# Completed evidence forms

**Contents page**

# EE31 Richmond CCG

## Organisational Information

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| Name of organisation | NHS Richmond Clinical<br><br>Commissioning Group | Contact Number | 020 8734 3085 |
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| Contact Person<br>Name and Position | Aileen Jackson – Commissioning Manager<br><br>Thomas Herweijer – Project Support Officer | Number of attached evidence documents | |

Background:

The HESL 'No Health Without Mental Health Workforce Development' project is an ideal example of integrated, patient focused primary care, as it aims to improve the health of people with long term conditions (one of the main groups in need of primary care) through equipping the workforce across health and social care including health, statutory, private, voluntary and independent sectors as well as the relevant service users/patients and carers with the knowledge skills and understanding to recognise the impact of mental health on physical health conditions. NHWMH is a joint project of Merton CCG, Croydon CCG, Kingston CCG and led by Richmond CCG.

Modus Operandi:

- The delivery of mental health awareness training on the impact of long term conditions on a person's mental health and the availability and access to services for someone with a possible mental health need.
- Motivational Interviewing – engaging with clients/patients, elicit change talk and evoke motivation to make positive changes from the client.
- Train the Trainer – sustaining the knowledge and skills gained from mental health awareness workshops within providers of health and social care organisations

Examples of providers:

Through these different methods of engagement and education, primary care, GP practices and other healthcare providers are linked together:

- GPs and Practice Staff
- Community health services staff
- London Borough of Richmond Adult and Community staff
- Commissioned Voluntary Sector services

Feedback:

Mental Health Awareness workshops and Motivational Interviewing sessions have been provided in Richmond and Merton since October 2014. Feedback so far has been very positive, with people thoroughly understanding the need for change, the integration of services and the link between mental health and

physical health. The same applied to the motivational interviewing feedback, in which providers indicated to have learnt how to engage with their clients/patients in a different way to evoke motivation to make positive changes from the clients/patients. This demonstrates that this model is working well.

Please note we will be unable to give an evaluation of the No health without Mental health workforce development project until February 2016. This is due to the delay in securing providers to deliver the project accross all 4 CCGs , 2 of the CCGs will not complete until December 2015 .

Any report In April wil be a commentary on the outcomes to March 2015 , ( for 2 of the CCGs this is data for one quarter only )

# EE32 Royal Pharmaceutical Society

## Organisational Information

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| Name of organisati | Royal Pharmaceutical Society | Contact Number | 0207 572 2602 |
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**Outline below the evidence that you would like the Commission to consider.**

In November 2013 the RPS published a report 'Now or Never: Shaping Pharmacy for the future'. This was a report from an independent commission, overseen and authored by Judith Smith, Director of Policy at the Nuffield Trust. During the development of this report we put out a call for people to submit their innovative mdels of care. We received a huge number of responses and we would like to share some of these, particularly the ones demonstrating outcomes, with this Commission.

Following the report the RPS have published five areas where we believe pharmacists can make a significant different to the care of patients, potentially improving patient outtcomes as well as saving the NHS money in the longer term. We will provide examples and evidence around this five areas.

The Five areas are:

Improving Urgent and emergency care through better use of pharmacists: the better use of pharmacists in this agenda can take pressure away from other parts of the system, such as A&E adnd GP Out of hours services. We will provide evidence that can demonstrate this. Nationally there is evidence that demonstrates that pharmacists dealing with minor ailments could save the NHS a considerable amount of money and the outcomes for teh patient are the same as if they had attended GP OOHs or A&E.

Pharmacists and GP surgeries: We will demonstrate how better collaboration between pharmacists and GPs can lead to better patient care. There are two main areas of focus; pharmacists being employed by a GP practice, which is particularly relevant when there is a shortage of GPs, and secondly, community pharmacists working more cosely with GP practices.

Pharmacists improving care in care homes: People in care homes are often frail and elderly and pharmacists an play a significant role in improving the patient experience. We have examples of pharmacists undertaking medicine reviews with full patient engagement, resulting in medicines being stopped, better quality fo care for patients and savings for the NHS.

Pharmacist led care of people with long termconditions: Pharmacists working in primary care can have a much greater role in supporting and managing patients with LTCs. We will provide several examples of where pharmacists have made a difference to patient outcomes, particularly around asthma.

Pharmacist access to the patient health record: The RPS belives that pharmacists should have read and write access to the patient health record to enable them to have the information they require in order to undertake clinical roles.

We are also aware of the workforce issues in primary care and the fact that we have a surplus of pharmacists within the current system and this excess of pharmacists is likely to increase over time. The current crisis in GP and nurse workforce is causing problems across the porimary care workforce. We will demonstrate how

the better use of pharmacists can help to address some of these problems.

# EE33 NAPC

**HEE Primary Care Workforce Commission – Evidence Submission of the NHS Confederation and National Association of Primary Care (NAPC)**

**INTRODUCTION**

The NHS Confederation and National Association of Primary Care (NAPC) welcomes this opportunity to contribute to Health Education England's Workforce Commission, which looks to identify models of primary care that will help to better support and meet the needs of our members across the NHS, support more integrated working between primary care and other services and overcome the barriers that our members tell us, currently inhibit them from implementing new models of care within the NHS. We look forward to continued involvement with the Commission's ongoing work.

The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation that represents all types of providers and commissioners of NHS services. We speak for the whole of the NHS on the issues that matter to all those involved in healthcare. We also reflect the diverse views of different parts of the healthcare system.

The NAPC represents and supports the interests of all primary care professionals including general practitioners, nurses, practice staff, pharmacists, opticians and dentists.

Our joint response builds on the principles laid down in previous work both organisations have done, including:

- NAPC's 7 Point Plan to deliver its priorities, empowering primary care to deliver patient centred population healthcare
- NHS Conf ederation's submission to the NHS England Improving General Practice consultation,
- Evidence we jointly gave to the RCGP Inquiry into Patient Centred Care
- The joint paper we published last year, 'Not more of the same' which calls for a change in the way the primary care workforce is modelled and trained.
- Further to this our response also draws upon case studies drawn from interviews with NAPC members, which highlight some of the innovative tools and ways of working which are already being used to support those working in primary care to take a population health management approach and to better meets the needs of patients.

**SUMMARY**

Our members agree that the short-term need to develop the primary care workforce is clear and that medium-to long-term workforce planning requires an alternative approach – a patient-centred, population-based model. This requires an enhanced skill-mix, new capabilities, and regulatory and training curricular change. Financial modelling is also needed to understand the impact of such a change.

The development of a future model for workforce requires a whole-system approach. This is already happening in London and Kent, Surrey and Sussex local education and training boards (LETBs) through the community education provider network model.

In designing the new system, it is crucial to consider the following requirements:

Purpose The new models of healthcare delivery will need to meet growing demands for access, keep people healthier for longer by preventing illness and promoting wellness, meet changes in patient expectations, and deliver care to people with often complex conditions as part of a team, in an integrated manner.

Environment The setting that care takes place in is important, recognising that an attractive environment has positive effects on the workforce as well as on the wellbeing of patients.

Accessibility and the availability of a variety of different services at one location is also desirable.

Capabilities The primary care workforce, including GPs, should be capable of taking a population health approach, including risk profiling. Training and development needs to ensure that staff can work as part of a team made up of different health and care professionals

Systems Training, workforce planning, payment systems and contracts all need to be considered, to ensure that they are encouraging and not creating barriers to creating new models of care. Contracts will need to allow for more flexibility, enabling different professionals, particularly specialists and generalists, to work together to meet the needs of patients with complex conditions.

Culture, behaviours and attitudes More multi-disciplinary working will require the cultural and behavioural barriers across sectors and professions to be broken down. Patients will need to be viewed more as partners in managing their own care.

Leadership GPs and others in the wider primary care workforce need to be able to lead teams and make decisions in the new, more integrated, team-based environment.

**PRINCIPLES FOR THE FUTURE OF PRIMARY CARE WORKFORCE MODELS**

General Practice as part of the wider system of primary care

We are pleased that the Primary Care Workforce Commission will look broadly across the whole of primary care, which includes ophthalmologists, community pharmacists, dentists and practice nurses as well as practice receptionist managers and GPs. We strongly recognise the importance of developing the role of general practice to support new models of care, but it is vital that general practice is understood as part of a much wider system of health proivision, which makes up primary care.

We therefore highlight the definition of primary care, which has been developed by the NAPC, providing both a description of its form as a level in a health system and its strategy or philosophy for organising approaches to care (its function).

The NAPC regards effective primary care as having four central features;

1. The first point of contact for all new health needs

2. Person-centered (holistic), rather than disease-focused, continuous lifetime care

3. Comprehensive care provided for all needs that are common in a population

4. Co-ordination and integration of care when a person's need is sufficiently uncommon so to require special services or provision from another sector (secondary or tertiary care).

Primary care provision is universally accessible, comprehensive and community based and is supplied by a multi-professional team, where these teams operate, many also include

community health and social care professionals. It is accountable for addressing a large majority of both a person and a population's health needs.

These services are delivered in a sustained partnership with patients and informal caregivers, in the context of family and community and play a central role in the overall coordination and continuity of people's care.

We strongly support the view that the characteristics of primary care, identified in this description, should be used to their full advantage in order to better meet the needs of patients. We believe that in some cases it will be appropriate for general practice to take a coordinating role in an individual's care. Our members have also suggested that this role could be done by other health care professionals, who have the necessary skills and who understand the importance of integrating care around the patient. They have cited GPs, community matrons and social workers as all being capable of taking on the role of coordinating care for those with complex long term conditions.

Taking a Population health approach

In our response to NHS England's, 'Improving General Practice', we have argued for a more proactive approach from general practice, recognising that many of its characteristic features mean that it has great potential for improving the health and wellbeing of local populations.

Our members take the view that by engaging more proactively with promoting the wellbeing of local populations, primary care can play an important role in meeting the challenges facing the NHS and reducing demand for services.

The paper, 'Reclaiming a population health perspective', written by the Nuffield Trust in partnership with NAPC, provides a definition of what is meant by taking a population health focus within general practice. In summary, the paper defines population health as having an interest in the health and wellbeing of local populations or communities as well as individuals and families. Furthermore, it suggests this means focusing on the distribution of health within populations, being proactive about preventative care for the healthy, those at risk, as well as the chronically ill, and also thinking about the health of those who do not see their GP regularly. The paper identifies three key reasons for general practice being particularly well positioned to take this approach. These are:

- general practice is the most accessed part of the NHS
- the registered GP list, which is described as the 'basic tool' for a population health approach, providing GPs with a 'stable cohort of patients, who reside in a broadly defined geographical area'
- the generalist tradition of general practice in the NHS, which sees individual patients in their wider context and allows GPs to be uniquely positioned through working in local practices, where they are able to build and capitalise on their knowledge of their patients, contacts and community.
- Improving data and develop skills in risk profiling

While most primary care professionals already understand risk profiling to be a fundamental part of their role, there are many different factors impacting on the ability of primary care to focus more on wellbeing and prevention in this way; notably, the availability and use of high- quality data and risk profiling tools. Patient profiling and segmentation can be a powerful tool for identifying individuals at risk of developing a disease or of deterioration in an existing condition. The ability to identify potential need and intervene early can help in the short term, for example by preventing unscheduled hospital admissions, and in the longer term by reducing the overall burden of disease in a population. Tools such as shared patient records across the health and care system can help better monitor and tailor interventions.

We recognise the challenges in establishing effective disease and risk registers, including getting information on lifestyle indicators, like smoking and body mass index, which can predict the risk of future illness. Obtaining

this kind of data across whole populations will clearly require imaginative approaches to identifying those at risk and collaborative working with other healthcare professions and partners from across the wider system. Clinical commissioning groups, which are expected to have a detailed understanding of their local populations' health needs, have an important part to play in this, for example in commissioning risk and population profiling tools. Importantly, we also need to ensure that those working in primary care, including GPs, get the support and training to be able to use these tools effectively.

In order for primary care to make the most effective use of risk and population profiling tools and to implement subsequent interventions to reduce need and demand, it will require greater collaborative working across practices within a CCG and with the wider health and social care system as well as with local authorities, many of which have already begun making use of population profiling tools themselves. Greater collaboration would allow the sharing of knowledge and data about the health and wellbeing of the population and individual patients. It would also enable resources, such as risk and population profiling tools, to be shared amongst practices, helping them to better understand and more effectively meet the needs of their community.

In the paper 'Reclaiming a population health perspective', interviewees from NAPC's membership offered examples of innovative approaches to identifying those at risk who do not attend a GP practice regularly, for example this case study which GPs and public health workers used a community setting –a supermarket to conduct instant health checks on members of the public.

Ensure that primary care can facilitate the outcomes that patients want and more self- management

The primary care workforce should value the outcomes that are most valued by people themselves. It is vital that the conversation that clinicians have with people changes from "What is the matter ?" to "What matters to you ?". Currently, conversations with patients focus on illness or injury, not on the person. This dehumanises them, by identifying them as their disease group.

Current performance and outcome measures are largely focused around diagnosing, treating, managing or curing diseases. In many cases, these measures are of limited value to individuals and people would prefer outcome measures based around wellness, quality of life and experience.6

Clinicians will need to think about patient outcomes in a different way. This will require enhancement of the GP training curriculum, which is not currently geared to preparing GPs to coach for health or have conversations with patients that enable them to identify what outcomes (not always medical outcomes) patients would like for themselves. Whilst many clinicians can do this, it is not widespread enough amongst different professionals within primary care, such as practice nurses and physicians' assistants.

Self-care needs to be part of joined-up health and social care training and development

.A s well as more participation by patients in defining their own health and wellness outcomes, we also believe in harnessing the power of people to improve their health through self-care. There is significant evidence, from Nesta and other organisations, that supported self-care improves outcomes and reduces costs. This is reinforced by the NHS Confederation who, with the Local Government Association, has called for:

"a national sector-led programme to be set up which would give self-care parity with direct care delivery and which would support health and social care organisations to adopt participation and self-management approaches for all those people who would benefit. This should embrace all potential providers, including the third sector, social enterprises and private sector providers."

Supporting new collaborative models for primary care and beyond

Significantly, most of our members have highlighted the need for greater system-wide collaboration to care for patients. They have suggested that it is unhelpful to speak about patient care in the framework of different sectors, such as primary care, secondary care, social care etc. and they recognise the need to integrate care effectively around the needs of the individual. This will require a change in behaviour's as well as culture and relationships, with greater emphasis on collaborative working between professionals across the different sectors. It will also require a shift towards collective responsibility for patients, which would mean, for example, that GPs would need to be informed about hospital admissions of patients who are registered with their practices and supported by technological tools like patient record/data sharing across practices and hospitals. Our members support greater

collaboration across the health and social care system, so that care is more integrated and learning and knowledge can be better shared across the system.

We recognise the huge pressures that general practice is facing in terms of workload, particularly with the increasing numbers of patients suffering with long term conditions. However, our members have clearly highlighted to us the importance of ensuring improved access to general practice in order to reduce the demand on hospital services. We believe that developing innovative models of care and new staff roles within practices are both important ways of relieving some of these pressures. Furthermore, our members have also told us that they agree with several primary care organisations, who have suggested that the solutions lie in more collaborative working between practices across primary care, hospitals and community services as well as with the wider social services, local government, government departments and voluntary sector. Moreover, we argue that this collaboration should be enabled by greater alignment of financial incentives and through using technology more innovatively.

**Preventative services**

We are convinced that the scale of the challenges demands an even more imaginative approach, which involves paying much more attention to the provision of preventative services. This approach will undoubtedly mean collaborating more widely than just the NHS and will require thinking about non-health based solutions as well.

In order to fulfil this ambition, general practice needs a better understanding of what different services and agencies can contribute and what community initiatives are already going on. This approach and similar approaches are already going on in several places, such as Halton, where Wellbeing Enterprises CIC and NHS Halton Clinical Commissioning Group have developed the CCG Community Wellbeing Practice initiative (CWP) in response to the need to address the social determinants of health and to develop innovative ways of improving population health outcomes through the primary care setting.

The CWP approach centres on aligning community assets and resources around the GP practice, supported by a team of dedicated Community Wellbeing Officers who provide one- to-one support to patients and help them navigate around a plethora of support in the community sector. They also provide a range of psychosocial support, such as life-skills training, a social prescribing programme, volunteering opportunities and training.

We recognise that different models involving different agencies will be needed to suit the particular needs of specific communities and we have therefore encouraged NHS England to enable these models to be driven locally and support them to become more mainstream.

Primary Care federations and encouraging wider NHS, local government, government agency and voluntary sector collaboration

A key priority of the NAPC's Seven Point plan is to support new models of primary care provision, through collaborative networks for the purpose of improving population health outcomes. It has developed the National Association of Provider Organisations (NAPO), representing 30 plus primary care federations to enable this through promoting and sharing of intelligence and best practice. NHS Confederation and NAPC's members both agree that strategic alliances with other practices and providers in the local area, for example a network of GP practices, community pharmacies, local care providers, voluntary organisations etc, is key to taking a more systematic approach to population health.

Groups of practices and other primary care providers working in federated or networked organisations could allow for more pooling of resources and combined 'back office' functions, as well as helping to provide extended services (otherwise known as locally enhanced services).The RCGP, which has also called for this type of collaboration between GP practices1 suggests that these models can better enable the coordination of out-of-hours care, by pooling GP time across several practices and asking those GPs to work different shifts, covering longer hours.

Primary care providers working together can also help better monitor and understand inappropriate variability in clinical performance through sharing comparative data and peer review. Even more importantly, working collaboratively and sharing ideas across federations and networks can help to enable new models of care and new staff roles to emerge, which better meet the healthcare needs of the local population and support people to manage their own health.

We believe that federated models and other collaborative networks, are part of the key to enabling primary care to draw on the skills of a wider pool of multidisciplinary staff working across several primary care providers. This wider pool of staff could be engaged in various existing and new roles that help to free up GP time and resources, as well as helping to better meet the changing healthcare needs of the local population.

Our members have also highlighted the need to work much more collaboratively across organisational and professional boundaries. This means, for example, enabling community nurses and practice nurses to work together to care for patients and enabling generalists and specialists to work more collaboratively to share knowledge. In order to make sure this happens we need to ensure there is flexibility in contracts, to allow specialists to move away from being hospital-based, to instead becoming an expert resource available to GPs in the wider community.

In our paper, 'A primary care approach to mental health and wellbeing', we have highlighted the commissioning approach developed by Sandwell and West Birmingham CCG as one way of successfully collaborating across organisational boundaries to deliver care. The collaborative primary care model for wellbeing adopted by Sandwell works on the principles of co-location, integration and collaboration and is aimed at aligning mental and physical wellbeing. It uses a stepped approach, with different levels of care to ensure consistent flow of service users, graduating from low to high intensity, starting with self-help and one to one support in community settings and stepping up gradually to psychological interventions and liaison psychiatry. The framework inverts the current focus on the specialist needs of the few to more population wellbeing, prevention and primary care.

Innovating to create new models of care and alternative professional roles that support integrated working

Fundamental to ensuring primary care is able to provide the access and service that is required to meet population health needs, within the resources allocated, is the development of new innovative models of care delivery. This means encouraging and supporting general practice to develop and test new ideas. We believe that innovations will be better enabled by making funding available through greater alignment of funding across the healthcare economy, to create the financial flexibility necessary to allow for changes to be made to the way that care is delivered. It will also be reliant on empowering and enabling clinicians, through

professional development and education and training, which specifically helps them to lead the changes and work more collaboratively to share ideas.

We recognise and support the principle that many of the ideas and innovations which will provide better outcomes for patients within the resources available will involve making more effective use of existing practice staff and exploring the possibilities of using different kinds of staff in new ways. A variety of staff working in general practice, especially nurses, are already engaged in managing specific high risk patients and those with particular diseases, such as diabetes. This approach, as well as the introduction of an appropriate skill mix within traditional roles, is increasingly happening in some GP practices. For example, some GP practices have developed their reception staff to act as care navigators to sign post patients appropriately to local services. Others have developed their nursing teams to incorporate a wider variety of roles including health care assistants. Still others are using apprentices in innovative ways.

There is also the enormous potential for embedding new roles within general practice. For example some GP practices are using physician's associates and other paramedical roles to provide support to GPs by taking medical histories, performing examinations, analysing test results, diagnosing illness and in some case managing specific high-risk patients. We think it is vital that general practice is supported to continue to innovate with staff roles in this way and to develop new ways of working. If this happens it may mean that the modelling of workforce numbers for general practice will need to be reviewed.

There is an urgent need to focus on alternative professional roles that support integration, increase capacity and reduce admissions by freeing up GPs' time to manage increasing complexity. Such roles include primary care physicians' assistants, primary care paramedical staff and specialists (for example, community paediatricians, geriatricians and gynaecologists). We welcome the Shape of Training recommendations,8 which offer the opportunity for specialists with relevant qualifications and appropriate credentials to work in community and primary care settings, thereby enhancing the care of patients closer to where they live.

Predicated on the biomedical model with care centred around health professionals and resources, changing service models, enhanced skill-mix, and regulatory change have the potential to meet the challenges of increasing capability and capacity in out-of-hospital services, improving quality for managing those with chronic and multi-morbid conditions and ensuring primary care physicians continue to provide generalist care to those most in need. The financial consequences of a differing approach need to be costed to understand its impact.

**Changes to Workforce planning and training**

In our joint paper 'Not more of the same', we have highlighted the need to create alternative workforce models in which workforce planning is based on population health needs as set out in the local Joint Strategic needs Assessment, taking into account other factors, such as new technologies, patient empowerment and wellness/self-care and alongside the introduction of newly developed roles which could help better meet demands such as primary care physicians' assistants and primary care paramedics. We recognise that this would also require a change in the training curricula, to promote new competencies, for example, health coaching, quality improvement, understanding population health and health economics alongside regulatory changes to support and enable specialists working within the primary/community environment.

**Development of the GP training curriculum**

The GP training curriculum2 could be developed and enhanced. Changes might include training in understanding population health and health economics, supporting behaviour change through health coaching and enhanced leadership to support coordinating and managing teams..

**More inter-professional learning**

We need to ensure that primary care training does not take place in a vacuum – it should work with the rest of the health and care system. It needs to have links with and knowledge of social care as well as the voluntary and community sector and its workforce. We need team players – if care is going to be delivered by multi-disciplinary teams, experts and generalists, then different professions need to be able to work together and understand each other. Inter-professional training will ensure that relationships and mutual respect are engendered across professions which can often seem to have very different cultures and structures.

Community-based provider education networks (CEPNs) are supporting the development of high quality placements and educational opportunities in local communities. CEPNs are groups of primary and community care providers that come together with partner organisations (including local universities) to collaborate regarding workforce, education and training and expansion of placements. The membership of CEPNs could include (although not be limited to) GP practices, community pharmacies, community dentists, community optometry, community service providers, acute providers and higher education institutions.

Community-based provider education networks ( CEPNs)

CEPNs are supporting workforce planning locally, developing educational opportunities, supporting quality management and innovating in terms of education and training.

It is anticipated that by 2018/19 the development of primary care education roles within Health Education England supported by CEPNs will:

- support significant increases in primary care placements for undergraduate nurses
- increase opportunities for primary care placements for community pharmacists and support evolution of the role of the community pharmacist
- work with secondary care and higher education institutions to develop new roles such as primary care physician associates and paramedics • maintain and develop pre- certification GP training and offer the whole range of educational interventions required to support return to practice as well as post-certification continuing professional development opportunities for established GPs
- be linked in with the emerging Health Education England research and innovation strategy to support and learn from best practice
- support and deliver education related to new service models in relation to integration around patient needs, wellness and enhanced.

**Role of Community pharmacy**

We would also like to highlight emerging evidence showing the potential role that other parts of primary care, in particular community pharmacy, can play in improving and maintaining health. The NHS Confederation paper, 'Health on the high street, rethinking the role of community pharmacy', which was produced by the task group of the Pharmacy and Public Health Forum, found that as trusted and professional partners in supporting individual, family and community health, sitting at the heart of communities, effective community pharmacy services have a significant and increased role to play in ensuring we have a sustainable healthcare system.

The paper highlights the view that community pharmacy's role not only extends to providing the essential services that they are required to, like public health campaigns, signposting prescription-linked healthy lifestyle advice and support for self-care, but that it can also deliver advanced services to support patients' adherence to medicines, involving the provision of associated lifestyle interventions. Furthermore, the paper argues that community pharmacy can be commissioned to provide locally commissioned services, such as stop smoking services, emergency contraception and needle and syringe exchange services.

However, in order to play this sort of role, community pharmacies require NHS England, CCGs and local authorities to develop a coherent approach to commissioning them, which balances national consistency and efficiency with local innovation and customisation to local services.

Moreover, it will also require strategic investment and awareness raising amongst commissioners, providers, patients and the public about how it can help improve people's health

Using technological innovation and sharing data.

We believe that using and innovating with technology has an important role to play in enabling general practice to improve outcomes and enabling more self-care. Within constrained resources technology has an important role in facilitating and enabling different parts of the system to collaborate more easily, as well as helping to ensure improved accessibility to services, which will in turn help to reduce pressures on the rest of the system.

Our members agree with several organisations, including the BMA, who have called for general practice to offer more alternatives to face-to-face consultations, this includes virtual consultations and dedicated telephone or Skype-like surgeries. We believe that general practitioners need to be encouraged and supported to develop new, innovative, secure ways of using technology to communicate with patients and make themselves more accessible to the population as a whole.

From a patient's perspective, communication about care between different parts of the health service can often be poor. Much of this breakdown in communication or sharing of data can be laid at the door of incompatible IT systems. Having systems in place that do not talk to each other leads to a lack of clinical data on patients' arrival in hospital and post-discharge. This is an issue that was not only highlighted by members. In our 2013 NHS Confederation-ADASS survey on integration, aimed at directors of adult social services and senior CCG leaders, the most frequently-cited factor holding up integration efforts was 'data and IT systems' with 64% saying they are an impediment to delivering integrated services3.

A lack of data-sharing in the health service also occurs because of concerns surrounding data protection rules, due to a lack of understanding about what those rules mean. Senior people in the NHS and local authorities have highlighted employees' worries about breaching information rules and suggest this is as much to do with perception or lack of understanding, as worries over being disciplined.

In our joint paper with the LGA we have also reflected these issues, particularly highlighting the lack of clarity on the legal framework for data-sharing and a plethora of guidance as being continued barriers to effective integration of health and social care. In order to address this, we have called on the Government to clarify the legal position and remove national barriers.

If you require any further information with regards to this response, please email Matthew Macnair-Smith, Senior Policy and Research Officer, NHS Confederation at

:Matthew.Macnair-Smith@nhsconfed.org

# EE34 Health Education East of England

## Organisational Information

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| Name of organisation | Health Education<br><br>East of England | Contact Number | 01223 597554 |
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| Contact Person<br>Name and Position | Professor John Howard | Number of attached evidence documents | 8 |

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

**1 Stakeholder responses**

HEEoE has sought evidence from stakeholders across the healthcare system and we attach below the responses we have received.

**2 HEEoE response**

HEEoE has worked hard to develop the understanding in primary care that change in the delivery of primary care services is essential, the first step towards change. This response is a brief submission and further evidence will be supplied to the Commission by Friday 3rd April. Inevitably, this initial response focuses on our current initiatives rather than a considered response of the likely future shape of primary care service and educational arrangements.

Importantly change must occur in parallel in both the delivery of service and education. At present both are delivered inequitably in relation to deprivation; a key feature of the future of primary care must be the equitable siting of training within deprived communities to support service development.

How this is achieved is at present unclear given the current contracting system for primary care education which occurs with over 350 individual practices across the East of England.

HEEoE considers the development of educational federations, which could be based on current structures such as CCGs or new models such as Federations, to be an essential feature of new models of primary care service provision. To support these statements we attach the output of the East of England GP and Primary care task force which reported in March 2013 and a paper written for the HEEoE Board in November 2014.

HEEoE also believes that support for post registration GPs and nurses is currently poor within the primary care system.

An early method of supporting change is the development of post CCT/registration Fellowship schemes; the attached paper provides an outline of our current proposals.

# EE35 East and North Hertfordshire CCG

## Organisational Information

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|---|---|---|---|
| Name of organisation | East & North Hertfordshire<br><br>CCG | Contact Number | 07917085057 |
| Address | Charter House, Parkway, Welwyn Garden City, Herts, AL8 6JL | Email | James.gleed@enhertsccg.Nhs.uk |
| Contact Person Name and Position | James Gleed Associate Director Commissioning Primary Care | Number of attached evidence documents | 4 (all embedded in main document) |

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

Below is an overview of models of care, services and/or schemes either operating or in train within East and North Hertfordshire, which are believed to meet the criteria set out in your call for evidence. East and North Hertfordshire CCG (ENHCCG) would be pleased to discuss in more detail any aspects of its submission that may which are considered to be of particular interest or importance by the Primary Care Workforce Commission.

ENHCCG will submit its final evidence by 24.03.15 in accordance with the commission's timetable. In addition to that which is provided in this submission, the commission may also be interested to see ENHCCG's Primary Care Strategy which contains a section on both workforce and education, training and development. This is currently in draft from only, however we would be very happy to share this document once it has reached the requisite editorial stage.

**Home First**

**Description**

HomeFirst encompasses a Virtual Ward model and brings together health and social care staff to work as one team. The two key elements are:

1. Risk stratification - Case management - Identification of patients most at risk of an unplanned hospital admission using a risk stratification tool. The tool used for risk stratification is called Care & HealthTrak and it is already used by local health and social care organisations. This tool generates a monthly list of patients within a locality with the highest predicted 'risk' of requiring and unplanned admission. It is then disseminated to all eight general practices and the HomeFirst team. Multi-disciplinary meetings are held and the output of these meetings provide the HomeFirst team with a list of suitable patients with Long Term Condition(s) to be pro-actively case managed on the Virtual Ward.

2. Rapid Response – This element of the service offers a timely assessment and rapid social and health care for patients who are in a 'crisis' and who, without rapid intervention, would otherwise need a hospital admission. Referrals to this service come from professionals involved in a patient's care, including GPs, ambulance staff and other health and social care practitioners.

**Objectives**

- To demonstrate that responsive health and or social care can facilitate patients' needs being managed in the community setting.

- To improve the management of patients that are identified as 'high risk' using the risk stratification tool (Care and Healthtrak).
- To improve the patient's carers' and GPs perception of a responsive community service across health and social care.

**Challenges**

It has been important to ensure that recruitment to this new model doesn't destabilise existing Core community nursing services. This new model has attracted new staff from outside the Cuurent workforce.

This model has been successfully rolled out in two out of the six localities of East and North Hertfordshire CCG. In addition the model now benefits from pharmacy and community mental health input.

**Interface Geriatrician**

**Description:**

- Rapid access weekday acute comprehensive geriatric assessment (CGA)
- Monday to Friday 9-5 access to senior geriatric medical telephone advice or e-mail advice (via secure mailbox) and assessment in conjunction with clinical navigators.
- Geriatric Consultant interface sessions via weekly MDM's to intermediate care beds (4-5 sessions in total).
- Geriatric Consultant interface to high risk nursing homes, attending weekly MDT etc. 1 session each per week.

**Objectives:**

- A joint approach to developing care pathways across primary and secondary care to ensure effective continuity of care
- Consultant Geriatrician leadership and input into community and social care environments and improve communications and signposting across the whole health and social care system
- Provide an opportunity to see and review patients before a crisis precipitates to an acute environment
- Avoid acute admissions where possible and reduce LoS for care home residents over 75 and intermediate care community hospitals

**Measures of success:**

- Reduction in hospital ED attendances for 'older' patients through the introduction of telephone and email advice
- Reduction in admissions from 'targetted' nursing homes specifically short stay 0-1 day length of stay cohort
- Reduction in LOS stay in Intermediate Care community hospitals
- Increase in attendances to rapid assessment clinics over 6 month period.
- Increased patient and staff satisfaction in community and social care settings where interface geriatrician initiative is deployed

**GP Front Door A&E Pilot (this new service is at the scoping phase – it has not yet gone live)**

**Description**

- Primary care clinician (GP or Nurse Practitioner) based at front of local door acute hospital A&E triaging patient footfall
- See and treat model: patients requiring GP treatment urgently will be seen immediately; Patients with non-urgent need will be referred back to own GP

**Objectives**

- Reduce A&E waiting times
- Reduce unnecessary A&E admissions
- Transfer of inappropriate secondary care activity back into primary care

**Challenges**

- Primary care staffing working in A&E setting seeing potentially higher patient acuity – enhanced skill set/experience is required compared to traditional general Practice in community setting

**Over 75s Health Checks**

**Description**

The purpose of the Health Check is to augment preventative care for people over 75 years through ensuring that patients are on the correct care pathways and also identifying gaps in the current pathways. The Health Check should be GP led, but may have practice nurse and HCA input. Each practice must ensure that all staff involved in delivering the health checks have received the appropriate training and have been assessed as competent.

**Anticipated Benefits:**

- Early identification and proactive management of conditions that affect older adults
- Formation of individual personal health plans to enable patients to self-care and understand when and how to seek appropriate care in the event that their illness deteriorates
- Targeted utilisation of wider resource, for example falls service and Home First.
- Identification of gaps in service provision for older adults
- Potential for planning & delivery of additional services in the future

**Challenges**

There exists considerable variation in the skill set, experience and competence level of HCAs. To help manage the recruitment and retention issues of GPs it is important that practice nurses and unregistered healthcare workers can play a significant role in delivering this service.

**Community Pharmacy**

East & North Herts CCG is actively exploring ways to make better use of the expertise and access that exists within community pharmacy. This may include a minor ailment scheme whereby patients would at the point of contacting their GP with one of a defined set of illnesses be redirected to a community pharmacist for a consultation. Pharmacists that are independent prescribers are underutilised locally and this untapped resource will be fully considered in designing new models to increase capacity in primary care and improve quality and access.

**GP Single Point of Access**

ENHCCG is embarking on a pilot study of a single point of access model in general practice. Patients of a participating practice requesting a same day appointment with a doctor are diverted through to 111 and then taken through the NHS 111 Pathways. Should the patient require an appointment with their GP the 111 service has direct access to the practice's booking system and can book this. The objective being to Reduce unnecessary consultations in primary care, improve access and make the system more efficient for patients.

Some of our member practices already operate a triage model, however these are all staffed internally led by GPs or nursing staff. Anecdotal evidence as part of evaluation of these models suggests that telephone triage requires a particular skill set and not all practitioners will immediately feel comfortable undertaking this role.

# EE36 North East Essex CCG

## Organisational Information

| | | | |
|---|---|---|---|
| Name of organisation | North East Essex Clinical Commissioning (NEECCG) | Contact Number | 01206 286711 |
| Address | Primary Care Centre, Turner Road, Colchester, Essex, CO4 9UF | Email | Valerie.pentney@nhs.net |
| Contact Person Name and Position | Valerie Pentney Commissioning Project Manager | Number of attached evidence documents | |

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

In May 2014 NEECCG commissioned GP Primary Choice (GPPC), a consortia of local GP surgeries to provide phlebotomy services to the patients of North East Essex within primary care. Previously, phlebotomy had been provided at the local main acute hospital, two community hospitals and a walk in centre, hence limiting the actual locations of this service, limited provision had been provided within primary care too but capacity and financial investment here was low. NEECCG also wanted to even out the fragmentation of this service within our area which is split into Colchester and Tendring, in addition to multiple other outcomes.

Tendring offered more primary care provision of service than Colchester which was also observed by Tendring having a domicilary service, Colchester did not (this was commissioned to a community interest company and not into primary care).

The new phlebotomy service provides a high quality service closer to the homes of patients with more choice, an easy and fluent referral process with the option of walk in or booked appointments, urgent and routine appointments are available both with their own timed target periods which previously was not available and the service reduced the age of patients down to 6 years which reduced paediatric referrals into the acute sector and made phlebotomy easier for parents being local and more familiar to the child. In addition, NEECCG wanted any community phlebotomy site to bleed any registered patient of NEE, as GP surgeries were the predominant location, patients not registered with that surgery could still be bled hence increasing patient choice massively.

Benefits to other providers and the services they operate include reduction in waiting times for pathology results with prompt access to diagnostic testing allowing for earlier diagnosis and treatment, perceived reduction in pathology requests as GP's are able to concatenate pathology requests which is also beneficial to the patient in the reduction of samples required and visitation to the service.
Furthermore, the acute sector has been able to continue to perform out-patient monitoring within the community that requires phlebotomy and also pre out-patient appointment work ups.

GPPC perform an annual clinical audit in addition to regular monitoring of performance and subsequently, manage any discovered poor performance issues. Patient feedback is also monitored to identify whether there is a demand to provide appointments outside of core hours, surveys therefore reflect questions regarding the hours of service required. Surveys also include children and young people's views. Comments received from the patients survey prove high satisfaction and include:

"I have to have regular blood tests requested by the consultants. Being able to have this test at the surgery has made thins so much easier. Also all my information is at the surgery so any additional checks e.g. BP can be done at the same time"

"It is very easy to have a blood test in my surgery because I am very near and don't have to travel far"

"Very happy with these arrangements for blood tests. Vast improvement on waiting at the hospital blood

clinic”

This service utilises the skills offered by phlebotomists, Health Care Assistants and Practice Nurses and has hence increased the work mix of these members of staff i.e. by bleeding children. Patient comments prove that this model is working well, not only due to choice, locations the availability of patient notes and appointment availability but also due to the familiarity of staff and the environment (especially for nervous patients).

The main concern for implementing this elsewhere within the NHS as is and one area that was highlighted as a concern for patients, is the additional workload on GP’s. However, as other healthcare professionals within the GP surgeries are involved the impact on GP’s themselves has been low from the perspective of workload. On a sustainability front, surgeries are now being paid to offer this service which increases income and hence investment back into the surgery itself.

# EE37 Acorn Surgery

## Organisational Information

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|---|---|---|---|
| Name of organisation | Acorn Surgery | Contact Number | 01480 483107 |
| Address | The Oak Tree Centre,<br>1 Oak Drive, Huntingdon | Email<br>Trish.hawittpalmer@nhs.net | |
| Contact Person<br>Name and Position | Trish Hawitt Palmer<br>Practice Manager | Number of attached evidence documents | |

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

We wish to offer the opportunity to demonstrate ways of utilising the skills of different professional groups with the General Practice Nursing Team with specific reference to the role of the Assistant Practitioner. We believe, evidenced by practice and supported by robust internal protocols, that this role can safely and appropriately encompass skills traditionally undertaken by NMC Registered Nurses.

With the aim of supporting the evolving role of healthcare support staff within General Practice, via learning and development in a GP Training Practice environment, we have clear evidence that Assistant Practitioners and experienced Health Care Assistants can competently undertake procedures such as spirometry, swabs, learning disability and mental health assessments, long term condition reviews, podiatry management for diabetic patients, complex dressings, ECGs and cervical sampling.

This model offers enhanced flexibility, improved patient access and a holistic care approach for patients, in addition to increasing uptake of the national screening programmes such as cervical cytology, chlamydia screening and general health screening of patients with long term conditions.

We have developed new approaches to deploying traditional skills using a 'bottom-up' approach, offerering sustainability to Practice teams and allowing deployment of traditional skills from Registered Nurses to appropriately trained Health Care Assistants and Assistant Practitioners and from General Practitioners to Practice Nurses.

We believe this is an exciting and ground-breaking approach to the future of primary care and works to support current and future recruitment issues, specifically within the field of General Practice.

# EE38 NHS Blackpool CCG

## Organisational Information

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|---|---|---|---|
| Name of organisation | NHS Blackpool CCG | Contact Number | -1253 651309 |
| Address | Blackpool Stadium<br>Seasiders Way<br>Blackpool<br>FY1 6JX | Email | Stephen.gornall@blackpool.nhs.uk |
| Contact Person<br>Name and Position | Steve Gornall<br>Head of Primary Care Development | Number of attached evidence documents | |

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

Blackpool CCG, with other local stakeholders have agreed to design and implement a range of patient-focused models. These will drive improved outcomes and quality through far more proactive and efficient care.

To achieve our ambitions for Blackpool, one of our main aims is to change the way we manage and treat patients with complex health needs. These patients often have recurrent exacerbations of their condition and are very likely to have frequent admissions to hospital to be managed.

We intend to reduce the number of these admissions by providing intensive management to complex patients within the primary and community care setting, based on multi-disciplinary neighbourhood teams.

The development of neighbourhoods will comprise groups of general practices, covering populations of between 20,000 and 40,000 people, associated community and primary mental health services, and strong links to third sector services, led and directed operationally by GPs. The expectation is that more services will in future be delivered within these neighbourhoods. This will enable care to be 'wrapped around' the patients rather than the patients progressing through different levels and types of care that are isolated from each other.

Such neighbourhoods will contain sufficient mental health support, care of the elderly, community, extended primary care and third sector services to ensure that patients' health is maintained at a higher level than the 2014/15 baseline. Admission to hospital for unplanned urgent treatment and by care-managed patients (both social and health care) will be considered a system failure requiring improved system responses to prevent recurrence.

In addition, we will develop 'extensivist' services, each covering populations of up to 2,000 care-managed patients across several localities. This will ensure that they are treated and cared for on a continuous basis within their homes, which will provide higher quality, cost-effective care compared with unplanned hospital admissions. These services will free up time in the general practices to be able to develop the Enhanced Primary Care (EPC) services for people with long-term conditions and those requiring episodic interventions and support.

There will be a shift in neighbourhoods of primary care working more closely with the community. Community Orientated Primary Care (COPC) is an amalgamation of public health practice with delivery of primary care, community and social care services. This will include:

Reviews of long-term conditions to inform and educate patients, their carers and families on choice and the management of their conditions (including relapses etc.).

We are aiming to provide integrated out-of-hospital services to deliver consistently better outcomes for our patients across the region, by reducing unwarranted variation in the quality and provision of services. To do this we will work collaboratively and cohesively with local communities, partners and colleagues, ensuring our strategy is based on patient and public insight to reflect the six characteristics of high quality care set out

in 'GP – A Call to Action'

**Current position**

In collaboration with Fylde and Wyre CCG Blackpool is part of the NHS Accelerate (New Models of Care) programme in 2014-15 across the Fylde Coast

- Based around supporting test of new models of care, e.g. extensive care service
- Fylde Coast successful in applying for Integrated Care Pioneers 'Wave Two'
- Focus on development of new models through Five Year Forward View
- Wide consensus that new care models need to:
- Manage systems (networks of care), not just organisations
- Deliver more care out of hospital
- Integrate services around the patient
- Learn faster, from the best examples around the world

CCG plan on a page

In addition to the above A Fylde Coast Diabetes Education group recognised inconsistencies in professional skills, knowledge and competencies supporting the delivery of diabetes across the Fylde Coast. In 20914 a training needs analysis was undertaken across all health professional caring for patients with diabetes. As a result a training programme has been developed for basic, intermediate and advanced skills around diabetes management.

The CCG is mindful of the recent HENW workforce audit and the challenges it presents to deliver our new models of care. The high level finding below have recently been presented and discussed at our clinical leadership team.

- Over a quarter (29%) of the GP Workforce will be 58-60 in ten years' time.
- The GP workforce makes up 16% of the Primary Care workforce in Blackpool CCG compared to 21% in the North West and 26.9% Nationally
- Going forward the rate of GPs per 100,000 population will reduce from 77.0 to 60.6 if the National trend for retirement age is followed for this profession
- Only 33% of the female workforce is working full time once they reach 50
- 38% of the existing Nurse force is aged 50 and over and over 43% of the direct patient care staff (health care assistants etc.) are aged 50 and over
- 43% of the Admin and clerical work force is aged over 50 but also has a large proportion of staff that are under 30. Main issue is that approx. 40% of Practice Managers fall into the 50+ age group.
- There are currently 12 vacancies that were recorded the majority being GP posts

Our membership practices state that recruitment to GP principal vacancies and salaried positions is challenging. In additinon FY doctors and those on the GP rotation are not choosing the Fylde coast as an area to settle once qualified. The CCG is currently discussing flexible options about recruitment and retention.

# EE39 NHS Chorley and South Ribble CCG and Preston CCG

## Organisational Information

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|---|---|
| Name of organisation | NHS Chorley and South Ribble CCG and NHS Greater Preston CCG in partnership with Health Education North West, Lancashire Teaching Hospitals Foundation Trust and Lancashire Care Foundation Trust |
| Contact Number | 01772 214611 |
| Address | Chorley House, Lancashire Business Park, Centurion Way, Leyland |
| Email: joanne.platt@chorleysouthribbleccg.nhs.uk | |
| Contact Person<br>Name and Position | Joanne Platt – Project Manager |
| Number of attached evidence documents | 3 |

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

This project is a piece of research to find ways of creating portfolio careers across the Central Lancashire health economy that will help us to address existing and predicted workforce gaps.

This health economy (comprising both commissioners and providers) has identified significant challenges to the workforce across many specialties and disciplines.

We struggle to compete with Manchester and Liverpool to attract and retain the best medical and nursing graduates to this area despite the quality of training at our local acute provider ranking as one of the best available.

On top of this we have a legacy of under investment in the primary care workforce and premises in comparison to other areas of Lancashire. We are also a 'City Deal' area with an expected increase in our population of 14,000 residents in the next five years. This poses an obvious challenge and a need to focus on modernising our workforce and the services we provide across social and health care settings.

We want to encourage people to positively choose this area to work in, offer interesting and imaginative opportunities for staff and to provide the support needed to retain skills and capability locally.

Strategic context

The five year strategic plan of NHS Chorley and South Ribble and NHS Greater Preston Clinical Commissioning Groups has at its heart 'care closer to home' and a shift in emphasis away from hospital based care.

This project with the workforce as its priority is a key element of delivering this strategy. The project will embed different ways of working across the local health economy.

We need to address the workforce challenges that exist today. In particular focus needs to be on the gaps in the clinical workforce and the difficulties we have in recruiting to and retaining expertise in key clinical posts.

We need to 'future proof' our clinical workforce across the local health economy (within primary, secondary and acute care). This will require transformational activity to tackle organisational cultures that may act as barriers to the introduction of a more flexible workforce across organisations.

Overall, we must ensure that we have the right levels and range of skills available to deliver our plans over the next five years, whilst ensuring we can sustain this over at least the next 10 to 15 years.

To date we have completed Phase 1 of the project. This has included quantitative and qualitative research to identify workforce gaps and to learn from clinicinas (trainees and established clinicians) what will make a difference. We will be sharing the outcome of this research at an event to be held in late April / early May, during which we will meet with key strategic leaders to prioritise the actions to be taken in phase 2 of the project. This will include the development of a number of pilot portfolio job roles to test out the impact of this on patient care and on the local health economy's ability to recruit and retain high quality clinicians across the primary, secondary and acute sectors.

# EE40 Salford Royal Foundation Trust

## Organisational Information

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|---|---|---|---|
| Name of organisation | Salford Royal Foundation Trust | Contact Number | 0161 206 1857 |
| Address | Stott Lane, Salford, M6 8HD | Email | Stephanie.webb@srft.nhs. |
| Contact Person<br>Name and Position | Stephanie Webb | Number of attached evidence documents | 1 |

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

Salford's vision for health and social care is to create an integrated system of support services that responds to local needs, gains public trust and helps people to help themselves to improve lives and the long-term health of the population. This is a key component of Salford's Health and Wellbeing Strategy which aims to improve the lives of citizens of Salford by improving health, wellbeing and removing health inequalities.

We have developed an Integrated Care Programme (ICP) to support Salford's vision to improve the lives and long term health of it's population. As part of this programme there are three key workstreams, Community Assets, Centre for Contact and Multi Disciplinary Group (MDG) Meetings.

3. What is our model? – Multi-Disciplinary Group Meetings

4. A Multi-disciplinary Group (MDG) is a group of health and social care professionals who unite as a team for the purpose of improved decision making, planning and delivery of co-ordinated person centred care to promote wellbeing and independence.
5. The aspiration of the MDG is to achieve greater independence and improved wellbeing for people aged 65 and over in Salford by integrating care and support within neighbourhood communities. The MDG focus is to review and formulate a shared care plan for people identified through a process of risk stratification in order to promote independence and improve care delivery where necessary.
6. A care coordinator will be identified to work with the person at risk and the carer/family if involved to ensure an appropriate care and support plan is delivered and reviewed as required.

There are six essential elements of the MDG model required to deliver person centred care for people requiring a level of care co-ordination between health and social care services to promote wellbeing and independence. The six elements are

a. A **holistic assessment** of health and social care needs.
b. **Joint working** and decision making with all organisations/agencies involved in order to deliver person centred co-ordinated care.
c. Regular **MDG reviews** to plan person centred care, review and amend care and to signpost to community support as required.
d. The appointment of a named **Care Coordinator**.
e. The development of an electronic **Shared Care Record** to enable essential information to be shared between statutory agencies.
f. An agreed **Shared Care Plan** within the Shared Care Record based on Multi-Disciplinary (MDG) working.

7. How are we using the skills of different professional groups as well as new approaches to deploying tr skills

### Risk Stratification

The ICP has taken an approach of risk stratification to classify all people aged 65 and above to support appropriate person centred planning and management. The MDGs will risk stratify each person within the four levels of Sally and record with the appropriate GP READ code.

We have used elements of Social Care risk stratification alongside some investigatory work conducted with GPs to look at people who are at risk of becoming unstable and needing a higher level of support. We have combined this with work conducted with the Community Assets work stream to identify where people would consider themselves to be at risk of becoming unstable and where an MDG conversation may be of benefit.

| Level of Sally | Level Descriptor | READ Code |
|---|---|---|
| **L1** | **Able Sally**: Able to support and sustain own health and wellbeing needs | **13CI** |
| **L2** | **Needs Some Help Sally**: Likely to have contact with at least one service agency. A need for education/intervention to enable self-management. Two or more long term conditions, potentially at risk- recently bereaved, lonely, carer ( including informal carers), co-dependant couples, frail living alone . | **13CK** |
| **L3** | **Needs Some More Help Sally**: Regular visits from health and/or social care services. Meets 'substantial' risk on FACS* criteria. Intermediate Care/re-ablement | **13CM** |
| **L4** | **Needs a Lot of Help Sally**: Needs 24/7 care either in a residential, nursing or EMI home. Or at home with high level of need e.g. often over a 24 hr period. Meets 'Critical' risk on FACS criteria | **13CN** |

* The national Local Authority eligibility criteria 'Fair Access to Care Services' (FACS), risk to independence, should also be used as frame of reference to support risk stratification.

'Trigger' points for activating an MDG discussion can include:

a. Lives alone/socially isolated/self-neglect
b. Low mood/anxiety/depression/mild cognitive impairment/dementia
c. Multiple Long Term Conditions
d. Increased use of services
e. Providing informal care/receiving informal care

The MDGs will operate alongside the work for the *'National Direct Enhanced Service – Proactive Care Programme, Avoiding Unplanned Admissions'*, where GPs are required to identify 2% of high risk vulnerable

patients (over 18 years of age) who would benefit from a proactive case management approach, to reduce unplanned admissions to hospital. Within Salford GPs are using a variety of methods to risk stratify and identify patients who would benefit from this approach.

In addition to the Risk Stratification, taking into account the 'trigger points' for other services involved in providing support, we have changed the way a 'traditional' MDG is formed and included Mental Health and Geriatricians in the core membership, and widened as it is recognised that other health and social care workers and other professionals have a significant role to play in supporting vulnerable people. Their contribution will be managed via liaison with core members of MDGs, where it is agreed as an action from discussion within MDG meetings

**Core Membership** of MDGs for attendance, pre & post work at MDG (across each area of Salford) are:

- GP
- Practice Nurse
- Social Worker
- District Nurse
- GMW Worker (Community Psychiatric Nurse (CPN)/ Consultant Psychiatrist)
- MDG coordinator (Administrator)
- Geriatrician
- Health improvement worker

All core members are responsible for ensuring alternative cover is arranged if they are going to be absent (for any reason) from the meeting. This will include attendance and also the completion of any pre or post work.

**Wider MDG membership** if involved in direct care or support for the individual (not exhaustive) are:

- Health Improvement Officer
- Other GMW Mental Health Practitioners (Community OT, Social Worker, Clinical Psychology)
- Community OT
- CAST
- Pharmacist
- Rapid Response
- Housing Officer
- Intermediate care workers
- 3rd Sector organisations (where appropriate/necessary; Age UK, Carers Centre, Stroke Association, etc)

**ICP Care Coordinator**

The Care Coordinator within the ICP is defined as a designated practitioner with the appropriate level of authority, qualification, training and/or experience, who has responsibility for co-ordinating the delivery of the agreed care plan. They will work with the patient/service user and their carer/family and with the other professionals/workers involved to ensure that the care plan is delivered and reviewed as required.

The Care Coordinator will usually be the person best placed to oversee care planning and can be of any discipline depending on capability and capacity. Care Coordinators must be employed by one of the two statutory services; Health or Social Services.

Care, support or therapeutic input may be provided by a number of people and the Care Coordinator is not necessarily the person who has most contact with the patient/service user

In a situation where two people are living in the same household and both require Care Coordination, it will be for the relevant MDG to decide if this person should have the same Care Coordinator. This will be based on need and best interests.

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

In respect to older people, Salford's 2020 vision is for a radically changed health and social care system, where older people are enabled to retain their independence and take a much more active role in their own care. The plan is for GPs, community and social care staff, working with communities and third sector providers, to work in an increasingly integrated way, with single needs assessments and rapid and effective joint responses, provided in and around the home.

Integrated care is not entirely new for Salford; for example it already works extremely well for individuals with a learning difficulty. Therefore remodelling all health and social services to work in a more integrated way has started in Salford by focusing on the care needs of older people.

However, the changes to take place are anticipated to benefit others, not just those over a certain age. Whole services, such as district nursing and adult social care are involved in the changes. The aim is to learn from, and build upon, this start for other population groups in Salford, such as children, families and young adults. There is also growing evidence from within the UK and internationally on how better integrated care improves experience and makes better use of resources.

The model of joint assessment and care management continues to be refined in Salford as part of the ICP and will be further reviewed in the light of the new GMS contract for 2014/15 in respect of named GP for over 75 year olds and systematic care planning. It is also supported by the National Enhanced Service for Avoiding Admissions and Readmissions, and on a local level, by the Proactive Case Management for Locally Commissioned Services (currently being outlined by the CCG). As the model evolves it is anticipated that the MDGs will also merge with / complement the existing GSF meetings to ensure holistic and streamlined care at all points of a person's pathway.

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

- Engagement of all services involved (this is dependent on investment to support additional staff to support 'core business' alongside the MDG involvement until MDG working becomes the 'norm').
- There is a noticeable lack of capacity in public sector at present and staff are working 'above and beyond' to bridge gaps in service provision while additional posts are recruited to
- Primary Care is incentivised with Enhanced Services and Locally Commissioned Services which initially look to support the work of our Integrated Care Programme, however, there are criteria in these enhancements with deadlines that require GPs to provide care plans for patients in advance of our Shared Care Plan being ready. This is causing some duplication of work, and whilst the CCG have tried to encorporate all elements of the ICP, alongside the enhanced service requirements the GPs are feeling a lot of pressure to provide a number of care plans for the same cohort of patients
- Inter-service relationships and behaviour change, developing a culture of trust and shared ownership can and will take time
- Use of IT is varied, having an electronic shared care record that services involved can access to inform service provision and support where needed where needed is essential, however, is

highlighting a further need for training where IT skills have not previously been needed in order to support or deliver services to patients. This is both costly and timely.

- Training on Behaviour Change, Chairing meetings and providing coaching management skills to new members staff to support the new way of working.

# EE41 COGPED

## Organisational Information

| | | | |
|---|---|---|---|
| Name of organisation | Committee of General Practice Education Directors (COGPED) | Contact Number | t. +44 (0)207 4906827<br>f. +44 (0)207 4906811 |
| Address | Caroline Clerk<br>Executive Assistant to Chairs of COPMeD & COGPED<br>Academy of Medical Royal Colleges<br>10 Dallington Street<br>Clerkenwell<br>London, EC1V 0DB | Email | caroline.clerk@aomrc.org. |
| Contact Person Name and Position | Caroline Clerk, EA<br>Professor John Howard, Vice Chair | Number of attached evidence documents | |

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

1 Commentary

1.1 Much has been written about the need for a change in the primary care service provision model within the UK. The debate has been focussed on qualitative discussions about the current service; frequently there is a synonymous use of "general practice" and "primary care" without defining the difference between the two terms. This confusion has arisen because the UK primary care system has been provided by general practitioners working as independent contractors to the NHS. While this has been a very successful working model and has met the health care needs of the population since the inception of the NHS, there is abundant evidence that the system needs radical overhaul to provide high quality, equitable and affordable primary care to the UK population in the future , , .

1.2 A major problem is the fact that there is no systematic data available with regard to the workload by function in primary care; neither is there data about the available workforce in primary care with the appropriate training and skills to deliver those functions. While primary care has been provided by general practitioners working as independent contractors to the NHS, this data has not been necessary – responsibility for the delivery of primary care has rested with the highly trained - and regulated – individual GP. Most data collections have therefore focussed on the number of consultations rather than function of the consultation. A systems orientated view of the primary care service, considering the nature of the function to be undertaken with the resources available before defining the structure of services to provide the functions, is very difficult to achieve.

1.3 A traditional view of the service functions provided within general practice are:

- First contact general medical services, usually undertaken by general practitioners and their employed nurses
- Some element of emergency medical care, varying depending upon location and local services
- Chronic disease management services
- Preventative care, such as immunisations, screening and cervical screening
- Additional medical services, such as minor surgery, contraceptive care, travel care advice

- Ancillary services such as chiropody, counselling, dietetic services and physiotherapy.

1.4 Because the services are owned and responsibility for delivery rests mostly with the GP, of the 345m consulations recorded in primary care in 2014 it is difficult to know how many satisfactory consultaitons occurred with other team members rather than the GP. Anecdotally about 30% of consultations in general practice are currently provided by nurses. Estimates of the cost-effectiveness and quality of consultations undertaken by advanced nurse practitioners again do not separate consultations by function . Because there has been no national coordinated set of standards for practice nurses and no consistent training standards, it is very hard to generalise about what sort of work is generally being undertaken by nurse clinicians. However the evidence suggests that nurses in primary care function best when following protocols, so that simple emergency care, chronic disease management and preventative, contraceptive and travel care can all be provided through the nursing team.

1.5 The current recruitment crisis with regard to general practitioners has meant that HEE is urgently working to increase the supply and professionaliation of other clinical roles in primary care, including nursing, Physician's Associates and Health Care Support Workers. It is interesting to speculate on how primary care might have developed if previous funding models had not been directed through general practitioners, allowing the support and development of these roles. In secondary care and other internatonal models these roles have been more clearly defined, allowing innovation in service delivery. The use of other clinical roles as a "disruptive innovator" within the current model has the potential to produce a rapid and significant re-evaluation both of the service model and cost base in general practice.

1.6 In the absence of quantative data theoretical models provide a different view of primary care. These are often dominated by the general practice first contact model but include :

- The Canadian Medical Home model .
- The RCGP's 2022 GP - a vision for general practice in the future NHS
- Patient centred care in the 21st Century
- Securing the Future of general practice

1.7 Key features which are acknowledged internationally as being important for good first contact primary care include9, , :

-
- A registered list of patients in a geographical area
- Pro-active, population based care delivered by a multidisciplinary team
- A senior clinician capable of making decisions about care involved early in the consultation process
- Efficiency of resource and data use with early access to diagnostic tests
- Continuity of relationship where important, set against timely access where necessary
- Care with respect to multi-morbidity should be tailored to the needs of the patient
- Quality and outcome data should be publically available
- Professional leadership, management and organisational development

In addition, the international evidence strongly supports general practice as being the main contributor to the effectiveness of primary care.

- Increasing one GP per 10,000 population in the US provides an average mortality reduction of 5.3%
- The availability of more primary care physicians (but not specialists) increases access to and equity of access to health services
- The technical quality of primary care is better than that provided by specialists, probably due to greater

appreciation of the importance of addressing multi-morbidity

- Both primary and secondary preventive activities are more adequately performed in primary than secondary care
- Education matters. Achievement within most QOF areas occurs in both deprived and affluent areas – but differences in achievement are smaller between training practices in deprived and affluent areas .

1.8 Analyses of primary care provision often do not have available or account for all of the following:

- Strategic and operational developments in secondary care
- Educational constraints and innovations. For example the available educational workforce and resources, statutory and other regulation, developments and innovations; all of which can impact on service provision, e.g. Shape of Training and credentialing
- The financial and societal context – what can the country afford in terms of investment in staff?
- Demographics and demand projection15 – widely considered to be likely to be higher than current projections
- Workforce supply projections for all clinicians – but particularly GPs and primary care nurses ,
- The international context

Of these, the most pressing concerns at present are the workforce supply issues, with projections suggesting that GPs for example may have a vacancy rate of over 10% by 2018. However, reform of medical training to create a different form of community generalist as envisaged in SHAPE may have the greatest potential to produce new models of primary care delivery.

1.9 It is only by combining all this information that new models of primary care provision which might be fit for th current and future context can be considered. Even then, local variations in history, culture, systems resources, morbidity and mortality (usually linked to deprivation), mean that local solutions must be determined with local people. The key values of primary care – person-focused (longitudinal) care, first-contact use, comprehensiveness and coordination, are paramount and must be upheld as general practice continues to evolve and expand in to team-based primary care, available through a regulated and governed structure, in the future.

2 But what does all this mean?

2.1 COGPED strongly supports the following with regard to service models:

- Primary care in the UK must move from being a GP provided, small scale activity to being a GP led, multi-disciplinary team provided service delivered at scale through regulated and governed NHS bodies
- There is an urgent need to understand the categories of service that should be provided within the context of primary care
- There is an urgent need to obtain current, accurate and reliable workforce information (which will be fulfilled through the worforce minimum data set –WMDS – initiative currently being implemented).
- There is an urgent need to obtain current and projected workload data using demographic data which can be mapped to the service functions delivered by primary care
- Given the lack of information and the current workforce crisis with predictions of greater workload pressures in the future, support for the training and introduction of new clinical roles in primary care is essential at the present time
- There is a clear need to develop models in conjunction with secondary and community care, such that shared pathways, resources and understanding can be developed in local health economies in the future.
- There must be equity of service and educational provision across all communities; inequity of educational provision may have more lasting and damaging effects on a local health care economy than inequitable

service provision

Most importantly and as stated in paragraph 1.9 the key values of general practice which have served primary care in the UK so well must not be lost within future service developments.

2.2 In addition the future management of education for primary care must be modernised and must be an integral part of any future service model as a design principle. COGPED strongly supports:

- The development of models such as Advanced Training Practice networks, educational federations/community education provider networks. These models increase flexibility to use resources other than training practices and increase inter-profesional learning through the placement of trainees from a range of clinical disciplines in primary care.
- Since education is a generic process set in different contexts, COGPED supports common standards for environments, educators and educational processes in primary care, accepting that there is some way to go before these can be achieved across different disciplines
- Educational principles must be included from the beginning of any disucssions about new models of primary care provision
- Workforce planning withina local health care economy, and therefore the planning of training and education, should span primary and secondary care.

3 Finally

This short initial paper represents the views of a small number of UK GP Directors; a further submission will be made before the 3rd April.

Developing the primary care workforce for integrating care

North Central and East London has developed a number of approaches to supporting patient-centric integrated services. Details are provided along with sources of evidence:

1. Community based educational provider networks (CEPNs)

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Early evaluations demonstrate the following:

- Organisations think networks are adding value: The organisations involved in networks think that networks add value and are helping to plan and streamline educational provision in a way that has not occurred in the past. It takes time for networks to develop and there are many practical, financial and ideological hurdles, but overall the organisations involved feel they are making a difference.
- Networks support more robust workforce planning: Networks have helped to systematise the way that education and training is planned. Needs analyses have helped to identify how many workers of different types are available and their training needs. This helps to plan how to address gaps between population needs and current capacity.
- Networks increase the amount of training available: Networks have been associated with an increase in training placements available for primary care nurses and the number of practices training general practitioners compared to previous years and compared to areas without networks.
- Networks increase the focus on interdisciplinary learning: Networks have offered more opportunities for collaborative learning across disciplines and sectors compared with previous years.
- Networks have many intangible benefits: Networks have helped organisations build relationships with one another which has follow-on impacts for service delivery. Members of network boards and steering groups have seen the greatest impact, as they have met regularly with colleagues from other

organisations. Individual staff taking part in promotional events and training activities run by the networks also report learning more about other services and roles.

- Downstream impacts remain uncertain: It is too early to say whether educational networks have directly impacted on the wellbeing of local people. In some areas, members of the workforce have said that they feel more confident in the training available and the skills they are developing, which they hope will help them provide safer and higher quality care.

2. Deploying skills differently

We have piloted a number of different approaches to encouraging GP trainees to think "differently" about patients and populations.

a) Coaching for health skills training for GPs to improve behaviour change and patient empowerment strategies. Our evaluation is attached. This has subsequently been expanded to other professional groups within primary care, with c100 further staff being trained in 2014/15.

b) Developing a module in population health management to consider the development of systematic and cross-organisational methods and skills for improving patient outcomes. This module has a specific focus on the development of leadership skills and quality improvement.
http://www.publichealthjrnl.com/article/S0033-3506(14)00201-7/abstract

c) Learning together programme – In this programme we have developed strategies that encourage GP and paediatric trainees to learn together. The powerful learning was tested as part of an evaluation attached.

d) We are currently undertaking a pilot programme to encourage community based learning between medical and student nurses. The evaluation will be completed through 2015.

e) Post certification GPs are learning alongside other primary care professionals (pharmacists, nurses, consultants) based around patient case studies. The evaluation of this programme will be available by June 2015.

f) 'Darzi 7' leadership programme placements are being commissioned specifically in relation to the integration agenda and Five Year Forward View.

g) All major university and postgraduate medical providers are being funded to develop 'person-centred care' within their curricula.

3. Developing primary care workforce to work differently

a) Commission training for practice nurses to develop new skills such as prescribing, managing chronic disease, support a broader scope of activity.

For 2014-15 HE-NCEL has commissioned 90 GPN training places for practice nurses already employed in primary care but who either have not had formal education and training in GPN or who are an experienced GPN who the practice wishes to support to become a Nurse Practitioner via a postgraduate ANP programme. We intend to commission at or around the same level in 2015-16, with a shift in focus on supporting nurses that are new to primary care. We are supporting the development of an integrated approach through encouraging district and practice nurses to learn and work together. This is being achieved through nursing super hubs based in Newham and Islington. We have also invested in core CPD for Practice Nurses (e.g. immunisations, non-medical prescribing, medicines management, sexual health and contraception, mentorship), delivered through main contracts with our HEIs.

b) Develop primary care as a venue for primary care placements for student nurses to be able to make

career choices involving primary care.

We are supporting an increase in the number of student nurses undertaking a placement in primary care. This programme is being delivered in collaboration with the 4 HEIs in HE-NCEL and GP training practices in the area. It includes investment in mentorship so that there are good role models and quality learning support, tailored placement pathways so that students with a desire to work in primary care /community nursing can have final year placements in settings which will recruit them on qualification. To further support early entry into primary care nursing HE-NCEL has explored the feasibility of developing a 3-year pre-registration course with a 4th year integrated MSc with Middlesex University.

c) Support the development of health care support workers to extend the scope of their practice through commissioned courses.

We have invested in a number of core projects focused on primary care HCSW development, including:

- Healthcare Assistant Blended Learning Programme – a programme delivered in partnership with the London-wide Local Medical Committees to train 36 HCAs in primary care. The programme consists of blended approach, with a range of core training modules delivered via e-learning supplemented by taught days and mentoring from trained Practice Nurses
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- A range of schemes to develop apprenticeships in primary care, including both General Practice and Community Pharmacy.

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We have funded a number of innovative transformational projects in primary care that are supporting primary care teams to work differently and better care for patients out of hospital settings:

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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.

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.

# EE42 HENCEL

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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.

# EE44 Health Education North West London

## Organisational Information

| | | | |
|---|---|---|---|
| Name of organisation | HENWL | Contact Number | 02078628970 |
| Address | Stewart House<br>32 Russell Square<br>London<br>WC1B 5DN | Email | Catherine.O'Keeffe@n |
| Contact Person<br>Name and Position | Catherine O'Keeffe<br>Acting Deputy Director of Education and Quality | Number of attached evic documents | **4** |

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

Updated submission

Health Education North West London (HENWL) is supporting a range of innovative Primary Care models in North West London. Dr Julia Whiteman, Postgraduate Dean HENWL, has already submitted evidence to the commission regarding HENWL's Community Education Provider Networks. Another important area of HENWL's work is supporting the development of Practice Nurses in North West London.

HENWL have funded a series of scoping studies to identify the education and training needs of Practice Nurses and practice support staff aligned to the requirements of Shaping a Healthier Future Future (a programme which applies a whole systems approached to optimise service delivery in order to improve health care for people who live in North West London) . The studies have highlighted local challenges related to enabling Practice Nurses to identify and access short term CPPD courses as well as engaging in more comprehensive career development activities. The roles and training needs of support staff suggest considerable variation across practices in HENWL. A range of interventions have been developed to provide initial support including: training Practice Nurses as mentors with the aim of increasing capacity for pre and post registration student placements in General Practice; providing incentives to GP practices to release Practice Nurses to attend CPPD courses and network development days ; ensuring that CPPD courses are relevant to Practice Nurses learning needs in content and mode of delivery.

HENWL's Primary Care Nursing steering group is currently revewing lessons learnt over the past 18 months with the aim of buidling on acheivements and clearly defining strategies to further develop the capacity and capability of the Practice Nursing workforce in North West London. A draft strategy is currenlty under discussion. The three key draft strategic priorities are as follows :

- Increase capacity for pre and post-registration placements for students nurses/ learners through further support to mentors, providing CPPD for practice nurses and supporting innovative network based learning opportunities that include developing links with community nurses and interprofessional learning.
- Promote sustainable approaches through making use of existing and new/emerging frameworks that aim to address career pathways, curriculum and employment issues that may impact on recruitment, retention and professional development for Practice Nurses.
- Develop a 'community of interest' to influence local and national stakeholders in order to raise the professional profile of Practice Nursing.

Further discussions will refine the strategy. A supporting document with more details will be available shortly.

The following documents are attached and have already been submitted as supporting evidence :

- Report from the University of West London on the Education and Training requirements of Practice Nurses and Support Staff in North West London
- Sahf presentation for Lord Willis' Shape of Caring review
- Minutes of Lord Willis' Shape of Caring review meeting with Sahf representatives

An additional documents now also attached :

- Practice Nurse Education Needs Analysis survey results: Buckinghamshire New University University of West London

# EE45 Urgent Care Commission

## Organisational Information

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|---|---|---|---|
| Name of organisation | Urgent Care Commission | Contact Number | +44 (0) 20 7822 1726 |
| Address | 1 Red Lion Court,<br>London, EC4A 3EB | Email | hannah.barlow@portland-communications.com |
| Contact Person<br>Name and Position | Hannah Barlow<br>Account Manager | Number of attached evidence documents | 1 |

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

**Please see attached**

# EE46 South East CSU

## Organisational Information

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|---|---|---|---|
| Name of organisation | South east CSU | Contact Number | 07557 849977<br><br>Pers. 07941 040174 |
| Address | Kent house 81 station road<br>Ashford TN23 1PP Kent | Email | Caroline.flasse@nhs.net |
| Contact Person<br>Name and Position | Caroline Flasse<br>Lead Practice nurse Adviser | Number of attached evidence documents | 12 |

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

Our practice nurse adviser team ( 4 PNA and 1 health care support worker adviser) support the quality Agenda in Primary care in Kent and Medway. We are still currently funded by the Area team, but may be Partly funded by CCGs in the future. I have attached documents that we have produced , we also run Respiratory, diabetes forums, clinical supervision, monthly PN forums, assist the area team for SI in Primary care involving nursing teams, organised a big HCA conference in November, advise the kent GP staff Training team in identifying the best courses to run for PN and HCA and also teach some of the courses, we also work with PHE and support practices identified to have issues with immunisations and cervical cytology, we represent PN on various regional bodies , work in collaboration with Primary care tutors in place in CCGs to develop the workforce agenda and help to run the CCG protected learning afternoons nursing sessions. We also produce a bi-monthly newsletter with important information on guidelines, local educational events and most importantly act as a resource for PN who often work in isolation and who contact us for advice , support and sign-posting. We have also recently developed guidance for HCAs employed in general practice. This has been endorsed by the RCN and will be peer reviewed shortly before being disseminated in the 4 countries.

We believe that this support and leadership in Primary care is essential to ensure that we have a safe and Well trained workforce in Kent and Medway.

# EE47 George Freeman

## Organisational Information

| | | | |
|---|---|---|---|
| Name of organisati | **n/a** | Contact Number | 0118 984 1401 |
| Address | 25 St james Close, Pangbourne, Reading RG8 7AP | Email | g.freeman@imperial.ac.uk |
| Contact Person Name and Position | Prof George K Freeman<br>Emeritus Professor of General Practice<br>Imperial College London | Number of attached evidence documents | four references |

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

''Segmentation of care' has been proposed as a way of improving primary care delivery, particularly in hard-pressed inner-city areas. I became aware of the concept when recently Mike Farrar spoke in favour of the motion:
'This conference believes that general practice should be
(a) organised among people with similar diagnoses and care needs, and
(b) integrated with secondary care providers.'
The motion attracted no support in a meeting of generalist clinicians (in this case GPs) but I wondered where the idea came from.

Porter et al strongly advocate the model in their paper (attachment 1). On p518 they write "the starting point for value based primary care is to identify groups of patients with similar needs, challenges, and ways to best access care. Then care teams and care delivery processes can be designed for each patient subgroup, outcomes can be measured, and …costs can be understood". Their appendix provides an example of five possible subgroups:

- Healthy
- Healthy with a complex acute illness
- At risk
- Chronically ill
- Complex

The concept has been taken further in the recent Report of the Health Commission for London (attachment 2). Here eight subgroups are proposed:

- 'Mostly' healthy (rest of the population)
- One or more physical or mental long-term conditions
- Cancer
- Severe and enduring mental illness
- Learning disability
- Severe physical disability
- Advanced dementia; Alzheimer's etc.
- Socially excluded groups.

I served on the Independent Commission on Generalism in 2011 and indeed we concluded that care needs to be improved for some of the above groups: we specified those with learning disabilities, mental health conditions, children, and residents of care homes. But our prime recommendation was for the enhancement of high quality generalism in care (attachment 3).

There is no doubt that more resources are needed for inner-city primary care, both within and outside London. The most thorough testing of the possible benefits has been the so-called Deep End project in Glasgow, with its expressed aim of countering the effects of Tudor Hart's inverse care law. The essential intervention was the allocation of extra funded time for generalist clinicians to assess and care for people with multiple chronic problems including mental health problems.

GPs are no strangers to risk stratification and so, on the face of it, segmentation is not such a strange idea.

But, as so often, the devil lies in the detailed implementation of the concept. One related model, discussed in London, is 'carve-out' epitomised by the Chenmed group in the USA. Here intensive integrated primary care is delivered specifically to frail older people.

"Our physicians typically see 350 to 450 patients a year - a fraction of the national average of 2,300 patients per doctor - so Chen and JenCare Neighborhood Medical Center doctors really get to know their patients. Our doctors build strong relationships with each of the seniors they serve."

As well as losing the advantages of generalism, the resource implications of carve-out are considerable and I am concerned that certain high-risk groups will attract manpower and resources such that so called healthy adults will no longer have access to a generalist physician. And yet, like the neighbourhood matrons scheme, we have no evidence that carve out would work in the UK context (attachment 4).

PS
In the 1970s I took part in an age-specific care system of general practice in Southampton. We field tested Tom McKeown's 1965 suggestion that primary care might best be delivered by specialising according to the patient's age. (Then, as again now, it was argued that a generalist clinician could not cope with the full range of medical knowledge.) We offered primary care paediatrics, mediatrics and geriatrics with additional specialisation for maternity care. This was superficially attractive, potentially offering enhanced liaison with specialist care, and initially welcomed by many patients. But the disadvantages of losing generalism steadily became apparent and the experiment was thankfully abandoned after three years.

Attachment 1

Porter ME, Pabo EA, Lee TH. Redesigning Primary Care: A Strategic Vision to Improve Value by Organizing Around Patients' Needs. *Health Affairs* 2013;**32(3)**:516-525. Also see their online appendix for details of proposed care sub-groups (ref 16 in the paper).

Attachment 2

Darzi et al. London Health Commission. 2014 October. Available at: http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf see pp 43-46 for proposed subgroups.

Attachment 3

Brindle D, Finlay I et al. Guiding patients through complexity: modern medical generalism. Report of an Independent Commission for the RCGP and the Health Foundation. 2011 October: available at: http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf

Attachment 4

An overview of Chenmed is available at http://investors.8x8.com/releasedetail.cfm?releaseid=877210

# EE48 BAcC

## Organisational Information

| Name of organisation | British Acupuncture Council | Contact Number | 0208 735 1219 |
|---|---|---|---|
| Address | 63 Jeddo Road London W129HQ | Email | nick@acupuncture.org.uk |
| Contact Person | Nick Pahl, CEO | Number of attached documents | 5 |

The British Acupuncture Council has around 3,000 members. To achieve BAcC membership, practitioners must have completed the equivalent of three-years full-time degree-level training in acupuncture; this includes physiology, anatomy and other biomedical sciences appropriate to the practice of acupuncture. The BAcC is accredited by the Professional Standards Authority which ensures that our regulatory approach meets the required standards of public protection and accountability.

The BAcC were featured as a success story in a report from the Professional Standards Authority about its Accredited Registers programme. We were glad to see endorsements from a wide range of health leaders. See the full report at http://www.professionalstandards.org.uk/library/document-detail?id=98755a9e-2ce2-6f4b-9ceb-ff0000b2236b

The BAcC is working with the NHS as a partner to improve health – for example with Public Health England and NHS Citizen. The BAcC also links with Clinical Commissioning Groups, Health Watch and NIHR as a non commercial collaborative partner. BAcC is a member of the Arthritis and Musculoskeletal Alliance.

**EVIDENCE BASE**

The National Institute of Clinical Evidence has recommended acupuncture as a cost-effective option for lower back pain and for prevention of headache. In Scotland, Acupuncture is recommended for the treatment of Chronic Pain. Acupuncture has an excellent evidence base within long term conditions (e.g. see http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/long-term-conditions-substantive/), care for the elderly, end of life care and preventive care.

professional acupuncture allows people to live a healthy, independent and fulfilling lives. It provides patients with access to the high quality, person-centred care that people want in primary care. It's clear from the millions of acupuncture treatments a year (over 2.3 million by BAcC practitioners, mostly for MSK conditions), the public wish to choose acupuncture.

In the UK, there are many examples of how acupuncture is being integrated into primary care. Here are some reference points:

- http://www.communityspiritacupuncture.co.uk/Gateway%20Outcomes.pdf
- You can see an analysis of outcomes data from 14 CAM NHS services in the attached (Wye et al)
- There is also an impact report of the Nottingham service – attached
- GetWellUK re CAM (incl acu) pilot in N. Ireland, 2008 –attached

- There have been a few fairly recent NHS audits done by BAcC members eg the Kens&Chelsea back pain service – attached.

A recent review by Arthritis Research UK sets out the results of research into the Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS) of the 152 local authorities that have a statutory duty to publish them, along with any supporting documents. It looked for the number and context of mentions of generic mentions of arthritis and musculoskeletal conditions/diseases ; osteoarthritis ; back/back pain and Fragility fractures, bone health, osteoporosis and falls owing to an underlying musculoskeletal conditions. One in four local authorities (26%) have not included any mentions of arthritis, musculoskeletal conditions or osteoarthritis in their JSNA. Only 36% mentioned osteoarthritis and 38% included back pain. One positive result is that 93% of local authorities mention falls, fragility, bone health and osteoporosis. See attached.

**Recommendations**

- Health Education England support training of degree level practitioners in Acupuncture accredited by the British Acupuncture Accreditation Board. Practitioners should meet the stringent professional education and training standards required of BAcC members, as this would provide meaningful additional public protection.

- New models of primary care are developed by NHS England that supports more integrated working between primary care and other services, such as acupuncturists.

- Acupuncture practitioners should be part of primary care teams.

- Local authorities include data on musculoskeletal conditions in their JSNA

- CCGs commission new MSK pathways

- NHS England commission MSK networks and new ways of delivering primary care

We would welcome the opportunity to discuss these issues with the Commission

# EE49 TCSW

**The College of Social Work Response to the Primary Care Workforce Commission Consultation on New Models of Care**

The College of Social Work (TCSW) is the centre of excellence for social work, upholding and strengthening professional standards to the benefit of the public. It holds the professional standards for social work, supports the professional development of social workers, and campaigns on issues relating to social work policy and practice. An independent membership organisation, The College provides quality assurance for initial and post-qualifying education through its training and education endorsement scheme.

**Like colleges for other professions, our role is to**:

Hold the standards for the profession and support and enable our members to meet those standards

Be the voice of the profession to policy makers and the media, ensuring that our members speak up for the profession

Be led by and accountable to our members – the profession. We do this in order to improve the outcomes for the people served by our profession.

Michael Simpson, Strategy and Policy Adviser

Telephone: 020 8453 2923 Email: **michael.simpson@tcsw.org.uk**

Response

What models of primary care work well and are likely to meet the future needs of the NHS (by 'models' we include both care provided within general practices or other primary care providers, and organisations that link providers together)? We are also interested in models that support more integrated working between primary care and other services

In October 2014 The College of Social Work published a report, GPs and Social Workers: Partners for Better Care, in conjunction with the Royal College of GPs. The paper set out our shared view that the integration of the NHS and adult social care would better serve the British public and lead to cost savings if GPs and social workers were in the driving seat.

Our proposed model shifts the centre of gravity in health and social care towards the individual and the community, cutting across the traditional distinctions to integrate services in the interests of the people who use them. Social workers and GPs, working in partnership, are the axis around which it revolves but the model also involves nurses, occupational therapists and allied health professionals.

Sitting at the interface between health and social care, GPs and social workers can nurture a community infrastructure to help people live independently for longer and avoid spending time

unnecessarily in hospital. This could release resources locked up in hospitals and long-term care to be used much more cost effectively in community settings.

This aligns with NHS England's proposed House of Care framework. TCSW has consistently argued that social workers have a crucial role to play in health and social care reform, giving people more choice, control and opportunities for active citizenship, and enabling more of them to live independently in their own communities rather than in long term care.

The RCGP proposed that GPs will oversee personalised care plans integrating all services as well as supporting self-management plans which ensure that frail older people are better cared for in the community and hospitals admissions are reduced.

The Commission will be interested in evidence of work that may demonstrate ways of using the skills of different professional groups as well as new approaches to deploying traditional skills.

Evidence you have for why you think these models work well

The report identified five primary care examples that we believe set out good examples of integrated, patient focussed primary care.

Central Manchester Practice Integrated Care Teams

Since November 2012, 32 out of 34 GP practices in Manchester have become the focus of an integrated model of care for 500 high risk patients/service users. Social workers have contributed by helping to change the terms of the discussion. Integrated teams have moved from being "predominantly medicine and health care based to a more rounded discussion of wider social needs." A&E attendance and hospital stays have fallen significantly.

An independent evaluation by HALL Aitken published at the beginning of 2014 found that the teams were becoming more 'democratic', even if GPs were still playing a central role. Indicative of this trend was they had moved from being predominantly medicine and health care focussed to include a more rounded discussion of wider social care needs.

Nonetheless the evaluation found that the importance of patient involvement in developing care plans was not always properly understood by team members. Nonetheless social workers were increasingly comfortable working in what had once been an unfamiliar environment. As one social worker stated:

*"The regular meetings have allowed all multi-agency professionals to develop an improved understanding of each other's practice. This from my social work perspective has made our links more efficient and improved timescales."*

Financial analysis of the practice integrated care teams had also found a:

20% reduction in hospital admissions

20% reduction in hospital bed delays

20% reduction in A&E attendances

15% reduction in residential/nursing care

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

Working together will require social workers and GPs to understand the similarities and differences between the two professions if they care going to develop better.

We argued in our joint report with the RCGP that integration would fail unless there was trust between social workers and GPs. The two professional groups can often fail to understand each other's unique role, responsibilities, and perspectives. There are powerful historic reasons for the existence of these cultural barriers. The language of service user empowerment, for instance, has long been current in social care whereas in the NHS the language of 'diagnosis' and 'cure' remains prevalent. However we do not that patient rights, particularly following the Francis report, are growing within health settings.

Contrasting governance arrangements and accountabilities have also allowed the two professional cultures to diverge, as have the differences in professional power and status. Ipsos MORI polling has consistently found that GPs are generally well regarded by the public. Though social workers are not included in the data, professionals – though admittedly often those working with children – have often in the past been singled out in the media.

Professional relationships will therefore be the critical factor in the successful implementation of integrated models. Reconciling the two cultures will depend on sound relations between GPs and social workers where each is confident of the competence and contribution of the other.

# EE50 Lyn Romeo

## Organisational Information

| | | | |
|---|---|---|---|
| Name of organisation | **Chief Social worker (adults)** | Contact Number | **020 72105284** |
| Address | Richmond House<br>79 Whitehall<br>London SW1A 2NS | Email | **lyn.romeo@dh.gsi.gov.uk** |
| Contact Person<br>Name and Position | Lyn Romeo<br>Chief Social Worker | Number of attached evidence documents | **3** |

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

Social work is the one profession that brings a unique combination of skills and knowledge in working with individuals, families and communities to support their safety, and wellbeing to have better lives. They manage risk, build resilience and promote inclusion.

Social work is complex, balancing the values of promoting independence with positive risk taking and enabling people to achieve best outcomes.

Social workers can improve the behaviours and relationships between social care and GPs to enhance older people's outcomes. This is borne of a set of diagnostic phases across 10 or more sites that looked at the influence and relationships GPs, adult social works and others had on the decision making of older people and advanced medicalization and movement into care homes. It links to Better Care Fund outcomes.

The clinical (aka therapeutic) aspects of social work practice in a medical setting provide interventions during times of stress and crisis, and social workers can assist patients in making changes to maintain their wellness. They can also provide a more holistic, social work perspective to medically trained co-workers – doctors, nurses, etc.

Social workers in primary care settings can undertake diverse tasks and have the potential to work across primary care, mental health, specialty care, etc.to assist the "whole person".

I have managed social workers in the past who have been based in GP health centres who are there to provide much more than the traditional functions of the local authority social worker. With increased investment via primary care , more social workers supporting GPs and other primary care colleagues will provide better case co-ordination of frail elderly , people with levels of mental ill health, people with LD, people facing end of life and people facing challenging times due to poverty, relationship difficulties , housing issues and needing support to link to appropriate resources. Social workers have core counselling and family work skills and also are able to enable people to access their own inner resources and those within their social system. They also work across agencies and really can ensure that people are linked to the right places to get the right support at the right time. They have an understanding of working with communities and linking individuals and families to their communities to provide connection and reduce loneliness.

The value that Primary care would gain from investing in a profession which is already taking on the challenges of the emerging paradigm for health is worth thinking about and incorporating into the primary care offer.

This emerging direction of the NHS is characterized by empowerment through connection, relationship work

and valuing diversity of thought to enable patients and others to tackle challenging health and social care issues. This is why social workers and a greater emphasis on the social aspect of the bio/psycho/social model of health and care is an opportunity not to be missed.

The sector leads from BASW, The College of Social Work and Skills for Care are well placed to provide the detailed evidence to support this proposition and we look forward to our discussions with you on 20th April

# EE51 NHS England

## Organisational Information

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|---|---|---|---|
| Name of organisation | **NHS England** | Contact Number | **07889102982** |
| Address | | Email | **Erika.denton@nnuh.r** |
| Contact Person Name and Position | Prof Erika Denton | Number of attached evidence documents | **2** |
| **Outline below the evidence that you would like the Commission to consider.**<br><br>**Community diagnostic services, details below** | | | |

**Logistics of Diagnostic Modalities in Primary Care: a Framework Map and Synthesis – Review Protocol Background**

Recent years have witnessed increasing momentum towards improved access to diagnostic services for general practitioners and community-based allied health professionals [1, 2]. Political drivers towards improved primary care access to diagnostic services are identifiable from such Department of Health documents as *Care Closer to Home* [3] and *NHS Next Stage Review: Leading Local Change* [4], chaired by Lord Darzi. These documents outline a need to achieve change through "disruptive innovation", *i.e.* change involving radical service redesign and an emphasis on empowering the frontline by devolving key aspects of care pathways from secondary to primary care [1].

Concerns around service redesign include material dimensions (including the test platform, equipment, reagents and supplies) and the health professionals, their roles, their relations and the socio-cultural context in which testing occurs. In addition little operational research has been undertaken into health system requirements and the impact of technologies on diagnostic accuracy, retesting and diagnostic delays. Factors associated with reconfiguration within the health system relate to skills, training, cost, equipment, premises, and referral linkages between primary and secondary care.

Empowerment of general practitioners and community-based allied health teams requires identification of perceived barriers and facilitators to redesign of diagnostic services. A recent systematic review of qualitative studies revealed that primary care clinicians believed point-of-care testing improved diagnostic certainty, targeting of treatment, self-management of chronic conditions, and clinician-patient communication and relationships [5]. At the same time clinicians expressed concerns about test accuracy, over-reliance on tests, undermining of clinical skills, cost, and limited usefulness.

This Framework Map and Synthesis is being undertaken as part of a larger review project looking at provision of diagnostic services in community settings. Initial literature mapping revealed a variety of diagnostic modalities with different implications for being located within Primary Care. In addition to examining one modality in detail, diagnostic ultrasound (See accompanying Review Protocol) it was agreed that it would be helpful to characterise modalities against a common set of logistic and service delivery considerations. These considerations would not only be populated by data relating to existing modalities but the resultant framework could become a basis for evidence gathering for potential and future technologies.

**Review question**

What are the logistic and service delivery considerations associated with the introduction and ongoing provision of diagnostic services in community or primary care settings? These should include implications for NHS organisations (e.g. related to provision of staff, premises, training and equipment, costs and cost-effectiveness) and patients (e.g. related to changes in management/pathways, acceptability to patients, accuracy of diagnosis, differential performance of tests and longer-term clinical outcomes).

**Inclusion/exclusion criteria**

Population: people requiring diagnostic services for any condition (excluded: universal screening and monitoring, including pregnancy). Studies that describe screening for selective populations (e.g. by age, gender, ethnic group) or for individuals indicated to be at risk will be included provided factors that are identified are either common or concentrated within the UK population.

Intervention: diagnostic services provided in a primary care or community setting by primary care/community staff using any type of equipment. Open access services provided to GPs by a hospital using its premises, equipment and staff will be treated as a comparator intervention.

Comparator: hospital-based diagnostic services (open access or traditional). 'Outreach' services using hospital-based staff to deliver services in community settings would also be relevant comparators

Outcomes and study designs: the main focus is research studies conducted in any developed world setting that evaluate community diagnostic services against a comparator. Audits, service evaluations, descriptive studies, economic evaluations and qualitative research studies will be included if they have been conducted in a UK setting. Systematic reviews with no geographic limits or where geographic limits include UK settings will also be eligible for inclusion. In addition, we will include relevant expert opinion or reports from professional bodies that identify and/or discuss practical issues related to the provision of community diagnostic services. (4)

We will use our innovative STEPUP framework as the basis for comparison and analysis.

**S**KILLS: Skill mix; Extended roles; Inappropriate Test Ordering

**T**RAINING: Training Needs; Training Costs; Duration

**E**QUIPMENT: Equipment for modality and for analysis; consumable costs

**P**REMISES: Cost of Premises

**U**SER PERSPECTIVE: Waiting Times; Acceptability; Repeat Procedures.

**P**RIMARY-SECONDARY INTERFACE: Referrals, Changes to Diagnosis or Management Pathways; Differential rates of Diagnosis in Primary versus Secondary Care

Given that the focus of the review is on models of service, studies that only report on the diagnostic accuracy of modalities will not be included.

Methods

Searching

We will undertake a two stage search strategy:

**Stage One - Identification and location within STEPUP framework of sub-factors of relevance to each modality**

This requires rapid mapping from systematic reviews, opinion pieces, "barriers" literature, feasibility studies, policy documents etcetera to generate a comprehensive framework across modalities. The aim is to be expansive in identifying as many factors as possible across all modalities, rather than exhaustive.

*Search methods:*

Database searches: 2005 to present using review filters.

Citation searching

Internet searching: Specified websites (including Oxford Diagnostic Evidence Co-Operative) plus limited searching of Google Scholar

Contact with experts

**Stage Two - Population of extended STEPUP framework with empirical evidence**

This will require systematic identification of comparative studies [UK/international], qualitative studies [UK/international], audits and service evaluations [UK only], economic evaluations and cost studies [UK only]. The aim will be to identify the most rigorous, useful and informative studies within a finite search period.

*Search methods:*

Database searches: 2005 to present. (i.e. only factors of current relevance to technologies/ UK Primary Care settings) using a combination of study filters and "hedges" linked to each domain on the STEPUP framework.

Internet searching: Specified websites (including Oxford Diagnostic Evidence Co-Operative) plus limited searching of Google/Google Scholar

Citation searching

*Study selection*

**Stage One: Development of Framework**

Search results will be imported into an Excel Spreadsheet to allow ease of coding. Items for inclusion will identify one or more perceived or actual factors facilitating or inhibiting the introduction of diagnostic technologies into a primary or community care. A cumulative list of sub-factors will be developed and then examined for redundancies or interrelationships. Subfactors will be organised within the STEPUP Framework. Where specific empirical research is cited in support of a particular facilitator or inhibitor the reference will be documented and carried over for detailed examination in Stage Two.

**Stage Two: Population of Framework**

Search results will be stored in a reference management database, where decisions on inclusion/exclusion will be recorded. Selection of studies for inclusion (scanning of titles/abstracts and full text publications) will carried out by one reviewer. In cases of doubt, a second reviewer will independently examine the full text.

Data extraction and quality assessment

Stage One: Development of Framework [Any reference type]

All data will be handled through the Excel spreadsheet which will include reference identifiers, bibliographic details and identified factors. Links between references and identified factors will be explicit to aid transparency.

Stage Two: Population of Framework [Empirical Studies and UK Audit/Evaluations only]

Data will be extracted by a single reviewer to a template of study characteristics plus a three-four line summary of main study findings using forms/tables set up in advance and piloted on a small number of studies.

As the intention is to highlight issues, against the best available evidence currently available to address them, there will not be a formal assessment of quality for each included study. A brief indication of study quality based on study design and any highlighted study limitations will be used to annotate each included study.

Synthesis of evidence

We will use the data as identified above to develop and populate the following framework:

**S**KILLS & EXPERTISE: Skill mix; Extended roles; Inappropriate Test Ordering

**T**RAINING: Training Needs; Training Costs; Duration

**E**QUIPMENT: Equipment for modality and for analysis; consumable costs

**P**REMISES: Cost of Premises

**U**SER PERSPECTIVE: Waiting Times; Acceptability; Repeat Procedures.

**P**RIMARY-SECONDARY INTERFACE: Referrals, Changes to Diagnosis or Management Pathways

We expect to accompany this framework synthesis with a narrative synthesis that characterises the type and nature of the evidence for each factor. Evidence will be grouped by modality and by factor allowing comparison across and within modalities. The synthesis will include a brief notation that will indicate both the quality of evidence and the strength of findings in support of each factor. A major output of the process will be a map that indicates evidence gaps by which to inform future research.

Deliverables:

Stage One: Development of Framework

Fully Developed Conceptual Framework indicating both generic and modality-specific considerations relating to introduction and delivery of diagnostic services in a primary or community care setting

Stage Two: Population of Framework

Map of available empirical and UK evidence relating to logistics of delivering diagnostic services in a primary or community care setting indicating level of uncertainties and priorities for future research.

Timeline

| *Activity* | *Start* | *Finish* |
|---|---|---|
| Protocol development | 20 January | 6 February* |
| Protocol sign-off (HS&DR team & Prof. Denton) | 8 February | 13 February |

| | | |
|---|---|---|
| Literature searching – Phase 1 – Iterative Development of Framework | 16 February | 13 March |
| Literature searching – Phase 2 – Population of Framework | 13 March | 31st March |
| Presentation of draft framework to HS&DR Team | Late March – Early April | |
| Study selection and mapping | 1st April | 31st May |
| Analysis and report writing | 1 June | 30 July |
| Delivery of draft developed and populated framework | | 31 July |

*Including internal peer review by team

References

[1] Birchall, D. (2010). Primary care access to diagnostics: a paradigm shift. *Primary care*, *83* (986).

[2] O'Riordan, M., Collins, C., & Doran, G. (2013). *Access to diagnostics: A key enabler for a primary care led health service*.

[3] Department of Health. *Care Closer to Home*. London: Department of Health; 2008.

[4] Department of Health. *Our NHS Our Future: NHS Next Stage Review – Leading Local Change.* London: Department of Health; 2008.

[5] Jones, C. H., Howick, J., Roberts, N. W., Price, C. P., Heneghan, C., Plüddemann, A., & Thompson, M. (2013). Primary care clinicians' attitudes towards point-of-care blood testing: a systematic review of qualitative studies. *BMC family practice*, *14*(1), 1-9.

Appendix – Search Strategies

Stage One

| Setting | Primary Care or General Practice or Community Care |
|---|---|
| Intervention | Diagnostic Techniques and Procedures; Diagnostic Services; Diagnostic Tests or One of the following modalities:<br>Audiology; Point of Care Testing; Cardiac Services; ECG;<br>Echocardiography; Diabetic Services; Endoscopy; Genetic Testing<br>Laboratory Tests; Magnetic Resonance Imaging; Radiology/X-Ray<br>Respiratory Tests; Ultrasound.<br>"direct access imaging" "direct access mri" "rapid access cardiology" |
| Factors/Considerations | Barrier$ or Facilitator$ or Logistic$ or Cost$ OR Feasib$ OR /organization & administration OR /economics |

Stage Two

| Domain | Concepts | Search Terms |
|---|---|---|
| **SETTING** | Primary Care or General Practice or Community Care | Family Practice |
| | UK | Great Britain |
| **MODALITIES** | Audiology | exp Diagnostic Techniques, Otological |
| | Cardiac Services | exp Diagnostic Techniques, Cardiovascular |
| | ECG | |
| | Echocardiography | exp Echocardiography |
| | Diabetic Services | |
| | Endoscopy | exp Endoscopy |
| | Genetic Testing | exp Genetic Testing |
| | Laboratory Tests | |

| | | |
|---|---|---|
| | Magnetic Resonance Imaging | exp Magnetic Resonance Imaging |
| | Point of Care Testing (haemoglobin A1c (HbA1c) and urine albumin: creatinine ratio (ACR) on patients with diabetes, total cholesterol, triglyceride and high density lipoprotein (HDL) cholesterol on patients with hyperlipidaemia, and international normalised ratio (INR) on patients on anticoagulant therapy). | Point-of-Care Systems |
| | Radiology/X-Ray | exp Radiography |
| | Respiratory Tests | exp Diagnostic Techniques, Respiratory System |
| | Ultrasound | exp Ultrasonography /ultrasonography |
| | | |
| **FACTORS/ CONSIDERATIONS** | **S**KILLS & EXPERTISE: Skill mix; Extended roles; Inappropriate Test Ordering | Physician's Practice Patterns /manpower |
| | **T**RAINING: Training Needs; Training Costs; Duration | /education |
| | **E**QUIPMENT: Equipment for modality and for analysis; consumable costs | Diagnostic Equipment<br>Equipment Safety<br>Equipment Design<br>Equipment Failure<br>Equipment Failure Analysis<br>Maintenance<br>/economics /utilization |
| | **P**REMISES: Cost of Premises; Health & Safety | /economics |
| | **U**SER PERSPECTIVE: Waiting Times; Acceptability; Repeat Procedures. | Waiting Lists<br>Patient Acceptance of Health Care |
| | **P**RIMARY-SECONDARY INTERFACE: Referrals, Changes to Diagnosis or Management Pathways | /utilization |

# EE52 Health Innovation Network South London

## Organisational Information

| | | | |
|---|---|---|---|
| Name of organisation | Health Innovation Network South London (an Academic Health Science Network). St George's University of London and Kingston University. | Contact Number | **079 3223 7899** |
| Address | School of Rehabilitation Sciences, Faculty of Health, Social Care and Education, St George's University of London and Kingston University, 2nd Floor Grosvenor Wing, Cranmer Terrace, Tooting, London. SW17 0RE | Email | **Michael.hurley@sgul.kingston.ac.uk** |
| Contact Person Name and Position | Michael Hurley Clinical Director, MSK Programme, Health Innovation Network Professor of Rehabilitation Sciences | Number of attached evidence documents | **0** |

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

**Osteoarthritis Practitioner: a new role in primary care for people with osteoarthritis of the knee and/or hip.**

**Background**

Musculoskeletal (MSK) conditions are extremely common. People usually try to self-manage their problems but when their pain and related problems increase they will seek help from their GP. It has been estimated that about 20% of GPs caseload involves management of MSK conditions. The most commmon cause of MSK is osteoarthritis (OA), whose cardinal clinical feature is chronic joint pain, is a major cause of suffering, physical and mental ill-health (Conaghan, Porcheret et al. 2014), healthcare expenditure and socioeconomic spending (Cross, Smith et al. 2014). In the UK, OA affects 8.5 million people, annually accounts for 1-2% of GDP, 2m GP consultations, 36m lost working days. Annually, about 20% of the UK population over 65 years old consult their GP with disabling OA pain. These problems are increasing rapidly as people live longer (Conaghan, Porcheret et al. 2014).

About 90% of people with OA are managed by GPs. Guidelines strongly recommend patient education, exercise and weight control to help people self-manage OA, thereby reducing pain, disability, co-morbidity and delaying surgery (National Institute for Health and Clinical Excellence 2008; Hochberg, Altman et al. 2012; Fernandes, Hagen et al. 2013; McAlindon, Bannuru et al. 2014). Unfortunately few people receive these core interventions and effective lifestyle advice (Roberts, Adebajo et al. 2002), because GP training emphasises drug management, and they lack time and skills to give effective lifestyle coaching (Cottrell, Roddy et al. 2010). Most patients are maintained on analgesia, which is often ineffective, unpopular and side-effects can add to the personal suffering, indirect and hidden costs (Solomon, Glynn et al. 2003; Hippisley-Cox and Coupland 2005; Hippisley-Cox, Coupland et al. 2005). Consequently many people endure many years of unnecessary pain and disability. Moreover, 40% of sufferers think this management is ineffective (Conaghan, Porcheret et al. 2014).

Enabling GPs to deliver lifestyle coaching effectively would require additional training, and more /longer consultations, which would be prohibitively expensive. Allied healthcare professionals (AHPs) – such as nurses and physiotherapists - routinely deliver lifestyle advice to people with chronic conditions (Wetzels,

van Weel et al. 2008; Martinez-Gonzalez, Djalali et al. 2014). Increasing involvement of AHPs in primary care management of OA could provide a more effective, efficient way of helping the large number of people suffering OA (Department of Health 2006; Foster, Hartvigsen et al. 2012 #5983; Ludvigsson and Enthoven 2012). The lack of need for additional training and lower workforce costs mean this model could be implemented easily, quickly and have wide benefits on associated co-morbidity (Smith, Holder et al. 2013).

AHP-led care is now common for many long term conditions (diabetes, cardiovascular and respiratory disease), but although there is some data showing this model of care may be effective for OA it has not been widely implemented.

The Health Innovation Network (the Academic Health and Science Network for South London) covers a population of approximately 3.5 million people. Over the past eighteen months we have been running three projects to improve the management of osteoarthritis in the community. These are:

1) the design and implementation of a new role for primary care management of osteoarthritis
2) supporting local organisations to implement an evidence-based rehabilitation programme for knee osteoarthritis, ESCAPE-pain (see separate submission),
3) to deliver to GPs across our 12 CCG areas, MSK training (accredited by the Royal College of General Practitioners and Arthritis UK)

In focus groups we held with staff and patients in General Practice, patients said they would be happy to be advised about their chronic joint pain by healthcare professionals other than their GP, and the GP partners were keen to consider alternative ways of supporting their patients better.

Based on the available evidence and feedback from our staff and patients we designed the Osteoarthritis Practitioner (OAP) role. The Practitioners work in Primary Care to identify people with knee and hip OA (from patient database, referral from GP partners and self-referral), review their management, advise and work with them to ensure core management guidelines are observed. They ensure patients are adequately informed about their problem, advise them how they might manage it and teach them about the importance of self-management strategies (weight control, exercise) to help improve clinical outcomes and help cope with their problems. They refer patients to other relevant agencies if necessary (e.g. weight control clinics, exercsie on referral, physiotherapy, podiatry) and provide information education and training to the local healthcare team to improve their skills.

Patients are followed at 6-month intervals to reinforce health messages, review the impact of their joint pain on their life, and provide reassurance. This model is similar to the regular reviews in place for other long term conditions, and meets NICE guidance for management of osteoarthritis.

The new role is being formally evaluated. This includes measuring:

clinical outcomes (physical and mental health and wellbeing)

costs of running the new service

process outcomes: identification of patients, uptake rates, DNA rates, return rates, referral rates and uptake

wider social return on investment

Staff and patient satisfaction are also being assessed through qualtitive interviews etc.

In addition to the above, the processes, barriers and facilitors involved in implementing the new service are

also being formally assessed.

The pilot started in mid-February 2015. In the first month nearly 50 people were identified and contacted. Early indications are the service is proving very popular and that patients are engaging with the service (~75% uptake), that the GP partners, nursing and practice staff are referring to the service and neighbouring practices now wish to implement the model.

The main challenges have been setting up the new role, establishing mechanisms of referral, recording notes and assessments on local electronic databases systems; all have been overcome.

The OAP role is currently filled by 2 local NHS physiotheraists working at Agenda for Change band 6, but the role has been designed to be generalisable to non-specialist healthcare workers, working at lower levels, probably approximately band 4 in line with other roles involved in giving practical general lifestyle advice (as opposed to specific physiotherapy treatment.)

Currently the OAP is supported by funding from the Health Innovation Network MSK programme and Health Education South London but longer-term we would anticipate that such a model could be funded by CCGs/GP Federations/Local Area Networks.

**Summary**

In summary, we anticipate that our results will demonstrate that the Osteoarthritis Practitioner role will provide a cost-effective, sustainable model of care using a relatively unskilled workforce; such a model would be sufficiently flexible to help cope with the growing demand of chronic joint pain.

Benefits will be:

- *Improved care* for people with OA/chronic joint pain in line with NICE core recommendations – information, self-management advice, body weight, participation in regular physical activity – assessed by clinical outcomes above pain, physical and psychosocial function etc.

- *Better experience and satisfaction* for patient and healthcare providers – faster access to effective treatment and increased efficiency

- *Better 'fit' with model of care* for other chronic diseases (diabetes, cardio-vascular-respiratory disease) – regular follow-up, better individualised care plan linked to co-morbidities

- *Efficient utilisation of workforce skills* – relevant use of professional (e.g. GP) skills, releasing clinical time for more relevant cases

**References**

Conaghan, P. G., M. Porcheret, et al. (2014). "Impact and therapy of osteoarthritis: the Arthritis Care OA Nation 2012 survey." Clinical Rheumatology: 1-8.

Cottrell, E., E. Roddy, et al. (2010). "The attitudes, beliefs and behaviours of GPs regarding exercise for chronic knee pain: a systematic review." BMC Family Practice **11:4**.

Cross, M., E. Smith, et al. (2014). "The global burden of hip and knee osteoarthritis: estimates from the Global Burden of Disease 2010 study." Annals of the Rheumatic Diseases.

Department of Health (2006). The Musculoskeletal Services Framework. A joint responsibility: doing it differently. London, UK.

Fernandes, L., K. r. B. Hagen, et al. (2013). "EULAR recommendations for the non-pharmacological core management of hip and knee osteoarthritis." Annals of the Rheumatic Diseases.

Foster, N., J. Hartvigsen, et al. (2012). "Taking responsibility for the early assessment and treatment of patients with musculoskeletal pain: a review and critical analysis." Arthritis Research & Therapy **14**(1): 205.

Hippisley-Cox, J. and C. Coupland (2005). "Risk of myocardial infarction in patients taking cyclo-oxygenase-2 inhibitors or conventional non-steroidal anti-inflammatory drugs: population based nested case-control analysis." BMJ **330**(7504): 1366-9.

Hippisley-Cox, J., C. Coupland, et al. (2005). "Risk of adverse gastrointestinal outcomes in patients taking cyclo-oxygenase-2 inhibitors or conventional non-steroidal anti-inflammatory drugs: population based nested case-control analysis." BMJ **331**(7528): 1310-1316.

Hochberg, M. C., R. D. Altman, et al. (2012). "American College of Rheumatology 2012 recommendations for the use of nonpharmacologic and pharmacologic therapies in osteoarthritis of the hand, hip, and knee." Arthritis Care & Research **64**(4): 465-474.

Ludvigsson, M. L. and P. Enthoven (2012). "Evaluation of physiotherapists as primary assessors of patients with musculoskeletal disorders seeking primary health care." Physiotherapy **98**(2): 131-7.

Martinez-Gonzalez, N. A., S. Djalali, et al. (2014). "Substitution of physicians by nurses in primary care: a systematic review and meta-analysis." BMC Health Serv Res **14**: 214.

McAlindon, T. E., R. R. Bannuru, et al. (2014). "OARSI guidelines for the non-surgical management of knee osteoarthritis." Osteoarthritis and cartilage / OARS, Osteoarthritis Research Society **22**: 363-88.

National Institute for Health and Clinical Excellence (2008). Osteoarthritis: the care and management of osteoarthritis in adults N. C. C. f. C. Conditions. London.

Roberts, C., A. O. Adebajo, et al. (2002). "Imporving the quality of care of musculoskeletal conditions in primary care." Rheumatology **41**: 503-508.

Smith, J., H. Holder, et al. (2013). Securing the future of general practice: new models of primary care: Research report. London, The Kings Fund.

Solomon, D. H., R. J. Glynn, et al. (2003). "The hidden cost of nonselective nonsteroidal antiinflammatory drugs in older patients." Journal of Rheumatology **30**: 792-8.

Wetzels, R., C. van Weel, et al. (2008). "Family practice nurses supporting self-management in older patients with mild osteoarthritis: a randomized trial." BMC Fam Pract **9**: 7.


# PRIMARY CARE WORKFORCE COMMISSION

## Submission of evidence by the Royal College of Nursing

**Executive Summary**

Across the health and social care sectors the nursing role is pivotal to the delivery of a wide range of care services. Working across boundaries and in partnership with social services and secondary health care, they plan, manage and co-ordinate the care of people with diverse needs. However for the purposes of this response the RCN has focused only on primary and community care as these were the areas that the Primary Care Workforce Commission invited us to comment on.

The RCN has strongly highlighted in the attached response that the need to introduce new models and new ways of working cannot be separated from the wider challenges facing the primary care workforce. If new models of care are to be implemented under the five year forward view or similar initiatives, then there is a clear need to increase the total workforce working in primary care as this sector has experienced significant under investment. It is crucial that the design of health and social care structures fully take into account workforce implications and how staff need to be supported and developed to deliver high quality care to patients that fully meets their needs.

The RCN understands that there is no 'one size fits all' with regards models of care delivery and appreciates that what works well in one area may not in another. As primary care continues to evolve it must constantly adapt to reflect and accommodate the needs of a diverse population. People, are with justification, demanding greater control over their treatments and more personalised services, tailored to their preferences. The need for strong, medical input clearly remains, but nursing expertise and leadership plays a vital part in delivering continuity of care for individuals accessing services[1]. Primary care nurses have increasingly taken on more responsibility in the management of long term conditions, such as asthma, hypertension, heart failure and diabetes under the supervision of medical practitioner colleagues. They also provide key roles in assisting more vulnerable groups in accessing primary care, such as people with a learning disability. At the same time, many nurses have developed a generalist primary care role: they diagnose, prescribe, review and refer patients to other services. This is a role that is highly valued by patients who feel nurses offer them time, as well as expert and personal care.

The current financial context emphasises the need to use primary and community care resources in the most effective and efficient way possible. We know that timely intervention from primary care and community staff at the right time prevents more costly care being required in the acute sector. Medical treatments that were once provided in hospital are being increasingly administered in the community. Within health systems there is a renewed focus on delivering health care in the community, freeing hospitals to provide more complex and specialised and emergency care.

The RCN believes that a range of population based models must be used in primary care to accommodate different demographic, geographic and social

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[1] Marina Lupari (2015) *Editorial: Nurse Leaders can Shape the Future* Primary Health Care April 2015 Vol.25 No. 3

and health needs. The models that we present in this submission demonstrate the value of nursing to tackling some of the key challenges facing primary care today and in the future. The RCN believes that primary and community nurses can be the champions of new care models, raise standards, deliver improved outcomes and embed innovation within the NHS.

**Introduction**

***About the RCN***

With a membership of around 420,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

**Background**

This document responds to the Primary Care Workforce Commission call for evidence. The RCN welcomes this consultation, faced with economic and political challenges, a robust and strong model is critical for securing high quality care in primary care. The RCN is keen to work with the Primary Care Workforce Commission to this end.

In setting out this request the Commission has identified that although high quality care is provided through primary care in the UK and is often held up as a model in other countries, there are major challenges in terms of workload and the changing nature of that workload. In relation to the main groups with needs for primary care (for example, acute illness, long term conditions, frail elderly, end of life care and preventive care), the Commission asked for the RCN to consider;

What models of primary care work well and are likely to meet the future needs of the NHS (by 'models' the commission includes both care provided within general practices or other primary care providers, and organisations that link providers together)? The commission are also interested in models that support more integrated working between primary care and other services

Evidence of work that has been undertaken by RCN that may demonstrate ways of using the skills of different professional groups as well as new approaches to deploying traditional skills

Evidence that the RCN has for why you think these models work well

Problems that the RCN perceive in implementing these models within the NHS at present.

***Methodology***

The RCN in compiling their response have adopted a rapid appraisal methodology in terms of policy, practice, professional and research evidence.

Within the College the work of the following RCN professional forums are relevant to this consultation and their Committee members have assisted in the collation of the evidence contained within this report.

Practice Nurses Association[2]

Advanced Nurse Practitioner Forum[3]

District Nurses forum[4]

*Definitions and clarification of terminology*

It is worth highlighting at the outset what is meant by primary care. All too often, primary care is understood to mean general practice, general medical practice and General Practitioners (GPs). Whilst this arguably is at the core of primary care, we would advise that the definition is interpreted broadly, that primary care includes all primary medical care services such as general practices, community settings, community pharmacy services, dentistry and eye health.

**General comments**

The traditional model of general practice, whereby primary care is delivered by one or more GPs, is no longer considered adequate to deliver effective care for today's primary care patients.

More people are living longer. For the first time, there are now more people aged over 65 in the UK than there are aged under 15, and with older age comes greater care demands. Also an increased number of people are living with long- term conditions, due to demographic changes and improved therapies.

Individuals are with justification, demanding greater control over their treatments and more personalised services, tailored to their needs and preferences. Patients who regularly access primary care services, often patients with multiple long term conditions may prefer a continuous relationship with a single health professional. A series of Government led initiatives have been launched, but with limited impact. The most recent has been the Department of Health (2014) *Transforming Primary Care: Safe, proactive, personalised care for those who need it most*[5], this document clearly identifies the key strands of improvement that are required.

For other groups of patients with different needs, accessing healthcare services as and when they want is a more important priority. It is important to recognise that people have different needs at different times of their lives.

It is also important to also recognise that primary care has not always provided well for some groups who do not currently choose to access services, for example young men, travelling families and other marginalised groups.

As Primary Care continues to evolve it must constantly adapt to reflect and accommodate wider changes in society. The need for strong, medical input clearly remains, but nursing expertise and leadership plays a vital part in delivering and understanding patient care needs and experiences, from cradle to grave, in every community.

The Five Year Forward View references the role of more public health interventions, patient empowerment, and the central role of primary and community care in supporting patient outcomes. The Forward View advocates that a one size fits all approach is inappropriate for such a diverse country and suggests a range of local solutions to integrating care.

The options proposed under the forward view include multispecialty community providers, encompassing multiple GP surgeries and multidisciplinary community staff working more closely together and providing care for more patients out of hospital. The Forward Plan also proposes primary and acute care systems being brought together under single organisations providing both NHS GP and hospital services, alongside mental health and community care.

The College is aware that NHS England are working to explore the multi- speciality community provider (MCPs) model, as outlined in the 'Five Year Forward View' with CCGs in London. The project aims to determine what good MCPs should look like. The project stakeholders, of which RCN is one, look forward to hearing the experiences of frontline staff on the progress of this work. The RCN believes that delivery of the vision in the forward view will require challenging traditional beliefs about how best to provide primary care services, diversifying skill-mix, empowering and employing the skills of all members of the multidisciplinary team and educating staff, patients and the general public about how best to access and use developing models. Primary care services must be planned and developed based on the needs of users, not providers, to ensure the health needs of diverse communities are met.

The RCN have recently worked with the BMA on a joint statement of principles to demonstrate the commitment of both organisations to support joint working between doctors and nurses to meet future demands. This document is presented in draft form and available in **Annex 1** of this response. Nursing staff play a distinct and critical role in joining up health and social care. They frequently work on the interface of the two care communities and have a key collaborative role in ensuring that patients do not notice where the current boundaries start and end. There is a wealth of evidence to connect nursing practice to high quality care and improved patient safety and patient experience. In particular, evidence points to the clear role of the nurse in preventing deterioration in patient health through rapid intervention, reducing infection, building a climate of safety, reducing costs and preventing errors in the management of medicines[6].
However, the percentage of nurses working outside the acute sector has remained virtually unchanged over the last decade. In addition the non-acute nursing workforce is ageing and it is essential that they are revitalised in order to meet the challenges of the future and achieve the ambition in the Forward Plan to deliver prevention focused services closer to home.

The Primary Care workforce, understanding and enhancing the current model
*Workforce challenges*

The RCN believes that new models of care in the community cannot be developed and implemented without sufficient investment to grow and sustain the workforce. It is important to recognise that the way nurses are distributed varies across different settings and sectors. In general there has been investment in acute, elderly and general medicine sectors (seen as a response to the Francis report and other associated reports which have highlighted problems with NHS care and staffing levels) yet this has been at the expense of community based nursing. Recent RCN Frontline First reports[7] have identified worrying evidence that the recent renewed recruitment, or 'Francis effect', has been limited to the acute, elderly and general sector, with community services, mental health and learning disabilities nursing lagging far behind; having suffered heavy workforce cuts in past years.

There are immense challenges ahead in primary and community care, and the current workforce configurations do not currently support all models that need to be put in place to strengthen the primary care sector and facilitate a shift from acute to community provision.

The RCN has concerns about the availability and level of detail in the official data published covering the primary care workforce as it is currently not possible to 'drill down' into the types of workforce configurations that exist in different settings. Despite this, the total nursing workforce figures still show a lack of progress in the overall supply of nursing staff for primary and community care.

The table below shows that many sections of the non-acute sector workforce have experienced significant under investment over the last 4 years.

Figure 1: Health and Social Care Information Centre Qualified nursing, midwifery and HV staff, NHS hospital and community services data set[8]

| Type | Number of nurses | |
|---|---|---|
| | May 2010 | December 2014 |
| All community services | 48,068 | 47,427 |
| District nurses | 7,813 | 5,645 |
| Health visitors | 8,092 | 10,783 |
| School nurses | 3,067 | 3,051 |

It is particularly striking that community nursing currently accounts for 21 per cent of the total nursing, midwifery and health visiting workforce according to Health and Social Care Information Centre data[9]. The RCN notes that the share of the workforce employed in community settings has decreased since September 2009 when it was 23 per cent.

Estimates of the age profile of qualified nursing staff using available data shows a progressively ageing primary care nursing workforce. The nursing workforce as a whole is progressively ageing, in 2013 46 per cent of the workforce was aged over 45, compared to 37 percent in 2005. The average age is even higher in the community than in acute settings[10] and there is expected to be an increase in the numbers of senior nurses to retire within the next five years. Many nurses enter into community roles later on in their career, and a key concern is the lack of exposure to community nursing in education and career pathways[11].The RCN notes that the ageing profile of the workforce may lead to shortages in some areas as nurses retire. There can be considerable variation in the retirement plans of individual nurses, particularly as they work to an increased retirement age.

Suitable methods for attracting and retaining primary care and community nurses are urgently required. These include effective preparation, fair reward and appropriately challenging career pathways. The College has highlighted this issue in a range of publications including the RCN's *Pillars of the Community* document[12].

Recruitment and retention for primary care nurses must be seen in the context of local economies across the country. It is important for the RCN to note that unlike hospital or other community nurses there is no agreed pay scale for nurses working in general practice. This has led to a gap in terms and conditions between nurses working in general practice and those working in the wider NHS. The RCN have consistently recommended the adoption of

Agenda for Change as the model for nurses employed within general practice. Unlike staff working in hospitals the annual incremental rise under Agenda for Change has not been automatic for staff working in primary care. As independent practitioners pay remains at the discretion of the employing GPs. The RCN believes that Agenda for Change terms and conditions should be adopted for all nurses employed within primary care.

At present there is no nursing workforce model within primary care. Nursing roles often sit in isolation of a nursing support structure but are aligned instead to the GP practice management structure. There is no accepted staff allocation ratios per head per GP population for general practice nursing staff. There is also no accepted skill mix ratios in terms of qualified nursing to healthcare assistant ratios. There is sometimes ambiguity around roles and responsibilities, for example, with one task being undertaken by a Nurse Practitioner in one practice but being undertaken by a Practice Nurse in another practice.

*Current nursing roles within primary care*
The following are a selection of key roles undertaken by nurses within primary care. There are also a range of community nurses who work in a variety of community settings to provide primary nursing and health care across the lifespan. Their role includes the management of specific diseases as well as broader community development and public health promotion work. The types of community nurses include Community Matrons, School Nurses, Community Children's Nurses, Community Mental Health Nurses (CMHN), Health Visitors, Learning Disability Nurses. The RCN has not covered the role of all these groups of nurses in this submission but have highlighted below the distinct role of District nurses.

Practice nurses

Practice Nurses who work in generalist roles often provide the following services:

They diagnose, prescribe, review and refer patients to other services.

They play a distinct and pivotal role in delivering improved public health
The nursing perspective on delivering personalised care means they are well placed to advise on ensuring services provide value for money, are efficient, effective and high in quality
Nurses provide valuable insight into the practical issues of service delivery – e.g. knowing what hours best suit patient needs and why – to more complex issues such as barriers to services provision (e.g. emotional, cultural barriers) and how services might be tailored to overcome them
Nurses play an integral role by working in partnership with patients in making choices about their healthcare via initiatives such as information about prescriptions and care-planning.

These roles are highly valued by patients who feel nurses offer them time, as well as expert and personal care. Patients report that they have confidence in the treatment prescribed, as nurses are skilled in involving people in decision making and explaining treatment in an understandable way[13].

Practice nurses have developed important roles in the management of long term conditions, such as asthma, hypertension, heart failure and diabetes[14]. The RCN has provided the following case study as a typical example of a Practice Nurses remit.

**Case Study 1: Perspective of an individual Practice Nurse**

"In my clinical role, I mainly work in general practice duties, chronic disease (lead in respiratory care asthma and COPD), family planning and sexual health promotion i.e. smear screening. I do all immunisation with the exception of baby immunisation as I stopped doing for a long while. Our practice has a dedicated P/N who just does this every Monday. I do perform at least 10 smears per week with no inadequate rate. As a practice nurse and a Non- medical prescriber I have added advantage I am able to complete an episode of care for the patients (within the areas of my prescribing competencies) in order to improve on patient accessibility to respiratory treatment, patient satisfaction due to continuity of care and monitoring, saving GP time."

"My clinical achievement since being the named lead for smear in a single handed GP practice was to raise their smear standard from low performing to the expected higher targets of 80-90%, our targets have improved significantly and we consistently maintain higher targets throughout monitoring with a robust recall system."

"In development of workforce for practice nursing within my mentoring/assessing role, I have mentored /assessed students allocated to me at BA level doing specialist branch in practice nursing. Enabling new practice nurses to gain the appropriate skills to do their job is our priority. Most new Practice Nurses (coming from other speciality) do not have transferrable skills to do smear taking. Therefore learning to take smear competently through learning from mentor support in practice has enable student after their 2 days training to achieve their competency successfully is so fulfilling and worthwhile."

In many areas, practice nurses also provide high quality triage care, which supports the whole team in using their skills to best effect. Triage has already proved to be an effective way to prioritise urgent and serious clinical cases. Nurses have developed models of telephone and face-to-face triage in general practice, which have proved to provide value for money and a user friendly system. Such models allow GPs to predominantly focus on complex care, diagnosis and to specialise in the management of particular priority groups such as those with long term conditions[15].

Practice nurses provide key roles in assisting more vulnerable groups in accessing primary care, such as people with a learning disability[16]. For example, learning disability nurses and those in liaison posts help ensure 'reasonable adjustments' are made in general practices for people with learning disabilities.

Extended roles and Specialist Nurses

For a number of years, specialist nurses have worked at the forefront of delivering more specialised, high quality nursing care to increasing proportions of acutely ill patients and those with long term conditions. Areas of practice where specialist nurses provide high level care include cardiac, respiratory, neurological conditions, stroke, renal, haematology, haemophilia, and cancer care.

These nurses perform specialist roles in the fulfilment of many aspects of the services that are currently covered under GP contract arrangements, including General Medical Services

and the Quality and Outcomes Framework (for example immunisation, cervical screening, travel clinics, minor illnesses and chronic disease management)[17]. The specialist nurse role demands a high level of decision making skills in order to accurately assess and manage patients with a wide range of clinical conditions. This role is highly valued by patients and these interactions are often characterised by a unique bond of closeness developed over time, enhancing the environment for shared decisions. Specialist Nurses working within primary care settings have contributed significantly to the level of patient care and expertise.

The value of specialist nursing roles is widely recognised, for example studies on the impact of gerontological nurse practitioners in the care of older people suggest that such roles can help reduce length of stay, lead to reductions in adverse events and lead to improved outcomes for older people[18]. In addition a recent report by the HSJ[19] highlighted the benefits of specialist nurses to reducing costs and increasing efficiencies, supporting service redesign, bringing care closer to home and delivering person-centred care. A study by the Nuffield Trust reported in the HSJ[20] also suggested that an increase in consultations in a sample of General Practices over the period 2010/11 and 2013/14 could be partly attributed to more nurse-led consultations. The total number of patient consultations increased by around 11 per cent during this period at the practices analysed, with consultations by nurses growing by 8 per cent in comparison to just a 2 per cent increase in consultations by GPs.

Advanced Nurse Practitioner

The Advanced Nurse Practitioner (ANP)[21] is a dedicated Nurse with extensive experience within primary care, practicing autonomously at an advanced level. The nurse can act as an independent prescriber, bring strong organisational and communication skills and have developed a strong network within both primary and secondary care as well as those within the social and voluntary sectors.

The ANP currently provides care for patients presenting with undifferentiated symptoms, from initial history taking, clinical assessment, diagnosis, treatment and evaluation of their care. ANPs are able to demonstrate safe, clinical decision making and expert care for patients within the general practice. Advanced Nurse Practitioners are often the main lead for the provision of certain long-term condition clinics such as diabetes and chronic obstructive pulmonary disease (COPD).

Abos-Mendizabal et al (2012)[22] in their research describe the experience of introducing new advanced nursing competencies which has been rated as positive by the participating patients and those around them (their caregivers and families). This is considered to have resulted in care that is more personalised, better planned and focused on the patient than traditional healthcare. This work undertaken in Spain reported that the implementation of advanced competencies have shown that case management leads to improvements in social and health care for patients, and their caregivers and families, compared to traditional care models.

Health Care Support Workers

Health Care Support Workers (HCSWs) come to work in Primary Care from many different settings with their duties being appropriately delegated by a registered nurse or doctor. The role of the HCSW has grown considerably in recent years and HCSWs are seen as an

integral part of the overall nursing team. The role of HCSWs in GP surgeries has developed considerably in recent years.

The use of HCSW roles has enhanced access and patient satisfaction in many areas of primary care. The development of the Care Certificate[23] is intended to further support the successful utilisation and training of this workforce. The Certificate[24] been designed to meet the requirements set out in the report of the Cavendish Review[25] and explicitly states the learning outcomes, competences and standards of care that will be expected of HCSWs.

District nurses

District nursing teams, through vital work in the community, have a crucial role in reducing hospital admissions and supporting early discharge. The RCN believes the fundamental goal of district nursing to be:

'The planning, provision and evaluation of appropriate programmes of nursing care, particularly for people discharged from hospital and patients with complex needs; long-term conditions, those who have a disability, are frail or at the end of their life.'

In developing the position paper *District Nursing: Harnessing the Potential*[26] the RCN identified the three care domains for the effective delivery of district nursing services such as:

- acute care at home
- complex care at home
- end of life care at home.

Integral to all three domains is the key role of the district nurse in delivering public health, as outlined in the RCN publication Going Upstream.[27]

The RCN believes there is a further need for resources to be developed building on national standards to and make them relevant for HCSWs working in general practice. The RCN highlights as an example of good practice a resource pack containing Core Standards, Code of Conduct and Code of Practice for Health Care Support Workers (Health Care Assistants (HCA) & Assistant Practitioners that has been developed in partnership with Kent Local Medical Committee.[28]

The *'Care in Local Communities: a new vision and model for district nursing'* document from January 2013[29] gives a clear description and clear principles about the functions and the types of services community nurses might work in.

The RCN developed a position statement in 2010 on the development of the registered nursing workforce in the community and this document[30] sets out the value of general practice nurses who are integral members of the primary care and community nursing team.

The RCN believes that there is a critical need for district nursing expertise if health services are to effectively meet emerging demographic, social and disease challenges. To rise to these challenges the pivotal role of district nurses and their teams must be acknowledged and developed. In the drive to ensure faster throughput from hospitals to the community, over the last 10 years we have witnessed a range of initiatives designed to transform services in the community. These include the introduction of intermediate care teams, chronic disease management specialist nurses (often called community matrons), virtual wards, in-reach and

outreach teams, and specialist teams. Significant resources must be found to ensure we maintain an expert district nursing workforce and a quality service that is fit for the future. It must include all community nursing teams, led by nurses with a specialist practice qualification in district nursing.

*Indemnity*

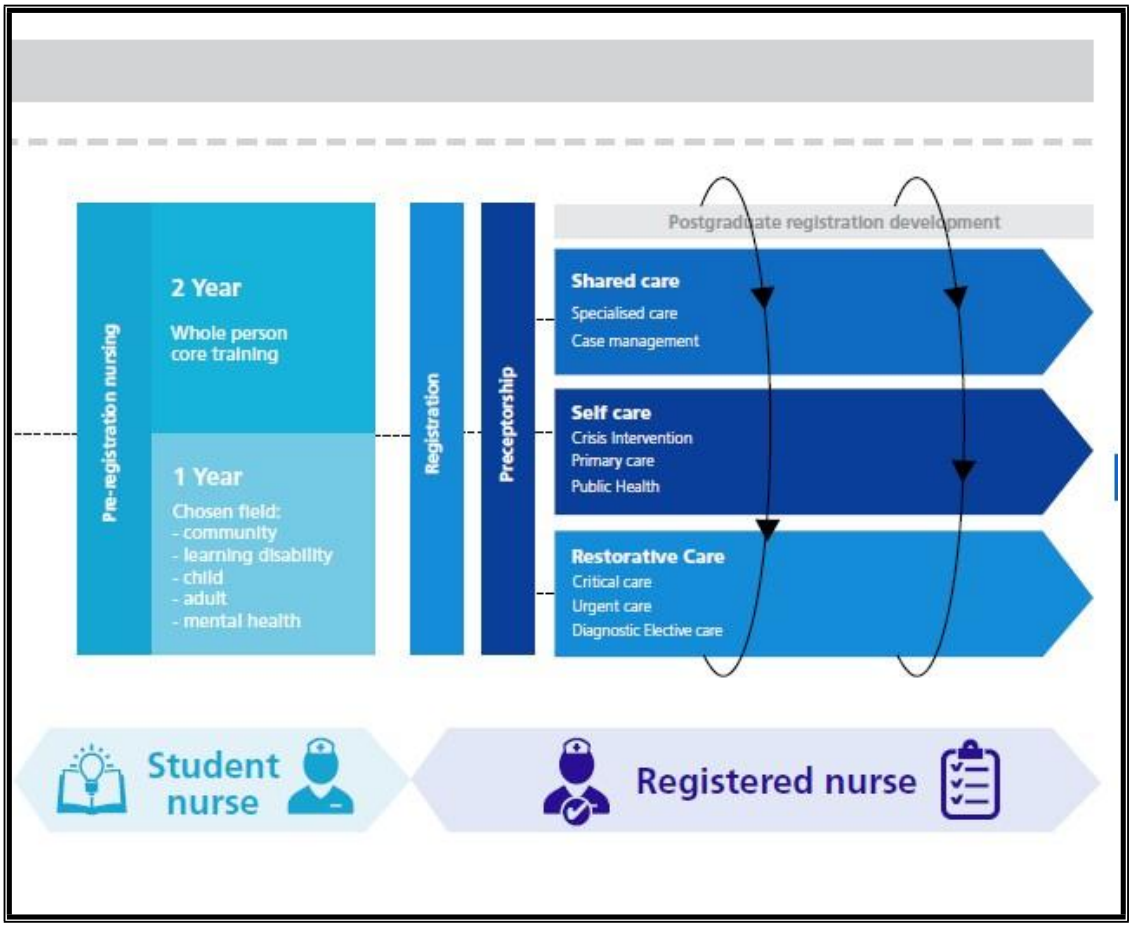
The introduction in 2014 of the requirement that professional health regulatory bodies (such as the GMC and NMC) made it a condition of registration that practitioners certify that there is an appropriate indemnity arrangement in place for their practice. The RCN notes that if a nurse is working under a contract of employment, the employer is always vicariously liable for the actions of the nurse during the course of employment. For this reason, claims of clinical negligence are almost always directed against the employer and an employed nurse should not be expected to pay for the indemnity cover. It is important that appropriate arrangements are made for indemnity cover for employed primary and community care nurses when new models of care are designed and implemented[31].

*Education and training to support the nursing workforce*

Pre Registration

There is a need for education and training for pre-registration nurses to be enhanced to better equip newly-qualified nurses for work in community settings. The Shape of Caring review makes 34 recommendations for the future education and training of nurses and HCSW's. In the report[32], commissioned by Health Education England (HEE) and the Nursing and Midwifery Council (NMC), the Chair of the review, Lord Willis made a series of proposals, which include more general training in the first 2 years of a nursing degree and the creation of a new community nursing field. Significantly the review report states that "we need to ensure that our future registered nurses and care assistants have the skills, knowledge, resilience and support structures necessary to work in complex, demanding and occasionally isolated conditions outside of hospital". The RCN has stated that the report recommendations deserve close attention.

Figure 1: Detailing Proposed educational model for nursing




Post Registration

Under the Shape of Caring recommendations primary care nursing staff must receive high quality training and development. The Review noted that:

Future health demands require new skills in primary care;
General Practice is facing and will continue to face difficulties in the recruitment and retention of skilled and experienced nurses unless such standards are delivered.
Investment in developing the wider team, to enable the provision of services by an appropriate workforce and skills mix, will benefit communities and individuals and better meet their needs.
In addition, the more creative and wider use of health care support worker roles needs to be further explored.

Access to Continuing Personal Development (CPD) and further qualifications is vital to a healthy primary care nursing workforce, yet the current provision of CPD is variable. Surveys carried out by the RCN and the Working in Partnership Programme in 2008 revealed that the employment standards experienced by general practice nurses vary considerably. Having access to CPD opportunities is a particular problem identified by RCN members. A more recent audit was conducted in partnership with RCGP and HEE[33] and found similar variation, and a lack of standardised training, with many of the CPD opportunities being carried out 'in-house'.

The RCN continues to raise concern about the availability of developmental opportunities for general practice nursing staff. We have previously stated that there is major inequity and inequality across England in terms of access to and utilisation of developmental opportunities.

Newly employed nurses require clinical and professional nursing support to ensure they practice safely as well as building on their skills realistically over time.

**Case Study 2: professional/personal development, perspective of a Practice Nurse Advisor**

"I am employed within NHS West Kent and Medway as a Part-time (4 day per week) as Practice Nurse Advisor. Additionally to fulfil my role I continue to be clinically active as a practice nurse for at least 1 day a week."

"In our current commissioning role we merged with Primary Care Workforce and Development and our vision is to ensure the continuous recruitment and training to ensure we nurture practice nurses to meet CQC standards and "fitness for purpose" as well as keeping pace in this fast, expanding role."

"My Practice Nurse advisory role also includes being the thematic leads in diabetes management and Non- medical prescribing for Practice nurses. Examples of activities I undertake include:

- collaborate with educators, internal/external organisations to ensure P/N needs are met by accessing the right support and to ensure appropriate education update are available.
- have successfully implemented a ½ diabetes update for practice nurses at 3 localities and I am a committee member for the local diabetes Implementation group
- together with my colleague I have attended and contributed to Non medical prescriber meeting with university to ensure training need at met for student and qualified non-medical prescribers
- am also involved in setting-up and running peer support groups at Medway and Dartford, Gravesham and Swanley
- I have successfully identified experienced colleagues with leadership qualities amongst P/Ns to get their support to take over clinical supervision group in order for the group to expand."

The RCN believes that a clear range of training and resources should be provided for practice nurses, and that a national educational support structure is essential if the optimisation of general practice nurses contributions are to be realised. Some of the tools are already available, for example those developed through the Working in Partnership Programme (WiPP)[34], which was set up in 2004 to support general practice with capacity building resources and strategies, and completed its pioneering £11m programme in 2008. During that time WiPP created a wide range of valuable tools and resources have been developed including online training courses, best practice guides, toolkits and frameworks to create capacity and support NHS professionals. A General Practice Nurse toolkit has been developed as part of this programme.

Adequate training and development for staff using IT for telephone consultations and email communication is also necessary to support efficiency as well as data protection and confidentiality.

It is also necessary to provide best possible opportunities for nurses to complete post-graduate education. The RCN highlights that in 2013, the Department of Health England (DH) published a new vision and service model for district nursing which supports District Nurses in having a graduate level education and a specialist practitioner qualification recordable with the NMC. The document[35] also highlights the need for evidence-based workforce planning for district nursing teams.

*Primary care nursing leadership*

Innovation through strong leadership is crucial to the future of the profession if nurses in the community are to continue to adapt to provide the best services for local people based on an understanding of what works.

The RCN highlights the need for a robust nurse leadership model to be developed for primary care. For the NHS to meet the challenges ahead, decisions about health services within primary care needs to be provided by nurses leaders as they are able to:

understand the health needs of their local communities and the quality of local services
involve local communities in improving services
work with other clinicians across organisations to improve outcomes for patients
coordinate and integrate care for patients across different services; and
challenge poor quality care.

The role of the nurse leader at a senior level is vital as they provide a high level of professional expertise and can provide an independent strategic clinical view on all aspects of primary care business. Nurse leaders are able to contribute a generic view from the perspective of a registered nurse and bring detailed insights from nursing into discussions regarding service re-design, clinical pathways and system reform. Further information about the role of the nurse leader can be found in an RCN RCGP information paper.[36]

**Case study 3: Community Chief Nurse in Sweden**

Since the 1990s all local authorities (municipalities) in Sweden have had a Community Chief Nurse role, which is unique to their healthcare system.

The Community Chief Nurse role was introduced to improve care of older people but has evolved over time and has had a key leadership role in shaping and coordinating health and social care at local level, includes ensuring liaison between GPs and community practitioners, promoting patient safety as the key priority particular as care is delegated between providers and ensuring quality standards are upheld.

Nurse Partners

In light of their growing confidence in delivering primary care, a number of nurses have become nurse partners and several practices are now managed by nurses. The RCN believes that nurse partnerships should be considered as part of a long term strategy for primary care where appropriate. Partnership arrangements that incorporate nurses work well when the professional contribution of the nurse to the partnership is recognised and valued.

**Example Job Description: Advanced Nurse Practitioner Partner:**

Providing autonomy, clinical leadership, expertise and senior clinical management.

Locality Cervical screening mentor. Teaching and assessing on a one to one basis.

Main responsibilities

- Patient consultations - assessment, arranging appropriate investigations, clinical haematology, diagnosis, prescribing and referrals when necessary.
- Management/delivery of care for those with long-term conditions.
- Development of nurse education, in-house nursing training, and mentorship.
- Strategic planning of operational services for patient provision.
- Development of standards and protocols.

The RCN also highlights the importance of nurse leadership in General Practice Federations (GPFs). The position of the Nurse Director in primary care ensures accountability lines are achieved both managerially and professionally for all nurses working within an organisation. The RCN advocates that the commission consider this model and make recommendations to ensure effective models are adopted in the future. RCN intend to work with RCGP regarding the requirement to appoint a nurse leader with vision, presence and a senior profile with autonomy to lead and respond to issues across the GPFs.

Nursing leadership is a critical element for ensuring successful models of delivery from professional leadership and clinical management across primary care teams, through to participation in strategic and population level planning, succession planning, workforce planning and development of the primary care nursing profession through research and development opportunities. The proposed general practice nurse leader within general practices would enable the mobilisation and leadership of the wider GPF, ensuring mechanisms for both quality, challenge and scrutiny are clear and takes place within an environment that is supportive but enable the local GPF system to assure accountability.

All primary care nurses should be supported, guided and inspired by nurse leaders throughout their careers. Increased development opportunities to strengthen competencies in leadership must be made available and funded for nurses who wish to progress their career in this way. The RCN also suggests that existing primary and community-based nursing leadership should be fully engaged at an early stage in the planning processes around further local or national redesign of primary care nursing.

An identified nurse leader must lead the nursing contribution to developing, implementing, and evaluating subsequent changes to practice, roles or

structures. This would add a level of expert scrutiny to changes that will directly affect the nursing profession.

Nurse leadership and walk-in centres

NHS walk-in centres were introduced in 2000 to help modernise the NHS and increase accessibility to health care. They developed rapidly and have been successfully used by the public. The RCN notes the potential role of nurse leaders in taking forward the work of walk-in centres as part of a wider primary and community care strategy[37]. There has recently been a renewed interest in the role of walk in centres as part of a package of measures to deal with the huge increase in demand for A&E services. The RCN believes that walk in centres continue to have an important role in health care provision and the nurse led centres provide valuable solutions when looking at new models of care.

Nurse leadership in commissioning

The RCN successfully campaigned for a nurse to be represented on each clinical commissioning group and that the term 'clinical commissioning' should be retained on future commissioning programmes to reflect the multi- disciplinary nature of the primary care team.[38]

Nurses have an invaluable insight into the practical issues of service delivery, including advice on value for money, efficiency and effective and quality care profession. They help patients to navigate the system and are able to assess future care demands. Nurses are also best placed to understand the training and development needs of the nursing profession. No single profession can have sole responsibility for commissioning services and if the appropriate range and mix of health and social care professionals are not involved in the commissioning process, new models will fail. Nursing expertise must also be recognised and utilised at all levels of the commissioning process**.**

*Multi-disciplinary working and new approaches to deploying traditional skills.*

The RCN supports close working relationships between local practices and community health teams, configured according to local need, to ensure the very best, joined up healthcare is delivered sustainably.

The primary health care team has been a core element of community health services. The RCN has raised concerns about the continued reorganisations of community health services over recent years. We have seen fragmentation in care provision as a result, even in teams that were previously considered to be delivering high performing community nursing services.

The RCN wishes to strongly support the further development of more enhanced and robust primary health care teams in the future. In this respect we believe that the public benefits from having easy access to highly skilled, well resourced, stable and secure primary healthcare teams.

A diversity of providers can appropriately accommodate different demographic, geographic and social and health needs. For example, in order to successfully tackle health inequalities, some practices will need to provide services in a ways that can be accessed by a particular target group. Central to the provision of any service must be the needs and preferences of those for whom the service is designed. GPs, practice nurses and the wider primary care team will not be able to provide this step-change on their own. They will need work as part of multi-disciplinary teams

including community nurses, pharmacists, allied health professionals, care assistants, social workers, mental health workers, volunteers and others able to provide high quality care. These teams will work with individuals, their families and carers, recognising that not all care is provided by formal health and care services.

The RCN highlights a briefing paper describing the new integrated teams being established in Barnet, London[39].

Case Study 4: Barnet's Integrated Teams

The teams will support the delivery of health and social care to better manage the needs of the local population.

The target cohort are frail and elderly people (Older Adults) especially those with multiple long term conditions (approximately 1-2% of the registered older adults aged 65 and over)

Each team, with the support of general practice, will help coordinate and manage the care of the identified Older Adults in the community. The team will be responsible for supporting identification for those 'at risk' of admission or escalating social care need, for establishing and supporting care plans via episodic interventions and to provide a watching brief for those that require it. These teams will hold regular Multi-Disciplinary Team (MDT) meetings with General Practices to discuss the Older Adults to discuss care planning, agree a 'Key-Worker' for the Older Adult and monitor progress.

Following extensive stakeholder and user engagement, it is proposed that the core team comprises community nursing, social care teams (social work, occupational therapy, telecare), case navigators and generic long term condition support. Additional needs are also emerging for core support for carers, mental health (particularly dementia), end of life and medicines management and these have been factored in. The design of the integrated teams will ensure access to streamlined care within the community and lead to a reduction of unscheduled admissions to hospital and a reduction in elderly residential care placements and care packages.

To fully integrate services and to prevent fragmentation of healthcare in the community, patients should be able to access a range of multidisciplinary services. However, significant investment will be required to ensure that the infrastructure of the practices is able to support multidisciplinary services. A large challenge in multidisciplinary working is ensuring that patient records can be shared effectively between different members of the extended primary care team.

**Case Study 5: The Geriatric Care Model**

This model was implemented by 35 primary care practices in the Netherlands. During home visits, practice nurses conducted a comprehensive geriatric assessment and wrote a tailored care plan. Multidisciplinary team consultations were organised with the aim to enhance the coordination between professionals caring for a single patient with complex needs.

Models of delivery within primary care settings

The RCN presents below a selection of models of primary care that have led to improved continuity of care, coordination of information, greater integration of acute and community care and patients' improved relationships with clinicians. The role of nurses in leadership and delivery are key to all of these approaches.

Use of E-Health to support models of care

As new models of long term care management and self-care emerge, the role of eHealth technologies, such as remote diagnosis facilities and telecare systems, should become ever greater. The RCN is supportive of such advances that support nurses in focusing interventions on promoting independence and enablement among patients in the community. IT also offers nurses in the community an opportunity to take on the role of 'knowledge broker', actively helping patients to access the information they need, and deciding how to use it. As the eHealth programme develops, community nurses must be fully engaged in eHealth developments at local and national level.

An example of a study that adds to the body of evidence around the benefits of E-health to models of delivery is outlined below.

**Case Study 6: Simple Telehealth initiative Flo**

This project introduced Simple Telehealth "Florence," a software-based short message service to support self-management. The technology works as a texting system to monitor a variety of conditions, such as diabetes, hypertension, and wounds, initially in one region of the East Midlands, England, UK, and now to be rolled-out by the Department of Health across England.[40]

Coordination of healthcare in the community for older people and people with chronic conditions

The RCN believes that a key focus of development for new models of care should be on the management of health and care needs of people with chronic conditions and older people within the community.

**Case study 7: Kings fund research into coordinated care**

The Kings Fund report *Coordinated care for people with complex chronic conditions (2013)*[38] presents the findings from a two-year research project funded by Aetna and the Aetna Foundation, which aimed to understand the key components of effective strategies employed by studying five UK-based programmes to deliver coordinated care for people with long-term and complex needs. It provides some key lessons and markers for success to help identify how care co-ordination might be achieved. Certain design features appear more likely to deliver successful care co-ordination which includes:

- A holistic focus that supports patients and carers to become more functional, independent and resilient is preferable to a purely clinical
- focus on managing or treating symptoms
- Building community awareness of and trust in care co-ordination programmes promotes legitimacy and engagement
- Effective communication based on good working relationships between members of the multidisciplinary team is essential
- Shared electronic health records can support the process, but a 'high- touch, low-tech' approach can also be very effective.
- Care co-ordination programmes should be localised so that they address the priorities of specific communities.
- Leadership and commitment (from commissioners and providers alike) is vital to establish a shared vision and challenge silo-based working.
- Integrated health and social care commissioning can support longer- term strategies and provide greater stability.

Across the five sites cited within the report common challenges included: funding; inability of the wider health systems to see innovation as 'core business'; a lack of integrated IT systems; and problems caring for people in remote and rural locations.

**Case Study 8: House of Care (HOC) model**

The HOC and its associated delivery system provide a sound conceptual framework to analyse and determine an individual's care needs. However, care must be taken to ensure that the wishes and requirements of the service user are not subordinated to rigid and inflexible care planning protocols.

NHS England's HOC model takes a whole system approach to the management of long term conditions, putting the person, their requirements and wishes at the centre of care. It is about aligning levers, drivers, evidence and assets to enhance the quality of life for people with long term conditions no matter what or how many conditions they have. The integrated personal commissioning programme, announced in July 2014, is another opportunity to explore how to bring together health and social care funding streams and enable people to plan their care based on what makes most sense to them and their family.

Case Study 9: Buurtzorg

Founded in the Netherlands in 2006, Buurtzorg[41] is a unique district nursing system which has garnered international acclaim for being entirely nurse-led and cost effective. Ongoing financial pressures within the health sector led to home care providers cutting costs by employing a low-paid and poorly skilled workforce who were unable to properly care for patients with co-morbidities, leading to a decline in patient health and satisfaction. Buurtzorg's answer to this problem was to give its district nurses far greater control over patient care
a factor which it attributes as key for its rapid growth.

The Buurtzorg model comprises six key services. These are:

- Holistic assessment of the client's needs which includes medical, long-term conditions and personal/social care needs. Care plans are drafted from this assessment
- Map networks of informal care and assess ways to involve these carers in the client's treatment plan
- Identify any other formal carers and help to co-ordinate care between providers
- Care delivery
- Support the client in his/her social environment
- Promote self-care and independence.

The aim of this approach is to engage three key national health priorities:

- Health promotion,
- Management of conditions, and
- Disease prevention.
- Buurtzorg has achieved some notable breakthroughs, particularly in the following three areas:

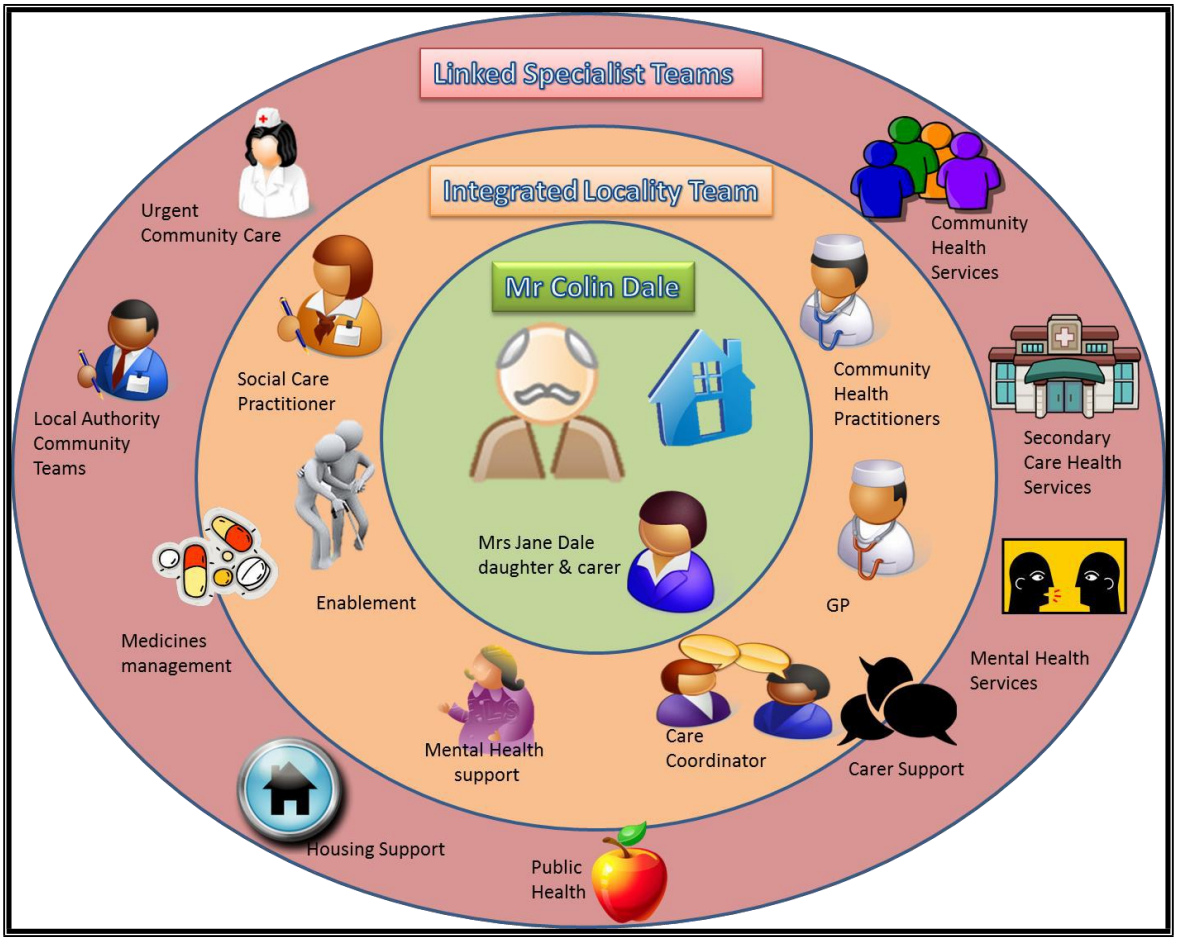
Higher levels of patient satisfaction
Significant reductions in the cost of care provision, and
The development of a self-management structure for nurses.

Importantly, it's not just nurses who have noted the positive impacts of Buurtzorg. While better patient outcomes are the most notable of its successes, Buurtzorg has also drawn attention from politicians and other health workers as a money-saving model.

**Case Study 10: New model of care in Barnet**

Barnet[42] are introducing a new integrated care model for frail older people which aims to achieve improved outcomes for individuals in need of health and social support, enabling them to live not just longer, but better lives. The integrated locality care teams will be based in each of the three localities with staff co- located and having one operational manager. The teams will liaise directly with the GP practices within serving areas registered population.

Figure 2: Pictorial Representation of the functions within Barnet's new model



Models of Care in Care Home Settings

The RCN believes that nurses have a key role to play in providing care in care home settings for frail older people. Older adults in care homes have complex health needs. Many live with multiple chronic conditions, including frailty, and reduced functional and cognitive capacity.

The RCN would like to advise the commission of an initiative which is typical of those being undertaken within this setting.

**Case Study 11: Barnet's Care Home initiative**

The pilot worked with 5 Care Homes, with the main objective focusing on improving outcomes for Care/ Nursing Home residents within Barnet. The pilot focused on the implementation of changes to the way in which health and social care practitioners work within care homes. These changes were grouped around the following key themes:

- Management and Leadership – supporting care home staff to develop better leadership and clinical care skills providing the right tools, training and long term support.
- Dementia – supporting care home staff to develop greater skills in caring for older people with dementia
- Care Home Web Portal – to provide a source of information and a forum for care home staff, commissioners, residents, carers and relatives
- GPs support to Care Homes – reviewing existing arrangements to understand and encourage more integrated working between GPs and care homes
- Pressure Care - supporting care home staff to develop greater skills in the prevention of and caring for older people with pressure sores

The RCN also lists below a series of further studies regarding case management of older people.

A nurse-led case management model in Northern Ireland for Older people with multiple comorbidities in the community setting[43].

A research paper[44] by describing the examination of the effects of a nurse-led case management programme for hospital-discharged older adults with co-morbidities. The post discharge interventions led by the nurse case managers on self-management of disease using the empowerment approach were able to provide effective clinical and patient outcomes for older patients having comorbidities.

Evidence published by Leung et al[45] on the effect of a virtual ward program on emergency services utilization and quality of life in frail elderly patients after discharge: a pilot study. A virtual ward service was piloted to deliver "hospital-at-home" services by community nurses and geriatricians to frail older patients immediately after their discharge from hospital to reduce emergency services utilization. The virtual ward group showed a greater significant reduction in the number of unplanned emergency hospital readmissions.

End of life care

Nurses and other members of the multi-disciplinary team have key roles to play in making sure that individuals are treated with dignity and respect, and are supported in making choices about the care they receive as they approach the end of their life. Despite the development of national end of life care strategies, there has been insufficient investment to enable the community workforce to meet the projected demand for end of life care, and too many people are not receiving end of life care that meets their needs and wishes.[46]

Evidence on the value of expert end of life care services based in the community suggests that multi-disciplinary teams are shifting the emphasis away from hospital based care towards better co-ordinated, person centred home-based care where with the right support most people prefer to be in the last weeks of life. Once a care plan has been agreed, it is essential that all the services[47] the individual requires are effectively co-ordinated between primary care, community and hospital based providers, general practitioners, the local hospice, transport and ambulance services and social care.

Case study 12: EPaCCS

The 2008 National End of Life Care Strategy[48] recommended locality registers as a way to enable effective communication among professionals. From this experience grew the Electronic Palliative Care Co-ordination Systems (EPaCCS), which are now being implemented across the country.

EPaCCS provide a shared locality record for health and social care professionals. They allow rapid access across care boundaries, to key information about an individual approaching the end of life, including their expressed preferences for care. Most people approaching the end of life would prefer to die at home rather than in hospital, in comfort and with the people they love. Across England, Electronic Palliative Care Co-ordination Systems (EPaCCS) are playing a key role in making this possible, by allowing professionals to share information about a person's care preferences across organisational boundaries.

With national support and core resources, EPaCCS started with eight local pilot sites. Since that beginning in 2009 there has been rapid growth, with 24 localities partially or fully implementing EPaCCS and 17 more planning to introduce these systems.[49]

This work is starting to have benefits for many individuals. Including

More than 29,000 people have been included on EPaCCS which means the information can be communicated to everyone involved in their care.
In areas that have EPaCCS in place, currently about one in seven people at the end of life have had their care co-ordinated through EPaCCS.
Localities that were among the first to introduce EPaCCS are already showing significant improvements in helping people receive care and die at home if this is their preference. For example, in some parts of London 79% of people with their care co-ordinated through EPaCCS have been able to die in the place of their choosing.

So far, GPs, palliative care services and out-of-hours services are the key services with access to EPaCCS where they are in place. Increasing use by social services is an important aim as EPaCCS mature and come into wider use.

A lack of co-ordination can ultimately mean that a person's needs and preferences are not met. To meet the end of life care needs of people who chose to remain at home, investment is needed in all primary and community care. This investment would enable nurses to provide 24 hour anticipatory care to ensure that people with complex health needs die well at home, in the way that they chose, supported by home visits from their nurses and GP if they wish.

It is important that end of life care reflects the needs of people with long term conditions. Taking the area of heart failure as an example, research[50] has demonstrated that nurses are key as they may initiate and support palliative and hospice care, focus on delivering patients' goal-directed, coordinated care, champion patients' and caregivers' needs, and facilitate optimal quality of life. Despite the inclusion of palliative and hospice care for heart failure patients in published guidelines, health care providers are frequently unfamiliar with palliative and hospice care and the needs of heart failure patients and their families. This research highlights the importance of the nurses' role in determining for whom, and when palliative and hospice care is appropriate; where and how palliative and hospice care should be provided; and the communication needs of patients and their families regarding referral.

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Out of hours care
Finally, the RCN notes that when exploring new models of care, out-of-hours (OOH) care should not be seen as separate or additional service but should be embedded in whole systems across health and social care. The opening hours of primary care services should accommodate the needs of the population including minor illness, acute care interventions and palliative care. There will be many reasons why patients, and not just those who work, cannot make appointments in standard nine to five working hours.

The RCN believes that local variations in approaches to OOH cover must be balanced with providing high quality and consistent care to all people regardless of location. This is particularly challenging in remote and rural areas.

An RCN survey[51] focusing on remote and rural out of hours care has highlighted three groups of particular concern:

Patients with mental health issues who may not receive high quality and consistent care in rural areas. Examples include lack of overnight 'mental health place of safety' and registered mental health nurses for patients awaiting OOH transfer to a mental health unit.

Babies, children and adolescents who may not have access to OOH expert specialist advice.

Patients requiring OOH palliative care, where communication issues have been highlighted as contributing to poor quality care.

Many of the problems patients encounter in the OOH period can be treated effectively by an advanced nurse practitioner. There are examples of nurse-led services being provided, with back-up and support, linked to the OOH hub Primary Care Emergency Centre (PCEC).

**Case Study 13: Grampian**

In NHS Grampian, advanced nurse practitioners and paramedic practitioners work together with GPs in rural areas overnight. The nurse and paramedic practitioners are in telephone contact with GP colleagues with telemedicine links to PCEC and A&E in Aberdeen for advice if required. Practitioners can assess, diagnose and treat a variety of acute conditions as well as make referrals to hospital for admission. The nurse practitioners also refer to the district nursing team and social services.

Nationally, NHS Direct was considered an integral part of the NHS until recently and evidence showed that over 60% of patients who called NHS Direct were given self-care advice for their problems, thus avoiding visits to their local doctor or A&E and savings millions of pounds. The change to NHS 111 in 2013 resulted in call handlers replacing nurses for initial triage work. NHS Direct until its closure was a clinically led service that benefitted from nursing expertise to assess the urgency of calls and is still a model being copied and implemented across the world. A similar scheme to NHS Direct still operates in Scotland.

In OOH periods practitioners can assess, diagnose and treat a variety of acute conditions as well as make referrals to hospital for admission. The nurse practitioners can also refer to the district nursing team and social services.

Evidence supporting one model of out-of-hours care is summarised below.

**Case Study 14: Shropdoc: integrated nursing service Out-of-hours**

Shropdoc introduced a Nurse Practitioner (NP) team during 2004 in the wake of the new GMS contract (2004), with the intention of ensuring a robust more cost effective service for the future. During the past 10 years the NP team has gradually grown to around 35. Around half of the NP work within the Care Coordination Centre (CCC) and Shropdoc is their sole employer. All NP have retained an OOHs triage element to their role.

Shropdoc has provided OOHs community nursing since 2007. This was an initiative developed in partnership with, what was then the PCT, to address the absence of OOHs community nursing. However, very quickly all nurses opted to be employed directly by Shropdoc and we have retained full autonomy of this service.

Community nurses also work within this service and have a high level of practical skills and a 'can-do' attitude. Each nurse has a substantive post within the Community Trust during the day. All enjoy the challenge off unscheduled nursing needs during OOHs and recruitment is via word of mouth. Two of the community team have developed primary care NP skills. More recently, a further 2 have also completed telephone triage training. The workload demand for OOHs nursing intervention has exceeded the capacity of this service for several years. 'Winter monies' has enable 6 month expansion of the service for past 2 years, however we have not been successful in securing recurrent funding.

# EE54 BSR

## Organisational Information

| | | | |
|---|---|---|---|
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| Address | Bride House, 18-20 Bride Lane, London, EC4Y 8EE | Email | arivett@rheumatology.org.uk |
| Contact Person<br><br>Name and Position | Ali Rivett, Director of Clinical Affairs | Number of attached evidence<br><br>documents | 0 |

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

The British Society for Rheumatology (BSR) promotes excellence in the treatment of people with arthritis and musculoskeletal conditions and supports professionals delivering such care in a range of settings. The professional association represents the whole multi-disciplinary team: consultant rheumatologists, trainees, specialised nurses, physiotherapists, occupational therapists, psychologists and GPs with special interest (GPwSIs) in rheumatology. The BSR aims to improve standards of care in rheumatology and secure a high priority for rheumatology services across the UK. We welcome the opportunity to respond to Health Education England and Primary Care Workforce Commission 's call for evidence and offer the below in response.

Rheumatic and musculoskeletal diseases (RMDs) are a current and growing challenge for the NHS, rates of RMDs are to significantly increase till 2030 due to the ageing population, increasing rates of obesity and low rates of physical activity.[1] The burden of this challenge is going to predominantly fall on primary care, where 30% of GP appointments relate to musculoskeletal problems.[2] Therefore the BSR recommends that any future models of primary care need to collaborate more closely with rheumatology services in secondary care to meet the future needs of the NHS. This approach is complemented by the fact that a significant proportion of RMDs can be treated by secondary care in collaboration with services operating in primary and community settings, rather than treatment having to take place solely within secondary services.

Reconfiguration needs to be carefully managed however, in consultation with local clinicians and patients, in

[1] The Kings Fund (2015) Non-communicable diseases. http://www.kingsfund.org.uk/time-to-think-differently/trends/disease-and-disability/non-communicable-diseases [Accessed on 27/03/2015]

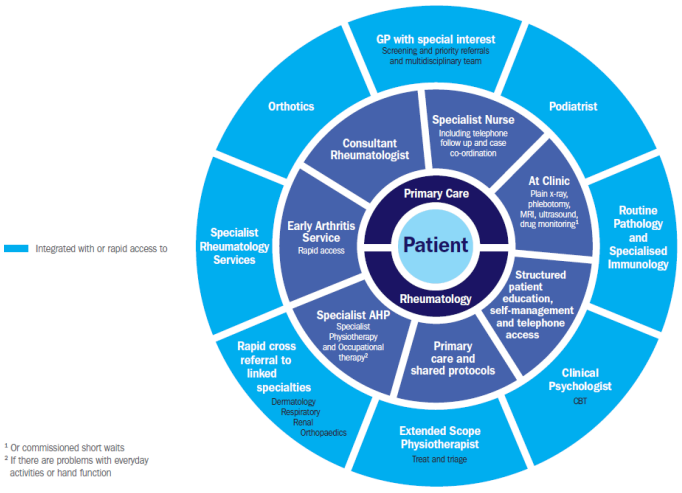
[2] Department of Health (2006). The Musculoskeletal Services Framework – A joint responsibility: doing it Differently. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4138412.pdf [Accessed on 27/03/2015]

order to avoid compromising quality and standards of care. Unfortunately, elements of rheumatology care have been established in local GP practices without consideration of the other services, such as diagnostics or access to therapies, which are vital to patient care. There also may be poor, long-term condition management in primary care of RMD patients who, as a result, may develop avoidable complications

The BSR therefore favours a more collaborative, approach that improves the interface between primary and secondary settings and staff. This collaborative, multi-disciplinary approach was underlined in the Department of Health's *Musculoskeletal Services Framework*,[3] which recommended that practitioners with special interests, such as GPs, triage, assess, diagnose and treat RMDs. The *Framework* additionally recommended the creation of clinical assessment and treatment services (CATS), an intermediate service which would liaise with rheumatologists and primary care specialists to improve the efficiency of treatment. More recently, *The NHS Five Year Forward View* similarly recommended providers and commissioners promote opportunities for secondary and primary care to develop closer working. [4]

In light of the impetus to deliver a more collaborative service, the BSR believes that this multi-disciplinary model should be adopted for rheumatology:

**Components of a rheumatology musculoskeletal medical and long term conditions service**




*Source: NICE commissioning guidelines: Royal College of Physicians, Working with patients – Rheumatology (2011)*



www.rheumatology.org.uk

BSR The British Society for Rheumatology

Within this model, care co-ordination can be facilitated by a specialist nurse, who acts as a case manager to

[3] Department of Health (2006). The Musculoskeletal Services Framework

[4] NHS England (2014) The NHS Five Year Forward View. http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf [Accessed on 27/03/2015]

coordinate access to care across secondary, community and primary care for patients (see x, p.2). This can be demonstrated by Pennine Musculoskeletal Partnership's Pennine MSK Partnership Ltd, which is an integrated musculoskeletal service based in the community with rheumatology pathways led by specialist nurses.[5] The services used to work closely with secondary care rheumatology services, now decommissioned, and currently collaborate with primary care services and voluntary organisations. The service was found to be 'outstanding' in the Rheumatology Best Practice Awards 2013, an initiative which aimed to highlight existing examples of innovative practice in the UK.

GPs can play a supportive complementary role to a rheumatology MDT. An example of GPwSIs involvement in multidisciplinary team is demonstrated at Haywood Rheumatology Centre in Stoke which integrates GPwSIs working alongside advanced practitioners to triage patients.[6] Working within a rheumatology MDT provides GPwSIs an opportunity to develop skills in triage and treatment that can be utilised within their practice and provides them with the knowledge of secondary care services to enable them appropriately refer.[7] This service was cited by the Kings Fund as one of six case studies where specialists were operating in out-of-hospital settings.

The collaborative approach to delivering rheumatology services effectively utilises the workforce, breaks down barriers to referrals and places the patient at the centre of their care. However the existing multiplicity of approaches has resulted in a significant variation in service provision across England.[8] The BSR therefore recommends closer collaboration between NHS England and professional bodies in developing and managing standardised care pathways, including the creation of protocols for shared care and drug management across the pathway.

As set out earlier to improve early diagnosis and treatment, the BSR recommends training for all professionals who come into regular contact with patients. Understandably, health professionals outside rheumatology have limited knowledge of the field, with a survey of GPs finding that only 58% had read NICE's current osteoarthritis guideline for example.[9] This limited knowledge is fostered by the narrow training provided on rheumatology; an audit of musculoskeletal services found 51% of commissioners do not provide GP education and training on RMDs.[10] The BSR believes that the expertise of rheumatology services within secondary care should be utilised for training, not least since research has found that GPs regard rheumatology consultants to be a valuable resource in meeting their learning needs.[11] The Department of

[5] The British Society for Rheumatology (2013) Pennine MSK Partnership Ltd – Clinically-led integrated musculoskeletal services. http://www.rheumatology.org.uk/includes/documents/cm_docs/2014/p/1_pennine_msk.pdf [Accessed on 27/03/2015]

[6] The Kings Fund (2014) Haywood Rheumatology Centre.

[7] The Kings Fund (2014) Haywood Rheumatology Centre.

[8] Arthritis and Musculoskeletal Alliance (2012) Joint Delivery? An updated audit to assess progress in the implementation of the Musculoskeletal Services Framework in England. http://arma.uk.net/wp-content/uploads/2013/03/Joint-Delivery-Zinc-final.pdf [Accessed on 27/03/2015]

[9] Clarson, L.E., Nicholl, B.I., Bishop, A., Edwards, J., Daniel, R., and Mallen, C. (2013) Should there be a Quality and Outcomes Framework domain for osteoarthritis? A cross-sectional survey in general practice. Quality in Primary Care, 21(2), pp. 97-103.

[10] Arthritis and Musculoskeletal Alliance (2012) Joint Delivery?

[11] Roberts C, Adebajo A, Long S (2002) Improving the quality of care of musculoskeletal conditions in primary care. Rheumatology 41(5):503–508

Health recommended CATS be integrated into continuing professional development (CPD) programmes. [12] Health Education England should work with the BSR on expanding training to a wider range of health professionals to promote early diagnosis and treatment and facilitate collaborative working between primary and secondary care.

To conclude, the BSR calls for best practice in care collaboration between primary and secondary care services to be consistently applied across the NHS, with care coordinated between a multi-disciplinary team (MDT). To facilitate this and to promote early diagnosis and treatment, the BSR would welcome the opportunity to work with Health Education England work to expand training on rheumatic conditions to a wider range of health professionals.

[12] Department of Health (2006). The Musculoskeletal Services Framework

# EE55 College of Occupational Therapy

## Organisational Information

| | | | |
|---|---|---|---|
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| Contact Person Name and Position | Karin Bishop - Head of Professional Practice | Number of attached documents | 0 |

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

**Primary Care Workforce Commission**

**Response from the College of Occupational Therapists**

**Introduction**

The College of Occupational Therapists (COT) is pleased to provide a response to this Call For Evidence.

COT represents over 30,000 Occupational Therapists who are either working or studying across the United Kingdom. The college also supports a number of support workers who are known as associate members. Occupational Therapists (OTs) work in the NHS, Local Authority Social Services and Housing Departments, schools, primary care settings, and a wide range of vocational and employment rehabilitation services.

Occupational Therapists are regulated by the Health and Care Professions Council (HCPC), and work with individuals of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties. Occupational Therapy is founded on the principle of occupation as a crucial element of health and well-being. Practice is based on holistic, client centred care.

The College's response will include examples of integrated care models and 'new models of care' that outline new approaches to healthcare compared to the traditional care pathways. These examples will include a short background and a short summary of their beneficial outcomes.

The College's response will end with a short summary of the potential problems in implementing these models within the NHS at present.

**<u>Occupational Therapists in an integrated care setting</u>**

**1) Croydon Children's Occupational Therapy Service – Integrated Health, Social Care and Education Occupation Therapy service**

**Background**

Identifying an opportunity to improve services for families, in 1998 Croydon Children's Health Occupational Therapy service offered to take on the Social Care Occupational Therapy roles in order to streamline Children's Occupational Therapy provision in Croydon. There were significantly long waiting times for Social Care Occupational Therapy provision. This was causing distress and frustrations for families and consequently impacted on health provision due, for example, to necessary equipment not being in place in the home environments to commence therapy programmes.

Since 1998, the Local Authority's Children with Disabilities team has commissioned Croydon Health Services' Children's Occupational Therapy team to provide Croydon residents with the Social Care Children's

Occupational Therapy input of home equipment, adaptations, housing and home safety needs. The Social Care home equipment budget was also provided to Croydon Children's Occupational Therapy service to purchase necessary specialist home equipment.

Croydon Children's Occupational Therapy service was one of the first in the country to deliver a fully integrated service across Health and Social Care Occupational Therapy and enables the Occupational Therapist to work with children in their own homes as well as in educational and health settings to promote and enable access, independence and safe care. This offers a one stop shop for families who do not need to navigate the maze of providers

The service is fully integrated, in that the same Occupational Therapists will deal with all Health, Social Care and Education needs for the children on their caseloads, consulting with other Occupational Therapists in the team who have specialist skills in the areas of Occupational Therapy that they are less familiar with. Croydon Children's Occupational Therapy service has excellent links with the Local Authority's Children with Disabilities, Housing and Adaptations departments in order to effectively provide the Social Care Occupational Therapy roles within the Croydon Health Services team.

**Beneficial Outcomes**

Due to the long standing integrated service arrangements, the majority of the Croydon families know no difference in Occupational Therapy service provision as one Occupational Therapist addressing all of their child's Occupational Therapy needs is the norm.

The Occupational Therapy service is well managed and the workforce is supported to develop the new skills, ensuring that the wide range of skills and experience needed is available within the team to make the integrated service work effectively. Skills and experience developed within the team is necessarily broad and provides the Occupational Therapists with a wide range of Occupational Therapy skills across Health, Social Care and Education needs.

The Children with Disabilities team has been able to entrust the commissioned work to the Children's Occupational Therapy team for over 16 years and through the effective management of the service, positive service feedback has been received over the years. The integrated service ensures a good relationship between client and the service which is reflected in the lack of complaints.

A key component is information management, with recording of all Occupational Therapy input on one computer database, Epex, where Health, Social Care and Education funded work can be separately reported on. This provides transparency between organisations. Due to organisation wide budget cuts, the Social Care funding for an Occupational Therapy post was in danger, which would have had a significantly detrimental impact on the service. Data collected was sufficient depict this and ensured the continuation of appropriate resources for the service.

There is significantly reduced duplication of assessments due to one professional assessing all needs, improved crossover of recommendations across the home and nursery/school environment, a shared computer database with other health professionals and reduced liaison time between OT services due to it being an integrated OT service. Demographics are changing with the children's Occupational Therapy service dealing with more complex cases, which would ordinarily require much input (resource) to coordinate care.

In the current climate of Commissioning and tendering services, the Children's Occupational Therapy service has maintained and continued to promote the significant benefits of a fully integrated Health and Social Care Occupational Therapy service. Commissioners have integrated new Occupational Therapy service

specifications and have taken on board the significant benefits and savings of an integrated Occupational Therapy service.

Over the years, numerous London boroughs have approached Croydon Children's Occupational Therapy service for information on the integrated Children's Occupational Therapy team, with intentions to develop a similar structure within their own Children's Occupational Therapy service.

The service has continued to respond effectively and efficiently to an increase in demand and complexity of children through on-going review of pathways and processes. This has resulted in a 57% increase in the number of contacts undertaken since 2008/09.

With the advent of the new Education, Health and Care Plans as part of the Children Act 2014, joint working is essential and integrated services pave the way for this.

**2) Sheffield Teaching Hospitals NHS Trust**

**Background**

The following case study demonstrates the work that has been done by the occupational therapists to link hospital community and social services, in order to provide the best experience for the patient. Alongside an integrated AHP workforce, being able to rapidly access community services and transport has streamlined the flow from hospital to discharge home.

Key aspects of the integrated pathway include:-

- Integrated working between A&E, Rapid Response Team (RRT), Frailty Unit, Ambulance Service, Reablement Service and the Falls Prevention Team.
- Use of a 'Request for Services' document, devised by the Trust, to identify a patient's health and social care needs at the point of discharge.
- Health and care workforce receiving necessary training, for example, Occupational Therapists and physiotherapists (PTs) receiving training in generic competencies; therapy being provided by specially trained Therapy Assistants working in the Falls Prevention Team.
- Services being designed around the needs of the client, for example, Rapid Response Team responding to referrals within 2 hours, equipment services being available 7 days per week, private ambulance service being used so that the client's arrival home can be coordinated with the RRT intervention at home.
- Use of private and 'third sector' organisations, for example, private ambulance service, City Wide Alarms.

**Beneficial Outcomes**

- Improved patient centred care
- Greater admission avoidance
- Patient being assessed and treated in their own home.
- Integration of services across the city of Sheffield.
- Increase in the job satisfaction and self-esteem of OTs, as they are able to demonstrate their specialist skills in helping to achieve the above.

**3) Westminster Community Health Falls Service**

**Background**

The Westminster Falls Service is a multi-disciplinary team with Occupational Therapists playing a key role in offering multifactorial falls risks assessment and targeted intervention for clients referred following a fall or who are at risk of falling. After assessment clients are stratified to receive either 1:1 multi-disciplinary rehab and/or attend a 12 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 evidence based falls prevention groups via 'Steady and Stable' classes in partnership with a voluntary organisation to promote long term life style change.

**Beneficial Outcomes**

The falls pathway enables clients to reach the recommended 50 plus hours of strength and balance required to prevent falls in the long term. They also review high risk clients by telephone. Clients followed up a year post discharge reported a 60% reduction of falls, 55% fewer fractures, 92% fewer A&E admissions, and a 80% reduction in GP appointments compared to the year prior to intervention.

**Occupational Therapists working in Accident and Emergency**

**'Admission Avoidance Team' pilot based within the Emergency Department (ED) in Peterborough City Hospital (PCH)**

**Background**

With building pressures on A&E departments in September 2013, Peterborough City Hospital (PCH) piloted an 'Admission Avoidance Team' based within the Emergency Department (ED) in order to help tackle winter pressures. This was set up by the local Commissioning Group with winter pressures money.

**Beneficial Outcomes**

The pilot ran for 6 months and proved very successful, with funding being secured for the financial year 2014/2015.

On average the team assessed over 150 patients each month and over ¾ are being successfully turned around from ED resulting in the prevention of an acute medical in-patient bed.

**Occupational Therapists Working in 'New Models' of Care**

**Occupational Therapist working within a General Practitioner network in the Republic of Ireland**

**Background:**

A senior Occupational Therapist is attached to West Cavan Primary Care Team which is based in a rural area of Ireland and has a high population of elderly residents. The other members of the core Primary Care Team consists of Public Health Nurse, Physiotherapist, Speech and Language Therapist and Clerical Administration. There are a number of GPs in the area who work collaboratively with the Primary Care Team. A Community Dietician and Social Worker are part of the Primary Care Team but also cover other areas/networks.

The Republic of Ireland carried out pilot studies for this model of service delivery before widespread dissemination in 2009. The role requires one occupational therapist to deal with a broad spectrum of skills, covering all age ranges and conditions. Initially limiting services physical areas, it became obvious that the

service needed to be extended to mental health and learning disabilities too. This is a different style of working and when the model was implemented, occupational therapists, due to their dual training, were quickly able to broaden their skill base and undertake more training in order to work with a greater broad spectrum of patients. Working with children, offering cognitive assessment and stroke rehab have all been new areas of practice for the experienced occupational therapist.

**Beneficial Outcomes**

Expansion of this new model of care would offer an excellent service for a greater number of patients who would now see AHP's (Allied Health Professionals) more locally via their GP surgery, reducing their overall travel time and increasing accessibility. Occupational Therapists working in Primary Care Teams have had an immediate effect in reducing waiting times and have allowed GPs to be able to refer patients directly and immediately. It is cost effective for the Health Service Executive and Occupational Therapists are now covering more and more roles. This type of role can assist the GP by offering prevention advice, assistance with public health issues such as obesity, smoking cessation, return to work, motivation, fatigue, and also traditional occupational therapy roles such as helping patients who are having difficult bending and reaching and experience functional problems such as dressing. It has taken the pressure from specialist services and means, for example, reducing children's waiting lists for specialist services.

**Potential problems in implementation of these models of care**

From the examples provided there are overarching issues that could be an obstacle to their implementation.

1) **Understanding**: The skills of an occupational therapist are wide ranging and often not well understood. This could lead to underutilisation. Occupational therapy is about supporting and empowering the client/patient to self-manage their situation. The focus is on what matters to the individual, whether this is getting back to work, being able to participate in community activities or being able safe from falls at home. This could lead to Primary Care not recognising the potential of the dual trained, (mental and physical health) workforce to meet the needs of the population.

2) **Awareness of access**: It is imperative that awareness of the beneficial role of Occupational Therapists is made clear and that people understand which services they can and should access and how.

3) **Integration:** Within a Primary Care setting there still remains artificial organisational barriers which bring a lack of co-ordination and integration and prevent seamless services for individuals.

4) **Investment in the workforce**: Due to the expansion of Occupational Therapists roles in any new or integrated models of care, investment in the skills of the workforce will be needed to ensure their breadth of skills match the required needs.

5) **Appropriate joint funding**: The significant budgetary pressures that Local Councils are facing, and will face after May 2015, means there may well be proposed reductions in care service provision. Occupational therapists offer excellent value for money for the services they provide, covering prevention, promoting health and wellbeing and supporting self-management, workforce reductions due to financial considerations, would mean their effectiveness for their clients would be significantly undermined in the long term.

# EE56 Chartered Society of Physiotherapy


| | |
|---|---|
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**Executive Summary**


When planning the primary care workforce of the future we need to have a clear picture in mind of a primary care sector that is responsive to patients' needs, reduces hospital admissions and social care needs, and support people to remain active and independent.

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. A transformation in primary care will not be achieved if workforce planning is premised on pre-existing models of workforce supply and service delivery.

To deliver this the NHS must create a new frontline of primary care professionals that makes full use of the talents at its disposal. Physiotherapists and physiotherapy support workers have the skills, knowledge and clinical autonomy to be a central component of this new NHS frontline, working in multi-disciplinary teams to keep people living well and independently. Greater use of physiotherapy workforce within primary care is a cost effective and clinically effective way to reduce the pressure on General Practitioners and deliver the whole-person care required of a modern primary care sector. It is currently an underutilised asset.


**Physiotherapists as first point of contact Practitioners**

There is strong evidence that Physiotherapists can be the first point of contact in primary care for patients with musculoskeletal disorders, providing a clear and effective alternative to GPs . We need to move away from a 'tunnel vision' view of General Practice to one , where patients are able to access as their first point of contact the most appropriate professional for their needs. As primary contact practitioners in surgeries physiotherapists assess, diagnose and, where needed, treat the 30 per cent of patients each year who visit

their GP with a musculoskeletal condition. There are already examples of GP services developing in this way. (see page 15)

Within primary care we need to use risk stratification tools to direct patients more effectively and efficiently to the treatment pathway that is right for them. (see page 12)

**Patient empowerment model**
We also must move away from the traditional medical model to one of patient empowerment and develop a culture and service delivery models in primary care to support this.

People with long-term conditions often develop an awareness and understanding of their condition that allows them to know when they need a clinical intervention.

For this growing group one of the biggest frustrations of the current system is that they feel they have to start from beginning each time. This is also the most inefficient way to provide health care. More services in primary care need to be provided on a self-referral basis, so that people can get them when they need them without having to go back to the GP first to seek a referral. The physiotherapy workforce already has extensive experience of delivering self-referral services that triage and prioritise patients. Many of these services have increased further their accessibility by using technology for virtual consultations. We need to learn from the success of these services and make this the norm for a range of conditions.
(See page 12)

Key to a patient empowerment approach is making full use of digital technology and a range of communication means for assessment and follow up advice and support. It also means having shared record-keeping systems between patients and health and social care professionals.

We need to develop our primary care services to integrate with voluntary activity in the community, building on the success of exercise and social prescriptions, and supporting people to lead active lives in the interests of their physical and mental health. The award winning Hope Specialist Service in North East Lincolnshire for people with COPD and older people at risk of falls is an example of an empowering model of service delivery involving patients and volunteers as key partners, reducing hospital admissions and saving money in the process. (See page 10)

**Fit for work**
Keeping people fit to remain in work and facilitating return to work needs to be a priority for primary care. Musculoskeletal (MSK) conditions are the biggest cause of absence from work in the UK, causing 27% of total days lost to sickness absence and account for 30% of GP appointments. Rapid access to occupational health services, including physiotherapy, gets people back to work quicker and reduces the risk of MSK conditions and stress as they become older. (See page 11 )

**Multi-disciplinary approach to prescribing**
Making the most of the skills and capacity we have in the community requires us to redesign primary care services to make full use of medicine prescribing rights by non-medics, including physiotherapists. It also means reducing the over reliance on medication through providing non-pharmaceutical interventions. (See page10)

**Sharing skills and expertise across professions**
We need to use the existing expertise in the health and care workforce to raise the standards of care across health and care professionals – for example physiotherapy staff can support other professions to enable patients to be mobile or use screening tools so support early intervention. (see page 16)

**Supporting physical activity**

Exercise and movement is the one of the cornerstones of physiotherapy practice. This set of skills need to be utilised to give older people and people with long term conditions the confidence to remain active and exercise. (See page 6)

**Physiotherapy education and professional development**
Pre-registration physiotherapy education is subject to robust regulation and quality assurance arrangements. With low attrition rates it represents value for money and an excellent return on investment.

There are already signs that it is becoming harder to recruit physiotherapists and this needs to be addressed as an imperative, with more training places made available. (See page 19)

Our future workforce is primarily made up of those already in the profession, so greater investment is needed to post qualification to enable the physiotherapy workforce to develop in primary care.

**Commissioning models that support integration and transformation**
Integration between primary and secondary care, between health and social care and between physical and mental health services is key to the transformation of primary care. The physiotherapy workforce is already playing a central role in this (see page 14). It is essential that commissioning models support this. There is currently a danger that there are instead undermining integration. (See page 17)

Introduction

With an increasing aging population, living with a greater number of long term conditions, and the requirement for people to remain in work for longer, there are significant challenges for the future in terms of planning a healthcare workforce which is fit for purpose. To be sustainable and fit for the future the health and care system needs to become more preventative, delivered closer to where people are and around their needs. This means transforming primary care.

Traditionally the physiotherapy workforce has predominantly delivered services in secondary care and been underused in primary care. So in order to optimise the contribution of this workforce, the NHS must create a new frontline of primary care professionals that patients are able to access as their first point of contact as the most appropriate professional for their needs.

1.0 Responding to Drivers for Future Primary Care Service Demand

1.1 Increasing Complex Needs

The age profile of the population, the prevalence of long-term conditions and medical and technological advances mean that patients will live longer and require greater access to services as a result of increasingly complex needs. Patients with multi-morbidity account for eight in ten primary care consultations.[(1)] Physiotherapists in the primary care setting offers a holistic approach based on high level diagnostic skill and treatment predicated on non-pharmacological modalities. Thus physiotherapy can help avoid the risks and costs associated with polypharmacy including; adverse drug reactions, falls, poor treatment compliance, and medication errors.[(2)]

Pre-registration physiotherapy education prepares physiotherapists for working with patients with complex needs. Physiotherapy students learn how to work with and enable people with long term conditions (LTCs) within academic and a wide range of practice settings. The knowledge and skills required to support patients with LTCs is further developed throughout professional practice, meaning that the profession is excellently placed to meet the increasingly complex demands of the population.

1.2 Growing and aging population

The number of people over 85 in the UK is predicted to double in the next 20 years and nearly treble in the next 30.[(3)] Physiotherapy can improve people quality of life, help to prevent hospital admissions, reduce bed days and individuals' dependence on complex care packages, and decrease the need for residential home placements.

Physiotherapists recognise that this increasing demand on health and social care services is unsustainable in the current financial climate. The profession's high adaptability and skill in responding to changing patient and population needs has already resulted in service re-design and new ways of working. One example includes collaborative working across three health trusts in a region to improve services for older people and specifically ease pressure on A&E department. The physiotherapy-led service operates seven days a week, 12 hours per day. The service saw 1,015 patients and identified that 584 could be treated at home, rather than needing to be admitted to hospital. This created a saving of £1.6million in 6 months.

An increasingly frail elderly population means that each year, 35 per cent of over-65s experience one or more falls. Based on 2009/10 costs, each hip fracture avoided saves approximately £10,170. Physiotherapy-led falls prevention services increase an individual's confidence to reduce the number of falls and fractures, improve outcomes, keep people living independently and reduce hospital admissions and GP appointments.[(4)]

1.3 Increasing patient and public expectations of healthcare

Patient and public expectations continue to rise. The exponential increase in availability of healthcare information, particularly through the internet, has meant patients pose questions to healthcare professionals, rather than always being supplicants for information. Patients expect to be offered choice and broad access to services like other service industries. In line with the CSP's quality assurance standards physiotherapists must ensure that; "***Service users are respected as individuals and placed at the centre of service planning and physiotherapy management".***[(5)] **Thus, shared decision making with service users is a key and well established part of physiotherapists practice.**

Patients and carers can expect physiotherapy communications to be professional, caring, compassionate and person-centred as this is core to practice. Physiotherapists provide information to service users in a variety of formats. For example, a patient-owned folder of information about treatment and self-management is helping to improve the services of a community neuro-rehabilitation team[(6)] and expectant mothers can access a video explaining the benefits of physiotherapy for pelvic floor muscle problems.[(7)]

The physiotherapy profession has been proactive in broadening patient's access to appropriate assessment and treatment. It is possible for patients to self-refer for physiotherapy and also to access support and advice by phone.[(8)] A breadth of developments such as flexible service hours and seven-day service operation are embedded within physiotherapy to ensure a focus on the requirements of service users. Close attention and responsiveness to user feedback is integral to physiotherapy care. The profession is fully engaged with the importance of delivering services that engage people effectively in decisions about their care and ensure they have the information required to make the choices that work for them.[(9)]

1.4 Public Health

Although smoking as a risk factor has decreased in recent years, new ones have emerged, most notably obesity. 24.4% of adult men and 25.1% of adult women in England are obese[(10)] and this is predicted to increase to 60% and 50% respectively by 2050.[(11)] If these trends are not reversed there will be substantial increases in the number of people diagnosed with associated LTCs.

Physiotherapy in a primary care setting would be ideally placed to prevent and manage obesity. Obesity leads to restriction in movement, affecting engagement in physical activity. Exercise and movement is the cornerstone of physiotherapy practice.[(12)] Along with a holistic, patient centred, and problem solving approach, physiotherapists have advanced knowledge and skills in:

anatomical, physiological, and psychosocial mechanisms of health and disease

assessment and diagnosis

behaviour change

biomechanics

exercise prescription and therapeutic exercise

management of long-term conditions.

Physiotherapists are therefore ideally suited to address the physical and psychological complexities of obesity.[(13)] While the importance of being physically active is well recognised, in reality patients often

experience difficulties in doing so. An assessment and treatment plan from a physiotherapist will help overcome the barriers to exercise.

Physiotherapists in a general practice role would be well placed to respond to the rising risks and demands of obesity. The existence of the registered list of patients and the knowledge of these patients presents a unique opportunity for illness prevention.[14] This is an area physiotherapists could comfortably lead forward using the knowledge and skill previously detailed.

2.0 Challenges for Future Primary Care Workforce Supply

The Royal College of General Practitioners (RCGP) estimates that patients have had to wait a week or more on 67million occasions in 2015.[15] This presents a sharp increase on 62.4million in 2014 making it a fourth year running of significant increase. Data from the NHS England GP Patient survey reveals an increase from 9 to 11% of people who have failed to get an appointment. Both these figures suggest growth in unmet need. Compounding the above is the rise in the number of practicing GPs who plan to leave the profession.[16]

The Physiotherapy workforce is one which could rapidly respond to this increasing demand, as is already has the knowledge, skill and diagnostic expertise to work in this environment. Physiotherapists have particular skills and make particular contributions in the areas identified on the following page.

| Skills | Service contribution |
|---|---|
| Assessment, diagnosis and problem-solving | First-contact practitioners, including enabling patient self-referral, leading triage services and integrating independent prescribing into their care of patients (subject to post-registration development/HCPC annotation) |
| Care planning, implementation and evaluation | Lead and implement integrated care pathways as part of multi-disciplinary/cross-sector team-working |
| Communication, education, behaviour management and partnership-working | Support individuals to manage and take responsibility for their own health and to promote healthy living and illness prevention |
| Rehabilitation and enablement | Meet individuals' needs relating to complex, long-term and chronic conditions and lead 'fit for work' initiatives relating to key health care priorities |
| Physical approaches to care | Enable individuals to optimise their functional ability, health and well-being and quality of life. Build individuals confidence in participating and sustaining higher levels of physical activity and fitness |

3.0 Physiotherapy – quality assured and value for money

3.1 Pre-registration education

Pre-registration physiotherapy education in England (as well as the rest of the UK) is subject to robust regulation and quality assurance and enhancement arrangements. Processes ensure that programmes are measured and kept under review against high standards set by the HCPC, CSP, QAA and host higher education institution. The CSP asserts its expectations of UK qualifying physiotherapy programmes through its Learning & Development Principles and accreditation processes. The L&D Principles help programme providers develop

learning and teaching opportunities that prepare physiotherapy students for changes in population and patient needs, role and service delivery reconfigurations, and an increasing plurality of providers within health and social care and public health and therefore career development opportunities.

*3.2 Value for money*

Pre-registration physiotherapy programmes in England represents value for money and an excellent return on investment. Attritions rates form physiotherapy programmes are extremely low - currently at 2.8% across the UK. This is comparable to a 16% attrition rate average across all university courses.[17] There is also a very high translation of physiotherapy graduates into members of the health care professions workforce. This is across an increasing plurality of service providers, but with the majority of physiotherapists continuing to work within the NHS and NHS-funded services.

| | **Pre-registration training** | | | **Post grad training** | **Totals** |
|---|---|---|---|---|---|
| | Tuition | Living expenses/ lost production costs | Clinical placement | Tuition and replacement cost | Total investment |
| **Physiotherapist** | £25,454 | £37,418 | £4,603 | £44,991* | £112,446 |
| **Nurse** | £24,111 | £49,890 | £4,603 | £42,021** | £120,625 |
| **GP** | £42,964 | £59,287 | £129,415 | £247,455 | £479,121*** |
| **Consultant** | £42,964 | £59,287 | £129,415 | £493,026 | £724,692*** |

* *Physiotherapist post graduate training calculated by:*
Full time MSc = £9,280 (Nottingham advanced practice MSc Leading to an advanced clinical practitioner post)
Backfill for post = 29,759 (mid-point band 6)
On costs = 5952 (20% for pensions/sickness/training etc)
TOTAL = **44991**
** *Nursing post graduate training calculated by:*
Full time MSc = £6,310 (Nottingham Advanced Nursing MSc)
Backfill for post = £29,759 (mid-point band 6)
On costs = £5952 (20% for pensions/sickness etc)
TOTAL= **£42,021**
*** *GP and Consultant calculations & other figures taken taken from:*
Unit Costs of Health and Social Care 2012, PSSRU, University of Kent

3.3 Post-registration education

Physiotherapists qualify as autonomous practitioners; investment is still needed, In line with the King's Fund *Time to Think Differently* initiative[19], to ensure support is provided to enable the physiotherapy workforce to continue to develop in primary care. Our future workforce will primarily comprise of those already working with in the profession. Sufficient financial support is therefore required to ensure that the workforce remain sufficiently skilled, particularly in the complex multi-specialist area of primary care.

In tight financial times it is essential patients see the right professional at the right time. For example it is less expensive for an advanced physiotherapist in the Locomotor service in Homerton to provide an ultrasound guided steroid injection and two follow up appointments than it is for a GP to provide one blind injection without ultrasound guidance. Not only is this more cost effective, being ultrasound guided increases accuracy

and avoids the need for repeat injections based on a suspicion that the original injection was not in the correct place. To enable this kind of efficiency of service the correct support for post graduate training is essential. A typical cost for injection therapy training is £840. When considering the above efficiency savings which could be realised over a long period this presents a sound investment.

Independent Prescribing

Costing on average £1250, independent prescribing courses offer excellent value for money considering the impact the knowledge and skills gained could have on patient care. Physiotherapists being able to prescribe at the point of patient need avoids additional doctors time being spent. Patients quickly get the treatment they need without having to be reassessed by a doctor resulting in a streamlined service. Equipping physiotherapists with this skill in a first point of contact primary care setting could ensure time isn't wasted on having patients return for prescriptions from their GP. To enable this, support is needed to allow physiotherapists to access appropriate training, continued professional development and supervision.

Having been able to independently prescribe since 2014, the first large scale evaluation of physiotherapy and podiatry independent prescribing is currently underway at the University of Surrey. For more information on the project please visit:
http://www.surrey.ac.uk/fhms/research/healthcarepractice/evaluation_of_physiotherapy.htm

4.0 Current quality primary care services – examples of excellence

4.1 Long term conditions

An estimated 18.1 million people in the UK have at least one long-term condition. The UK currently spends £19 billion on people with three or more long-term conditions. This is projected to rise to £26 billion by 2016. Physiotherapy reduces these costs through prevention, early intervention and rehabilitation and at £34 per session, provides excellent value for money. [20-22]

The Hope Specialist Service in North East Lincolnshire is an award-winning integrated primary care based one stop shop service for people with COPD and older people at risk of falls. In 2005 a local primary care survey found that COPD services in the area lacked integration and importantly lacked capacity. This allied with a significantly high incidence of COPD highlighted by the Lincolnshire Public Health Report meant that change was needed. With input from local patients a specialist physiotherapy led initiative was developed – The Hope Service.

Fundamental to the services success was the introduction of Pulmonary Rehab Buddies. These are expert patients, whose role is to motivate and encourage patients, provide peer/emotional support and help in the running of the programme. In combination with specialist physiotherapists, nurses and physiotherapy assistants, an atmosphere was created where patients felt free to express their concerns and their ideas for improvement. The programme continues to show dramatic life changing outcomes for patients, in both their physical capabilities and quality of life. Furthermore it has been found that the programme saves on average one hospital admission per patient, resulting in an average saving of more than £2600 per patient.

The innovative Bradford teaching hospitals NHS Foundation Trust Early Supported Discharge (ESD) pathway helps people regain their independence and function following hip fracture or other orthopaedic problems. The ESD team of physiotherapists, OT's and therapy assistants provide a direct link between acute and community services, delivering intensive post discharge rehabilitation immediately patients return home. The team undertakes home visits twice a day for an average of 5 days focusing on setting individual goals to

promote independence and optimise recovery. Liaison with other agencies helps ensure people receive the help they need to return to their normal lifestyle.

Between 2011 -2013 the service saved the Trust a total of 2,698 orthopaedic bed days equating to an estimated cost savings of more than £600,000. Readmission rates fell from 10-12% to 5-6%. Other outcomes included a reduction in falls risk and standard measures evidenced clinical improvements of between 25-50%.[23]

These examples show how physiotherapists can lead change in the primary care setting whilst integrating with other professions, build confidence in patients to better self manage and support and develop volunteers.

4.2 Working age population

Occupational Health

Keeping people fit to remain in work and facilitating return to work is a priority. Musculoskeletal (MSK) conditions are the biggest cause of absence from work in the UK, causing 27% of total days lost to sickness absence.[24] Rapid access to occupational health services, including physiotherapy, gets people back to work more quickly and reduces the risk of MSK conditions and stress as they become older. York Teaching Hospital Foundation Trust was losing 5.5% of total working time due to sickness absence. This amounted to an annual cost of £3.7 million. The Trust started a project in 2008 to tackle this. By 2011 the Trust had invested £160,000 in a multidisciplinary team (MDT) including occupational health physiotherapists. This team worked in partnership with hospital managers and trade unions to help sick or injured employees return to work. By January 2011 absence rates were down to 3.8% and by November 2011 had reduced further to 3%. Long term absence has fallen by 72% for those off for four weeks or longer and 77% for those absent for three months.

Measured on a full-time equivalent basis there are now 54 more staff available to work with direct savings in pay costs of almost £1.2 million per year from a reduced need for bank and agency staff.

The above is a good example where physiotherapists are already the first point of contact for patients. With an increase in the physiotherapy workforce capacity, primary care based physiotherapy interventions such as the above could be more widely adopted. If more widely adopted this could have a significant impact on the burden to GPs.

Self-referral

The Quality, Innovation, Productivity and Prevention (QIPP) process in England has endorsed self-referral for MSDs to allow easier access to treatment. It has been shown to not increase demand for physiotherapy in the long term and also reduces patient related costs; such as prescribing, X-rays, MRI and more expensive medical consultations. Holdsworth et al demonstrated that in Scotland, an episode of GP prompted self referral costs 10% less and full patient self referral costs 25% less than traditional GP referral for physiotherapy, resulting in savings of £25,207 per 100,00 population.[25] The English pilot showed 41% of referrals came from the traditional GP route, 35.4% came from prompted self referral and 23.6% were full self referral. This shows the potential for greater cost savings for three quarters of patients with MSDs if full self referral were properly promoted.[26]

Risk Stratification

Within the UK each year, up to 9% of adults see their GP about back pain. Some patients have a simple ache which will correct itself whilst others will have a long standing pain. The evolution of 'risk stratification', where patients are screened to identify the risks which may affect their treatment outcome, allows patients to be directed to the treatment pathway that is right for them rather than applying a one size fits all 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 a £34.39 saving per patient was shown when comparing the STarT Back intervention group with those who received usual care.[27]

The STarT Back method asks patients to fill out a questionnaire with the GP or physiotherapist. This identifies 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.[27]

Accident and emergency

In 2012-13, 18.3million people attended A&E units; 43% were under 30 years old, 24% were aged 60 or over, 21% were admitted to hospital and almost 21% attended for joint, muscle, tendon, ligament and soft tissue injuries.[28]

Physiotherapists work either as frontline emergency physiotherapy practitioners (EPP) or as part of the multidisciplinary therapy team in A&E and medical admission units (MAU) to reduce delays and inefficiencies, prevent unnecessary admissions and enable timely discharge of patients to home or community settings.

EPP's see patients with, mainly, musculoskeletal (MSK) problems independently of medical staff, undertaking activities including expert assessment, requesting and interpreting investigations, managing wounds, soft tissue injuries and fractures, providing advice and treatment freeing doctors up to manage more complex conditions and improving patient flow.[29, 30] Physiotherapists managing MSK injuries have equivalent clinical outcomes and lower direct costs than doctors or emergency nurse practitioners.[31-33]

Salford Royal NHS Foundation Trust treats 88,500 Accident and Emergency patients per year. An advanced physiotherapy practitioner post was established in 2010 for people attending A&E with musculoskeletal injuries. 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 members of the multi-disciplinary team.[1]

Through stronger support of post-graduate training and career development these advanced roles could be expanded across primary care. If the service model demonstrated above were widely adopted this could be a huge saving for the NHS and a significant improvement in the quality of patient care, including decreased waiting times for accident and emergency primary care.

4.3 Frail and Elderly

Costing the NHS over £4.6 million each day (= £1.7 billion per year), falls in later life represent a major burden on the health and social care systems.[34] Prevention is better than cure. Physiotherapy led Falls prevention programmes are proven to prevent falls, reduce hospital admissions and restore independence. NICE guidance

requires all older people with recurrent falls, or at increased risk of falling, to be considered for an individualised intervention including evidence based strength and balance training.

The Westminster Falls Service ran in the community by a team of physiotherapists' 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 published a falls prevention economic model[35] 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 in the community for older people could lead to 187,462 fewer falls resulting in £274,998,720 cost savings.

4.4 Mental Health

750,000 people in the UK live with dementia. Two thirds live in their own homes & one-third in care homes.[36] Thus this presents a considerable challenge for primary care. Physiotherapists, as autonomous practitioners, can undertake detailed, individually tailored assessments of the impairments, activity restrictions and participatory limitations faced by people with dementia.

Physiotherapists work as part of a multi-disciplinary team ensuring the delivery of high quality, effective care, in line with the NICE Quality Standards for people with dementia.[37]

This standard advocates provision of assessment and ongoing personalised care plans, addressing individual needs. NICE[38] and SIGN [39] guidelines recommend physiotherapy for promoting and maintaining independence for this client group. As well as treating this client group in the community and therefore essentially in primary care; physiotherapists acting as first point of contact practitioners would be well placed to identify the needs of this patient group.

4.5 Integrators of care

Physiotherapy staff work across sectors and have a long experience of working in multi disciplinary teams, building strong working relationships with other professionals. The review of the Primary Care workforce needs to be informed by the experiences of integrated health and care services.

The Integration Pioneers contain many useful models for delivery of primary care services in the future. For example:

In Greenwich, multi disciplinary teams based around a hub of GP practices respond to emergencies within the community and in care homes. The teams include physiotherapists, occupational therapists and social workers.

In Southend on Sea there are community level multi-disciplinary teams that span across primary, community and social care and include GPs, physiotherapists, district nurses and community matrons. The model provides

one route of access for all unplanned care and specialist teams in the community to prevent A&E admissions and support early discharge.

In Worcestershire the Well Connected Programme includes a clustering of services around GP hubs, and includes virtual wards with multi disciplinary team case management for older people, facilitative discharge to provide intensive packages of care and rehabilitation to support the return home. The programme focuses on provision of services in the community for people with long term conditions, including tele-health to support self-management and a defined role for the voluntary sector.

The Locomotor pain service in Homerton is another fantastic example of how integrated services using the expertise of multiple professions can have a real impact on patient outcome. The service integrates psychologists, physiotherapists including extended scope practitioners with independent prescribing rights and sonography qualifications, pain consultants, pain nurse and occupational therapists. The success of the service has resulted in a number of benefits including; reduced GP appointments, decreased need for MRI referral, and decreased reliance on spinal injections. These all have significant associated cost savings. Patient satisfaction and outcomes have also been outstanding.

### 4.6 Further information

For further evidenced based briefings on how physiotherapy can help a multitude of patient populations please visit: http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/physiotherapy-works

## 5.0 New approaches to using traditional skills

### 5.1 First point of contact practitioners

It is estimated that 30% of all general practitioner consultations are for musculoskeletal (MSK) conditions.[40] They are also the most common reason for repeat appointments in primary care.[24] With an aging population[3] and rising public expectations; the demand for musculoskeletal services in primary is set to significantly increase. These statistics coupled with the evident shortfall in the general practitioner workforce presents a real challenge to providing care for the population and an opportunity to do things differently.[41]

Physiotherapists have the ability to provide a first point of contact service to patients in the primary care setting easing the burden on GPs and providing a solution to growing demand for MSK services. One NHS vanguard site in West Wakefield is doing just that for MSK patients. Up-skilled reception staff use a set criteria to select appropriate patients for the service. Therapists have 15 minute appointments to assess, advise and signpost. Procedures are in place to ensure that investigations, medication or referrals required do not create unnecessary follow-up appointments with GPs. Patient feedback has been excellent with high satisfaction and low rates of return to the GP. With the appropriate post-graduate training these physiotherapists could take further responsibility by independently prescribing and ordering further investigations. This is an area where HEE could provide greater support.

A similar first point of contact service has developed in Nottingham. The service which initially started in 2 GP practices was quickly expanded across 26 practices due to its early success. In addition to having high patient satisfaction the service is proving cost effective by saving more costly GP time.

Physiotherapists are specifically trained, skilled and knowledgeable in the management of MSK conditions. The interventions physiotherapists provide align neatly with best evidence guidelines for the care of MSK conditions including exercise programmes, manual therapy and acupuncture.[42] Physiotherapists have also

proven themselves to be effective in triaging and providing appropriate onward referral, particularly in the orthopaedic setting.[43] Research has also shown health professionals such as physiotherapists are equally as able to identify serious pathology as general practitioners.[44]

As well as providing a safe and effective service, self-referral to physiotherapy has significant opportunity for cost savings. As previously mentioned in this document, physiotherapists have been early adopters of stratified care for patients with low back pain. Not only has this been shown to be more cost effective, it is also more effective for patient outcomes. There are greater economic savings are also to be had by having physiotherapists as first point of contact practitioners. This is backed by research which shows early access to physiotherapy reduces time patients are off sick and prevents acute problems becoming chronic.[45]

*Leading care pathways*

Working with nine GP surgeries and a total patient list of over 77,000, Connect, an independent NHS provider of MSK healthcare has led an innovative reform of their local MSK services in Newcastle. A community MSK Clinical Assessment and Treatment Service (CATs) was developed. General practitioners referred all MSK patients to the community service, leaving the decision to access secondary care to the MSK CAT service. With new physiotherapy services sited in numerous GP practices to improve access and reduce wait times, every referral was coordinated via a specialised 'call referral management' centre. This resulted in patients being dealt with promptly and efficiently.

Telephone triage was introduced so patients could receive immediate guidance from the comfort of their own home. In six months of operation the service had saved the NHS £42,000 whilst also improving patient satisfaction with 96% of patients rating the care they received as "excellent" or "very good". The service also had widespread GP support with 97% of GP's rating the reformed service as "better" or "much better".

If physiotherapists were the first point of contact in the above scenario the patient pathway could be even further streamlined. Resultantly, patient satisfaction would likely improve secondary to having a single point of access as well as greater continuity of care. Furthermore, it is likely further cost savings would be attained by avoiding the use of costly GP time.

5.2 Educators and enablers of others in delivering care

Core skills of physiotherapists are being able to support patients in self-managing their condition through education and facilitate behavioural change to optimise their health and well-being. Commonly people worry if they're doing the right thing in the context of their condition. Physiotherapists are skilled at helping people to develop the confidence needed to safely engage in physical activity. Within primary care settings, the profession could make a strengthened and considerable contribution to promoting and supporting the health and well-being of local populations through enabling them to be more active.[46]

As experts in movement, including manual handling, physiotherapists have an increasingly important role to play in supporting carers and the invaluable role that they play in patient care. There are already twice as many unpaid carers—nearly 6.4 million—as there are paid staff in the health and social care systems combined.[47] One physiotherapy service in Leeds noticed that residents in a local care home were not able to mobilise or sit comfortably due to the care staff not being confident in manual handling. A training programme was therefore developed; physiotherapists taught the healthcare assistants appropriate ways of moving and handling, thus enabling ongoing care and better quality of life for the residents. This type of programme has

significant scope to expand across primary care. The Stoke Association noticed this opportunity and has approached the service to discuss using the programme.

Physiotherapists are also excellently placed to educate their healthcare professional colleagues. Progressing risk stratification approaches to ensure patients receive the right care is given at the right time, and that staff and other resources are most appropriately deployed to meet specific needs, is one example where physiotherapists have worked with GPs to adopt innovative practice. Physiotherapists commonly support nurses to ensure ongoing care for patients is optimised. Furthermore, physiotherapists educate and work alongside unregistered physiotherapy assistants. Assistants are an invaluable resource. When supported, including through appraisal and structured opportunities for learning and development, they can vastly improve the timeliness, access and sustainability of care and therefore the quality of patients' experience and outcomes. [48]

## 6.0 Barriers to implementation of new models of care

### 6.1 Commissioning Models

Commissioning models such as Any Qualified Provider, Prime Provider and Alliance Contracts have recently come to the fore in an attempt to drive more transformational service integration. The CSP is concerned these models, which use multiple providers, in fact risk working against the shared aim of better integration across healthcare. 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.

The Any Qualified Provider (AQP) model of commissioning is one such example where service development has been limited by the commissioning model. In Cornwall, an MSK self-referral pathway under AQP was stopped due to fears of increasing cost. If the CCG had understood the demand on the service before introducing AQP, this may have identified the latent need within the local community and enabled planning for subsequent rise in demand for physiotherapy. Research shows that patients do refer themselves appropriately. By stopping the self-referral service GPs would have had to pick up those patients who would have originally gone through a more cost-effective and efficient self-referral route.

### 6.2 Workforce Development

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

It is also essential 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, rather than there being a narrow focus on particular parts of the workforce that have traditionally practised in these settings. The real benefits of strengthened inter-professional team working and stronger collaboration within and across sectors and services need to be achieved to ensure that the care that patients can access and achieve is thoroughly integrated and sensitive to their individual needs.[49]

We see the physiotherapy workforce as being excellently placed to engage in and contribute to workforce transformation to strengthen primary care. However, 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:

A more supportive structure for post-registration/postgraduate education and development for AHPs that aligns with changing job roles and optimising the professions' potential; we would see the proposals recently published by HEE and the Nursing & Midwifery Council for developing an infrastructure for career development for nurses as providing a valuable model for a broader range of professions.[50]

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)

As part of the above, we see robust models for peer review and supported professional development and leadership (within and across professions and in ways that can foster genuine collaboration within multi-disciplinary teams) as being central to creating a sustainable, affordable model for the primary care workforce and that optimises the contributions of each profession and occupational group

Related to the all above, we see it as essential that the workforce, across the professions and including physiotherapy, is supported in making shifts from practice from one setting and service design to another (including from acute to primary care settings and from 5- to 7-day service delivery models), including so that the development and implementation of their knowledge and skills can be optimised and the needs of patients can most effectively be met

Again, we see it as essential that attention is given to developing supported opportunities for individuals across the workforce to return to practice after a career break (as is now being done within nursing and for GPs) - as recognised for these other professions, this is a key way in which the expertise and experience held by individual practitioners can be tapped into to meet patient need and for them not to be lost as a valuable component of workforce supply (we are keen to explore with HEE how such an initiative could be progressed, including in ways that ensure appropriate economies of scale to make delivery of return to practice schemes (in line with HCPC requirements) feasible

We are concerned that the Talent for Care strategy is implemented in ways that are genuinely inclusive of all parts of the support worker workforce (including those who work with the AHPs), such that learning and development opportunities available to individuals align with and support changing job roles and optimise how care can be delivered in accessible, timely ways (including in ways that facilitate patients' increased access to care in primary care settings)[48]

We are likewise concerned that our members have strengthened access to support for research-related and service evaluation activity, including in line with the HEE strategies on research and innovation and library and information services. Ensuring that all members of primary care teams have access to information and research resources and opportunities (including those relating to research collaborations and standardised data collection) are essential for developing and using the evidence base to underpin continuous improvement in service delivery and design.[48]

6.3 Workforce Capacity

The physiotherapy workforce is showing signs of entering shortfall. Managers are reporting increasing difficulty in recruiting physiotherapists. The CSP's manager survey completed in March 2015 demonstrated that of 167 responses from England 46% reported severe difficulty in recruiting band 6 physiotherapists and

39% reported moderate difficulty. Similarly, 71% of managers reported moderate or severe difficulty in recruiting experienced band 5 physiotherapists. In addition graduate employment rates have significantly increased. This indicates that there is high demand for newly-qualified staff, with supply not keeping pace with demand (figure 1).

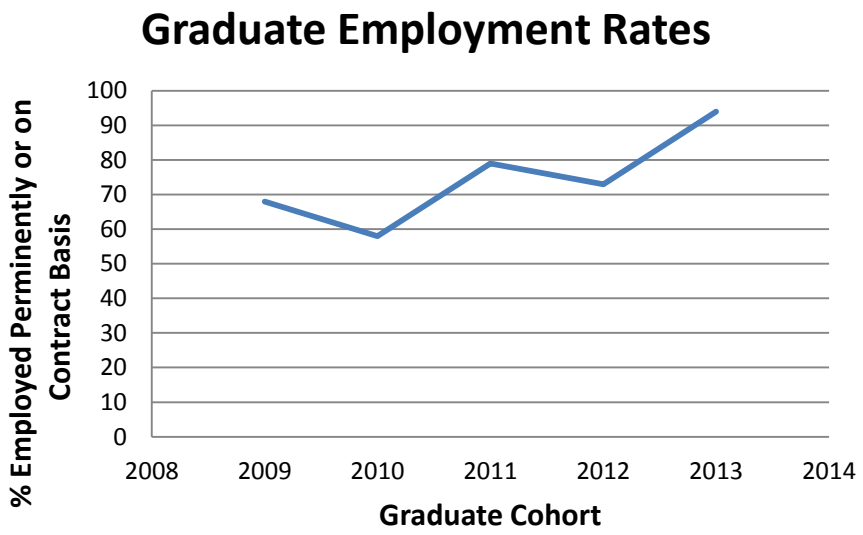


*Figure 1. (Based on the CSP's annual graduate survey)*

In line with our previous submissions to HEE and our on-going work to develop a workforce data modelling tool, we are concerned that physiotherapy workforce supply is fully predicated on projections of areas of changing and increased patient need. This is essential for ensuring that the full potential for meeting needs in clinically- and cost-effective ways is achieved, that the risk of under-supply of the workforce is averted, and that workforce transformation can genuinely be achieved.

As indicated above, additional ways in which workforce supply could be bolstered would be to provide 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. Again, we would see replicating the models that are being implemented for the nursing and GP workforces as key for maximising workforce support, including through enabling those with high-level knowledge, skills and experience to return to the workforce and meet service/patient need.

6.4 Optimising service delivery models, including through multi-specialty community providers

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 AHPs can contribute to primary care in significant, clinically- and cost-effective ways[(49)]. 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 to 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).

A further potential barrier to implementation of a physiotherapy primary care workforce could be if investment is heavily placed into new unregulated professions such as physician associates. We would consider investment would be better placed in developing the physiotherapy workforce. As an autonomous profession that is regulated and able to independently prescribe, physiotherapists are excellently placed to take on stronger roles in leading and managing whole packages of patient care, as outlined in this submission.

References

1. Salisbury C, Johnson L, Purdy S, et al. Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study. 61. 2011:e12–21 URL: http://bjgp.org/content/61/582/e12

2. Mannucci PM, Nobili A. Multimorbidity and polypharmacy in the elderly: lessons from REPOSI. Intern Emerg Med. 2014;9(7):723-34.

3. Office for National Statistics. National population projections, 2012-based. London: Office for National Statistics; 2013.URL: http://www.ons.gov.uk/ons/rel/npp/national-population-projections/2012-based-projections/stb-2012-based-npp-principal-and-key-variants.html

4. Department of Health. Payment by results guidance for 2010-11. London: Department of Health; 2010. URL: http://webarchive.nationalarchives.gov.uk/+/dh.gov.uk/en/managingyourorganisation/financeandplanning/nhsfinancialreforms/index.htm

5. The Chartered Society of Physiotherapy. Quality Assurance Standards. London: The Chartered Society of Physiotherapy; 2014. URL: http://www.csp.org.uk/professional-union/professionalism/csp-expectations-members/quality-assurance-standards

6. Hitchcock G. Rehab team recommends patient-owned treatment. Frontline. 2014;20(9):15.

7. The Chartered Society of Physiotherapy. Personal training for your pelvic floor. London: The Chartered Society of Physiotherapy; 2014. URL: http://www.csp.org.uk/publications/pelvic-floor-muscles

8. Salisbury C, Montgomery AA, Hollinghurst S, et al. Effectiveness of PhysioDirect telephone assessment and advice services for patients with musculoskeletal problems: pragmatic randomised controlled trial. BMJ. 2013;349:f43. URL: http://www.bmj.com/content/346/bmj.f43

9. Centre for Workforce Intelligence. Big picture challenges. London: Centre for Workforce Intelligence; 2013. URL: http://www.cfwi.org.uk/publications/big-picture-challenges-the-context-1

10. Health and Social Care Information Centre. Statistics on Obesity, Physical Activity and Diet: England 2014. Leeds: Health and Social Care Information Centre; 2014 URL: http://www.hscic.gov.uk/catalogue/PUB13648

11. Butland B, Jebb S, Kopelman P, et al. Tackling obesities: future choices – project report. 2nd. London: Government Office for Science; 2007.URL: https://www.gov.uk/government/publications/reducing-obesity-future-choices

12. The Chartered Society of Physiotherapy. Scope of practice. London: The Chartered Society of Physiotherapy. 2014. URL: http://www.csp.org.uk/professional-union/professionalism/csps-approach-professionalism/scope-practice-staff-only/introduct

13. Canadian Physiotherapy Association. Physiotherapists and the management of obesity. Ontario: Canadian Physiotherapy Association; 2007.

14. King's Fund. Commissioning and funding general practice: making the case for family care networks. London: King's Fund. URL: http://www.kingsfund.org.uk/publications/commissioning-and-funding-general-practice

15. Royal College of General Practitioners. New league table reveals GP shortages across England, as patients set to wait week or more to see family doctor on 67m occasions. London: Royal College of General Practitioners. 2015. URL: http://www.rcgp.org.uk/news/2015/february/new-league-table-reveals-gp-shortages-across-england.aspx

16.Hann M, McDonald J, Checkland K, et al. Seventh National GP Worklife Survey. Manchester: The University of Manchester; 2013. URL: http://www.population-health.manchester.ac.uk/healtheconomics/research/reports/FinalReportofthe7thNationalGPWorklifeSurvey.pdf

17. Schnepf SV. Do tertiary dropout students really not succeed in European labour markets? Bonn: The Institute for the Study of Labor 2014. URL: http://eprints.soton.ac.uk/363323/1/__soton.ac.uk_ude_PersonalFiles_Users_svs_mydocuments_WrittenPapers_PIAAC%20papers_University%20drop%20out_dp8015.pdf

18. Curtis L. Unit Costs of Health and Social Care 2012. Canterbury: University of Kent. URL: http://www.pssru.ac.uk/project-pages/unit-costs/2012/

19. King's Fund. Time to think differently. London: King's Fund. URL: http://www.kingsfund.org.uk/time-to-think-differently

20. Department of Health. Long term conditions compendium of information. 3rd. Leeds: Department of Health; 2012. URL: https://www.gov.uk/government/news/third-edition-of-long-term-conditions-compendium-published

21. National Public Health Service for Wales. A profile of longterm and chronic conditions in Wales. Cardiff: National Public Health Service for Wales;; 2005.

22. Northern Ireland Executive. Census 2011: key statistics Belfast: Northern Ireland Executive; 2012. URL: http://www.northernireland.gov.uk/news-dfp-111212-census-2011-key

23. Millett R. Home goal: The award-winning physio team at bradford royal infirmary. Frontline 2014. URL: http://www.csp.org.uk/frontline/article/home-goal

24. Department of Health. The musculoskeletal services framework. London: Department of Health; 2006.URL: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4138413

25. Holdsworth LK, Webster VS, McFadyen AK. What are the costs to NHS Scotland of self-referral to physiotherapy? Results of a national trial. Physiotherapy.93(1):3-11. URL: http://www.physiotherapyjournal.com/article/S0031-9406(06)00081-2/abstract

26. The Chartered Society of Physiotherapy. Musculoskeletal physiotherapy: patient self-referral. Leeds: QIPP; 2012. URL: http://www.csp.org.uk/documents/musculoskeletal-physiotherapy-patient-self-referral-qipp-endorsed-pathway

27. Keele University. STarT Back Screening Tool. Keele: Keele University. URL: http://www.keele.ac.uk/sbst/startbacktool/usingandscoring/

28. Health and Social Care Information Centre. Accident and Emergency Attendances in England 2012-13. 2014. URL: http://www.hscic.gov.uk/catalogue/PUB13464

29. Advanced practitioner: Accident & Emergency (A&E) and physiotherapy. Case study. URL: http://www.nwwmhub.nhs.uk/media/142869/adp-009-musculoskeletal-emergency-department.pdf

30. Anaf S, Sheppard LA. Describing physiotherapy interventions in an emergency department setting: an observational pilot study. Accid Emerg Nurs. 2007;15(1):34-9.

31. McClellan CM, Cramp F, Powell J, et al. A randomised trial comparing the clinical effectiveness of different emergency department healthcare professionals in soft tissue injury management. BMJ Open. 2012;2(6) URL: http://bmjopen.bmj.com/content/2/6/e001092.abstract

32. McClellan CM, Cramp F, Powell J, et al. A randomised trial comparing the cost effectiveness of different emergency department healthcare professionals in soft tissue injury management. BMJ Open. 2013;3(1) URL: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3549250/

33. Richardson B, Shepstone L, Poland F, et al. Randomised controlled trial and cost consequences study comparing initial physiotherapy assessment and management with routine practice for selected patients in an accident and emergency department of an acute hospital. Emerg Med J. 2005;22(2):87-92. URL: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1726666/pdf/v022p00087.pdf

34. National Institute for Health and Care Excellence. Falls: assessment and prevention of falls in older people. London: National Institute for Health and Care Excellence; 2013 URL: https://www.nice.org.uk/guidance/cg161

35. The Chartered Society of Physiotherapy. Cost of falls. London: The Chartered Society of Physiotherapy; 2014. URL: http://www.csp.org.uk/professional-union/practice/your-business/evidence-base/cost-falls

36. Department of Health. Living well with dementia. A National Dementia Strategy. Leeds: Department of Health; 2009. URL: https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy

37. National Institute for Health and Care Excellence. Dementia quality standard. London: National Institute for Health and Care Excellence; 2010. URL: https://www.nice.org.uk/guidance/qs1

38.National Institute for Health and Care Excellence. Quality standard for supporting people to live well with dementia. London: National Institute for Health and Care Excellence; 2013. URL: https://www.nice.org.uk/guidance/qs30

39. Scottish Intercollegiate Guidelines Network. Management of patients with dementia: A national clinical guideline. Edinburgh: Scottish Intercollegiate Guidelines Network. URL: http://www.sign.ac.uk/guidelines/fulltext/86/

40. Briggs T. Getting it Right First Time: Improving the Quality of Orthopaedic Care within the National Health Service in England. London: British Orthopaedic Association; 2012. URL: http://www.gettingitrightfirsttime.com/

41. Health Education England. Securing the Future GP Workforce Delivering the Mandate on GP Expansion. GP Taskforce Final Report. London: Health Education England; 2014.URL: https://hee.nhs.uk/2014/07/22/gp-taskforce-report/

42. National Institute for Health and Clinical Excellence. Osteoarthritis. The care and management of osteoarthritis in adults. London: National Institute for Health and Clinical Excellence; 2014. URL: http://www.nice.org.uk/guidance/cg177

43. Joseph C, Morrissey D, Abdur-Rahman M, et al. Musculoskeletal triage: a mixed methods study, integrating systematic review with expert and patient perspectives. Physiotherapy. 2014;100(4):277-89.

44. Taylor NF, Norman E, Roddy L, et al. Primary contact physiotherapy in emergency departments can reduce length of stay for patients with peripheral musculoskeletal injuries compared with secondary contact physiotherapy: a prospective non-randomised controlled trial. Physiotherapy. 2011;97(2):107-14.

45. Addley K, Burke C, McQuillan P. Impact of a direct access occupational physiotherapy treatment service. Occup Med (Lond). 2010;60(8):651-3.

46. Academy of Medical Royal College. Exercise: The miracle cure and the role of the doctor in promoting it. London: Academy of Medical Royal College; 2015.URL: http://www.aomrc.org.uk/publications/reports-a-guidance?view=docman

47. CarersUK. URL: http://www.carersuk.org/

48. Health Education England. Developing a flexible workforce that embraces research and innovation. London 2015.URL: https://hee.nhs.uk/work-programmes/hee-research-and-innovation/

49. Dayan M AS, Rosen R, Curry N,. Is General Practice in Crisis? London: Nuffield Trust; 2014.URL: http://www.nuffieldtrust.org.uk/publications/general-practice-crisis

50. Lord Willis. Raising the bar. Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants. London: Health Education england; 2015.URL: https://hee.nhs.uk/2015/03/12/the-shape-of-caring-review-report-published/

# EE57 British Orthopaedic Association

## Organisational Information

| | | | |
|---|---|---|---|
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| Address | 35 – 43 Lincoln's Inn Fields, London, WC2A 3PE | Email | policy@boa.ac.uk |
| Contact Person Name and Position | Matthew Barker BOA Policy | Number of attached evidence documents | n/a |

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

**About the British Orthopaedic Association**

The British Orthopaedic Association (BOA) is the Surgical Specialty Association for Trauma & Orthopaedic Surgery in the UK, representing approximately 40% of the surgical workforce. We promote excellence in professional practice, training and education, and research as part of our mission to care for patients and support surgeons.

**BOA Evidence**

The BOA welcomes this opportunity to contribute to the work of the Primary Care Workforce Commission. We also hope to have continued engagement with the Commission, Health Education England (HEE) and other interested parties. Our submission includes and builds on the following work:

- **The BOA's Undergraduate syllabus for Trauma and Orthopaedic Surgery**. The Syllabus is a flexible guide to teaching aimed at increasing the knowledge of future General Practitioners (GPs) in orthopaedic conditions. The syllabus targets medical students in recognition that 50% of medical students will ultimately become GPs.
  https://www.boa.ac.uk/wp-content/uploads/2014/10/TO-undergraduate-syllabus_website.pdf

- **Getting it Right First Time**. Getting it Right First Time is a NHSE-DH funded review of elective orthopaedics, led by the BOA. Whilst its focus is on secondary care, it highlights that referrals to Orthopaedics from GPs are increasing at a rate of 7-8% a year and recommends that GPs are provided with education in the benefits of different implant practices. A key priority of GIRFT is to promote service reconfiguration to ensure critical mass in orthopaedic capacity and to centralise activity in high-volume networks. It is in this context that there should be greater integration between Primary Care and Orthopaedics.
  http://www.boa.ac.uk/latest-news/press-release-girft-report/

- **Restoring Your Mobility.** Restoring Your Mobility is the BOA's Professional Practice Strategy. A key priority within the Strategy is greater integration between Primary Care and Orthopaedics so as to address the growing demand for Orthopaedic interventions and unnecessary variation in access to surgery.
  http://www.boa.ac.uk/pro-practice/restoring-your-mobility-2/

- **The BOA's NICE-Accredited Commissioning Guidance documents**. These provide clear and evidence based care pathways, based on input from patients, the BOA and colleagues across the multi-

disciplinary team, as per NICE processes. It is essential that service configurations facilitate smooth transitions within these pathways and that training and education produces the necessary skills mix to direct patients through them.
http://www.boa.ac.uk/pro-practice/commissioning-guidance-documents/

The BOA's priority for Primary Care is to ensure that General Practice and Primary Care Physiotherapy are effectively integrated with Orthopaedics. An excellent example of this integration is the Integrated Back Care Pathway developed in Aberdeen under the auspices of NHS Grampian. The model is based on joint General Practice and Physiotherapy management in Primary Care, linked to an MSK-hub providing specialist assessment and physiotherapy, which is in turn linked to secondary care. As a result of this model, triage now straddles primary and secondary care, providing smooth transitions through the pathway for patients.

The BOA's view is that the development of models similar to this, and alternative models of integrated care, would be well supported by increased knowledge of MSK conditions in General Practice. This is reflective of the fact that that 30% of GP consultations relate to MSK conditions, as well as the rate of growth in MSK presentations to GPs. It also reflects the short period of training, of approximately 4 weeks, that GPs receive in MSK. The BOA undergraduate syllabus was developed to address this issue, and we recommend that HEE and the GMC encourage its adoption by medical schools across the UK.

# EE58 BMA

BMA House Tavistock Square London WC1H 9JP

T 020 7383 6253
E TConnolly@bma.org.uk

Sabrina O'Neill
Health Education England
By e-mail: HEE.pcwcommission@nhs.net

16 April 2015

Dear Ms O'Neill

Primary Care Workforce Commission: Call for Evidence
The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 153,000, which continues to grow every year.

The Association welcomes the opportunity to respond to the Primary Care Workforce Commission. We hope that our submission is useful – please do not hesitate to contact us for more information if required.

Yours sincerely,

Raj Jethwa
Head of the Health Policy and Economic Research Unit

NHS
Health Education England

## PRIMARY CARE WORKFORCE COMMISSION

## CALL FOR EVIDENCE

The Primary Care Workforce Commission has been established as an independent Commission with the aim of identifying models of primary care that will meet the future needs of the NHS. The Commission wishes to identify good examples of integrated, patient focused, primary care, and its report will inform Health Education England's priorities for education and training as well as future decisions of commissioners and regulators.

The Commission will consider a range of evidence including a review of the national and international literature, evidence gained through visits to innovative service models and evidence submitted by a range of organisations. You are invited to submit evidence to the Commission either by completing the template below or by attaching documents which may include previous reports from your organisation.

We know that primary care in the UK already provides very high quality care in many areas and primary care in the NHS is often held up as a model in other countries. Nevertheless, there are major challenges in terms of workload and the changing nature of that workload. In relation to the main groups with needs for primary care (e.g. acute illness, long tern conditions, frail elderly, end of life care and preventive care), the Commission would like to consider;

1. What models of primary care work well and are likely to meet the future needs of the NHS (by 'models' we include both care provided within general practices or other primary care providers, and organisations that link providers together)? We are also interested in models that support more integrated working between primary care and other services,
2. The Commission will be interested in evidence of work that may demonstrate ways of using the skills of different professional groups as well as new approaches to deploying traditional skills.
3. Evidence you have for why you think these models work well
4. Problems you perceive in implementing these models within the NHS at present

Evidence submitted to the Commission will be published, but we recognise that this timescale may be too short for some organisations to get internal sign-off. Final versions of your evidence may therefore be submitted up to **Friday 3 April 2015**, but it is very important that responses are also received by **Friday 27 February 2015** in order for them to get full consideration by the Commission. A limited number of organisations will additionally be invited to give oral evidence to the Commission.

Please submit your evidence to Sabrina O'Neil at HEE.pcwcommission@nhs.net.

### Organisational Information

| | | | |
|---|---|---|---|
| Name of organisation | BRITISH MEDICAL ASSOC. | Contact Number | 0207 383 6253 |
| Address | BMA HOUSE | Email | TConnolly@bma.org.uk |
| Contact Person Name and Position | TIM CONNOLLY POLICY ANALYST | Number of attached evidence documents | 1 |

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

PLEASE SEE ATTACHED.

Primary Care Workforce Commission: Call for Evidence

1. The British Medical Association welcomes the opportunity to respond to the Primary Care Workforce Commission's call for evidence regarding models of primary care.

Models of care

2. Whether focusing on primary care providers individually or on ways of linking providers together, including the new care models outlined in the Five Year Forward View, it is important to emphasise that there is limited value in considering discrete models of primary care in isolation. The evidence base suggests that the usefulness of a particular model of primary care is heavily dependent on factors including, for example, the existing dynamics of the local health economy (with, for example, the shortage of district nurses having a big impact on many GP practices). It is also clear that there is no robust evidence on the impact of provider organisational forms on performance in the NHS1.

3. Given the absence of robust evidence as discussed above, we would question the value of seeking to privilege one model of primary care or indeed one new care model from the Five Year Forward View ahead of another. This lack of evidence does not negate the usefulness of the Commission considering the role of particular provider organisational forms, including GP networks. While there remains a need for robust and transferable evidence on the impact of GP networks, they are likely to be a good vehicle of transition from current structures towards more integrated care arrangements. As they are owned and managed by GPs, they are also among the most likely ways to preserve the best features of traditional general practice that both patients and GPs value. We are currently working to gather information on the current needs and future ambitions of developing GP networks.

4. It is useful to note that the new care models posited in the Five Year Forward View, including the Multispecialty Community Provider and Primary & Acute Care Systems, are being tested through a pilot scheme, known as the vanguard. To be helpful the results and information gathered from the vanguard need to be both robust and transferable between different health economies. It is also worth noting that the vanguard sites are largely groups of practices or larger units that have an existing history of collaboration. As such, the transferability of the results from the vanguard to areas without a history of collaboration may be limited. In addition, any additional funding or expertise made available to the vanguard may not be available more widely.

5. We welcome the emphasis in the Five Year Forward View on creating more integrated models of service delivery, by bringing together different parts of the health service (but not necessarily integrating organisational structures), while recognising that one size will not fit all. Any efforts toward new models of primary care must enable more integrated and more coordinated patient care.

6. The evidence base does not suggest that reconfiguration of services, including community-based models of care, will deliver significant savings. Cost should therefore not be the primary motivator for moving to new models of primary care or service delivery. In addition, it will be important that there is pump-priming available where the most appropriate model of care has been identified in a particular local health economy and local partners are ready

to act. This would need to be new money – the vision in the Five Year Forward View, for example, will not be achieved without additional upfront investment

7. Shifting the location of care will not reduce the overall levels of staffing required to provide the whole range of care that patients need. In order to prepare for the possibility that the provider landscape will undergo wide-scale change, it will be critical to ensure that the future healthcare workforce has the flexibility to be able to deliver care in different locations as required, without leaving parts of the health service inappropriately or under staffed.

8. We also note the growing body of evidence that providers that are research active provide higher quality care than those that are not3. In primary care this requires both the growth of the academic GP workforce, as referred to below, but also an increase in participation in research by the primary care workforce as a whole. This means ensuring that new models of care have space for research and education both literally in terms of physical facilities, but also in terms of the working lives of GPs and other healthcare professionals. In addition, where care moves from a secondary to primary or community care settings the capacity to educate, train and research and innovate in that area of work must move with it and be an integral part of the planning of such service change.

Recruitment & Retention

9. It is also vital to take into account the existing political, economic and workforce contexts in which providers of primary care operate and may operate within in the future. For example, the NHS is currently responding to significantly increasing demand for services with essentially static funding, and GPs have faced increasing demand for their services in recent years while the funding allocated to general practice as a proportion of total NHS spending has decreased.

10. These trends are very much linked to recruitment and retention in primary care, not least because of their impact on workload, a major factor driving trends in recruitment and retention. While it is important to consider models of care when planning the future primary care workforce, this should not be done in isolation from an examination of trends in recruitment and retention; this is for the simple reason that a primary care workforce is required in sufficient numbers to deliver any preferred models of care

11. Current problems in GP recruitment and retention have been well documented, for example in the recent Health Education England Taskforce report4 and the Centre for Workforce Intelligence GP in- depth review5. In addition to this, the BMA has now published a set of results focusing on GP workforce issues6 from our biggest ever survey of GPs, receiving responses from 15,560 GPs. This sheds further light on these problems and the reasons for them.

12. The main findings from this set of survey results, relevant to recruitment and retention issues, are as follows:

    - 34% of GPs who responded to the survey are hoping to retire from general practice in the next five years. This figure includes 36% of GPs aged 50-54, who currently make up 17% of the GP workforce7.

- 28% of GPs who are currently working full-time are hoping to move to part-time working in the next five years.
- 9% of GPs are hoping to move abroad in the next five years. Significantly, this includes 19% of current GP trainees.
- When asked which factors have a negative impact on their commitment to being a GP, the top three factors were excessive workload (71%), unresourced work being moved into general practice (54%) and not enough time with their patients (43%).
- 37% of GPs describe their current workload as being unmanageable. Linked to this, the survey also found that 93% of GPs feel their workload has negatively impacted on the quality of services provided to patients.
- Just under half of GPs (47%) would recommend a career as a GP to an undergraduate or doctor in training, but a third (35%) would not recommend it as a career.

13. Once the full set of survey results has been published we will be very happy to pass these on to the Commission, as many of the results will be relevant to the Commission's work.

14. In summary, our main proposals to resolve these GP recruitment and retention problems are:

    - A reduction in GP workload to manageable levels. As shown by the results of our survey, any strategy to address current GP workforce problems would fail without a reduction in GP workload. One of the main ways of achieving this is a proportionate, long-term increase in resources to general practice, to match demand for GP services. We have also suggested a number of ways that practices can manage their workload for the benefit of patients in our Quality First: Managing Workload to Deliver Safe Patient Care8 guidance, including managing inappropriate demands, assessing which enhanced services to deliver, working with other practices and working in partnership with patients to empower them to take more control of their own health.

    - Fully funded GP returner and retainer schemes, in order to retain GPs who have already qualified within the workforce.

    - Incentives for entering GP training, to encourage future doctors to enter GP training and to help ensure that training placements are filled.

    - An expansion of the primary care team, including pharmacists, health visitors, mental health workers and district nurses, to assist GPs in delivering services to patients and help deal with the high levels of workload in general practice. Investment in practice management training is also required, as effective practice managers can free up GPs to spend more time on clinical care.

    - A significant increase in the number of GP placements for foundation doctors, as many foundation doctors do not currently gain this experience, making it less likely that they will choose a career in general practice.

- An equitable and fair tariff for GP practice undergraduate placements, to ensure that practices take on undergraduates for these placements. This funding currently varies across the country.

- Improving the image of GP in medical schools. The visibility of GPs in medical schools should be increased by increasing the number of senior academic GPs teaching, mentoring and acting as role models to medical students. Universities need to be incentivised and encouraged to expand the number of academic GPs. We would see no reason why the proportion of academic GPs should be any different from the proportion of academics in the consultant workforce.

- Improved, fit for purpose premises to make working in general practice more attractive.

- A positive promotion of general practice by politicians and policy makers, to encourage a culture change in the view and understanding of GPs and encourage future doctors to enter general practice.

15. The joint agreed 10 point workforce plan and the linked introduction of a national Induction and Refresher Scheme are important first steps in addressing some of these proposals. However, the results of our GP survey show that a great deal more needs to be done, particularly in relation to problems with GP workload. Any primary care workforce plan needs to address these problems as well as planning for the models of care in which this workforce will operate.

# EE59 RMBF

I would like to submit some preliminary comments on behalf of the Royal Medical Benevolent Fund for consideration by the Commission, relating to the fourth area of enquiry, that of barriers to the development and maintenance of a healthy primary-care workforce fit for the 21st-century.

One of the main barriers to an effective workforce relates to its state of health and illness. The RMBF provides support to doctors, about one third of whom are GPs, facing physical, psychological and social difficulties, or more frequently a combination of all three, which have prevented them working .The characteristics of our beneficiaries have changed in recent years, and the majority of support goes to doctors under the age of 50 with complex physical and mental health problems. The aim of our support is to get doctors back into the workplace as properly functioning clinicians.

We are concerned that the NHS is decreasingly able to provide systemic support for these doctors, who to us and other charities for help. Funds that used to flow through the Strategic Health Authorities are no longer available and it is unclear whether CCGs have a responsibility for the health of the primary-care clinical workforce. The adequate resourcing of GP returner and induction schemes, and the additional training and coursework often required to support doctors in them, is a matter of particular concern.

We try to work closely with organisations including the RCGP, the GMC and postgraduate deaneries, and are able to provide mentoring, counselling and other packages of support, as well as funds. We call on the Commission to recognise the important problem of the health of the workforce, the under-provision of NHS resources to deal with it, and the potential deleterious effect of this on the future functioning of general practice and primary care.

I am submitting these comments in advance of your first, early deadline, and hope that we will have the opportunity to submit a more detailed response before the final deadline.