elements of practice nursing. Combined, these developments help to deliver good access for all patients to appropriate and timely acute and long term care, whilst also maximising work satisfaction for all staff.

Evidence based care underpins as much delivery as possible. We provide extensive reference re- sources to national and local guidelines within our clinical systems and back this with weekly clin- ical team meetings, which include updates on guidance, significant event reviews, prescribing policy decisions, peer review of referrals, individual clinical case discussions and commissioning development updates (including pathways). Any member of the team can propose changes to prescribing or clinical policy but is expected to provide the evidence for their proposal. Every member of the team is expected to work in accordance with policies agreed. Providing teaching/ training to undergraduates, F2 doctors and GP Registrars is an integral part of the model, supported by the evidence based, team approach with each tier of staff providing consultancy to others and the most experienced GPs as the ultimate resource, taking lead roles in different clinical areas, allowing for internal referral in many cases instead of external.

We maximise the use and availability of appointments by addressing a patient's needs as fully as possible at a single appointment, combining review of multiple long term conditions whenever practical and appropriate. We also use telephone contacts for many things as an alternative to bringing patients into the practice.

All of the above allow us to limit individual consulting sessions to a maximum of 12 face to face contacts,

which helps keep clinicians alert, maintaining their morale and satisfaction, and makes them able to make best use of the appointments. It also leads to high patient satisfaction with the experience of these appointments. Despite what would appear, to many practices, low numbers per session, we achieve high satisfaction with access, partly due to efficient use of appointments and the devolution of work described above. The final element to delivering good access is a flexible and tailored appointment system. The reception staff are trained to identify whenever possible what the reason for an appointment is so that patients can be guided to the most appropriate slot and any relevant prerequisites can be addressed eg investigation results, clinical reports. Thenumber and timing of release of appointments is varied by day, according to experience of demand eg with more acute appointments Monday mornings and a late Monday morning 'pool' availabilityto meet excess surges and avoid that having a knock on adverse effect on the rest of the week; the doctor on call only having planned appointments early Friday afternoons with the later after- noon available for any late presenting acute work so access is available before the weekend.

From 2001 to summer 2014, the practice list increased by approximately 20%, driven by high pa- tient satisfaction creating a high reputation for the practice in general and specifically for access and quality of care. Following closure of a practice in the town and closure of a nearby branch surgery, the list increased by a further nearly 10% in the last 6 months and at the end of January we are taking on the list of another practice and will provide services from two sites. This will increase the list by a further 50%. Our weekly complement for delivering these clinical services will be 32.5 general GP sessions (which includes 2 sessions modified for undergraduate teaching), 11 general NP sessions, 17 general PN sessions and 7 HCA sessions. In addition one session of GP time is used for each of the following: Specialist Headache clinic taking referrals from other GPs; GP Registrar tutorial; CCG work. Half a session is used for undergraduate teaching organisation. Two additional NP sessions will be dedicated to Diabetes reviews, one PN session also to Diabetes reviews and one to Respiratory reviews.

The practice is located in one of the most deprived wards in the area and the list has one of the highest deprivation weightings in the area. In spite of that, consistently high performance has been achieved against any measure of clinical quality, antibiotic prescribing is consistently 50% lower than average and the allocated commissioning budget has been underspent by 0.5 to 1 million in each of the years for which figures have been available.

The model has and could again be extended further. In the past joint working with health visitors reduced the number of children on the child protection register from the highest in the area to zero and joint working with an OT implemented a functional screening program for older patients to identify deterioration early, allowing less costly and planned intervention, which reduced hospital admissions and reduced social care costs. Both of these examples were undone by commissioner decisions under earlier regimes.

EE16 HETV

Organisational Information

Name of organisation	HETV	Contact Number	01865 785529
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Contact Person Name and Position	Jill Edwards GP Dean	Number of attached evidence documents	

Outline below the evidence that you would like the Commission to consider.

Oxfordshire

Name of organisation	Oxford Health NHS Foundation Trust, AND Oxford University Hospital Trust, AND Oxford GP Deanery, HEE Thames Valley.	Name of service/ project	Emergency Multidisciplinary Unit, & GP training scheme
Address	EMU, Witney Community Hosp, Welch Way, Witney OX28 6JJ	Email	Daniel.lasserson@phc.ox.ac.uk Jeanne.Fay@oxfordhealth.nhs.uk
Contact Person Name and Position	Dr Jill Edwards, GP Dean HEE Thames Valley Associate Professor Daniel Lasserson, Senior Trust General Practitioner, OUHT. Dr Jeanne Fay, Senior Interface GP, Oxford Health NHS Foundation Trust	Type of organisation	Profit ☐ / Not for Profit X
Have you consulted with the site?	**YES**X / NO ☐	Type of organisation	Commissioner ☐ / Provider

Outline below the service/project/programme that you would like the Commission to visit. Please state why the Commission should visit this site. (Maximum 500 words)

The Emergency Multidisicplinary Unit (EMU) provides rapidly responsive acute ambulatory care combining medical expertise from general practice and hospital elderly care specialists, alongside nursing, therapist and social care expertise. This care model, at the interface of traditional general practice and hospitals meets the care needs of older patients living with frailty (cognitive, physical and social) when they present in crisis. Moving the acute care paradigm where possible to ambulatory care allows more patients, who are at risk of deconditioning in hospital, to be treated in their own homes or care home environment during acute illness. Both the Royal College of Physicians Future Hospital Commission and the British Geriatrics Society Silver Book call for greater access to ambulatory care for

complex older patients with acute illness, yet there are few models that provide care that is a credible alternative to bed based care and can demonstrate breaking down traditional barriers between primary and secondary care and between health and social care.

The commission should visit the site to understand how new care models utilise primary care practitioners while extending the traditional role of the GP and blending it with acute care skills. This creates a system that can respond to the challenge of acute illness in our most complex and vulnerable patients where care in community settings can be provided, increasing the quality of patient and carer experience and reducing the need to escalate and transfer patients into more acute environments. Given that meeting care needs in this population of patients requires skills across the multidisciplinary team, the commission will appreciate how the EMU integrates knowledge and skillsets from nursing, therapists and social care professionals with interface medical decisions in order to provide progressive, contemporary care.

The EMU won the Guardian Healthcare Innovation Award 2013 for Service Delivery, and the model has been presented at national meetings and fora to encourage debate and dissemination of the principles of integrated multidisciplinary acute ambulatory care, including British Geriatrics Society, Society for Academic Primary Care, NHS Confederation Urgent Care Taskforce, Patient First Conference 2014, BMA Council as well as internationally to Australian and Chinese healthcare management teams.

Overall outline of the service/project/programme: (Education and Training in EMU)

- **Transferable Skills,**
- **Development of Advanced Practice,**
- **Novel GP Training Model in EMU**
- **Increasing practice placement capacity across primary and community care**

Adult patients with acute illness can be referred by paramedics, GPs (in and out of hours) and community nursing teams to the two EMU units. The units runs over seven days and aim to provide an ambulatory treatment path for acutely ill patients, but is also able to undertake procedures that usually require day patient hospital attendance (e.g. blood transfusion). Typical referrals include an elderly patient with falls, brought in by ambulance; or a middle aged patient with increasing fever and dyspnoea despite amoxicillin, referred in by GP; a patient with worsening dementia, possibly linked to acute infection, whose spouse can no longer cope alone; or a patient with leg ulcers and cellulitis not responding to oral antibiotics referred by a district nurse.

The EMUs are based in a community hospital site and use point of care blood tests, ECGs and on site xrays in order to determine underlying diagnosis or impact of acute illness. The EMU physio and occupational therapists can make same day assessment of the patients' mobility and safety, while the EMU social worker can access urgent crisis care packages, or respite care home placements if

appropriate. EMU have very close links with the Hospital at Home service (able to continue treatments with intravenous medications or fluids at home, together with dressings, nebulisers, and clinical review of the patient), the Integrated Locality Team (able to provide home assessments by OT, physiotherapists and nurses to identify care needs at home), and community nurse specialists such as those for Neurology (Parkinsons Disease), Diabetes, Heart Failure, & COPD.

The unit staffing includes health care assistants, advanced practitioners, nurses, physiotherapists and occupational therapists, a social worker and senior medical cover provided by a consultant or Interface GP. A dedicated patient transport service supports the EMU which radically improves the logistical problems of patient transport. For patients that are unable to be treated in an ambulatory / day attendance pattern, the EMU teams are also able to use up to ten community hospital beds for short stays, predominantly to stabilise patients prior to moving to an ambulatory treatment path.

Transferable Skills

In EMU, use is made of the transferable skills between emergency care practitioners (with paramedic training and experience) and nursing staff; and between the occupational and physio therapists. The EMU nurses come from a range of backgrounds including district nursing, minor injury units, and emergency medical assessment units.

Development of Advanced Practice

Oxford Health NHS Foundation Trust has encouraged a number of the EMU nurses and emergency care practitioners to undertake workplace based learning advanced practice courses via the University of West London, enabling them to take a history and examine acutely unwell patients, in a medical model, leading them on to appropriate investigation and management. They have subsequently gone on to undertake an introduction to IRMER Referrers course, for emergency care practitioners to request xrays under protocol. There are plans for practitioners to undertake independent prescribing courses in due course, and one of the Senior Interface GPs has mentored nurses through independent prescriber courses previously.

Novel GP Training in EMU

The EMU care model, at the interface of traditional general practice and hospital care, meets the care needs of older patients living with frailty (cognitive, physical and social) when they are in crisis, in a novel way, and one which we are keen to share with GP trainees. GP specialist trainees are able spend some months of the first year of their rotation working at EMU, along side the wide variety of community professionals that they will be able to continue to call upon once working in general practice, while honing their own skills in managing patients with multiple co-morbidity and polypharmacy. Other GP trainees have chosen to spend one or two days with us, perhaps following in a patient that they themselves have referred. In addition to the ST1s, we have been pleased to have an GP ST4 quality improvement fellow working with EMU in Witney, and hope to have further projects here that will be attractive to future ST4s.

Increasing practice placement capacity across primary and community care

In addition to the GP ST1s and ST4 mentioned above, there are second year foundation doctors working in Abingdon EMU, where there are also elderly care specialist registrars.

Medical students on placement in the Witney GP practices are sent across for a day's experience in EMU.

Oxford Brookes University has included Witney EMU in its student nurse clinical placement rotations.

Witney EMU is in discussion with University of Reading about the possibility of taking Physicians Assistants on placement later in 2015.

Name of organisation	Oxford Health NHS FT	Contact Number	
Address	Raglan House 23 Between Towns Road Oxford OX4 3LX	Email	Karen.campbell@oxfordhealth.nhs.uk Carol.duncombe@oxfordhealth.nhs.uk
Contact Person Name and Position	Karen Campbell Head of Community Hosptials to 31.03.15 Carole Duncombe – Manager of SPA	Number of attached ev documents	

Outline below the evidence that you would like the Commission to consider.

Oxford Health Single Point of Access

This is the point of access for two major patient flows

1.0 – Is the flow out of acute bed services into community beds, be these community hospital or intermediate care.

2.0 – The entry point from Primary Care and other health professionals to community services for:

- Urgent care through Hospital at Home and Emergency Multiplinary Units
- Same day to the community integrated locality team
- Planned care to the community integrated locality team

It operates 7 days per week, 8.00 – 20.00

N.B. – this has not replace choose and book to clinic based services such as Podiatry or the GP's ability to directly refer to a team they know such as Distric Nursing based in their practice

What does this mean for primary care – This means that the GP now can just make one phone call for all an individual's needs to a team based in their locality ; this team being made up of a range of health professioanls (from summer of 2015 this will include social care), including nurses, therapists, end of life care, reablement, and care home support.

The call handling is by either an experienced administor or clinican, the GP does not need to complete a referral form, the information is collected verbally by the SPA member, with the GP e-mailing any supporting information by a safe nhs.net e-mail.

SPA then pass the information through to the appropriate urgent or locality team, who pick up the work –

SPA has access to both the current IT patient records of both Oxford Health Oxford University Hospitals and Social Care, so can track the progress and answer any follow up questions from primary care.

The response from GPs has been very positive, they have great confidence with it. There reflection is that it takes appropriate information and ensures that the individual is seen in the right time frame. With the community health teams now working 7 days a week this has supported the out of hours GPs in supporting more people at home over the weekend, with SPA co-ordinating the best response available.

The CCG Clinical Chair comment – « SPA is a really good interface that helps the relationship between community and primary care and acts as one element of an catalyst to integrate ».

Case Study 1

Mrs B a 70 year old lady nearing the end of her life. It was her expressed wish to stay at home and not be admitted to hospital. The Hospital at Home Service contacted the SPA team on a Friday afternoon as they needed to arrange end of life care for Mrs B. Fast track funding was secured but there was no agency to pick up this care need for Mrs B until the following Monday due. The Hospital at Home Service also had staffing capacity issues and so could not offer support to Mrs B. Her family were unable to fully support her over the weekend and so external help was required.

The SPA team referred Mrs B to the Crisis Response Service who visited her at home until Monday, when the agency could provide support. The SPA team also contacted the Community Nursing Service who arranged for a hospital bed and other specialist equipment to be delivered to Mrs B's home. The Community Nursing Service also supported Mrs B to ensure that her pain and agitation were managed and that she was comfortable.

The involvement of SPA and the other services meant that Mrs B's wishes were met. She was able to spend her last days at home and died peacefully on the Monday. Mrs B's family expressed their thanks to all the services for making her final days and hours comfortable.

Case Study 2

Mr W a 74 year old man who had had a recent admission to the John Radcliffe Hospital. Staff from the John Radcliffe Hospital contacted the SPA team at 5pm on the Friday bank holiday weekend. Mr W was well enough to be discharged home but his usual home agency care had broken down. Mr W needed four visits a day and the care agency were only able to visit twice a day, starting from the bank holiday Monday. The SPA team assessed Mr W's needs. They arranged for the Hospital at Home team to visit him twice a day to provide support with PEG tube feeding and general care needs. The SPA team also arranged for the Community Nursing Service to visit Mr Witney twice daily over the weekend.

Mr W was discharged from the John Radcliffe Hospital the next morning. The referral of Mr W to the SPA meant that unnecessary delays to Mr W's discharge had been avoided. Hospital at Home team continued to visit Mr W at home until his regular care agency was able to support four visits a day

Admission avoidance

Since April 2014 SPA have received 279 referrals for community beds from the community / GPs. 114 admitted to community beds, 8 admited to an acute bed, the remainder were kept at home with appropriate community services

Since April 2014 SPA have received 489 referrals for patients in crisis in the community. All but 2 patients were kept at home with appropriate community services and family support

Referral rates

The table below indicates the increase in volume of referrals from both pathways since April 2014

	Month										
Team	**201404**	**201405**	**201406**	**201407**	**201408**	**201409**	**201410**	**201411**	**201412**	**201501**	**Grand Total**
Urgent Care - Single Point of Access	**316**	**337**	**323**	**388**	**338**	**431**	**462**	**384**	**412**	**480**	**3871**
Urgent Care - SPA Discharge Pathway	**249**	**285**	**238**	**265**	**247**	**262**	**287**	**256**	**329**	**341**	**2759**
Total	**565**	**622**	**561**	**653**	**585**	**693**	**749**	**640**	**741**	**821**	**6630**

Horsefair Surgery Banbury – Emergency Care Practitioner

2 surgeries in Banbury have an innovative method of dealing with requests for home visits. One has developed a nurse, the other a paramedic to undertake this work. The average average number of visits per day is six with a maximum of thirteen. They also pick up other activity such as acting on duty doctor phone calls and other phone calls. These are normally of a complex nature requiring liaison with a number of outside agencies and although small in number represent a significant shift in work away from GPs.

Horsefair Surgery list size is 17,682 ; the over 75 list size is 1,614.

The average ECP daily visit rate would be 1 home visit per 270 patients over 75, or 3.7 home visits per day per thousand patients over 75

I believe using this measure will give a more accurate measure of demand rather than raw list size as practices with large student populations could indicate the need for greater ECP provision than is actually needed.

Buckinghamshire

Milton Keynes

Newport Pagnell Medical Centre

Newport Pagnell Medical Centre have implemented this pilot over the last 6-9months , an interim review suggests it is working to reduce GP workload and reduce unplanned admissions. They seconded an experienced person from the ambulance service initially , I believe they have now offered him a permanent contract . He receives the urgent GP visit requests daily and goes out to do a thorough assessment , he will liaise with GP , Nursing and Care services , initiate treatment and arrange a care plan . He admits only those

who really warrant hospital based care.

Another pilot that works really well in our locality is that MKCCG supports a nurse led assessment service for visit requests from nursing homes. The nurse practitioners assess the patients and can treat minor illness (UTIs etc) . involving the GP only in more complex problems.

EE17 RCEM

Organisational Information

Name of organisation	The Royal College of Emergency Medicine	Contact Number	020 7404 1999
Address	7-9 Bream's Buildings London EC4A 1DT	Email	Gordon.Miles@ Collemergencymed.ac.uk
Contact Person Name and Position	Mr Gordon Miles Chief Executive of the RCEM	Number of attached evidence documents	Two (RCEM STEP campaign) (Acute and Emergency care: prescribing the remedy)

Innovative and sustainable primary care staffing for integrated and co-located urgent and emergency care services:

The current problems with the delivery of urgent and emergency care are well-known. The Royal College of Emergency Medicine (RCEM) would like the Primary Care Workforce Commission to consider the development of the future workforce for unscheduled care, particularly in "out-of-hours" periods.

RCEM strongly supports the concept of co-location of all urgent and emergency care services on one site, whenever practical and possible. This service development provides the "P" (for Primary care co-location) in the RCEM's four-part STEP campaign (see attachment and this webpage: http://www.collemergencymed.ac.uk/Shop-Floor/Policy/STEP%20Campaign) – a campaign that is strongly supported by the Secretary of State for Health. Similar themes are echoed in the publiciation Acute and Emergency Care - Presribing The Remedy which is available here: http://www.collemergencymed.ac.uk/Shop- Floor/Policy/Acute%20and%20emergency%20care%20-%20prescribing%20the%20remedy

The co-location of urgent primary care services with Accident and Emergency departments (A&E departments or EDs) is also recommended by:

- NHS England
- Monitor
- The NHS Confederation
- The Foundation Trust Network (NHS Providers)
- The Royal College of Physicians
- The Royal College of Paediatrics and Child Health
- Care UK's independent expert commission on urgent care
- Urgent Health UK
- The National Audit Office and the Nuffield Trust also advocate better integration of out-of-hours services. No significant NHS provider or advisory organisations have as yet opposed this concept.

The advantages of the co-location of urgent care services on one site are as follows:

Patients can be directed to the best place to obtain their care. Co-location will put more staff at the front line with a better distribution of skills for the wide spectrum of urgent and emergency presentations.

Patients can be transferred quickly and safely between urgent care and the ED. Inevitably, there will be people who are in the wrong place; this can be remedied without either patient harm or inconvenience.

Primary care OOH staff can have immediate access to facilities such as radiology, pathology and ECG. This is much cheaper than putting these services on a second site (or even in GPs'
surgeries as sometimes suggested). There is the additional advantage of the proximity of staff who can interpret ECGs and x-rays; immediate reporting by radiologists may also be available. The immediate result from an investigation may guide treatment and sometimes even prevent hospital admission. Sharing facilities in this way also reduces the costs of running an ED. Patient satisfaction is likely to be increased by the ability of GPs to request investigations.

Primary care staff and ED staff can share opinions and knowledge. This may be especially beneficial in the case of returning older people to their own homes with a viable package of care and support, as advised by primary care staff.

Other services such as emergency dentistry and frailty units can also be co-located on the same site. This has obvious benefits for both patients and the health economy.

The problem of EDs treating patients who could be dealt with more effectively in primary care will be eliminated.

Quotes from the NHS Confederation ("Ripping off the sticking plaster", March 2014):

"Our members know that people will often go 'where the lights are on' – wherever is convenient and accessible when looking for care or advice. In many cases, the preferred destination will be an ED. While this is understandable, this default setting can often lead to delays in patients accessing the most appropriate care, as well as sub-optimal use of the specialist resources in services that are already under pressure. The NHS's response to this cannot be to simply label people's decisions as 'wrong'."

"When people do make the decision to attend an urgent or emergency care service – or are taken there by ambulance – triage, referral and appropriate treatment needs to be prompt and efficient. We recommend that NHS England continues to encourage more widespread use of co-located urgent and emergency care centres that cater for all attendees, particularly in urban areas. In this model, patients are streamed to different parts of the centre on arrival and no condition is deemed inappropriate for treatment, advice or redirection. There are examples of this working well in the Netherlands."

Primary care workforce issues for co-located urgent and emergency care services:

There are obvious training and workforce issues for this arrangement that the RCEM would urge the PCWC to consider. The RCEM is not wedded to a fixed solution or indeed a single solution. Our views are as follows:

The care of patients with urgent and emergency needs is a vital, interesting and extremely rewarding part of medical practice.
This type of work has specific – and sometimes difficult to provide - training requirements.
The provision of urgent care is well-suited to being part of a primary care practitioner's portfolio career.
The work may take place in a co-located urgent care centre or in the A&E department itself. Sometimes (for instance, in very rural or remote areas), the urgent care centre may be a stand-alone unit with telemedical links to a distant A&E department.
A variety of primary care practitioners may be suitable for urgent care work: doctors, nurses, physiotherapists, pharmacists and dentists as well as new forms of health care practitioner.

The RCEM is a college that has stated as its remit the provision of high quality emergency medicine; it is not an organisation that is solely dedicated to the development of emergency physicians alone. Hence the College is prepared to consider and co-operate with a wide variety of innovative proposals and solutions, providing that they are clearly aimed at developing better and safer patient care.

EE18 Halton CCG

Organisational Information

Name of organisation	NHS Halton CCG	Contact Number	01928593577
Address	Runcorn Town Hall, Heath Road, Runcor	Email	Julie.holmes@haltonccg.nl
Contact Person Name and Position	Julie Holmes	Number of attached evidence documents	3

Outline below the evidence that you would like the Commission to consider.

NHS Halton CCG commissions Wellbeing Enterprises CIC, a leading health and wellbeing social enterprise, to design and co-deliver a social model of healthcare that is fully integrated with Primary, and appropriate Secondary, Care services. Called Community Wellbeing Practices (CWP's) – the service provides a comprehensive range of psychosocial support options for patients whose needs are predominately social in origin; such as social prescribing opportunities, educational courses, resilience classes, asset based community development projects and a community navigation service. The CWP has full coverage across the borough of Halton via all 17 GP practices which between them serve a population of 129,081.

A key aspect of the CWP service is to develop the skills and competencies of practice staff, including GP's, practice nurses, practice managers and reception/administrative staff, so that they feel empowered to work together with patients, families and the community to find new and innovative ways of promoting health and wellbeing, and to increase their use of, and confidence in, addressing wellbeing in everyday practice. This is achieved primarily via the provision of Wellbeing Enterprises CIC's range of established training programmes for clinical and non-clinical NHS staff, which focus on 3 key strands:

1. Understanding the evidence - Short information sessions to raise awareness amongst GP practice staff of the evidence underpinning wellbeing approaches – so as to build a greater depth of understanding amongst clinicians for the need for the CWP service and wellbeing approaches in primary / secondary care.

2. Brief interventions training - Training sessions for clinicians and reception staff that provide practical skills /techniques for brokering discussions with patients about the social dimensions of their medical presentation, as well as the ways in which GP's can reframe the patient consultation to promote a wider discussion about wellbeing and the practical steps people can take to improve this.

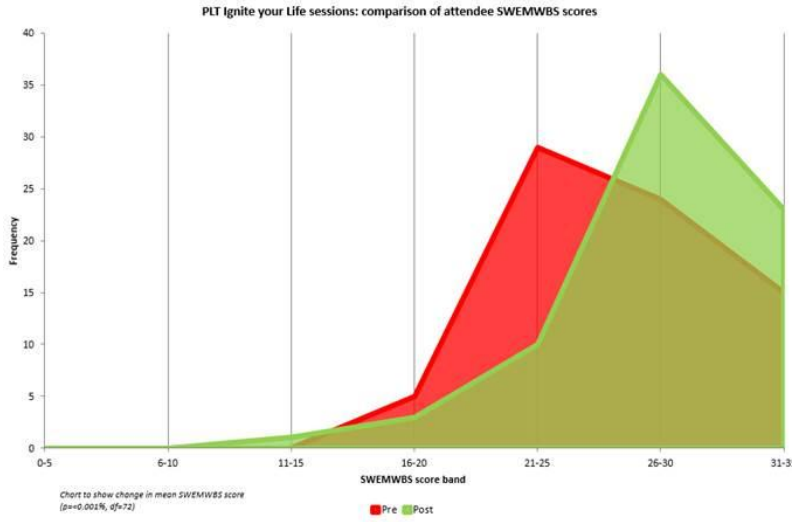
3. Resilience training for NHS staff – A series of half day interactive training events for staff to bolster their wellbeing and resilience linking with the 5 ways to wellbeing and using themes such as laughter, music and comedy.

The service is monitored via a suite of robust and thematic outcome and performance measures including: practitioners self-reported improved wellbeing scores ; confidence in engaging patients in discussions about wellbeing ; and embedding the BATHE technique into GP consultations. Overall, 86% of staff particpating in resilience training have shown an improvement in their Short Warwick –Edinburgh Mental Wellbeing Scale[1] (SWEMWBS) scores.

At a recent PLT Ignite your Life session run for practice staff, 68% of all participants showed an

[1] The Short Warwick-Edinburgh Mental Wellbeing Scale is a validated metric for measuring subjective wellbeing..

improvement in their subjective wellbeing levels when followed-up four weeks after their intervention.



The initiative has fostered stronger relationships between GP's and the voluntary sector and the majority of practice managers believe that more meaningful partnerships with partner agencies have been developed, which are improving the quality of healthcare provision. GP's are also being encouraged to release their own creative talents by leading on their own health and wellbeing projects in the Doctorpreneurs scheme. This unique scheme encourages clinicians and patients to work together to run health and wellbeing projects in their practices.

A five week training programme for care home staff to deliver compassionate carring in their role as care givers was recently piloted. After the training one attendee stated, "I now feel like I'm more focused on what our patients want – the things I learnt were very effective and everything ties in together using a whole person approach."

Feedback received from staff about being part of Wellbeing Practices:

"*Having our Community Wellbeing Officer on board is such a help to our team - it's great to be able to refer patients to somebody who they can talk to about issues that they have. Also just to have him there for advice has proved very valuable to me*." HCA at Grove House Practice

"*The CWP initiative has been nothing but positive, both for the patients and Clinicians, in opening up options to ease patients through difficult times and social circumstances*." GP at Appleton Village Surgery

"Our Clinicians and admin team have benefitted from attending Wellbeing Enterprises' PLT sessions…….. one of our Receptionists has even been empowered to run her own craft group in the local area for patients to attend!" Practice Manager at Windmill Hill Medical Centre.

Feedback from staff that have attended one of the resilience training sessions include:
"*Excellent – thought provoking – useful. Definately learned a lot which I will use in future*."
"*Feel more confident*"
"Excellent. Very intereesting – makes you think differently. Thank you. Will try to utilise some of the ideas!"

EE19 Skills for Care

Organisational Information

Name of organisation	Skills for Care	Contact Number	0113 241 1201
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Contact Person Name and Position	Sharon Allen, CEO	Number of attached evi documents	1

Outline below the evidence that you would like the Commission to consider.

Introduction

Skills for Care's submission is framed with regard to the '*Five Year Forward View*' and the associated '*The Forward View Into Action: Planning For 2015/16*'. Both of these documents stress the need to explore the development of 'new models of care' and acknowledge that these may include social care and require the involvement of social care stakeholders.

Consequently, we believe that in exploring new models for primary care, integration and the workforce implications that we are able to add value to the work of the commission. Principally we will seek to make the case that the greater integration of social care, health, public health and wider services such as housing will enable the development of more person-centred and efficient services that are organised around the needs of people who need care and are capable of yielding earlier, preventative services.

We believe that these new care models are likely to reduce the rate of admissions and re-admission to hospital as well as access to more costly resource intensive services. Achieving this may include co-location or a deeper level of service integration and this will undoubtedly require a greater shared understanding across social care, health, public health and wider services that might best be achieved by the adoption of a more integrated approach to workforce planning and development. This could include, for example, developing the professional skills of social care workers in understanding the signs of the onset of diabetes or the better integration of district nursing and domiciliary care staff.

We would argue that these kinds of approaches are already operating to a certain extent in areas of social work practice and social care. However, we believe that not only is there scope for a wider adoption of these approaches with social work but also a more significant contribution that can be made by the social care and wider workforces.

The social work contribution

Social workers are one of the key regulated professions employed within adult social care. Traditionally they have been part of secondary and tertiary services in assessing vulnerable people and planning for and reviewing care needs. The have a critical role in safe-guarding and protecting those at risk, and their work is set within a statutory framework, including in some cases (e.g. mental health) direct legal intervention. However, the current policy drivers have opened up much greater flexibility in the settings for social workers to be employed. This began when the Department of Health (DH) initiated the *'Social Work Practice Pilots'* with adults in November 2010, which saw the development of independent company's or community interest companies where social workers are employed to work in and take a leadership role in service delivery.

Additionally, Skills for Care's work in supporting employers to deliver the Assessed and Supported Year in Employment (ASYE) provides further evidence for the deployment of social workers in a variety of roles across the private and voluntary sector. All of this points to the potential links between social work and primary care services.

The Care Act is also a key policy driver as its requirements begin to be implemented. Focussing on prevention, communities and well-being, amongst other things, the unique skills, and values of professional social workers again makes them a key workforce group to be considered in a wide range of settings including primary care.

In our view the role of commissioners is critical to new and creative ways of developing the adult social care workforce in an integrated way alongside primary care. Commissioners will need to think 'outside of the box' to understand where social work can be utilised in providing joined up primary care services in local communities. This may be where personalised assessment and planning is delivered in a community setting and where outcomes lead to a prevention of the needs deteriorating or empowering the individual or their carer to take control of their situation. Alternatively, it could be commissioning social work in primary care settings to address needs at the point of contact, reduce the need for referral on to secondary services, and deliver more cost effective outcomes for social care and health needs.

Joint Assessment and Discharge Service

The Joint Assessment and Discharge Service (JAD) Service is a new and innovative model of care which consists of around 50 health and social care staff employed by London Borough of Barking & Dagenham as the 'host' organisation. The JAD is the single point of contact for all referrals of people who may require health and/or social care support at the point of discharge from the hospital, in the form of care and support at home or in residential and nursing care with a dedicated member of staff, either social worker or nurse, for each ward. The service has been made up of a number of teams employed by both NHS and local authorities brought together in one service and operates 7 days a week to both facilitate discharges at weekends and meet with family members who may visit relatives at weekends.

The service has been developed to positively impact upon the health and well-being of people who have received acute care and require support, information and advice to leave hospital in a timely and safe way. This is a key service in helping to deliver improvements in health and social care outcomes through integrated services and is supporting:

- Reduction of emergency admissions/bed days by carrying out joint assessments with the community matron and providing emergency packages of care, to enable clients/patients to remain at home. Matrons will do the health screens whilst social care can provide help with personal care and minor aids if needed.
- Integrated care plans delivered through either joint assessments or separate assessments and where appropriate produce an integrated plan which is stored electronically with the social work team and the GP practice so that at any given time the GP knows what social services are providing for his patient. The patient also has a copy and knows who to contact in an emergency.
- Early dementia intervention via the screening by community matrons and provision of telecare or minor aids to promote their well-being, independence and choice.
- Safeguarding by working together to raise alerts, coordinating safeguarding strategy meetings in line with Pan London protocol; and achieving the same outcomes of keeping people with Long Term

Conditions safe from abuse.

Further case study examples

We are in the process of drawing together further case studies which exemplify integrated working across social work and primary care, these include:

- A newly qualified social worker in the London ambulance service who is based in a team, which responds to ambulance service frequent callers. They follow up their needs as appropriate with the aim of reducing unnecessary call outs by paramedics
- A social worker working with a clinical nurse specialist as facilitator for palliative care delivering End of Life care training in care homes as well as holding a multi-professional workshop to identify issues and barriers to joint working.

Working together – joint social care and health projects

Skills for Care and Skills for Health have jointly published a series of case studies which highlight how social care and health working together in new models of care can deliver 4 key impacts:

- Reducing avoidable hospital admissions
- Reablement and timely hospital discharges
- Smoother transitions, and
- Better use of resources

The case studies can be accessed here:

http://www.skillsforcare.org.uk/NMDS-SC-intelligence-research-and-innovation/Workforce-integration/Working-together-%E2%80%93-social-care-and-health-projects-%28case-studies%29.aspx

Brief details, of the case study which is probably of greatest interest, are included below.

Right place, right time, right team

The 'Thurrock Rapid Response Assessment Service', which was a joint Thurrock social care and South West Essex Community Services initiative that helps residents in Thurrock get a rapid response and assessment for their healt and care needs. According to the published case study since 1 April 2012, when the service started, 817 patients have been seen. In the quarter, October-December 2012, 327 people were seen and 88% of them avoided the need for a GP call, 66% have avoided residential care and only 3% have required admission to hospital.

Integrated Care and Support Pioneers

Skills for Care is chairing the workforce work stream, of the Integrated Care and Support Working Group, whose purpose is to support the workforce issues for the 24 Integrated Care and Support Pioneers, in partnership with other support organisations across Health and Social Care, including Public Health England, Health Education England, Social Care Institute for Excellence, and the Association of Directors of Adult Social Services. The group takes direction from 10 of the Pioneer sites and has developed a work programme with a

focus on their priorities, which are;

- Exploring how to define the size and shape of the integrated care workforce, including profiling new worker roles. Examples include:
  - joint assessment & discharge teams
  - integrated commissioning
  - integrated dementia crisis service
  - new senior nurse care assistant within residential services
- Skilling the workforce: support for leaders to help them embed and promote change, modification of existing qualifications and learning and development opportunities to reflect the skills, knowledge and values needed by an integrated workforce.
- Developing a diverse market: supporting workforce culture which promotes, community engagement, prevention, or self-care and individual choice

The programme, which has been informed by clinical commissioning group colleagues in the pioneer sites, will commence in February 2015. Further details will be available when a project report will be launched on 27 February at an event on 'Workforce Size and Shape for integration' and will then be placed on Skills for Care's website and ICASE exchange websites:

http://www.skillsforcare.org.uk/Home.aspx

http://www.icase.org.uk/pg/dashboard

Working together to improve end of life care: training for front line workers

Models of care are often depicted at the level of strategic integration. In contrast, this project aimed to provide guidance to people working in both health and social care settings by finding out what mattered most to people on the 'front line': people at the end of life, their carers and frontline workers who support them.

A network of people (known as champions) who were committed to improving end of life care, were brought together in a series of workshops. The champions told us about their own experiences, what worked well and what didn't. During these conversations common themes emerged which have been translated into a set of key messages which have formed the basis for several resources and two powerful films to support joint training and more effective working. Further details are available here:

http://www.skillsforcare.org.uk/Skills/End-of-life-care/Working-together-to-improve-end-of-life-care.aspx

The Healthy Villages Programme – Complete Care

People living in any community will touch and engage with a number of statutory services and have a range of informal, community support networks in their area and involved in their life. The Complete Care project refers to this as a person's 'ring of confidence'. In most instances an individual's ring of confidence is not formal – not all organisations would recognise the role of one another within ring of confidence (particularly the role of those informal support networks) and organisational barriers are likely to exist.

The aim of this project which went live in June 2014, is to bring together the health and social care workforce in its widest sense - all statutory health and social care services alongside community assets (like neighbours,

volunteers, libraries) which allow people to stay well and connected to their local community to keep them, as long as possible, away from statutory services.

Importantly, the project is supported by a programme of workforce training and development and organisational change management. The workforce programme brings together all of those in an individual's ring of confidence to co-create an integrated way of working around an individual's health and social care needs:

- Breaking down silos
- Reviewing traditional role descriptions
- Challenging 'normal' behaviours and ways of working
- Culture change

The project has resulted in the development a generic role and function description with core competencies required of a Community Navigator/ Community Connector. Community Navigators/Community Connectors are required at all points in the widest health and social care system. Everyone in the system is and should be a Navigator/ Connector and the generic role, function description and core competencies are part of all job roles within the ring of confidence.

The current focus of the project is in bringing together all training provision by all participating organisations in the ring of confidence with the intention being the delivery of a core programme of training that can be offered out to anybody across the ring of confidence (and more widely) through pooled resources. The pilot has been running 6 months and system indicators include:

- Reduced visits to GP and A&E
- Length of stay in hospital
- Number of outpatient appointments

The project recently won a Foundation Trust Network (FTN) showcase and featured in the Health Service Journal as an innovation award. A full performance review will be undertaken in June 2015.

Boilers on prescription

We are currently preparing another case study based on a project undertaken by an organisation called Gentoo. What they did was explore what the key health issues were for people living in a local community. They concluded that poor housing was a key factor in people's health issues. Using this information they approached the local clinical commissioning group (CCG) to ask if they would pay for housing improvements to improve people's health. Over a period of 18 months the key barrier to making this happen was the CCG thinking it wasn't part of their role to fund housing improvements to improve health. Working together they developed a way to frame the objectives of the project so that they were consistent with the CGG's strategic operational plan so that they could fund the improvements.

The outcome of the home improvements was an alleviation of damp housing, a reduction in chest infections and a reduced demand for GP services.

Conclusion

We are aware of the recently published rapid review that was commissioned by the Department of Health to provide background evidence to support policy development on primary and community health care integration that was undertaken by Policy Research Unit in Commissioning and the Healthcare System (PRUComm): *'Moving services out of hospital: joining up general practice and community services?' (February 3, 2015)*. We note their conclusions include:

> *"New models of care such as the federation of GP practices into larger groups covering the same population as a neighbourhood nursing team have been advocated and proponents of this model offer compelling case studies to back up their claims. However, there is no good research evidence to back these up, and it remains unclear what the important ingredients of a successful model might be"*

We would maintain that social care can also offer a great many compelling case studies and instances that support new models of care that comprise greater integration of social care, including social work, and health but acknowledge that there is further work required to provide good research evidence to confirm this position.

Consequently, we would argue that a key outcome from the commission should be to recognise this position and advocate for further research into the essential ingredients of new models of care that includes the integration of social care and health, while exploring the implications for the future social care and health workforces.

EE20 RCPsych

Organisational Information

Name of organisation	Royal College of Psychiatrists	Contact Number	0203 701 2541
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Contact Person Name and Position	Helen Phillips Senior Policy Administrator	Number of attached evidence documents	These are not available at this stage, but we intend to provide further detail and references for the longer submission.

Outline below the evidence that you would like the Commission to consider.

Briefly, our major concern is the quality and extent of training of the workforce in mental health.

The exposure of GPs to psychiatry during their training is increasing with the advent of psychiatric posts in Foundation years, but is usually limited to time on acute psychiatric units which is unsuitable preparatio working in primary care as key knowledge and skills for working with common mental health problems are not acquired there. Clearly some mental health education is also provided during the vocational training course, but for many GP trainees this is insufficient.

Practice nurses have no systematic training in mental health even though they are involved in providing a great deal of care to people with chronic problems who have co-morbid mental health problems.

Education and training is required in models of effective joint working between mental health and primary care services to meet the needs of the growing population with multimorbidity. This includes not only t long term conditions, but also people with long term mental illness who have physical health problems, and are either currently under the care of mental health services, or (increasingly) being discharged to primary care.

We will extend this with added references for the longer submission.

February 19, 2015

EE21 South Sefton CCG and Southport & Formby CCG

Organisational Information

Name of organisation	NHS South Sefton CCG NHS Southport and Formby CCG	Contact Number 0151 247 7049	
Address	Merton House, Stanley Rd, Bootle, Merseyside, L20 3DL	Email Tracy.jeffes@soutseftonccg.nhs.uk	
Contact Person Name and Position	Tracy Jeffes Chief Integration and Delivery Officer	Number of attached evidence documents	2

Activities across both NHS South Sefton CCG and NHS Southport and Formby CCG

Supported by a joint management team, the two CCGs in Sefton are developing their own blueprints for primary care transformation. Whilst they have some similarities, the two CCGs service differing populations, with different health needs and therefore their models or focus of delivery may vary.

Of particular interest maybe the following workforce developments:-

Medical Students

Are being given unique opportunity in small service development and quality improvement initiatives as part of the Univerisity of Liverpool Research & Scholarship program.

Student Nurses

Student nurses are being offered placements in general practices across both CCGs with the aim to improve knowledge of career choices in primary care such as practice nursing.

Health Care Assistants

An apprentice health care assistant project commenced in November 2014. It is a 15 month programme consisting of education and practical training with education one day a week in college and employment in a local practice for the duration of the course. This is a bespoke programme to ensure that health care Assistants are fit for purpose working in a primary care setting. This has been developed jointly between CCGs and Hugh Baird College.

There are currently 10 students working across both CCGs.

The aim is to improve access in primary care, increase the skill mix in primary care, and support the role of the practice nurse.

Local Universities

We are currently working with local universities to support the development of a practice nursing foundation programme. This will improve access to general practice vacancies and provide a minimum level of knowledge.

Future Model of Delivering Primary Care – Southport and Formby CCG

As a move towards delivering 8 – 8 access in primary care, a future model of collaborative working by local clinicians is described in the attached Prime Ministers Challenge Fund Wave 2 bid.
This would include a mix of clinical staff working from a base Southport and Ormskirk Hospital on Monday to Friday evenings, and Saturday and Sunday mornings for bookable GP appointments. These appointments would also be accessible by A&E, OOH and NHS111.

There would also be 2 'roving GPs' who would visit frail elderly vulnerable patients between 6.30 and 10pm Monday to Friday, and Saturday and Sunday mornings, where practices have identified a need for further intervention.

The innovative working required by the local primary care workforce to deliver this scheme is exciting. It marks a real development in collaborative working across all practices in Southport and Formby in order to pull together the plans and ultimatey to run the service. The proposal has been supported unanimously by all 19 practices. It also shows a high level of collaboration with NHS Southport and Ormskirk Hospital Trust, which as an integrated care organisation enables closer working with community services as well as A & E, NHS 111, Informatics Merseyside and local care homes. The skills and workforce development required to work in this new way will be significant and will require strong clinical leadership and development of systems, particularly in relation to IT and clinical protocols.

Virtual Ward – South Sefton CCG.
Another significant development in the integration of primary care with other health and social care providers is highlighted in South Sefton's Virtual Ward Model. The aim of the Virtual Ward model is 'happy independence for frail and elderly people'. The main principles of the system are integration, relational coordination, proactive approach to care, and innovation. Each neighbourhood/ locality (~35,000 population) has a Virtual Ward. Each Virtual Ward has disctrict nursing, pro-active care and reablement functions with the coordination of a virtual ward manager. The team share a common case record and meet together face to face through a virtual ward round to discuss patients. Patients can be referred through a common referral form, risk stratification or step down from urgent care. The virtual ward has access to the community geritrician and can draw in any service from the respective organisations
represented which include the community provider, local authority, primary care pharmacists, Council for Voluntary plus input from the mental health trust.

Locality based Virtual Wards have been running for well over 12 months with overarching urgent care aspect since July 2014. The attached document highlights the model as planned in 2013 and
shows the involvement of a wide range of partners working collaboratively within this ratified framework

Outcomes include

- A study by the London School of Economics demonstrated a statistically significant reduction in healthcare
  utilisation costs post 3 month Pro Active Care program.
  (£333 / month pre program vs £72/ month post program, P<0.0001)

- Pre-post pro-active care program demonstrated a significant improvement in ability to self care, coordination of services and quality of life as measured by the PROM LTC-6 (29% improvement, p<0.0001)

- Pro-active identification of patients at risk of and with dementia, contributing to a rise in dementia awareness,
  now at 60.3% for the CCG. The Virtual Ward system was noted as an excellent model by the Royal College
  of Psychiatrists on a recent service inspection review

- Patient experience reviews and interviews highlight the positive integrated and coordinated approach of the
  virtual ward and is welcomed by patients and carers.

- The urgent care aspect of the model provides an average response time of 45 minutes with conversion
  rate to hospital of 6%.

This team mirrors the locality based virtual wards in providing integrated medical, nursing, therapies, social and personal care input for sub-acute patients and those at risk of deteriortion.

The team also serve as a portal into the VW system from A&E, ambulance service and GP OOH

Barriers to implementation

The key barriers to implementation of the new models of primary care are :-

- Relative underinvestment in primary care
- Ageing GP workforce with many planned retirements and fewer younger GPs available
- Difficulty in recruitment to parts of Sefton
- Ability of community services to respond to new specifications and ways of working
- Funding pressures on Local Authoirities to enable maintaince of current services and simultaneously develop new ways
- of working.
- Demands on secondary care services making shift of services and resources to community models more difficult.
- Resources and capacity to release clinical staff to develop innovative approaches.

EE22 Leeds North and Leeds South and East CCG

Organisational Information

Name of organisation	Leeds North and Leeds South and East CCGs	Contact Number	Emma Paipala – PA Emma.paipala@nhs.net 0113 8431643
Address		Email	elliemonkhouse@nhs.net
Contact Person Name and Position	Ellie Monkhouse Director of Nursing and Quality	Number of attached evidence documents	4

Outline below the evidence that you would like the Commission to consider.

I have attached 4 pieces of information: I work across 2 CCG's, but we work closely with Leeds West CCG.

The practice Nurse conference is a city wide event that we have done over the last 2 years, last year we

Called it 'lets celebrate' and showcased some of the work that is going on within practice nursing within

Leeds. Examples of this can be seen at:

www.youtube.com/watch?v=ndQen9vteT0&sns=em

www.youtube.com/watch?v=Bh7jjDGFAxY&sns=em

or search on You Tube for Lets celebrate, Leeds Practice Nurse Conference

1. A presentation that I have done to both my Executives.
2. The bid I put in for VTS
3. The bid I put in for Mentorship programme
4. My CCG nursing stratergy. Please be awre this is draft and not quite the finished article, but gives an idea of some of the work that we have ongoing. This hasn't been though my internal governace Structures, so please bear this in mind, but though was worth sharing.

EE23 CSP

Organisational Information

Name of organisation	The Chartered Society of Physiotherapy	Contact Number	020 7306 7821
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Contact Person Name and Position	Sally Gosling Assitant Director of Practice and Development	Number of attached evidence documents	1

Introduction

We welcome the opportunity to respond to the HEE primary care workforce commission.
In line with the two-stage process outlined, we are making an initial submission now and plan to make a more substantial submission by the later deadline of 3rd April. As part of our initial submission, we are appending extracts from that which we made to HEE in June 2014 to inform production of the 2015/16 national workforce plan.

Please note the numbering through this paper corresponds to the numbered items above which the commission will be taking into account.

1& 3 - Existing and future models of primary care

The CSP is strongly committed to exploring how population and patient care needs can be met through a shift to more services being delivered in primary care settings, including through the different models of care set out in NHS England's Five-year Forward View (for example, through setting up Multispecialty Community Providers [MCPs]).

Patient needs can be met more effectively through improvements in service design, integration and inter-professional/inter-agency working and optimising opportunities for role development, reconfiguration and substitution. Different approaches to how primary care is delivered, and by whom, should not compromise the quality of care experience and outcomes for patients; rather the potential to achieve both improvements for patients and cost savings, should be realised.

The physiotherapy workforce has real potential to strengthen its contribution to meeting primary care needs across a range of population and patient groups and to addressing identified health care priorities. Physiotherapy has the particular potential to support the development of new models of primary care in the following ways:

- Improving patients' timely access to individualised care and including through increasing numbers of patients being able to access directly access physiotherapy through self-referral - self-referral models are cost effective, reducing the pressure on GPs through reducing unnecessary GP visit; they put patients in the driving seat of their own care and support a culture of patient self-management.
- Fully optimising physiotherapists' knowledge and skills as autonomous practitioners in service delivery models, including through stronger use of their diagnostic and clinical-reasoning skills, ability to deal with complexity and uncertainty; the advent of physiotherapists who are independent prescibers is a resource that any developing primary care service needs to take full advantage of in order to benefit patients, streamline services and reduce costs.

- Playing a stronger role in patient care referral, triage and co-ordination, reducing current pressures on the GP workforce and achieving service improvements and efficiencies, for example including through telephone advice and rapid response teams; this includes reducing pressures on A&E departments, cutting hospital admissions (including urgent and unplanned admissions), reducing patients' length of stay (including through supporting early-supported discharge and community-based rehabilitation) and re-admissions.
- Optimising use of new technologies, including to increase care's responsiveness to individual need (including through stronger stratification of care in line with acuity, dependency and risk), strengthen support to patients across their care journey (including in terms of self-management and behaviour change), and increasing how service access, co-ordination, delivery and evaluation are made more effective and efficient (thereby supporting on-going service improvements).

The CSP is keen to input to the Commission's exploration of both how existing models of care can be replicated (so that current innovations in practice become routine, integral elements of service delivery, subject to evaluation of their clinical- and cost-effectiveness), and how care delivery models that do not yet exist can be initiated and implemented.

We set out below some examples of current innovation and emerging models of care. We intend to provide more information in our second submsision in April.

1 & 2 - Examples of current innovation

STarT Back Approach

Keele University demonstrated that the STarT Back Tool for neck and back patients was clinically and cost effective. Significantly improved outcomes at four months and £34.39 saving per patient was shown when comparing the STarT Back intervention group with those who received usual care.

The STarT Back method asks patients to fill out a questionnaire with the GP or physiotherapist. This identifes whether the risks that may affect the treatment outcome are low, medium or high. The STarT Back questionnaire takes into account the patient's symptoms, their perception of their pain as well as how it is affecting their life. Patients can then be directed to an appropriate treatment pathway based on this assessment. The pathway may include greater emphasis on self management for low risk patients or greater management of psychological distress for high risk patients. [2]

Taking this concept further it has been shown in the IMPaCT study[3] that this approach can be successfully embedded into normal primary care practice.

Self referral[4]

Prompt treatment by a physiotherapist in the early phase of an injury can improve recovery; enabling a person to return to their 'normal life' as soon as possible. Self-referral services currently running have shown that people who self-refer to physiotherapy take fewer days off work, and are half as likely to be off

[2] Hill JC, Dunn KM, Lewis M, Mullis R, Main CJ, Foster NE, et al. A primary care back pain screening tool: identifying patient subgroups for initial treatment. Arthritis Rheum 2008;59(5):632–41 http://www3.interscience.wiley.com/journal/118902658/abstract

[3] Foster NE, Mullis R, Hill J, et al. Effect of stratified care for low back pain in family practice (IMPaCT Back):a prospective populationbased sequential comparison. Ann Fam Med. 2014;12(2):102-111.

[4] http://www.csp.org.uk/documents/musculoskeletal-physiotherapy-patient-self-referral-qipp-endorsed-pathway

work for longer than a month, when compared with people who have been referred using more conventional routes[5]. Evaluation has also shown self referral to achieve the following:

- Be less expensive than the GP referral route for access
- Enable best use of GP and practices' adminstrative staff time
- Require fewer healthcare interventions
- Increase service user satisfaction
- Be cost effective for service users re. their time and commitments
- Promote individual personal responsibility for health
- Promote autonomous decision making about personal health status and need
- Enhance motivation for recovery, enabling speedier return to previous health status.

Telehealth

The blurring of deliniation between primary, secondary and tertiary care is another aspiration of the NHS five year forward view. Physiotherapists are already using telehealth techology to do exactly that. A secondary care respiratory centre in the south east now links via a telehealth initiative to a tertiary centre in London. This link enables specialist consultants to support physiotherapists and nurses in managing patients with complex respiratory conditions. The techology is also planned to be used to allow interactive goal setting with patients including on return to the community.

A two-year pilot using physiotherapists for NHS 24 began in late May 2014, in response to the increasing number of people contacting the service about MSK-related issues. Of the 1.3 million calls to NHS 24 each year, nearly 92,000 are about MSK conditions, with low back pain accounting for about 40,600 of these. In the majority of cases reasurrance and expert advice avoided the need for these callers to require further services. This service intends to link with other community services including pharmacists and nurses to enable an improved patient journey.

Falls

The Westminster Falls Service offers risks assessment and intervention for clients referred following a fall or who are at risk of falling. After assessment clients are receive either 1:1 physiotherapy and/or attend a12 week strength and balance programme designed to increase physical capability and confidence, improve balance, and reduce fear of falling. On completion of the programme clients continue falls prevention exercise via 'Steady and Stable' classes in partnership with a voluntary organisation. Clients followed up a year later reported a 60% fewer falls, 55% fewer fractures, 92% fewer A&E admissions, and a 80% reduction in GP appointments compared to the year prior to intervention.

The CSP has produced a falls prevention economic model[6] which demonstrates how investment in physiotherapy in primary care produces cost savings across other parts of the health economy. The tool brings together data from high-quality sources including the Cochrane Collaboration and the Office of National Statistics to provide intelligence based on local populations. This is in line with the CSPs ambition to support services to be commissioned based on patient and population need. For example the tool demonstrates that in England preventative physiotherapy for older people could lead to 187,462 fewer falls resulting in £274,998,720 cost savings.

Accident and Emergency

Salford Royal NHS Foundation Trust treats 88,500 Accident and Emergency patients per year. An advanced

[5] http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089516

[6] http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/cost-falls

physiotherapy practitioner post was established in 2010 for people attending A&E with musculoskeletal injuries to provide holistic assessment and treatment for all aspects of their condition.
The role includes ordering and interpreting investigations such as X-rays and blood tests and onward referral for further physiotherapy if required.

Evaluation has shown increased service efficiency and care quality. Patients are provided with immediate access to expert physiotherapy advice and treatment, and waiting times have been lowered. A reduced requirement for more expensive medical staff has resulted in cost savings of £32 per patient - a 60% reduction. Patient flow through A&E has been improved and staff have reported better knowledge sharing between membersof the multi-disciplinary team.

2 - Examples of emerging innovation

Emerging model of MSK physiotherapy first contact assessment in GP settings

It is estimated that 20% of GP appointments are secondary to a musculoskeletal pain conditions.[7] With the evident stress on the GP workforce to provide for a increasingly complex population - physiotherapy as a first point of contact provides an ideal solution. Physiotherapists have the diagnostic and clinical-reasoning skills to enable them to effectively manage this caseload.

The CSP is currently in the process of scoping where in the UK physiotherapists are providing first point of contact GP style services. One CCG is currently commissioning a 1 year pilot of a MSK first point of contact service located in 25 GP practices across their locality. This service expanded from successful implementation in two GP practices. In its current format the service has been running since January 2015 and as such has limited data to draw on for evaluation. However, early patient feedback has been very positive. The service will shortly be undertaking an evaluation to understand its impact on patient outcomes and the economical efficiency of the service.

A similar MSK first point of contact service has been developed in West Wakefield.[8] This service similarly enables quick access to assessment and advice from highly specialist physiotherapists in 6 GP practices. Again having been in operation for less than a year the evaluation of this service is limited. Patient participation groups were consulted regarding the services implementation and have provided useful guidance regarding patients expectations. Data is being collected on what services patients would have accessed if the physiotherapy service was not available. This is also due to be analysed shortly.

Integration of health and care in a primary care setting

Physiotherpy is central to the majority of the Integration Pioneers. This initiative demonstrates a number of ways in which physiotherapy staff can work with other professionals in a primary care setting to support patients to remain independent and the need to be admitted to hospital. For example, in Greenwich physiotherapists work with occupational therapists, nurses and social workers in Joint Emergency Teams to respond to emergencies within the community, based around a hub of GP practices . In the first phase of the programme, over £1 million has been saved from the social care budget, 2000 patient admissions have been avoided, and there has been no delayed discharged. [9]

[7] Royal College of General Practioners - Birmingham Research Unit. Annual prevalence report 2006. - See more at: http://www.arthritisresearchuk.org/arthritis-information/data-and-statistics/musculoskeletal-pain-and-disability/how-big-is-the-burden-on-general-practice.aspx#sthash.8kVvX8ty.dpuf

[8] http://www.england.nhs.uk/wp-content/uploads/2015/02/pmcf-poster-west-wake-feb15.pdf

[9] http://www.csp.org.uk/news/2014/10/16/care-services-minister-praises-excellent-work-physios-greenwich-integrated-care-pilo

2 - Workforce/skill mix issues

We strongly support an approach to workforce planning, development and investment that appraises workforce supply need from the perspective of changing population and patient needs and taking different approaches to service design and delivery. This should enable more lateral considerations to be taken of how workforce demand can be met in responsive, clinically- and cost-effective ways, rather than workforce planning being premised on pre-existing models of workforce supply and service delivery.

We are concerned that the GP workforce action plan, recently published by NHS England, HEE, the RCGP and BMA, focuses narrowly on addressing current workforce challenges through initiatives focused on the medical profession. This misses a real opportunity to consider how other parts of the workforce, including physiotherapy and the other allied health professions (AHPs) can contribute to primary care in significant, clinically- and cost-effective ways. We are keen to contribute to exploring how a more lateral, strategic approach to addressing current needs – with fulfilling patient needs in safe, effective affordable ways brought to the fore – can be progressed in ways that achieve the kinds of workforce transformation required.

We believe that the physiotherapy workforce can play a key role in leading, integrating and delivering services in primary care settings, including through new models such as MCPs and across service delivery sectors (including health and social care; the public, independent, private and third sectors; and across illness prevention, health and well-being).

We provide more information in the appended information (originally submitted to HEE in June 2014) on how we believe the physiotherapy workforce can help to address primary care needs. Again, we will develop this further in our follow-on submission in April.

4 - Addressing current problems

While physiotherapy and other allied health professions (AHPs) can already make a strong contribution now to primary care - enabled through role reconfiguration/substitution, as well as service re-design and integration – their full potential could be realised through an increased commitment to workforce development and investment.

In support of this, it is important that the potential for skill mix review and role re-configuration /extension/development/substitution is considered broadly within how care is led and delivered in primary care settings. This needs to consider the benefits of strengthened inter-professional team working and stronger collaboration within and across sectors and services.

While we see the physiotherapy workforce as being well-placed to engage in this, we believe that the full potential for meeting patient care needs differently and more effectively and efficiently hinges on consideration being given to the following workforce development issues:

- Supportive structures for post-registration education and development for AHPs that align with changing job roles and optimising the professions' potential
- Stronger structures for professional leadership and peer review, particularly in the context of increasingly fragmented service delivery and the imperatives of more inter-professional team working and more collaborative working across sectors and settings (to achieve care that is genuinely integrated and person-centred)
- Stronger support for individuals both to return to practice after a career break and to make career shifts, including to meet changing patient needs and to deliver care within changing service models (as is currently being progressed for the nursing and GP workforces).

Funding Model constraints

Many clinical commissioning groups (CCGs) have started to develop novel contracting and commissioning models with the intension to drive more transformational and sustainable service integration. The prime provider model and alliance contracts are examples of such new contracting models. The CSP is concerned these models, which use multiple providers, risk working against the government's stated aim of better integration. The CSP believes this could lead to fragmentation of care; a plethora of different standards against which the quality of care is judged; and poor monitoring of non-NHS providers and a wide variation in employment conditions and pay. It is essential that these risks are mitigated in the interests of clinically- and cost-effective care for patients.

EE24 Westbourne Medical Centre and Dorset CCG

Organisational Information

Name of organisation	Westbourne Medical Centre / Dorset CCG	Contact Number	01202 752550
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Contact Person Name and Position	Dr Lawrence Brad GP	Number of attached Evidence documents	

I am a full time GP partner with 20 years experience.
My practice is on one site for 16,500 patients.
I am the education lead for Dorset CCG and representive at Health Education Wessex Board level.
I am an executive committee member of the Wessex GP EducationTrust.
I have experience of collaberation with Wessex LMC, Wessex Acaedemic Health Science Network and NHS Innovations South West.

Areas selected for evidence are the projects that I have personally led and that reflect the growing importance of

- culture change for patients and clinicians
- increasing use of technology
- developing capability of primary care

1. Models that work well and likely to meet the future need

Practice level

- Developing use of econsultations in pre consultation planning

(pilot project with West Hampshire practice and London based WebGP)

- Learning Organisation culture and development including

Mentorship time, to facilitate the development of the MDT
Developing use of IT templates within the consultation to facilitate skillmix, decision making , efficiency and safety.(NICE Implementing guidance Shared Learning Award 2008)
The creation of a managerial role for Clinical Intelligence to develop segmentation both for diseases and health behaviour, coupled with Knowledge Transition management (receiving , summarising and facilitating implementation of new clinical knowledge).
This needs established and robust support and our experience suggests that there are 4 common useful types of resource that we use;

- NICE clinical guidelines
- Commercial companies eg NB Medical (courses and educational material)
- Commercial publishing companies eg BMJ,MGP 'Guidelines'
- Commercial IT support packages eg DXS

- Using technology 'beyond the consultation' to support the patient when not consulting using 'Web App' technology (pilot project with Dorset CCG and NHS Innovations SW)

Dorset CCG Level

- Protected Learning time scheme for 100 GP Practices
- Dorset CCG/ NB Medical 'Hot Topics' education courses with educational support material to use in the

practice (2 years of feedback evidence to support)

2. Developing the role of the clinical pharmacist

We have over 150 hours of appointments that have been totally independent seeing patients for long term condition follow up. Predominantly asthma and hypertension.
The prescribing pharmacist has demonstrated excellent knowledge of the key issues ,assessing risk and improving compliance and ensuring optimisation of medications. Use of computer templates is an essential component which help aid decision making and prescribing.
Patients with polypharmacy benefit greatly from this development and we would propose that in future, LTC follow up is better than that undertaken by practice nurses.
We need resources to ensure pharmacists can attend in house education with the rest of the MDT and we need mentorship time for a GP to review the clinics.

3. (Evidence documents to be discussed and forwarded at a later date)

4. Problems

CQC

Finding time and resources to develop and share innovations at Dorset and Wessex levels (no formal structure)

Evaluation of developments in primary care (no formal structure)

e.g.

-we need to establish a network to understand the evolution of computer templates used in the consultation . How we can minimise duplication of work in practices, evolve and update templates personalised to the skill sets of the clinician and the role the clinician undertakes.

-Mentorship for GP trainer to help clinical pharmacist; community mental health OT, MSK physio, paramedic and nurse practitioner and Primary care HCAs to develop skills for primary care.

-Need funding as per GP training funding for the teacher and the learner to be placed and funding/ academic practical support for course design.

EE25 RCGP

Organisational Information

Name of organisation	Royal College of General Pracitioners	Contact Number	020 3188 7584
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Contact Person Name and Position	Lisa Johnsen Workforce Business Manager	Number of attached evidence documents	6 (including this document)

Outline below the evidence that you would like the Commission to consider.

The Royal College of General Practitioners (RCGP) welcomes the opportunity to respond to the Primary Care Workforce Commission. The recommendations from the Commission will form a key part of NHS England (NHSE) and Health Education England (HEE)'s responses to the challenges faced by primary care in responding to changing patient demand. The RCGP is the largest membership organisation in the United Kingdom solely for GPs.

In responding to the terms of reference, the document '150220_PCWC_RCGP_Submission final_v5 00' will outline the key themes of evidence and recommendations for the Commission to consider. However, in the appendix of the College's next submission, further supplementary and supporting evidence may be supplied. It is important to note that presented throughout the document are a wide range of approaches that have been proposed by our stakeholder group. Some of these new ways of working may be conflicting and others may not have undergone sufficiently rigorous evaluations for cost and effectiveness. However, for completeness, many of the models submitted from our stakeholders are included. Given the different options of models of care, it is the College's belief that locally led decisions regarding the best model of care for a particular locality must be made. As the RCGP strongly believes that knowing the number of GPs and other health care professionals required to provide an effective workforce is essential, we have submitted some evidence regarding this as part of this submission.

There are six documents included in this submission:

1. 150220_PCWC Call for Evidence_RCGP evidence submission_v1 0
2. 150220_PCWC_RCGP_Submission final_ v5 00
3. 150220_Appendix 1_Patient access to general practice_DRAFT
4. 150220_Appendix 2_Royal College of General Practitioners_Council Papers_Case studies - integration of care_DRAFT
5. 150220_Appendix 3_The Future of GP Out of Hours Care
6. 150220_Appendix 4_Examples of GP provided out of hours care

We look forward to the opportunity to provide oral evidence to the Commission and also to hear the recommendations that the Commission establishes.

Yours sincerely,

Lisa Johnsen

RCGP Workforce Business Manager

EE26 NHS England Devon, Cornwall and Isle of Scilly

Organisational Information

Name of organisation	NHS England Devon, Cornwall and Isle of Scilly	Contact Number	0776 997 2652
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Contact Person Name and Position	Magdalena Wood	Number of attached evidence documents	1

Outline below the evidence that you would like the Commission to consider.

1. Transformational change programme is underway across Devon and Cornwall aiming at mobilising and developing General Practice and Community Nursing workforce to advance the implementation of Forward View and support development of new models of care. The programme develops new models of joined up working and so that primary care nursing workforce was able to take the lead in partnership working across organisational and clinical boundaries. The programme is enabling the nurses to acquire new skills and knowledge, and also facilitate the immense cultural change needed so that out of hospital nurses are activated and motivated to work within this exciting and challenging environment of the future.

This piece of work is being delivered in partnership with all three CCGs in our footprint, community services providers, LMCs, education providers and other stakeholders using the NHS Change Model. There is a Programme Management Team consisting of a group of Nurse Leads from the general practice and community nursing progressing this.

I would like the Commission to consider this programme as an evidence of a progressive way of thinking about general practice and community nursing workforce development being realised according to principles of a transformational change. This approach has already received regional and national support and interest and even though the programme has not been completed yet, other areas are looking at adopting it.

Please see attached a programme manifesto on a page outlining programmme's goals and outputs.

EE27 Health Education Yorkshire and Humber

Organisational Information

Name of organisation	Health Education Yorkshire and the Humber	Contact Number	0113 343 1510
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Contact Person Name and Position	Mark Purvis GP Director	Number of attached evidence documents	7

Outline below the evidence that you would like the Commission to consider.

Primary Care GP Workforce Strategy for Yorkshire and the Humber.

This strategy acknowledges that across Y&H we have a variation in capacity, capability and organisational resilience to workforce pressures amongst our practices and that providers adopt conservative, evolutionary or transformational approaches to developing their workforce.

GP Workforce Tool

Our strategy is underpinned by engagement with local providers who are providing data to inform the strategy using our General Practice Workforce Tool.

Detasils of the tool can be found here:

http://yh.hee.nhs.uk/files/2013/07/GP-Tool-Flyer-A4.pdf

We enclose our latest return. We are able to provide a more detailed CCG level analysis.

An anlysis of the qualitative data contained in the last quarter's practice returns shows the following:

1. We have increasing engagement and data return for the survey and are using this data to help our local health community make informed choices when targeting support and commissioning services, education and training.

2. Whilst we currently have insufficient data for meaningful longitudinal analysis or trend analysis at this time, over time we will be able to use data to undertake trend analysis and to measure the impact of investment decisions.

3. We note a significant gap in FTE workforce/100,000 pts compared to HSCIC and other data sources. We note that we may be underestimating the reliance of providers on locum and agency staff. We recognise the importance of this information for practices (for planning and financial reasons) and are exploring options to improve data collection on locum/agency staff use.

4. We note that there is a large variation in workforce availability between providers with extremes that are difficult to justify (for example 9 practices with >4,000 pts per GP).

5. These data confirm a variation in capacity, capability and organisational resilience to workforce risk

that impacts most on rural remote or urban deprived populations.

6. We have recognised three broad approaches that practices are taking with respect to workforce: (i) like for like replacement (ii) evolutionary change- e.g. opportunistic skill mix or skill mix changes driven by necessity (iii) workforce transformation with some practices adopting a more radical approach to delivering the service.

7. The age profile of Practice Nurses shows that currently practices are not employing younger practice nurses (reflects traditional career pathway of recruiting older nurses with experience) – this may change with Advanced Training Practices providing a route for younger nurses to become practice nurses.

8. We have seen and increasing recognition of workforce risk by practices returning data.

9. Most vacancies relate to poor supply of suitable applicants, but we have a new finding this quarter of some practices no longer recruiting to vacancies because of financial constraints.

10. Many practices are looking at transformation solutions, but for the first time some are considering the option of dropping non-core services or even closure.

11. Federation and mergers means that the number of practices in Yorkshire and the Humber is falling. We have fewer practices, but practices are getting larger.

Action in Yorkshire and the Humber in response to "Building the Workforce – the New Deal for General Practice"

We are working on recruitment, retention, return to practice for the GP Workforce as outlined in the following paper:

The following evidence may also be helpful to the commission

Widening Access to Medicine scheme in order to improve participation in medical careers in our most deprived communities:

Evaluation of Foundation Taster Days to improve GP career orientation:

Creating Multi-disciplinary Training Capacity in Primary Care, promoting inter-professional learning: Advanced Training Practices

Details of Yorkshire and the Humber's Advanced training Practices, including strategy, case studies and detailed evaluation can be found here:

https://yh.hee.nhs.uk/what-we-do/education-training/advanced-training-practices/

Creating high quality inter-professional learning in primary care alters career choice, improves undergradautes "employability" in primary care once qualified and creates learning environments where learners are more likely to appreciate a person's wider needs.

Advanced Clinical Practice

We have agreed job description templates for advanced clinical practitioners and available here:

https://yh.hee.nhs.uk/what-we-do/education-training/primary-and-community-care/

We have a briefing paper about new roles (physicians Associates) and developing roles in General Practice for

advanced clinical practitioner roles. We are supporting placement in primaruy care for advanced clinical practioner roles and new roles such as PAs

Administrative and Management Roles

One of our workforce stakeholder groups specifically wanted to raise the issue of training the non clinical leadership for a sustainable future for primary care. The providers noted that the current ratio of practice managers: clinical workforce was inefficient and unsustainable. With federation, mergers and the move towards fewer providers delivering primary care at scale to larger populations there is a need to trainin, develop and support a “new breed” of practice managers. These stakeholders hope to submit evidence that investment in high quality practice management results in safer, more efficient and more effective clinical care. This fits with the “well led” agenda.

We are supporting apprenticeships in primary care

EE38 Health Education South London

Organisational Information

Name of organisation	**HE South London**	Contact Number	0207 866 3246
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Contact Person Name and Position	Ariadne Siotis (HESL) Programme Manager	Number of attached evidence documents	7 embedded documents

Outline below the evidence that you would like the Commission to consider.

Developing the primary care workforce for integrated care

Health Education South London has developed a number of approaches to creating a patient-centred workforce to deliver integrated services. Foremost of these has been the creation of Community Education Provider Networks which will act as the delivery mechanism for HESL's primary care workforce initiatives.

1. Community based educational provider networks (CEPNs)

The 4 LETBs in London and KSS are developing a programme of educational networks that promote inter-professional learning and working based around the needs of local populations. The attached document provides a description of CEPNs and the presentation outlines the case for their creation.

Both HENCL and HESL CEPNs are working towards performing the below 6 functions:

Workforce Planning: Developing robust local workforce planning data to inform decisions over how education and training funding should best be invested.
The HE Yorks and Humber workforce planning tool will be used by the CEPNs to capture previously unknown data on the primary care workforce.
Education Quality: Supporting improvements in the quality of education programmes delivered in primary and community care, for example, through peer review.
Wandsworth CEPN are running courses in arthritis management with Arthritis UK and the RCGP.
Developing local educational capacity and capability: For example, an ability to accommodate greater numbers of nursing placements or the development of multi-professional educators in community settings.
Bromley CEPN identified the need for more mentors and have now increased the number of mentors and placements available for undergraduate nurses.
Responding to Local Workforce Needs: Collaborating to meet local workforce requirements (such as specific skills shortages), including the development of new bespoke programmes to meet specific local needs. The CEPNs undertook staff surveys and identified an acute shortage of practice nurses. Working with HESL pilot practice nursing projects are now underway in two CEPNs.
Workforce Development: Developing, commissioning and delivering continuing professional development for all staff groups.
Croydon CEPN developed training for primary care and community nurses and HCAs in holistic care of over 65s.
Education Programme Coordination: Local coordination of education programmes to ensure improved

economy of scale, reduced administration costs, and improved educational governance. Richmond CEPN has created a local tool to monitor training offered and booked to co ordinate between practices.

An early evaluation of the original four prototype networks can be found here:

A more recent summary of the second wave of CEPNs can be found here:

The CEPN programme was is envisioned as a minimum three year development programme and 2015/16 is year two. Currently ten out of south London's twelve CCG/LA areas have CEPNS and HESL is hoping to have a CEPN in each CCG/LA area by the end of this financial year.

2. Deploying skills differently

a) Learning together programme – This programme was initially developed in NCEL and it has created strategies that encourage GP and paediatric trainees to learn together. The powerful learning was tested as part of an evaluation attached and the programme is now running in south London.
Based on the success of the original Learning Together work HESL is now piloting a Learning Together programme for Geriatric Registrars and GP Trainees working in nursing homes.

b) Using HESL funding community pharmacies in South London have trained over 600 front-line staff as 'Health Champions' supporting patients and the public to stay healthy. The Health Champion project is designed to develop the role of the wider pharmacy team to lead public health campaigns, recruit people into health and wellbeing services in the pharmacy and signpost to other services where appropriate.
Community Pharmacy is a key member of the Community Education Provider Networks and all south London GP practices have been given the attached contacts booklet laying out the Community Pharmacies in their areas and the names of the Health Champions at each pharmacy. Working together through the CEPNs the GP and Pharmacy teams are planning to train the next group of Health Champions together.

Developing the primary care workforce to work differently

a) CPPD
HESL has made a substantial CPPD allocation available for staff working in primary care over the last two years. This allocation was distributed via CCGs initially however from April, where CEPNs exist; the money will be allocated to them as networks of primary care providers. This will support the development of bands 1-4 to extend the scope of their practice through commissioned courses as determined by the local system, based on the needs of the local population.

b) Commission training for practice nurses to develop new skills such as prescribing, managing chronic disease, support a broader scope of activity.
We have used two of our CEPNs to pilot a programme to support a cohort of 20 post-registration nurses not currently working in General Practice to transfer to Primary Care. The programme will provide the nurses with the essential competencies and skills to transfer to a General Practice setting while the CEPNs manage the nurses' placements locally.
This programme allows the nurses to receive both practical on the job training, by spending between 2 to 4 days a week in the practice with their allocated nurse mentor, as well as the theory behind general practice nursing by attending a Higher Education Institutation (in this case London South Bank University) to demonstrate that specific competencies, as outlined in the RCGP framework, have been achieved. All nurses who complete the programme will themselves be accredited mentors thereby building sustainability into the system.
The nurses are employed by their practice throughout the duration of the programme, and it

anticipated that once the programme comes to an end, they will remain employed by that practice as a practice nurse.
There is early evidence that this programme is welcome based on the number of applications that were received for the limited 20 available places. There will be quarterly evaluation reviews with the full review expected in January 2016. HESL will be running a second programme with up to 40 placements available within the next financial year.

c) Develop primary care placements for student nurses to encourage career choices involving primary care.
Each of our CEPNs is working closely with their local HEI to increase the number of nurse mentors in general practice and to expand the placement capacity for undergraduate students in primary care settings. We anticipate that each area will add about 10 placements by the start of the next academic year, creating a possible total of 90 additional places.

3. Evidence you have for why you think these models work well

A number of documents are attached in relation to each of these streams of activity. We hope they provide adequate evidence and insights into the proposed approaches for developing the workforce to work in integrated ways.

4. Problems you perceive in implementing these models within the NHS at present

There are a number of challenges in implementing these models.

a) Developing sustainable models that can deliver on the integration agenda in an out-of-hospital setting is a significant challenge to the CEPN model;
b) Developing new skills and encouraging new ways of working for established staff is hampered by processes such as curriculum development and socialising new training approaches in the workplace;
c) Capacity (infrastructure and people) to provide high quality training in primary care is a significant challenge.
d) The shift of education from the traditional hospital setting to the community is a major change. Sufficient time is required to allow the development of community education provider networks which will serve as the vehicles for this change. Too short a time frame, or frequent organisational changes put this process at risk.

EE29 RCSLT

Organisational Information

Name of organisation	Royal College of Speech and La Therapists	Contact Number	0207 378 3631
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Contact Person Name and Position	Rebecca Veazey, Policy Officer	Number of attached evidence documents	2

Outline below the evidence that you would like the Commission to consider.

As outlined by NHS England's Five Year Forward View, the vision of primary care in England is evolving. The traditional boundaries between primary care, community services, and hospitals are dissolving, in recognition of the need for personalised and coordinated health services that meet patients needs. Speech and language therapists (SLTs) are highly experienced in providing integrated, patient focused care. Their work spans health, education and care settings, and they play an important role in multi-professional/ multiagency teams which support primary and community services.
Looking to the future, SLTs are already evolving roles and sharing skills and competencies with other professions to improve patient outcomes. The following case studies demonstrate some of the innovative practice employed by SLTs, and the valuable contributions that they can make to new models of primary care.

The following case studies also demonstrate how SLTs support integrated working between primary care and other services, how they have adopted new approaches to deploying traditional skills and the role they play in tackling health inequalities through interagency work.

Safe swallowing support

Speech and language therapists are showing innovation in areas of high risk.
Swallowing difficulties (dysphagia) are a high prevalence, and potentially fatal, medical problem which typically arise as the result of a wide range of other health conditions. Up to 78% of stroke patients are estimated to suffer from dysphagia (Chen et al, 2015) and 10% of acutely hospitalised elderly people develop dysphagia (Lugger,1994).

SLTs train nursing and other staff to ensure patients start eating and drinking as soon as possible, avoid the use of tube feeding and dehydration, and reduce the risk of infections (e.g. aspirational pneumonia) which delay recovery and rehabiliation. SLTs help co-ordinate a safe return home with community speech and language therapy support. This work and innovation in this area is highlighted in case studies one and two below.

Case study one: supporting integrated working between primary care and other services

SLTs work in the Sandwell and Birmingham NHS Trust's Integrated Care Service has helped to relieve winter pressures on A&E services, created financial savings and improved outcomes for patients. As a consequence, The Trust has reduced hospital admissions by 2478 per year, reduced length of stay in hospital from 10 days to 7 days, and saved approximately 17000 bed days, which has the potential to reduce costs by over £7 million.

Through the use of their specialist skills and the training of other professions, SLTs work in the 'rapid response therapy team' to:

- Prevent unnecessary hospital admissions, via a highly response service 12 hours a day, 365 a year, which assesses patient needs and pressure area.
- Work collaboratively with social work colleagues to support the patient to return home.
- Deliver urgent speech and language therapy assessment to ensure patients' swallowing can be managed back at home by community staff.

As part of an integrated care approach, SLTs also work closely with the discharging and community teams to ensure that patients identified as at risk of re-admission receive appropriate support in the home setting, and are psychologically and physically prepared to return home.

Case study two: new approaches to deploying traditional skills

In response to a growing older population and a high number of speech and language therapy referrals for domicillary assessment of swallowing difficulties, the speech and language therapy service at Blackpool Teaching Hospitals NHS Foundation Trust has begun using telemedicine to support the remote assessment and management of dysphagia.

Technology has enabled the following:

- Swifter responses to patient need (supporting early triage, assessment, provision of therapy and follow-up with patients)
- better use of specialist resources (SLTs have been able to maximise their time and reach a greater number of patients)
- efficiency savings and improved patient outcomes in local health systems (reducing incidences of admission, readmission to the acute care setting, and domicillary visits via rapid response to patient referals).

The use of telehealth has reduced the average time for speech and language therapy assessment from 90 minutes to 30 minutes, and reduced travel time and costs associated with home visits. Through a pilot programme, the speech and language therapy service has provided training to nurses in local nursing homes on how to prepare patients and documentation ahead of teleswallowing assessments, which then reduced assessment times overall.

Tackling health inequalities

Research highlights the links between speech, language and communication, educational achievement and health inequalities. The Marmot Review identified communication skills as critical for school readiness, a key social determinant of health. As recognised by the work of Public Health England, speech, language and communication skills have a direct impact upon both children's educational outcomes and health inequalities more widely.

7% of children around five years of age have speech, language and communication needs (SLCN), and it is estimated that a further 1.8% (1753 per 100,000 population) have SLCN linked to other conditions such as learning disability, cerebral palsy, autism spectrum disorders (Enderby et al, 2013). There is strong evidence, that the prevalence of SLCN is much higher in socially disadvantaged areas. Studies have demonstrated that in some areas upwards of 50% of children may start school with impoverished speech, language and communication skills (Lee, 2013).

Case study three: improving outcomes for children

In Sheffield, SLTs have worked using transdisciplinary approaches to develop tools and education and training to share knowledge and competencies with teaching staff. As a result, the number of primary school children who have performed well academically has increased, and SLCN are being more actively identified in school environments. The positive results of interagency working by local health and education agencies exemplifies an alternative model that can be used to support improved health outcomes for children and young people with SLCN, and integrated working between health services and other agencies.

RCSLT has not yet had capacity to fully explore the barriers to implementing these models, but some of these include: a fragmented commissioning and provider landscape, competition between providers as a result of the current drivers in the system, and a lack of opportunity to share both innovation in practice and workforce transformation.

EE30 CfWI

Organisational Information

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Contact Person Name and Position	Hannah Darvill Head of Health (Medical)	Number of attached evic documents	One covering letter to Professor Roland

Outline below the evidence that you would like the Commission to consider.

On behalf of the Centre for Workforce Intelligence (CfWI) thank you for the opportunity to respond to the Primary Care Workforce Commission Call for Evidence. You have asked for evidence relating to models of primary care that work well and are likely to meet the future needs of the NHS.

Whilst the CfWI is not in a position to propose future models of primary care per se, there are a number of ways we believe we can support the Commission in its work.

First, my colleague Grant Fitzner (CfWI Director of Analytics) and I would be delighted to meet you face-to-face to talk through the findings of our In-depth Review of the General Practice Workforce, which we published last year, and which you can read on or download from our website:

http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce

We believe a face-to-face meeting might be the best way to convey some of our more complex findings. Your team may also be interested in the outputs of our 'horizon scanning' exercise for the above review: http://www.horizonscanning.org.uk/projects/general-practitioner-gp-in-depth-review/

Second, we may be able to help with analysis, primary care workforce mapping and modelling relating to future models of primary care you wish to explore. For example we could model the workforce impacts of various 'what if scenarios' and different skill mix permutations (involving new primary care workers - such as the 'medical assistant' proposal as discussed in the NHS 5 Year Forward Plan).

This work would build on our recent review, and would be subject to the agreement of our commissioners, the Department of Health and Health Education England.

Please don't hesitate to contact me if you would like to discuss either of these ideas further.