Site visits proposal submissions

AA01 Lakeside Limited

Organisational Information

Name of organisation	**Lakeside/Lakeside+ltd**	Name of service/ project	**Corby urgent care centre**
Address	Cottingham Road Corby NN17 2UR	Email	**Susan.wadsworth@nhs.net** **Jamesburden@nhs.net**
Contact Person Name and Position	James Burden Educational lead Lakeside Susan Wadsworth Director Lakeside+	Type of organisation	Profit yes UCC / Not for Profit yes
Have you consulted with the site?	**YES** / ☐	Type of organisation	Commissioner ☐ / Provider yes

Outline below the service/project/programme that you would like the Commission to visit. Please state why the

Commission should visit this site. (Maximum 500 words)

Lakeside surgery with the Corby Urgent Care Centre (UCC)offers an innovative, sustainable future for primary care. Lakeside surgery has 47,000 patients and is situated 8 miles from the nearest DGH. It formed a provider arm (lakeside+) in 2008 and opened one of the first Darzi centres in the country. It quickly became apparent that patients with minor, often self limiting illness would be seen and treated rapidly and effectively , but those more seriously ill would be treated with a letter, a 999 call and transport to the DGH. The provider met with commissioners to think up a better solution for community based urgent care and the UCC was developed.

The UCC offers 8-8 7 days a week urgent care facilitites at a site remote from the local district general hospital. There is on site hospital level laboratory facilities in addition to X-Ray and Ultrasound. Observation bays enable safe assessment of illness whilst awaiting the outcome of tests or response to therapy. If patients are seriously ill there are full resuscitation facilities with all staff trained in ILS/PILS and senior staff certified in ALS.
The unit is staffed by GPs but best practice is taken from the RCGP as well as the CEM. There are standard operating proceedures for the management of conditions not usually treated in primary care.

The urgent care centre was opened by Sir Bruce Keogh in 2013 who went on record saying:

“The centre is improving the quality of care which is being provided cheaper – freeing up money which is able to help the people of Corby. My challenge to others is to visit the centre and see how it’s done”

The provider was a finalist in the HSJ awards 2014 under the category of primary care and community service redesign.

Service planning involved much collaborative working between primary care, secondary care consultants and community service providers.

The service has resulted in major improvments to the A&E figures at Kettering General Hospital , resulting in a 16%

fall in type 1 attendances and a 12% reduction in 24 hour paediatric admissions.

Lakeside Surgery is a long established training practice with 47,000 patients. There are currently 8 GP registrars who are able to access training in traditional primary care as well as the UCC facilities. Leicester University uses Lakeside and the UCC as a training base for medical students (12 at any one time).
GP registrars and doctors enjoy the variety of working across both sites. Some are quoted as saying they are enthused by the ability to use their medical problem solving skills with the advanced diagnostic facilities available and would like to be able to incorporate this into their future careers.

Patients apprecicaite the availability of care closer to home and the knowledge that they will only be sent to hospital if their clinical condition demands. The unit scores very highly on the friends and family test.

Overall outline of the service/project/programme:

This service relies on traditional GPs re-engaging in urgent care to give a 21st century solution to the crisis in A&E.

Patients presenting to their GP with an urgent problem can be sent to the urgent care centre for diagnositic testing so that a clinical decision can be made in the community.

Patients who perceive their problem as being too urgent to wait for the next GP appointment can self present to the UCC, reducing the reliance on A&E. Patients have physiological testing at triage and are seen in the order of clinical priority.

If someone is seriously ill, hospital level care can be commenced prior to patient transfer, which should result in better outcomes . (e.g. iv antibiotics can be given to stop the clock in sepsis).

Observation and full resuscitation facilities are available for those who are more seriously ill.

The unit uses SystmOne (in use by all local practices) so the full patient record is available to the clinician and communication back to the GP record is instantaneous.

Added value of the service/project/programme

Doctors: Are able to use the skills they trained for, giving a varied and stimulating clinical career. Portfolio careers can be developed with some time spent in a traditional GP environment and other time in urgent care.

Patients: Have care closer to home, have reduced dependency on secondary care. The bus stops outside the surgery and the car parking is free.

Training: GP registrars are taught to manage risk and decide when patients can be safely discharged home. Medical studentrs can see that general practice can give an exciting career opportunity.

Hospitals: Are more able to achieve their targets. A&E workforce freed up to deal with the high acuity patients. Hospitals are already swamped by patient demand: a GP in A&E will only continue to increase patient flows to the

DGH.

NHS: Was founded on the principal of primary, secondary amd tertiary care. An NHS that misses out on primary care is not sustainable.

AA02 StowHealth

Organisational Information

Name of organisation	**StowHealth** **Suffolk Federation**	Name of service/ project	**Prism project** **Primary care led integrated** **diabetes**
Address	StowHealth, Violet Hill House, Violet Hill Road, Stowmarket, Suffolk IP14 1NL	Email	David.pannell@suffolkfed.org.uk
Contact Person Name and Position	David Pannell – CEO, Suffolk Federation	Type of organisation	Stowe Health - Profit Suffolk Federation Not for Profit
Have you consulted with the site?	**YES** ☐ / NO ☐	Type of organisation	Commissioner/ Provider

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

The **Stowhealth PRISM project** has transformed our traditional GP/Nurse/HCA primarycare model in to one where a comprehensive team of health professionals working together under the leadership and guidance of the GP. This has addressed the lack of available GPs to meet demand whilst improving patient experience and reducing the financial costs of running the practice.

The Partners of Stowhealth (a market town GP practice serving 17,800 patients in Suffolk) viewed primary care through a different lens and to think of it as a spectrum of specialist activities that the GP manages. We used a Quality Improvement approach to analyse and transform the work of the practice.

Our team were already operating a 100% telephone consultation system, had implemented a dispensary technician medication review pathway and increased minor illness clinic availability, all of which improved efficiency. The partners agreed the solution existed in working with specialists who operated within their own area of the primary care spectrum, with the GP becoming the consultant.

The PRISM approach has firmly established the GP as primary care consultant, co-producing the care plan and utilising the skills of a wider team of professionals. This encourages GPs to offer patients more specialist consultations that actually save costs and improve the quality of diagnosis and referrals.

Suffolk GP Federation is a clinically led not for profit CIC owned by 61 GP practices across Suffolk and a provider of various local services including community ultrasound in East Suffolk and Lymphoedema in West Suffolk. The organisation is managed by a Board of GPs and practice managers and has a professional management team.

The Federation provides virtually all diabetes care in the neighbouring CCG of North East Essex. This has an annual budget in 2014/15 of £2m and includes 'outpatients', a primary care enhanced service, podiatry, education and a range of specialist services. It is structured as a 'prime contract' with sub-contracts for the delivery of the integrated pathway with Colchester Hospital University Foundation Trust, Anglian Community Enterprise CIC, 40 GP practices

and the local GP provider organisation. The Federation is responsible for the management of sub-contractors, overall contract management and reporting, clinical triage of referrals, referral booking and the direct delivery of specialist services.

- The service has created an integrated team of consultants, specialist nurses, midwife and dietician.
- Virtually all services have been moved from a hospital to community setting. The Federation manages inpatients which is an unusal arrangement.
- Suffolk Federation is a distinct type of GP organisation which combines professional management and systems with a social enterprise ethos.
- The diabetes contract is one of the few examples of primary care led working at scale across a whole CCG. The model being followed by the Federation uses data, financial incentives and peer pressure to motivate transformational change across primary care.
- The Federation extract monthly diabetes data from each practice and this technology/process could be applied to back office rationalisation within primary care or to all long term conditions.

Overall outline of the service/project/programme:

For the **Prism project, f**ollowing analysis of GP consultation activity in March 2014 we identified minor illness, physiotherapy, dermatology, paediatric and mental health as areas that could be delivered by a specialist other than a GP. Having identified potential professionals to work with we collaboratively designed pathways and governance framework arrangements which were improved upon with comments from our Patient Reference Group.

In June we employed a physiotherapist with secondary care experience for 2 sessions a week. In September we employed a Paediatric nurse on a Monday afternoon and a Mental Health practitioner all day on a Thursday. Finally a Dermatologist joined Stowhealth delivering a half day clinic a week. Patients access these clinics following a GP telephone consultation. As part of the improvement cycle 3-month evaluations were undertaken.

Results of the patient survey auditing the physiotherapist pathway showed that 66 of 67 patients would recommend the service to a family or friend. 50 patients rated the quality of the consultation as excellent and 14 very good. The 2015 GP Patient survey results released in January by Ipsos Mori show Stowhealth has improved its overall patient experience in 2014 with 88% of patients saying they would recommend the practice to a friend up from 81% in 2013 (CCG average is 81%, national average 78%). Furthermore a staggering 97% of patients reported that the last appointment they got was convenient.

The **Suffolk Federation** approach to the North Essex Diabetes service is detailed above.

See Stowhealth Total Care - Home Page and Suffolk GP Federation.

Added value of the service/project/programme

Through the **Prism project f**ocusing solely on the activity of Physiotherapist, Paediatric Nurse, Mental Health clinician and a Dermatologist, we did not require additional equipment and collectively provided 18 hours of face-to-face clinical contact per week at a cost of £525 per week (annual cost of £24,150 based on 46 weeks). To deliver this with a GP would equate to 4 GP sessions per week, which would cost £50,448 per year. Giving a practice saving of £26,298 per year.

Recently the Chartered Society of Physiotherapists suggested Physiotherapists can help alleviate pressure on AE admissions. Our experience is that their MSK skill set has been invaluable to primary care.

Our way of working fits neatly with the Five year forward view for the NHS and we have begun conversations with Ipswich Hospital about employing a Gynaecology Nurse Practitioner one session a week. The power of the PRISM approach, is that it relies on matching local needs with the appropriate health care team and can be supported with the trend for Federalisation of practices, in that they can come together to employ a part time or full time practitioner who can be shared across practices matching demand irrespective of the practice size. Thus overcoming potential barriers to recruitment of health professionals.

The **Suffolk Federation** approach to the diabetes contract has brought a primary care overview to a whole system service which allows the integration of primary and secondary based care founded on evidence based policies and a data driven multi-professional patient focussed clinical service. The fact that the organisation is not for profit provides a useful contrast to traditional business models.

AA03 Kingskerswell and Ipplepen GP Practice

Organisational Information

Name of organisation	**Kingskerswell and Ipplepen** **GP Practice (lead for pilot)**	Name of service/ project	**Newton Abbot Frail Elderly** **Pro-active case management** **pilot**
Address	Kingskerswell and Ipplepen GP Practice School Road Kingskerswell Newton Abbot Devon TQ12 5DJ	Email	**Nick.roberts@nhs.net** **Robert.hooper@nhs.net** **Tracey.waterfall@nhs.net**
Contact Person Name and Position	Dr Nick Roberts GP lead for pilot project Robert Hooper Practice Manager lead for pilot Tracey Waterfall PMCF Project Manager	Type of organisation	Profit GP Practices x 6 working together to run pilot
Have you consulted with the site?	**YES** x / NO ☐	Type of organisation	Provider ☐ GP practices Working closely with Torbay and Southern Devon Health and Care Trust

Outline below the service/project/programme that you would like the Commission to visit. Please state why the

Commission should visit this site. (Maximum 500 words)

The 6 practices in Newton Abbot are working together to offer their 'Proactive Case Management Register patients (PMCR) (2% high risk patients) **enhanced access to a local GP.**

The enhanced service is based around the 2014-15 national 'Avoiding Unplanned Admissions Enhanced Service' specification but the Newton Abbot locality has two important additional features

- GPs can refer to a local specialist frailty service (operating during normal working hours). This services provides a multi-disciplinary community hub for the 7-day proactive care of frail older people based in Newton Abbot hospital. GPwSI-led with support from interface geriatrician and wider multidisciplinary team including voluntary sector, palliative care, social care, mental health and pharmacy.

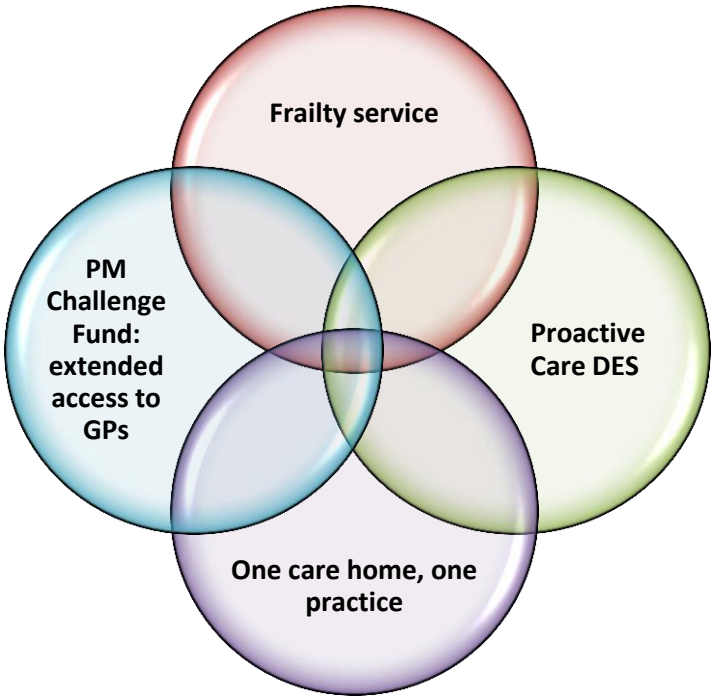
  and

- Patients and Care Home managers will have extended access to a local GP who can visit them to try and avoid an unplanned admission to hospital. The GP will have
  - Access to the patient's full medical records and care plans (all using same clinical IT system)
  - Be mobile and available Saturday and Sundays from 8am – 8pm

- Community nurse support if needed on home visits
- Access to:
  - Blood tests
  - ECG
  - Pulse Oximetry
  - Pain relief drugs

and

- One care home, one practice. Care home and practices have been aligned as evidence shows having continuity of care with one practice covering every resident in a care home leads to improvements in quality of care and significantly reduced emergency admissions



Metrics for Weekend Working

25th October – 31st December

No of Patients seen	No of Unplanned Admissions avoided
93	24

Other impacts:

Time to carry out complex consultations, including 'Best Interest' meetings with families, End of Life care etc. as part of weekend consultation.
Predicted Outcomes for the overall service are:

Year	All EM	Increase	Top 5% EM	Increase	Top 0.5% EM	Net Change

	Admissions		Admissions		Admissions	
0	10,529		3,573		907	
1	10,921	3.72%	3627	1.51%	862	-4.96%
2	10,702	-2.01%	3016	-16.85%	640	-25.75%

Demand for packages for domicillary care will reduce and improvement in patient reported experience measures (using the 'I'm Still Me' statements which is being supported by Senior Voice and Healthwatch).

Overall outline of the service/project/programme:

Prime Ministers Challenge Fund money, winter resilience monies, voluntary sector funding and working differently within existing team resources. The CCG is piloting 3 different models of service delivery targeted at the frail elderly through PMCF in order to evaluate comparative impact

Added value of the service/project/programme

Early results show a good impact on admission prevention and participating GP's report a high level of GP and patient/family/care home satisfaction with the service.

Builds on already strong collaborative working between GP practices and Torbay and Southern Devon NHS Trust -integrated health and social care provider

Longer term evaluation also been carried out with in partnership with Penclahrc

AA04 Beacon Medical Group

Organisational Information

Name of organisation	**Beacon Medical Group**	Name of service/ project	**Integrated Primary Care**
Address	Plympton Health Centre (Head Office) Mudge Way Plympton Plymouth PL7 1AD	Email	**Claire.oatway@nhs.net** **Jonathan.cope@nhs.net**
Contact Person Name and Position	Claire Oatway Chief Operating Officer Jonathan Cope GP – Managing Partner	Type of organisation	Profit Large Multi-site GP Practice Merger
Have you consulted with the site?	**YES**	Type of organisation	Provider ☐

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

Beacon Medical Group is a partnership combining three existing and respected practices in the Plymouth and South Hams Area. These existing practices are staffed by well respected and dedicated professionals at all levels of the organisation. As a partnership we formally merged on 1st April 2014 and provide GP services to approximately 33,000 patients. This was done in the belief that we could provide greater options for patients, including additional services and extended opening hours. We believe that nationally the shape of GP practices will move increasingly toward merger or federation and we want to share our organisational learning to benefit other practices. We currently are asked to talk across the region at key events and with small groups considering merger and believe that workforce development is a vital aspect of broader system change.

Patient-centred care is at the heart of our organisation and we know that respect, dignity and compassion have to be at the heart of decisions we make with and for patients. Those ideas come to life in everyday interactions and conversations and we are investing in our staff to help them deliver the excellent care that we believe our patients deserve. We are also redefining non-clinical support – our management, reception and admin teams; bringing patient-centred concepts, sustainability and innovation to the heart of the practice. This core purpose also shapes the relationships we are having with other providers including community health and hospital care to improve collaboration – both formally and informally.

As one of the largest GP practices in Devon and Cornwall we are wholly committed to delivering clinical excellence and the highest level of customer service every step of the way. We have reshaped our clinical teams – encouraging staff to work across sites, developing a new career pathway for our nurses and healthcare workers and introducing a new role of practice pharmacist. We are also the largest GP training provider in the area and support among the best emerging talent.

We want to be a sustainable practice that thrives on innovation and want to work with our patients, carers, communities and partners as one team. We see this as getting the right service to patients, done by the right person at the right time. This means that our offer to patients is continuously developing. In Autumn 2014 we launched a

variety of new services designed to provide expert support to people in their communities rather than in a hospital setting. In some cases we're making better use of the skills of our GPwSI, in others we've brought new members into the clinical mix – our pharmacist. We continue to work with our commissioners and other providers to deliver cutting edge clinical support in our local area.

We'd be delighted to host the commission to share both the broader elements of workforce development as practices increase in scale as well as the specific lessons that read across into any size practice – around changing the clinical skill mix of a team and explicitly bringing patient-centred care into non-clinical roles.

Overall outline of the service/project/programme:

There are a few programmes we'd like to share:

To support the change process facilitated by the merger the practice made a successful application for Prime Ministers Challenge Fund money via the CCG. This has enabled the practice to pilot some of its new skill mix developments such as dedicated urgent care/admission prevention support for the frail elderly/those with complex needs, the extended role of the pharmacist, and an HCA role including pro-active telephone contact with those with long-term conditions. This has improved access and care for many vulnerable patients, reduced costs in terms of medicines and unplanned admissions, and has enabled greater cross-pollination of ideas across clinical professional boundaries.

In October we launched two brand new services for patients – deploying the skills of our GPwSI for Dermatology and Musculoskeletal. The principle of the service is around local specialist management of issues rather than automatic referral to secondary care. For the patients concerned we have seen a dramatic reduction in delays with cases seen locally – rather than at the hospital within 2-4 weeks. We negotiated the project with local commissioners on a gain share basis and are therefore also tracking reduced system costs. For the GPs concerned this is a great way too for them to use and enhance existing skills – improving retention. The 5YFV opens the door to such innovative approaches to provision and we'd be happy to discuss what the workforce implications might be if more practices took on increased specialist healthcare.

In developing as a new larger organisation we have been able to develop our clinical and non-clinical staff to deliver improved patient care, provide additional opportunities for training and progression, improve financial sustainability and provide leadership and expertise to unlock opportunities for innovation. We have reorganised our nursing team and management team and are currently reviewing the key role that admin and recpetion staff play in supporting patient care – in projecting a caring attitude, customer focus, professionalism and in supporting patients to manage their own healthcare.

Added value of the service/project/programme

A local exemplar for practice merger/restructuring of primary care delivery who are now supporting other practices contemplating a similar process

A learning organisation who have delivered significant improvements to patient services and changed job content/satisfying roles for Partners and employed staff

AA05 St Austell Health Group

Organisational Information

Name of organisation	**St Austell Health Group**	Name of service/ project	**Integrated Primary Care**
Address	Wheal Northey Surgery 1 Wheal Northey St Austell Cornwall PL25 3EF	Email	**Bridget.sampson@nhs.net** **Stewart.Smith@whealnorthey.cornwall.nhs.uk**
Contact Person Name and Position	Stewart Smith GP and Clinical Lead Bridget Sampson Executive manager	Type of organisation	Profit
Have you consulted with the site?	**YES**	Type of organisation	Provider Merging GP Practices

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

This is an example of local GP practices working closely with the primary care contracts team in NHS England to find a sustainable service delivery model for primary care. It expects to demonstrate that by delivering at scale it is able to attract top quality clinicians by offering more flexible career options. It recognises the clinical safety and clinician burn-out risk created by the escalating demand for primary care through streaming work. This means individual exposure to the high volume/intensity of urgent care can be limited and people have improved opportunity to use their skills to provide excellent care for those with more complex needs

St Austell Health Group is a merger of 3 GP practices who originally came together to work with NHS England to rescue a failing practice caring for over 9000 patients in the town. The practices have now formally agreed to merge and are redesigning the care delivery system for the town. They have faced and worked through significant challenges and are now engaging with the local population to inform the design of a sustainable care delivery system for the 30,000 population in the town. SAHG is also intending to work closely with Peninsula Community Health the social enterprise which runs community hospital and health services in Cornwall.

The proposed model of care will create:

- One Primary care provider rather than the present separate GP practices working with other health and social

  care providers to deliver joined up care

- Improved access – one site offering same day GP led care for patients wanting urgent

  and/or episodic care and in time 7 day/8am -8pm opening

- Improved continuity – recognising that those with complex health problems or long term conditions need to be treated by the same GP led integrating community team
- Improved partnership working – developing plans to provide a wide a wider range of services in St Austell by working with other providers, charities and community groups

SAHG wishes to attract and keep the best clinicians in the UK and is exploring a range of staffing models to support this. Peninsual Community Health has developed portfolio career options to attract doctors and they and SAHG believe joint working could make this option even more attractive. The practices are already using nurse practitioners and a community matron and in addition to plans for increased integration with PCH plan to appoint a pharmacist as part of the clinical team dealing with minor illness and supporting those with complex needs.

SAHG are working with the CCG to reduce pressure on acute care and to repatriate more services – local ophthalmic care is already planned

Overall outline of the service/project/programme:

Merger and redesign of primary care and joint working with community provider and other local organisations

Added value of the service/project/programme

Driven by local GP's but with NHS England support and engagement of local community in developing the service model

Recognises recruitment challenge and need for be an attractive Partnership/Employer while also delivering public expectations for for both improved access and continuity of care

AA06 CityCare

Organisational Information

Name of organisation	**CityCare**	Name of service/ project	**Holistic worker model**
Address	1 Standard Court Park Row Nottingham NG1 6GN	Email	**Stephen.upton@nottinghamcitycare.nhs.uk**
Contact Person Name and Position	Steve Upton Assistant Director Urgent Care & Transformation	Type of organisation Social Enterprise	Not for Profit X (profits reinvested Into community)
Have you consulted with the site?	**YES**	Type of organisation	Provider X

Outline below the service/project/programme that you would like the Commission to visit. Please state why the

Commission should visit this site. (Maximum 500 words)

This site will be of huge interest to Commissioners because this will provide you with an example of how the workforce can and are delivering care in a very different way. We would like to introduce to you our Holistic worker model during your visit. This model addresses the aim that we have shared to make care services more person-centred for many years. Organisations and institutions have attempted to address this through various training sessions, changes to care planning and documentation to name just a few. However, real, tangible enablers for staff to work differently have been few and far between. In fact, despite many initiatives our workforce has continued to approach patient care in much the same way that it has for years. Individual interventions that focus on one specific professional discipline now have to be a thing of the past and we need to embed a new way of working within our health and social care workforce that translates into meaningful improvements in care and improved outcomes for our patients.

By visiting this site you will see this in action now. This is not an idea, nor is it a project, it is a programme of workforce change that we believe has the power to change the way we structure teams, plan work load and share responsibilities across health and social care in an integrated way.

You will be able to meet staff who work in this model and hear directly from them how it feels to be a holistic worker and experience how we implement this way of working on a practical level. We will also be able to demonstrate how we plan to embed this way of working throughout our workforce offering a revolution in approach which strengthens our integrated care programme and offers improved outcomes to patients.

Supporting this new way of working has required an organisational commitment to embed this throughout our services. From its initial implementation in Urgent care teams it is spreading to community Reablement and will soon be launched within our newly integrated health and social care neighbourhood teams which will bring community nurses, community matrons, community therapists and link social workers together working as holistic, person centred teams.

This way of working represents a rare opportunity to change the way in which we approach the pressures on resources and the increase in complex ageing within our communities. It provides us with a way in which we can redefine what team working means at a cellular level and expand learning and new skill opportunities to our entire workforce.

Overall outline of the service/project/programme:

The model has a set of core and clinically specific competencies covering the following:

- Occupational therapy
- Physiotherapy
- Mental health/ Dementia
- Nursing
- Social Care

The competencies are taught to all staff from band 4 to band 7 through face to face class room sessions and by observation in practice during direct patient care. The competencies are reviewed and skill gaps addressed where needed. The competencies existing within several service areas and are now being bought together to form a universal model that can be used across our entire workforce. In addition we are creating this model for band 2 & 3 staff to encourage people into health care who may not have had opportunity or qualification in the past. This will enable us to grow our own health care workforce from entry level through competency and grade and into professional roles.

Added value of the service/project/programme

This model of working has redefine how teams form and work together in an integrated way, truly putting the power to make every contact count by giving every worker a range of skills outside of their clinical discipline. People become nurses and AHP's because they want to make a difference to others lives, they have vocation and a calling to do good for others. This way of working as a team enables this to happen in real terms. It enables teams to do more in each caring moment, by being able to address the whole person not just a specific illness or disability. It also reduces the amount of times that patients have to tell their stories and allows time for professionals to build meaningful relationships with patients.

This way of working has enabled teams to bond as they appreciate the values and approaches used by the different clinical professions. It also challenges the divide we often find between the health and social care models of intervention by offering a way to deliver health care through the social care lens. This way of working is providing a practical way in which health and social care integration can be expressed within the workforce alongside any organisational, commissioning and process changes we may make.

Ultimately the value of this programme is the impact on patient care and workforce. Our workforce have told us that working in this way has increased their desire to stay employed by us, we also believe that this makes us an attractive employer of choice for the area by offering a unique educational experience beyond qualification. Staff report higher

job satisfaction because they are able to do more for each person they see. Patients are able to build more meaningful relationships with staff and it has reduced the number of times they have to tell their story now having less workers involved in their care because the ones they do have can do more in every caring moment. This way of working enables our workforce to make every contact count in a very real and practical way that has meaning to patients.

AA07 Lakeside Surgery

Organisational Information

Name of organisation	**Lakeside Surgery**	Name of service/ project	**Skills Made Easy**
Address	Cottingham Road, Corby, Northamptonshire, NN17 2UR	Email	**Jamesburden@nhs.net**
Contact Person Name and Position	Dr James Burden Partner and Education Lead	Type of organisation	Profit ☐
Have you consulted with the site?	**YES** ☐	Type of organisation	Provider ☐

Outline below the service/project/programme that you would like the Commission to visit. Please state why the

Commission should visit this site. (Maximum 500 words)

Lakeside surgery has developed into a large GP practice with 47,000 patients but will be 100,000 within 6 months after merger with other local practices

We believe we are modernising General Practice because we have many themes to our strategy:

- Ethical – We have introduced a salary cap with new projects directly improving patient care
- Safe – We have rigorous significant event analysis and methods to disseminate lessons
- Patient focused – The Friends and Family Test was piloted here, feedback dictates our strategy
- Choosing General Practice – Leicester Medical School – 12 students at a time from March 2015
- Integrating knowledge – Prospective referrals analysis by GPs leads reduce referrals
- Research – We are starting on our journey to develop a NIHR portfolio
- Protecting – We run a safeguarding MDT with HV/MW/GPs and a Social Worker
- Skilled – A skills clinic will allows doctors to safely learn to be intervention GPs on real patients
- Vertically integrated – GP practices with Consultants as equal partners – end of 2015
- The modern way – we will be launching our online consultation technology within months
- The Urgent Care Centre at Lakeside + - Is partially owned by many Lakeside GPs
- Continuity – Working in small groups within the partnership deliver continuity of care
- QoF – Nearly always around the top scores
- Professor Sheona Macleod, Dr Helen Mead, Dr David Poll, Dr Adrian Brooke have all seen our surgery.
- The largest barrier to overcome is the belief that “things never change”, Lakeside has a “can do, will do” attitude.

Overall outline of the service/project/programme:

The ‘Skills Made Easy’ project is going to help professionals expand their knowledge and abilities by enabling professionals to learn practical procedures in dedicated clinics. As a large GP practice we can produce dedicated clinics to enable accreditation of skills in a single day.

We deliver acute care in the Urgent Care centre to chronic mental or physical disease in dedicated clinics. We can minimise risk by near patient testing and learn to manage risk by sharing of expertise.

This project will start with intra-uterine coils, steroid injections, minor surgery and Nexplanon insertion and removals. The project will also expand to include teaching non-clinical staff with courses starting with courses for safeguarding children and a 'medical receptionist' school.

Traditional secondary care expertise will develop new methods of workings as Cardiology, Dermatology and Respiratory consultants moving into our partnership.

Lakeside will develop and progress all areas of physical and mental healthcare by on having a central ethos of education and research in our integrated knowledge centre.

Added value of the service/project/programme

Developing a workforce without organisational barriers that has a willingness to share skills and develop other professionals will help other organisations develop as well. This will be completed within the confines of a salary cap that reinvests income streams to patient care.

AA08 York Street Health Practice

Organisational Information

Name of organisation	**York Street Health Practice**	Name of service/ project	**Primary Care service and HALP**
Address	68 York Street, Leeds LS9 8AA	Email	**john.walsh@nhs.net**
Contact Person Name and Position	Mr John Walsh Practice Manager	Type of organisation	Profit ☐ / Not for Profit X
Have you consulted with the site?	**YES** X / NO ☐	Type of organisation	Commissioner ☐ / Provider X

Outline below the service/project/programme that you would like the Commission to visit. Please state why.

York Street Health Practice offers a model of care which is holistic and personal. York Street works in partnership with statutory, voluntary and faith sectors to provide best care for homeless people in Leeds. We are a specialist service working with those in the asylum system, vulnerably housed and homeless. York Street is a nationally recognised centre of health inclusion. We work across the NHS too in areas of organisational and culture development, digital technology and teaching.

Examples of work YSHP does includes:

- Multidisciplinary primary care provided under one roof including: GPs, nurses, health support workers, drug and alcohol therapists, mental health nurse assessments and therapeutic support.
- Outreach - organised health outreach and planned and unplanned street work.
- Inreach - where lawyers, benefit workers, housing support, CMHT and others come into York Street to work with us.
- Work inside Leeds Community Healthcare (where we sit) mentoring other services, individual leadership work, development of new ideas and possibilities.
- Work across the city - strategic work - work with Health and Wellbeing Board and how we try to make the HWB vision a reality - from streets to strategy approach.

Working with the Faculty for Homeless and inclusion health, we have been involved in developing Service Standards for Commissioners and Service Providers. (version 2) particularly in developing a Quality Assessment Framwork and piloting a peer assessment process?.

HALP (Homeless Admissions Pathway Leeds) is a service hosted by YSHP providing hospital inreach by a dedicated GP, nursing and care navigator team, supporting discharge planning for patients identified as homeless during admission to Leeds Teaching Hospital Trust. The role of the team is to provide assessment, advice and guidance to hospital staff re care planning and discharge planning. Working in partnership with housing services and utilising dedicated 'step down' beds at St Georges Crypt Homeless Shelter the team help acheive early discharge and support after care to prevent readmission of some of our most complex and vulnerable service users.

Overall outline of the service/project/programme:

We provide medical care for 1200 people in Leeds. We exist and operate as a specialist service

Provided by Leeds Community Healthcare Trust seeking to incorporate best practice and response.

Added value of the service/project/programme

- working in joined up way with other non health partners
- integrated care approach
- seeking to develop strategic approach to work in the and across the city
- working with Universities on development of best inclusion theory and work

AA09 Invicta Health

Organisational Information

Name of organisation	Invicta Health Community Interest Company	Name of service/ project	Health Connect – part of Prime Minister's Challenge Fund Wave1.
Address	1 Northgate Canterbury CT1 1WL	Email	kim@invictahealth.co.uk
Contact Person Name and Position	Kim Horsford	Type of organisation	Profit ☐ / Not for Profit ☐
Have you consulted with the site?	**YES** ☐ / NO ☐	Type of organisation	Commissioner ☐ / Provider ☐

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

Invicta Health is a community interest company owned by GP's in East Kent committed to working with all practices and local healthcare organisations to provide a community based response to the constantly changing NHS environment. We do not seek to create another large provider with the associated bureaucracy and overhead costs, but to work with those organisations to ensure that local GP's are involved in the development of integrated services. We seek to support all our member practices whether they wish to provide services within their own practice or work with federations of practices on larger projects.

Having begun with shareholders in the Canterbury Area we have sought to expand our base in order to develop East Kent wide integration of services, including out of hours. Towards the end of 2013 we recruited the majority of practices in South Kent. Currently we have 45 member practices covering a population of around 400,000 registered patients. We believe that our structure of devolved management for each area supported by a central board of directors provides opportunity for local planning and projects whilst ensuring a co-ordinated management across East Kent.

In addition to providing services we have worked to develop strategic alliances with other providers such as East Kent Hospitals University Foundation Trust and South East Coast Ambulance. We believe that this allows GP voices to be heard at a high level and offers opportunities for joint working. We have developed these relationships so that a joint bid to provide an alternative to OOH services with EKHUFT/SECamb and Invicta Health is possible, ensuring that local GP's can influence provision of this service.

Many of our services support local practices and CCG's to provide care within practices – e.g. diabetes and enhanced services. We work with practices in bids for any enhanced services that are offered via AQP for example and to develop solutions that allow practices to provide for their own patients and those of other practices that may not be able to offer additional services. We also support practices to bid for projects – we were awarded almost £2 million from the Primer Minister's Challenge to provide integrated community and GP care 7 days per week in Folkestone and Dover. The first phase of the project – Invicta Health Connect was launched on October 1st 2014.

Overall outline of the service/project/programme:

We are working towards town based federated GP practices linked to hubs at local hospitals that offer 7-day 8 to 8 GP access (this acts as a branch surgery to every local practice) as part of the first wave of the Prime Minister's Challenge Fund. The hub allows practices to offer patients greater choice and flexibility and addresses concerns re shortage of GP appointments the CCG. We are working with GPs to create more flexible career structures that allow them to work across practices and services without the usual restrictions of salaried roles or partnerships that involve long-term commitment.

We have also introduced paramedic practitioner visiting in conjunction with the local ambulance trust and practices, with GP's referring home visits to the PPs. We are also building on our successful mental health pilot for shared care with secondary care to develop an assessment service in the hub for mental health patients.
We are also working with our practices to implement productive general practice with a view to improving quality, reducing variation and building a foundation for future federated working and collaboration.

Added value of the service/project/programme

We are addressing a number of issues – patient access (7-day working), quality of care, integrated working across providers, GP career structures, delivering primary care at scale, lack of provision (e.g. mental health), variation in care and creating a base for a potential MCP in the future.

AA10 Cumbria CCG

Organisational Information

Name of organisation	**Furness Locality, Cumbria CCG**	Name of service/ project	**Minor Ailments Scheme with Independent non medical prescribing by a pharmacist**
Address	STAFFORD House 103 Abbey Road Barrow in Furness Cumbria LA14 5EX	Email	**Hazel.smith@cumbriaccg.nhs.uk**
Contact Person Name and Position	Hazel Smith Primary Care Development Lead	Type of organisation	Profit ☐ / Not for Profit X☐
Have you consulted with the site?	**YES** X☐ / NO ☐	Type of organisation	Commissioner ☐ / Provider ☐ **Joint project**

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

Cumbria has never provided access to medicines via a Minor Ailments Scheme (MAS) but has some areas of highest deprivation in England and serious problems recruiting GPs and nurse practitioners resulting in pressure for patients to access primary care services in a timely manner and increasing activity in the Out of Hours service.

Furness locality executive (Cumbria CCG) supported a pilot MAS over three sites in April 2014. A prescribing element was developed at one site to provide access to a Non Medical Prescribing (NMP) pharmacist to offer faster access to "Presciption only Medicines" to self manage minor illnesses, widening the remit of the standard MAS, developing the skills of the workforce. The pharmacist selected delivers healthcare in the one of the most deprived areas of Barrow in Furness where there is no GP practice and the business has funded a major refurbishment to develop a Primary Care Access Centre offering capacity for other healthcare professionals to deliver services locally.

The locality supported the pharmacist to complete a NMP course by offering a GP to act as designated medical practitioner and support to work with other GPs in practices and in the "Out of Hours service and facilitated the application process to the HEI.

The Local Pharmaceutical Committee and Local Professional Network for Pharmacy have worked in collaboration with Furness locality and the Pharmacy contractors to develop the scheme and roll out the MAS project to all pharmacies in the locality after successful results and excellent patient feedback from the pilot, collated via PharmOutcomes, access to which was arranged by LPC. This initial pilot has resulted in agreement to develop the MAS in four of the six other localities in Cumbria.

GP practices refer into the services and the pharmacists are able to fast track patients to practices if they require urgent appointments or exhibit "alarm symptoms".

CCG IG department and IT team have worked with the Primary Care Development team of CCG to develop access to GP shared medical records to support NMP by allowing access to co-terminous records via the Medical Interoperability Gateway (MIG). This element of the project is close to completion and all GP practices in the locality have willingly agred to share data and sharing agreements are in place.

Funding has been identified to support a further four community pharmacists to complete the NMP course in the coming financial year to ensure we develop a robust service in areas of highest depivation.

Work is also ongoing via LPN with University of Cumbria who have now managed to gain funding and support to develop an Advaced Diploma Course in Emergency Care for pharmacists.

Furness locality values its pharmacy workforce highly and are actively working with them to include them in

developing models of care recognising their unique knowledge and skills which are now being promoted nationally This work has also demonstrated how well CCG links with GPs,LPN, LPC, CCG, HEI and pharmacy workforce are so we can start to develop exciting future schemes and services.

Overall outline of the service/project/programme:

The project has implemented a Minor Ailments Scheme for Community Pharmacy but has
supported a pharmacist to complete a non-medical prescribing course working from a community pharmacy. This model is to be further developed enhancing the clinical skills of pharmacists to support access to advice and medicines (including prescription only medicines) and integrate pharmacists much more into the Urgent Care capacity.
A sub-project has identified the need for pharmacists to have access to shared patient records and work is nearing completion to enable this via Medical Integrated Gateway MIG).

The project has illustrated how collaborative, multi-organisational working can benefit patient care and how well pharmacists can contribute to service redesign and develop solutions to address obstacles.

Added value of the service/project/programme

The added value is that we now have a Minor Ailments Scheme within the llocality providing better access to medicines to treat minor ailments and reduce GP activity. The pharmacists provide advice and immediate access and support patients to manage their illnesses. The pharmacists have a referral option where patients needing to be seen by a doctor are fast-tracked (pharmacy providing a triage type service.
The prescribing element allows a much wider range of medicines to be accessed by patients via a faster route with advice and education to support self care available without a prescription. Over 90% of patients are seen within 5 minutes of attending the pharmacy.
We have an IT solution to allow prescribing remotely and integrated working of GPs and Community Pharmacies.

AA11 Gaywood House Surgery

Organisational Information

Name of organisation	**Gaywood House Surgery**	Name of service/ project	**Federation to create Bedminster Medical Group**
Address	Gaywood House, North Street, Bedminster, Bristol BS3 3AZ	Email Brent.stephen@ Gp-L81057.nhs.uk	
Contact Person Name and Position	Brent Stephen Practice Manager	Type of organisation GP Surgery	Profit X / Not for Profit ☐
Have you consulted with the site?	**YES** ☐ / NO ☐	Type of organisation	Commissioner ☐ / Provider X

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

There are five GP Practices covering the Greater Bedminster ward in Bristol. We have some 46,000 patients between us. The five practices are actively moving towards federation to create the Bedminster Medical Group. At the time of submitting this document we are engaged in a scoping exercise with consultants to understand the capabilities and attitudes of each practice to create a baseline for us to move forward from. Our commitment is to have the BMG entity in place by April 2015.

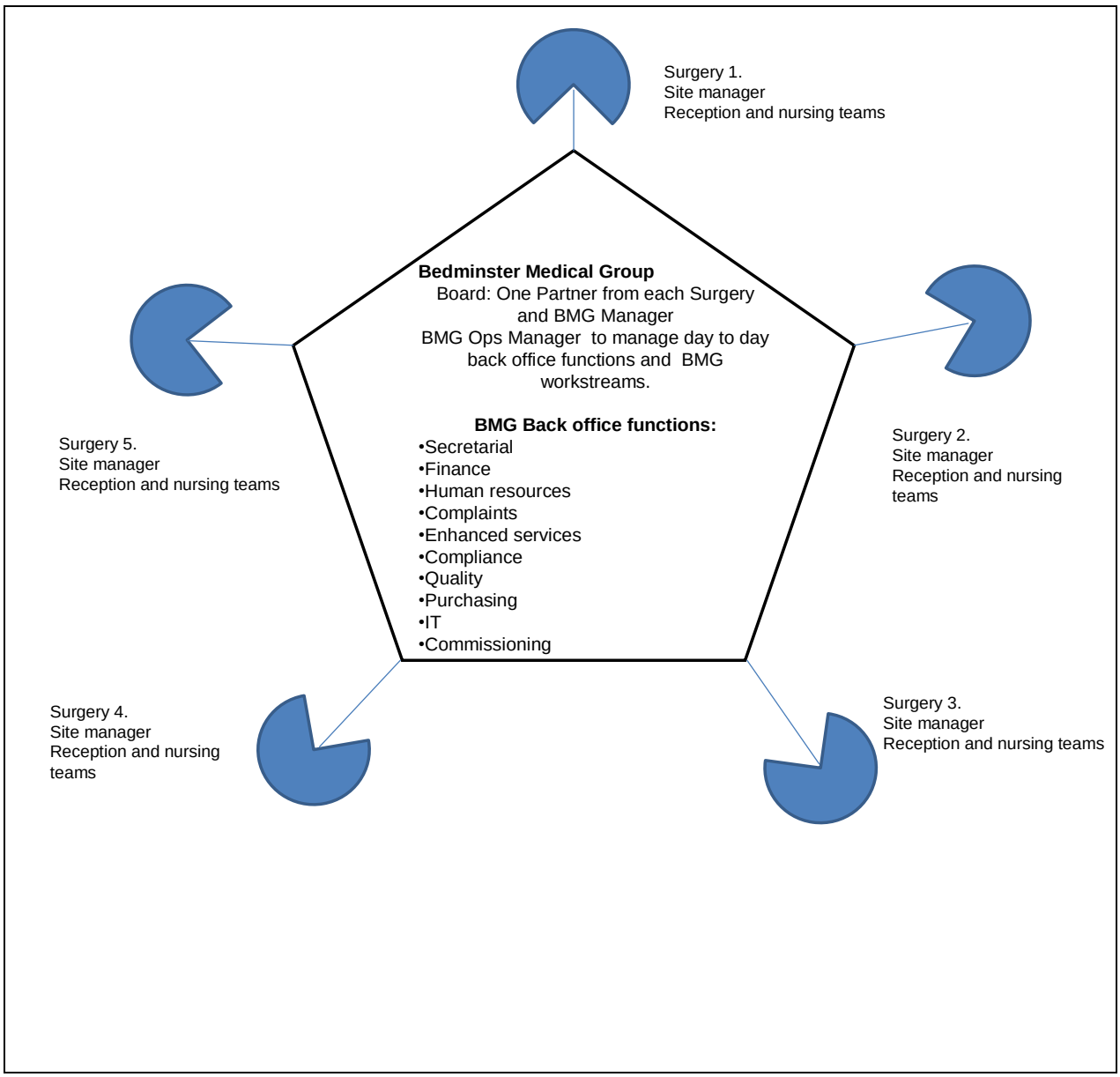
We believe that it would be beneficial for the Commission to visit the site in order to understand our approach to federation, and to then follow our progress. Federation of practices can only increase if we are to maintain our ability to deliver Primary Care effectively and safely over the coming years. We believe that the Commission could use fledgling federations such as ours to build up a body of evidence for hopefully good practice, but we accept that mistakes will be made that learning can also come from.

Overall outline of the service/project/programme:

The intention is to set up a federation of five practices under the umbrella of Bedminster

Medical Group. BMG will hold the central resources leaving the practices to make their own

Individual offering to their patients.



Added value of the service/project/programme

More robust delivery of primary medical services, reduced costs, improved quality across the practices by using examples of best practice. Improved community engagement through involvement on the BMG Board.

AA12 GMC

Organisational Information

Name of organisation	The GMC has identified the following organisations as potentially of interest for the commission's site visits:	Name of service/ project	The following projects:
	Health Education North Central and East London, North West London and South London (London LETBs)		Community Education Provider Networks (CEPNs)
	Royal United Hospital Bath NHS Trust		IMPACT service, including GP training posts in the IMPACT service
	Argyll and Bute Community Health Partnership (CHP)/ NHS Highland		Integration project
	NW London integration		Integration project
Address	London LETBs	Ian Bateman: ian.bateman@ncel.hee.nhs.uk http://hee.nhs.uk/about/our-letbs/	
	RUH Bath	RUH Bath email jay.suntharalingam@nhs.net	
	NHS Highland	NHS Highland Email: maimie.thompson@nhs.net http://www.nhshighland.scot.nhs.uk/OurAreas/ArgyllandBute/Pages/ArgyllButeCHP.aspx	
	NWL Integration	Lis Paice (contact)/Thirza Sawtell: lispaice@googlemail.com NWLWholesystems@nw.london.nhs.uk	
Contact Person Name and Position	London LETBs: Ian Bateman/Frances Wellburn	Type of organisation	Profit ☐ / Not for Profit ☐x
	RUH Bath: Jay Suntharalingam, Respiratory Physician.		Profit ☐ / Not for Profit ☐x
	NHS Highland: Maimie Thompson/ Dave Ritchie		Profit ☐ / Not for Profit ☐x
	NW London integration: Lis Paice/Thirza Sawtell		Profit ☐ / Not for Profit ☐x
Have you consulted with the site?	**London LETBs:** YES ☐ / NO ☐x	Type of organisation	London LETBs: Commissioner ☐x / Provider☐
	RUH Bath: YES ☐ / NO ☐x		RUH Bath: Commissioner ☐ / Provider ☐x
	NHS Highland: YES ☐ / NO ☐x		NHS Highland: Commissioner ☐ /

			Provider ☐x
	NWL integration: YES ☐x / NO ☐		NWL integration: Commissioner ☐x / Provider ☐

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

Context

The GMC regulates medical education and training and our evidence is focussed on education provision. Several of our examples concern the interface of service and education issues, as innovative practice in education is likely to have a positive effect on service.

Possible sites

We have identified examples from our evidence which may be of interest:

- Health Education North Central and East/North West/ South London (London LETBs)
- Royal United Hospital Bath NHS Trust (RUH)
- Argyll and Bute Community Health Partnership (CHP)/ NHS Highland
- NW London integration project

London LETBs
We identified the development of a network of primary care fora (CEPNs) by the London LETBs as of potential interest. They aim to:

- Develop capability and capacity to support future and current workforce needs
- Meet the educational implications of service related changes such as integrated and accountable care
- Take account of the increasing movement and roles of staff across traditional boundaries
- Manage the increasing demand for placements in primary and community settings

We have suggested this item because the aims of CEPNs support integrated working and overcoming barriers to change.

RUH, Bath

RUH offers a COPD service ('IMPACT') which includes a placement for a doctor training in general practice. IMPACT is a community based, multiprofessional service with inreach into secondary care. The role of the GP trainee in the department includes secondary care inreach, acute assessment, consultant-supervised clinics and ambulatory care work with community experience.

We have suggested this example as it integrates primary and secondary care in the delivery of a COPD service, and because it is an example of an organisation which is applying traditional skills (of a GP) to settings which link primary and secondary care. It also uses the skills of different professional groups in delivering primary care (and education).

Argyll and Bute CHP/NHS Highland

Argyll and Bute CHP is establishing a system of joint integrated health and social care between the local NHS and local authority. The CHP will bring together responsibility and budget for these two systems into a single body (clinical governance will remain with the local NHS). The CHP is working towards integrating primary care with other providers systems of health and social care; the stated aims of integration are to deliver primary, secondary and social care services side by side. The CHP also aims to increase coordination and information sharing between the different healthcare systems. We have not collated evidence directly on this project through quality assurance activity but are aware of developments in this area through our policy work.

NW London whole-system integration (pioneer project)

The NW London whole-system integration project aims to integrate all health and social care delivered in NW London. The project will involve primary care providers integrating services with other health providers. The programme started in 2011 with a small number of integrated services involving diabetic and elderly patients. From April 2015 whole-system integration is planned but early adopter schemes are currently in place. We have suggested this item as it includes integration of primary with other services, and because it includes strategies for overcoming barriers to integrated services. We have not collated evidence on this project through QA activity but are aware of developments in this area through our policy work.

Overall outline of the service/project/programme:

London LETBs

The CEPNs are reported to be playing a vital role in bringing together primary care providers to identify capacity for, and establish interprofessional training in primary care. Examples of changes delivered include:

- A module to equip GP trainees with the ability to think about whole populations as well as individual patients, and seek to make changes in practices that tackle the needs of populations
- A programme of interprofessional learning in community settings for medical and nursing students, led by general practice trainee in an 'innovative training post'

RUH Bath

The RUH operates a service called IMPACT (IMProving Access to COPD Therapies) which is delivered in the community by a multidisciplinary team and links into secondary care. Within this service, there is a general practice training post which links primary and secondary care. The services offered include :

- in-reach acute assessment
- consultant-supervised clinics by doctors training as GPs
- ambulatory care work shared with community experience - domiciliary visits, community clinics and admission avoidance.

The experience offered in the GP training post attached to IMPACT was reported by HE South West as offering :

> …doctors in training not only experience in diagnosing and managing chronic respiratory disease within a secondary care environment, but also an opportunity to manage these conditions in the community within a multidisciplinary setting. It is envisaged that the post will help tackle the challenge of delivering specialist training to GPSTs whilst also ensuring they spend adequate time in community-facing posts

In the community based components of the post, the GP in training is supervised by band 6-7 nurse specialists and physiotherapists. The post has received positive evaluation from those completing it and has been recognised as innovative through prizes awarded by other bodies (British Thoracic Society).

Argyll and Bute CHP:

The programme to integrate health and social care is a current national programme in Scotland. Each health board (equivalent to an NHS trust) in Scotland is required to implement changes to integrate these two services. Argyll and Bute CHP has been established between NHS Highland and Argyll and Bute Council to manage the integration project in the Argyll and Bute local authority area. The CHP aims to be operational by April 2015 and a range of services will be made accountable to a single joint board between the health board and local authority, which will have a budget to carry out the integration of services currently managed separately. Agreements and appointments have been made between the NHS and local authority to establish the partnership; an integration scheme has been produced and consultation on the scheme took place during December 2014.

NHS Highland also reported that it has reorganised its GP training programmes in a way which has increased GP recruitment by providing a 'rural track' training programme. Those on this 'track' spend more time in rural practices during their training and NHS Highland has increased the educational support it provides in this area.

NW London whole system integration (pioneer project)

The project encompasses reconfiguration of A&E services, primary care transformation work and seven day access to services in NW London. There is a lead for integration working with HE NWL, Imperial College Healthcare Partners, clinical commissioning groups (CCGs) and others. The area NW London is coterminous with the area covered by HE NWL and the eight CCGs within it.

Supporting the project is an integration toolkit online which outlines what will be done in each borough and how. The integration project includes pooling of budgets by individual organisations and there are examples of services changes from this and an innovation fund is in place for GP led service changes. Examples of innovations as part of the project include:

- Integrated community paediatrics and GP service at St Mary's Hospital for Westminster and Kensington & Chelsea patients
- Virtual ward to delivery 24/7 care outside hospitals in Hammersmith & Fulham
- Investment in care coordinator recruitment and GP receptionist training by HE NWL
- Development of a change academy to influence staff in different organisations

Added value of the service/project/programme

London LETBs

With the requirement for increased capacity for GP training, placements for student nurses and doctors, expanding community based placement for foundation doctors, the London LETBs consider that:

> …learning and working together across traditional boundaries, and the implications of the shape of training

CEPNs are essential to engaging the community educational and provider landscape.

As such, part of the additional value of the CEPNs is in bringing together the different community providers to consider how service needs can be reflected in education and training.

RUH Bath

While the focus of the case study is the educational impact of the placement on GP training, the service in which it is based integrates primary and secondary care, provides interprofessional learning opportunities and prepares healthcare professionals to understand and make links between primary and secondary care.

Argyll and Bute CHP

The integration of health and social care in a single body is intended to achieve greater coordination between the different healthcare systems in the Argyll and Bute area. Integration between health and social care is likely to create added value in terms of ensuring primary care services work constructively with social care; although the project is yet to be completed.

NW London integration

The integration programme has potential value in integrating all components of the care system, ensuring better working between different care professionals, better collaboration between organisations and information sharing, potentially resulting in improved patient experience. Additional value may be added by the Change Academy which is designed to overcome barriers to integration by influencing staff within organisations which are integrating with other sectors; recent issues considered by the academy include how to deal with perceived risk from integration by senior staff within healthcare management organisations. The integration project also has an education focus which is intended to ensure that the values of patient centred care are instilled through education and training of health professionals. Like the Argyll and Bute integration project, the NW London integration project is not yet completed.

AA13 East Lancashire Hospitals NHS Trust

Organisational Information

Name of organisation	**East Lancashire Hospitals NHS Trust** **(ELHT)**	Name of service/ project	**Refer-to-Pharmacy**
Address	Pharmacy Dept, Royal Blackburn Hospital Haslingden R, Blackburn BB2 3HH	Email	**Alistair.gray@elht.nhs.uk**
Contact Person Name and Position	Alistair Gray	Type of organisation	Not for Profit
Have you consulted with the site?	**YES** ☐	Type of organisation	Provider

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

In January 2015, after 18 months of development, Refer-to-Pharmacy goes live which allows the hospital pharmacy team to refer patients fromtheir bedside to their community pharmacist for various post-discharge pharmaceutical care interventions e.g. New Medicines Service, medicines use reviews.

Thirty to fifty per cent of people don't take their medicines as intended which can have consequences on their quality of life and may result in unnecessary illness or admission to hospital. Patients discharging from hospital can access services at their community pharmacy that will improve their medicines adherence, however community pharmacists have no easy way of identifying such patients. This is why ELHT pharmacy department conceived Refer-to-Pharmacy, a fully integrated electronic referral system that facilitates referral of eligible hospital patients to their community pharmacist when they are discharged to help them get the best from their medicines and to stay healthy at home. This innovation was developed in conjunction with software provider Webstar-Health, and is designed to offer a quick and easy referrals solution for hospital and community teams with the whole process wrapped around the needs and understanding of patients.

The NMS, where patients participate in three separate consultations during the first month of starting medicines for certain long-term conditions has been shown to improve adherence by 10%. MURs, and in particular post-discharge MURs, conducted with patients whose medicines have been changed in hospital improves adherence with a three-fold return on investment through reduction in A&E attendances, hospital admissions and drug wastage.

Refer-to-Pharmacy is the first fully integrated hospital to community pharmacy referrals system and I believe it is of value and interest to the health economy and society in general. Please view www.elht.nhs.uk/refer to see the patient facing film which explains how the system works and the benefits of referral to patients.

Part of the current A&E crsis is due to hold ups at the point of discharge. This system can improve the discharge experience for patients.

Overall outline of the service/project/programme:

As a pharmacist or pharmacy technician goes about their daily work they naturally identify patients eligible for the NMS, or an MUR. The patient is asked to watch a short information film on their bedside television designed to explain in lay terms the problems of poor medicines adherence, how Refer-to-Pharmacy works, and the benefits of being referred to their community pharmacist. This film can be viewed at www.elht.nhs.uk/refer.

If the patient consents the pharmacist logs in to the Refer-to-Pharmacy web application (their contact details are then included in the referral) and enters the patient's hospital number into the system that then auto-populates the referral with the patient's demographic details. Using a series of drop-down menus and 'radio buttons' the reason for the referral is captured in seconds. A 'Find-a-Pharmacy' function allows rapid identification of the patient's pharmacy, either through a list or an interactive map. Patients can be referred at any point in their hospital journey from admission onwards, not just at the point of discharge.

The whole process takes a few seconds; it is not time prohibitive and the team can make many referrals each day (the weekday target is 70); large-scale referrals are crucial to realising benefits across the health economy. The referral only leaves the hospital when (electronically speaking) the patient is discharged and their discharge letter is completed. A patient may have an optional text or e-mail reminder sent at discharge to reinforce the referral message.

The community pharmacy receives a message by any combination of fax, e-mail, or text, stating a referral has been received and to securely log in to the system to access patient details. They contact the patient to arrange a mutually convenient time for the consultation. A referral is closed when all actions are complete by capturing an outcome measure, and this archives the referral.

Added value of the service/project/programme

Refer-to-Pharmacy has in-built audit tools to identify the numbers and types of referral and outcomes in the community pharmacy. In January 2015 a research feasibility study commenced, led by the School of Pharmacy at Manchester University, into the outcomes of Refer-to-Pharmacy with particular interest focused on reductions in A&E attendances and hospital readmissions rates. The study will take 12 months to complete.

The Royal Pharmaceutical Society, through their Innovators' Forum, has produced a toolkit to allow other health economies to spread the concept of hospital to community pharmacy referrals (www.rpharms.com/referraltoolkit). The toolkit comprises two sections: Making a Case for Change provides evidence to support the arguments and business case to implement a referral system; and Making it happen gives practical advice, examples on how to implement an effective electronic referral system. A webpage features additional practical resources to aid health economies to spread the concept.

I am very hopeful that we will rapidly evidence the value of this scheme. I believe it is important that other health economies are made aware of this scheme and the value that hospital and community pharmacies working together can bring to health economies. This scheme has the potential to support patients to take their medicines as part of a shared decision making process. Refer-to-Pharmacy has been conceived to be integrated into other IT systems to make it easy to spread the innovation.

AA14 Health Education West Midlands

Organisational Information

Name of organisation	**Health Education West Midlands (HEWM)**	Name of service/ project	**Post-CCT GP Fellowship in Urgent and Acute Care** **Fast Track enhanced NMP for Pharmacists – pilot study**
Address	St Chads Court, 213 Hagley Road, Edgbaston, Birmingham, B16 9RG	Email	Matthew.aiello@wm.hee.nhs.uk
Contact Person Name and Position	Matt Aiello, Special Projects Manager, Transformation	Type of organisation	Profit ☐ / Not for Profit ✓
Have you consulted with the site?	**YES** ✓ / NO ☐	Type of organisation	Commissioner ✓ / Provider ☐

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

1) **Post-CCT GP Fellowship in Urgent and Acute Care:**

Site visit proposed at: Worcester University and / or South Warwickshire Foundation Trust.

Health Education West Midlands propose that, with an increasing emphasis on admission avoidance and reconfigurations resulting in minor injury units and step-down care units where GPs would be involved, additional skills training is necessary to meet such service requirements and provide comprehensive patient care. The Fellowship program aims to address this need, by providing a platform for GPs to gain enhanced skills in the provision of Urgent and Acute care.

Following a successful pilot rollout, the project team demonstrated the adaptability of this Fellowship model, by developing three primary care variations of the programme. The three practice areas were identified as requiring enhanced training for GPs, to allow for working outside of traditional General Practice:

1. **Mental Health (with an optional veterans health element)**
2. **Frail Elderly**
3. **Paediatrics.**

Through the Fellowship programme, HEWM, in cooperation with regional providers, aims to develop a new class of GP, capable of bridging the gap between primary and secondary care and enhancing the scope of General Practice, as part of the joined up, multi-skilled workforce of the future.

The commission should visit the site to meet the Fellows and gain an insight into how the programme operates. From this, they may form an objective view as to its potential for future national scaling.

2) **Fast-Track Non-Medical Prescribing Programme for Pharmacists:**

Site Visit Proposed at: **Either the Universities of Aston, Keele, Worcester or Wolverhampton.**

While the specific skills of the Pharmacist are recognised and considered necessary in the urgent and acute setting, a skills gap relating to clinical diagnosis and "minors" treatment was identified across primary, secondary and community practice. Clinicians who were involved during the course of 2013-14 (West Midlands) research – including Emergency Medicine Consultants, Advanced Nurse Practitioners, Junior Doctors and pilot Pharmacy teams - proposed that offering clinical skills training to the Pharmacist could allow for an effective mid-level, *medicines*-focused clinician; able to practice as a prescribing Pharmacist, while also assisting in minors-focussed clinical duties in an urgent and acute care setting. This increased role diversity is considered to be a necessary skillset for any clinician practicing in today's joined up, multi-skilled, multi-disciplinary urgent and emergency care workforce.

While the GPhC Non-Medical Prescribing module is currently offered by a range of national providers and considered fit for its stated purpose, the course content does not necessarily provide for ED-related clinical diagnosis and minors treatment skills, as applicable to "frontline" urgent and acute care. Further, the length and scope of existing courses is not considered to be optimised against current and anticipated workforce demands.

Following consultation with four West Midlands-based HEIs and a range of stakeholders, Health Education West Midlands proposed the piloting of a "fast-track,"clinically enhanced, non-medical prescribing course for pharmacists. The course was intended to be of particular benefit to those wishing to progress into an Emergency and Urgent or Acute care setting, but applicability to practice areas - including Mental Health, Paediatrics and Community Pharmacy - were also proposed and considered during the project evaluation.

The commission should conduct a site visit to learn more about the pilot programme, view training in the live environment and use their insights to assist consideration for future strategic commissioning.

Overall outline of the service / project / programme:

1) **Post-CCT GP Fellowship in Urgent and Acute Care:**

During the twelve-month fellowship, the GP Fellow will undertake a programme of clinical and academic training, to gain experience in the providing of care for step-down patients in the community. The Fellowship programme is divided into three, four-month phases, requiring a **weekly** commitment of ten (**10**) Programme Activities **[PAs]** to include:

i) **4 PAs** Trust commitment:

- **1st Phase:** Spent within the **Emergency Department** of the nominated Trust**.**
- **2nd Phase**: Spent within the **Acute Medical Unit** of the nominated Trust.
- **3rd Phase:** Undertaking a range of strategic and operational placements within the West Midlands Ambulance Service.

ii) **4 PAs** within a nominated GP practice. Here, the Fellow will work with their GP mentor to develop

ways of transferring skills, experience and innovative working (gained during each of their Fellowship phases) between primary and secondary care settings.

iii) **2 PAs**, during which the Fellow will complete a bespoke **Post-Graduate Certificate [PGCert]** in **Urgent and Acute Care**, delivered by Worcester University. The Certificate aims to develop in its students a deeper understanding of and increased confidence in dealing with the pathophysiological changes that underpin presentations of urgent and acute illness.

The week was set out in this manner to encourage each Fellow to enhance their cross-practice strategic and operational thinking, while also allowing for maximum opportunity to innovate.

2) **Fast-Track enhanced NMP for Pharmacists – Pilot:**

The proposed programme would take the existing NMP course content and condense its duration from six, to three-four months, without shedding any of the required content.

Further, with many employers having factored in the need for six month NMP training in their long-term workforce planning, it was considered appropriate to exploit this time allowance, by enhancing the fast-track NMP module with a series of additional, "bolt on" clinical health assessment and minor injuries / minor illness training modules.

The result would be a six month course, featuring the Fast-Track NMP module and a "to be determined" level of Minor Injuries, Minor Illness and Clinical Diagnosis training; specifically:

- A 3-4 month Fast-Track Non-Medical Prescribing Module for pharmacists (GPhC approved)
- An additional 2-3 months of blended minor injuries / minor illness and clinical health assessment training.
- Robust Evaluation – employers were expected to engage fully with the evaluation; a part of which was a post-project review of how the pharmacist prescribers have been deployed within their organisation.

To demonstrate the potential for cross-HEI collaboration on a standardised course structure, with the potential to influence regional and national
planning, four West Midlands HEIs were chosen to deliver a pilot course to HEWM specifications.

The chosen HEIs represent a geographical cross-section of the West Midlands, allowing West Midlands-wide access to training.

Course providers were asked to join the pilot programme against the following (summary) brief:

- The provider is able to provide / does already provide a GPhC accredited standard or "Fast-Track" NMP module for Pharmacists.
- That the course provider is capable of offering one cohort, of a size no less than 15 trainees.
- That, within the same programme, specific additional clinical training – as defined by HEWM and discussed above – will be offered. This additional training will be considered a part of the overall cost of the module and **will not be severable**.
- The programme should award a postgraduate certificate (min 60 credits), reflecting the extended curriculum and providing a suitable background to support further studies for higher awards.

- The entire programme – comprising Fast-Track NMP and clinical skills training – will take no longer than 6 months to complete.
- The course provider will allow HEWM access to all anonymised data collected in relation to the course (other than that restricted by University or National Regulations), to assist in national planning and including any internal or external evaluation process.

Added value of the service / project / programme:

1) **Post-CCT GP Fellowship:**

Upon successful completion of the twelve month programme, Fellows will be able to confidently:

- Demonstrate the ability to diagnose and assess urgent presentations in long term illnesses.
- Formulate, implement and evaluate current pathways of care according to best evidence.
- Show understanding of frail and elderly complex co-morbidities and how such patients are appropriately managed.
- Demonstrate competence in the interpretation and evaluation of evidence and the application of appropriate treatment and assessment.
- Apply knowledge and skills to the management of urgent care.
- Critically interpret and evaluate the current evidence behind urgent care.

As a result of the live pilot, the PGCert has been directly influenced by its contributor's exposure to each of the key clinical phases. The programme is unique in this respect, as it has been designed and influenced by its practitioners, with the aim of blending clinical and academic learning.

With the future joined-up workforce model in mind, the PGCert modules were designed to be relevant to a multidisciplinary intake (eg. Nursing / Pharmacists / Physician Associates) as well as GPs.

The programme aims to develop GPs capable of practicing effectively and with confidence in new roles in primary and community care, whilst continuing to use their skills in managing complex co-morbidity within the acute setting in emergency departments and medical assessment units. The Fellowship will enable the retention of generalist skills and the development of specific and enhanced skills to fit new settings of urgent care.

7 Pilot Fellows are currently undertaking and evaluating the programme (between January 2014 and November 2015), with a first cohort of 25 Fellows scheduled for September 2015 in the West Midlands.

HEWM are also working with London and KSS LETBs, who have expressed an interest in the programme.

2) **Fast-Track Enhanced NMP Programme for Pharmacists:**

- The aim of the enhanced NMP programme is to develop, initiate and evaluate a blended, clinically enhanced NMP module, capable of being standardised across the region and, ultimately, for national

scaling.

- To provide a workforce strategy to address identified workforce shortages in Urgent and Acute pathways, across secondary, primary and community care.
- To improve discharge times by providing a multi-skilled clinician, capable of undertaking “minors” clinical duties, while also using their specific skills as an Independent Prescriber Pharmacist to provide a service which may otherwise be undertaken (unnecessarily) by medical grades.
- To reduce patient waiting times and improve patient care.
- To provide effective and appropriate care to patients presenting with minor ailments and to pre-discharge / acutely ill patients.
- To address an identified need for drug therapy / management in emergency and acute care, from point-of-admission to point of discharge.

Phase 1 of the pilot was successfully completed, with 50 Pharmacists exiting (or due to exit) the courses as Independent Prescribers. Phase 2 will see a further 80 places offered to West Midlands pharmacists across primary, secondary and community care providers.

A collaborative evaluation is currently underway, involving HEWM and the Universities of Keele, Aston, Worcester and Wolverhampton. As well as providing the basis of a business case for future commissioning, the evaluation has also demonstrated good practice by creating a collaborative working relationship between regional course providers.

Overall, the project aims to demonstrate an appropriate use of the workforce - freeing up middle grades, junior doctors and consultants to conduct clinical work and developing the multi-skilled ED and AMU teams, resulting in a positive impact on patient safety and improved patient experience and throughput.

The project team firmly believe that continued development of near-patient clinical pharmacy training – within secondary, primary and community-care - will allow the role of the clinical pharmacist to evolve and gain increasing credibility, supporting the joined up multi-disciplinary workforce of the future in the delivery of high quality patient care.

AA15 Guys and St Thomas' Community Service NHS FT

Name of organisation	**Guy's and St Thomas' Community Service NHS Foundation Trust**	Name of serv project	**Integrated care clinical Pharmacist GSTT@home service**
Address	Walworth Road Clinic	Email	Lelly.Oboh@gstt.nhs.uk
Contact Person Name and Position	Lelly Oboh, Consultant Pharmacist Care of older people	Type of orga	Profit/NotforProfit
Have you consulted with the site?	YES/NO	Type of orga	Commissioner/Provider

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

This is an innovative and unique pharmacy service for patients within the GSTT @home service (Provides an alternative to hospital admissions and allows early discharge by delivering a range of advanced nursing interventions). The ICPs lead medicines optimisation by developing and delivering a clinical pharmacy service to improve patient outcomes, equip and enable multidisciplinary practitioners within the @Home team to optimise medicines use within their scope of practice.

In the last 2 years, the ICPs have developed a unique skill set and expertise to fulfil the role within the constantly evolving @home service. It involves clinical skills to undertake in-depth domiciliary medication reviews/assessments for patient (usually over 65s) with complex therapeutic health and social care needs who also require urgent care for acute infections and exacerbations of existing chronic conditions. The role also involves leading and supporting all aspects of medicines use within the team as well as promoting and developing safe medicines related processed and protocols.

There are two main aspects of the ICP's role:

- Direct patient care: This involves proactive screening for medicines related risks, medicines reconciliation and undertaking domiciliary medication reviews. @home staff identify and refer patients at the highest risk of medicines related morbidity and/or hospital readmission who needed ICP input. The ICP prioritises patients for a domiciliary visit according to their needs and undertakes a holistic medication review that considers various aspects of the individual's condition and circumstances. A care plan is then jointly agreed with the patient and the pharmacist makes recommendations to various health and social care practitioners to optimise the use of medicines. The pharmacist is able to carry out simple practical interventions to support the patient to take their medicines as prescribed. The pharmacist can also accept referrals from the locality community multidisciplinary team (CDMT).

- Medicines optimisation leadership: The ICP provides expert advice and support on all aspects of prescribing and medicines handling (e.g. procurement, prescribing, medicines reconciliation, administration, storage, record keeping) within the @home service to ensure that the use of medicines is optimised and meets safety, statutory and governance requirements. In addition to this, there is also the collating and analysis of prescribing data which enables the monitoring and improvement of clinical and cost effectiveness. Another important aspect of this role involves nurturing partnerships and facilitating collaborative working between

multidisciplinary teams especially during the transfer of care. Identifying and providing support to meet medicines related training needs for clinical and non-clinical staff to reduce medicines related adverse incidents and improve outcomes is also a crucial aspect of the ICP role. The service is constantly changing to cater for the increasing pressure of patients who present within A&E settings and aims to deliver care in domiciliary settings as much as it possible. As a result there are constant challenges for the pharmacists to meet the demands and challenges of procuring, supplying, prescribing medicines and delivering a "virtual ward" clinical pharmacy service in the community in a safe, way as well as meeting statutory requirements.

The ICP works collaboratively with health and social care practitioners, patients and their relatives to ensure that seamless care is provided

Overall outline of the service/project/programme:

The GSTT@home service is a team that provides 'acute clinical care at home that would otherwise be carried ou hospital. Interventions are delivered in the usual place of residence in order to provide the best possible patient e and outcome, and enable the patient to benefit from holistic integrated care. '

The @home Service consists of:

- Nursing staff of various levels (includes prescribers)
- General Practitioners
- Physiotherapists (PT)
- Occupational therapists (OT)
- Rehabilitation support workers
- Social workers
- Access to Geriatricians for specialist medical advice
- Integrated Care Clinical Pharmacists (1.5 WTE)

The @home service is part of a wider program (Southwark and Lambeth Integrated Care program older people program) to reduce hospital admissions and facilitate early discharge. It provides integrated case management of individuals with complex needs and a range of interventions in an individual's home that offer an alternative to hospital admission. The service is aimed at adults most at risk of being admitted to hospital (usually vulnerable older people), and care is coordinated by the @home service matrons with intensive support from a range of health professionals.

Added value of the service/project/programme

Benefits to patients

Patients are most vulnerable and at higher risk of medicines related errors at the point of transfer of care between services or settings. Many errors are picked up by the ICC pharmacists and potentially adverse events are averted e.g. wrong dosage, omitted drugs, inappropriate prescribing, duplication of therapy, non-adherence etc. There are

many examples of individual patient benefits:

- Better access to medicines through liaison with local community pharmacies.
- Adequate supplies of emergency stock.
- Improved adherence (particularly with inhalers).
- Resolution of conflicts between health and social care to facilitate safe administration of medicines.
- Liaison with GPs to discontinue long term prescribed medicines that are no longer indicated.
- Monitoring to improve therapeutic effects and reduce adverse effects of prescribed medicines.
- Supporting and empowering patients to self-administer medicines.

Historically, patients usually come into contact with pharmacists during their stay at hospital or in community pharmacy settings in primary care. Many of the @home service patient have multiple long term conditions or housebound and don't receive the appropriate level pharmacy expertise, input or support that could reduce the risks of medicines related hospital admissions. So the ICP reviewing medication and co-ordinating the medicines related aspects of their care is a bonus which many patients and health care professionals find beneficial.

Local healthcare system

The ICC pharmacists receive regular clinical supervision and support from a Consultant Pharmacist for older people and had access to Consultant Geriatrician advice.

Working with the Specialist and Consultant Pharmacists and the Medical Consultant for Infectious Diseases (amongst others), the ICC Pharmacists have led the development of an intravenous antibiotics guideline specific to meet the needs of this unique patient group presenting to the @home service. Previously there was confusion as to which guideline should be followed by the @home service as patients are mainly admitted from two different Acute Trusts and Clinical Commissioning Groups.

The ICC pharmacists also developed a process to improve access to medicines, as well as implemented a medicines reconciliation and recording system which has reduced delays, as well as prescribing and administration errors. The ICC Pharmacists have also reduced drug waste through tighter stock control and monitoring of prescribing data.

AA16 Innovation in Health and Wellbeing (Jhoots Pharmacy)

Organisational Information

Name of organisation	**Innovation In Health and Wellbeing** **Lead by Jhoots Pharmacy**	Name of service/ project	**Level 2 Weight** **Management Programme**
Address	Jhoots Group, 43-45 Church St, Darlaston WS10 8DU	Email	**manjitjhooty@jhoots.co.uk**
Contact Person Name and Position	Manjit Jhooty – Managing Director	Type of organisation	Community interest company which has private and public sector partners
Have you consulted with the site?	**N/A**	Type of organisation	Provider

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

IHWB operates as a Strategic Centre of Excellence, and is currently developing a training scheme which it hopes will create hundreds of licensed weight-loss experts to work with obese people in the community. The training scheme is focused on an evidence-based, weight management programme including dietary advice, physical activity, and psychological support - a programme that is continually evaluated and audited to ensure best practice.

Health problems associated with obesity include heart conditions, diabetes, high blood pressure, limited mobility, sleep apnea and depression, which all impact hugely on people's lives. Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity.

IHWB's Board includes senior representatives from across the Public, Private, and Community sectors - primarily from the Walsaii/West Midlands area· and is chaired by Andrew Hartland, Consultant Bariatric Physician, Walsall Manor Hospital. Its other members are Jatinder Sharma (Principal and Chief Executive of Walsall College), Manjit Jhooty (Managing Director, Private Sector Pharmacy Group), Pauline Jones (Jobcentre Plus, Dudley), Kuldip Bains (Pharmacist), Carole Wildman (Walsall Housing Group), John Fell (Walsall Council), and Akshay Parikh (Chairman, Accord Housing Group).

Where we are now:

- Secured Awards for All Lottery funding - £10k for Toolkit
- Design and deliver Weight Management Toolkit
- Set up 3 weight management clubs
- Make 150 contacts through promoting weight management clubs
- Set up a web site to enable access to NHS tools and applications
- Contracted Walsall College to accredit additional units to enable qualification to be publicly funded

- Secured grant from Walsall Clinical Commissioning Group to promote the qualification
- Secure funding to set up a professional development web site to support the qualification and those who achieve the level 2 qualification and set up weight management clubs

Overall outline of the service/project/programme:

Level 2 Weight Management Program delivering in the community by all key assests of the community (Jatinder Sharma (Principal and Chief Executive of Walsall College), Manjit Jhooty (Managing Director, Private Sector Pharmacy Group), Pauline Jones (Jobcentre Plus, Dudley), Kuldip Bains (Pharmacist), Carole Wildman (Walsall Housing Group), John Fell (Walsall Council), and Akshay Parikh (Chairman, Accord Housing Group).

Dr Andrew Hartland, consultant, NICE Fellow for diabetes:

– IHWB offered the opportunity to work with other strategic partners, including those not directly within the NHS, to develop integrated strategies to address current population health problems.

Department of Work and Pension

– Committed to partnership working to reduce poverty and workless-ness

– Innovative working to deliver services which improve customer outcomes and value for money

Jhoots (Pharmaceuticals and Healthcare)

– Integrated partnership working

– Opportunity to work with other strategic partners within the local population

– Using Primary Care assets to retain patients at home and release pressure on emergency admissions in to Secondary Care.

Ron Bains, Walsall Healthcare (Lead Pharmacist)

– Specialist in weight management service clinic and community focussed projects

– Social enterprise and not for profit model

– Improve health inequalities

– Enhance pharmacist recognition and integration with other stakeholders

Walsall College

– Training offer that will impact on poor health

– Achieve synergies and increased return on investment through partnership working

– Sustainable model for cross sector working to tackle health inequalities

– Serve local communities with innovative learning opportunities

Walsall Council

– Integrated working

– Promoting health as a priority linked to economic development

– Improved access to jobs through better health outcomes

– Joined up working and able to compete for and secure funding that meet collective priorities European, Lottery and Health funding

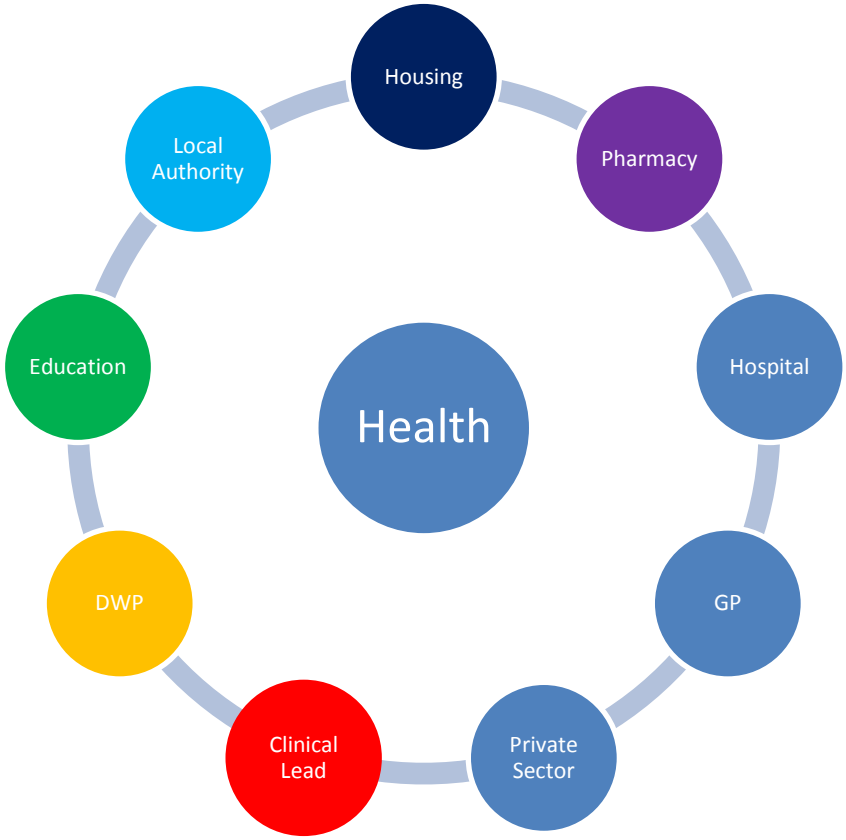
Walsall Housing Group

– Have successful Community Health Team in place funded through Public Health Walsall

– See health improvement as a pathway into work

– House a fifth of the borough in neighbourhoods where health is poorest

– Have a corporate objective to improve health outcomes for all customers



Added value of the service/project/programme

The analysis by the Government's "Foresight Report- Tackling Obesities: Future Choices" shows that over half of the UK adult population could be obese by 2050. The economic implications of this are substantial. The economic costs of obesity are estimated at between £3.3 and £3.7 billion per year. The
costs of overweight and obesity combined are estimated at between £6.6 and £7.4 billion per year. The NHS costs attributable to overweight and obesity are projected to double to £10 billion per year by 2050 with the wider costs to society and business estimated to reach £49.9 billion per year.

In recent years Britain has become a nation where being overweight is the norm. The rate of increase in overweight and obesity in children and adults is striking, and by 2050 forecasts indicate that 60% of adult men, 50% of adult

women, and about 25% of all children under 16 could be obese. Currently the delivery of most medical weight management programmes is not through doctors and nurses but through community-based, NHS sponsored commercial organisations such as Weight Watchers and Slimming World. The average NHS financial commitment is between £500,000 and £1million per annum per Primary Care Trust (each town has its own PCT, and many cities have two or three PCTs).

There is a great need for qualified bariatrics advisors across the UK. Organisations such as The Manor Hospital, Walsall have been delivering weight management programmes – in house and through clinics in the community - to encourage people to be lighter and healthier for the past two years.

Other Government funded provision of services and advice to help people to lose weight is provided by organisations such as Slimming World and Weight Watchers -and GPs can offer patients trial sessions at these organisations paid for through the NHS. However, while there is some limited training for weight loss advisors it is unregulated and not validated. That causes concern because it is difficult lo know whether the advice being given by the advisor is good advice.

IHWB, in conjunction with Walsall College, is developing a training programme for weight management advisors which is currently going through the stages of being endorsed by a recognised awarding organisation. The endorsement will come from Accredited Skills for Industry (asfi) - the awarding organisation which supports the accreditation of in-company training for employers by determining training needs, designing and validating modules, and producing nationally recognised qualifications.

Consequently, the IHWB training programme will enable individuals to undergo formalised training which will result in them being awarded a recognised qualification and a Quality Mark 'licence to Practice'. This will to help to provide assurance to people going to that individual that they are appropriately qualified.

The licence to Practice will cover areas such as nutrition, exercise, and psychological support strategies, and will be evidenced by clinical, social and financial outcomes. License to Practice regulations tend to be more extensively used in other countries than in Britain. For example, 29% of the workforce in the United States is subject to licensing compared to just 13.5% in the UK. It could be argued that a greater emphasis on the qualifications necessary to operate in the workplace results in a reduction in the need to
regulate what actually happens in the workplace.

IHWB is bringing a more professional and effective approach to weight management through the enthusiastic commitment of its 'team' members. For example, there are a number of key reasons why Housing Associations are likely to support weight management initiatives being put forward by IHWB.

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

Walsall Housing Group and NHS Walsall have just completed a three year health promotion programme funded through the Reaching Communities National Lottery. The IHWB activities will be taken up by Wallsall Housing Group and will assist in continuing their work in tackling obesity.

Housing Associations promote health and well being initiatives amongst their resident communities. A healthy resident

community is generally a more active community and, by inference, more receptive and responsive to ideas and initiatives that are put forward, and more willing to take part in training and learning schemes in order to be better prepared for the world of work.

Nearly 40% of the total population in Walsall live in Housing Association owned or managed properties. A significant proportion of this number may be regular receivers of healthcare support from the NHS. Dedicated initiatives could be drawn up to specifically target these audiences to try to reduce the financial and service provision drain on the NHS.

Another IHWB team member, Jobcentre Plus, is also committed to work in partnership to help address health issues - such as problems arising from obesity - for unemployed people, and has providers who can deliver to its customer group.

Moving customers back into work is the primary function for Jobcentre Plus as evidence shows that those who move off benefits • but then do not enter work • are more likely to report deterioration in health and well being.

There are two particular types of customers it focuses on • those on Jobseeker Support Allowance and Income Support, and those on Employment Support Allowance. There are 27,860 individuals receiving out-of-work benefits in Walsall as of May 2011. There are a number of different funding streams and partner organisations supporting Jobcentre Plus to move people back into work - including the Flexible Support Fund and the new ESF funded support to families identified as having multiple barriers to work.
Another way in which weight management programmes can be effectively delivered is through pharmacies - an approach being developed by another IHWB member from the private sector, Jhoots Pharmacy.

Jhoots has committed to putting staff from 46 of its stores across the West Midlands through the first awarding organisation endorsed weight management training courses at an investment cost to the company of around £150 per person.

Walsall Council Social Care and NHS Walsall are working together to ensure that Walsall residents have access to - and are using • services while remaining In their local community.

As well as weight management initiatives, the Council and NHS Walsall are, for example, investing in a Telecare/Telehealth Response Service which is free to all residents of over 80 years of age, and can also be used by any vulnerable adults in the community. This initiative also works in partnership with the ambulance response services.

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

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

A key focus of IHWB's current activities is identifying where funding is available (for example some £210m through the Clinical Commissioning Groups), how it is being spent, and how effectively the services are being delivered. This is being compared with how a co-ordinated approach by IHWB can bring greater efficiencies, reduced overall costs to the health service. and a more professional – and licensed and accountable - delivery of weight management services. A

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

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

AA17 NHS England devolved to St Helens CCG

Organisational Information

Name of organisation	**NHS England devolved to St Helens CCG (this is the Trust/Board** responsible for GP practices) Sherdley Medical Centre and Eldercare (both at St Helens Hospital, Marshalls Cross Road, St Helens)	Name of service/ project	**ElderCare**
Address	ElderCare 2nd Floor Orange Zone St Helens Hospital Marshalls Cross Road St Helens WA9 3DA	Email	01744627509 m.vandessel@btopenworld.com
Contact Person Name and Position	Dr Michael Van Dessel	Type of organisation	Profit ☐ / Not for Profit x
Have you consulted with the site?	**YES** ☐ / NO x	Type of organisation	Commissioner ☐ / Provider x

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

This is an innovative development for primary care services targeted at the need to deliver high quality primary care services to housebound patients and care of the elderly in residential nursing homes and to improve acess to primary care throughout the day from 8 - 8.

The services at Sherdley Medical Centre and ElderCare offer exclusive advanced access for patients with extended opening hours from 8 – 8 as a routine and have a range of primary care clinicians who can deliver care exclusively in the community.

Early indications are that this reduces the pressure on acute and unscheduled care services at time of high demand (winter emergency care pressures) and offers the opportunity for developing community based care plans and reducing admission rates for the elderly by developing advanced care plans.

The scope of practice extends to screening , prevention and care for patients with demetia and the holistic approach and palliative care in the community.

The scheme has been supported by developing it as an innovative training post for GP specialty training.

The benefit for the NHS is that it relieves some of the pressure on acute care but in addition it has the potential for

expansion of the primary care workforce locally in an area of deprivation with an anticipated retirement bulge 2015 – 17.

The visit is merited to understand how this project and the infrastructure has been developed, particularly using a hospital site that was due for redevelopment and the workforce development of the multi-professional team. It is a good example of addressing a local workforce and access to health care need by exploring innovate solutions (thinking outside the box).

Overall outline of the service/project/programme:

This is an innovative development for primary care services targeted at the need to deliver high quality primary care services to housebound patients and care of the elderly in residential nursing homes and to improve acess to primary care throughout the day from 8 - 8.

Added value of the service/project/programme

Early indications are that this reduces the pressure on acute and unscheduled care services at time of high demand (winter emergency care pressures) and offers the opportunity for developing community based care plans and reducing admission rates for the elderly by developing advanced care plans.

The scope of practice extends to screening , prevention and care for patients with demetia and the holistic approach and palliative care in the community.

AA18 Parklands Practice

Organisational Information

Name of organisation	**Primary Care Education Group**	Name of service/ project	**Advanced Training Practice Scheme – Student Nurse Training in General Practice**
Address	**Parklands Medical Practice** **30 Buttershaw Lane** **Bradford** **BD6 2DD**	Email	anne_lowe54@hotmail.com
Contact Person Name and Position	**Anne Lowe**	Type of organisation	**Not for Profit**
Have you consulted with the site?	**YES**	Type of organisation	**Provider**

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

Primary Care Education Group is a leading member of The Advanced Training Practice Scheme (described below) and is the Bradford Hub.

Context

General Practice has an unprecedented workforce crisis at all levels. We have increasing demands from an ageing population with multiple co-morbidities .There are high retirement levels for GPs and experienced practice nurses and shortfalls in GP recruitment. Furthermore there is the expectation that more services be transferred out of secondary care into a primary care setting.

What we do

The Advanced Training Practice Scheme (ATPS) was funded by Health Education Yorkshire and Humber 7 years ago to produce a model that would promote entry of nurses into General Practice.

At the outset of the scheme, only a very small number of students in the region had any exposure to General Practice nursing. Their only experience was short periods attached to “community staff” e.g. District Nurses in a largely observation role

The ATPS provides student nurses with accredited, high quality substantive placements (6-14 weeks) attached to practice nurse teams. Currently 200 nurses a year are placed across 130 participating practices, but with a growth strategy to reach 700 placements a year by 2016, resulting in 40% of all student nurses in the region will gain GP experience.

The ATP network consists of 8 educational “Hubs” based in General Practices covering the whole region which

recruit a network of surrounding practices (the Spokes) to take student nurse placements. The Hub liaises with University placement teams, organises appropriate mentorship training and induction for the Spokes. They organise ongoing support via mentor workshops and Inter-Professional Learning sessions and contribute to the expert steering group.

Impact/Outcomes

Coverage of scheme: Achieved region wide footprint, with intention that each hub grows to support 20-30 spokes.

An increasing number of Spokes have employed previous students in their own practice directly on qualification.

We have robust quality assurance in place to make sure standards of placement are consistently high.

Massive shift in career intentions: Outcome audits show a shift from 30% student nurses considering Practice Nursing as a first career choice prior to GP placement to 88% after placement. This is a reflection of the high quality and close supervision students get in their GP settings. Of those who have graduated since going through the ATPS more than 10% have been employed directly into Practice Nurse roles in GP.

Nurse mentor feedback: Many practice nurses have a wealth of experience and expertise but have not had active teaching roles so are nervous of having a student. Feedback from mentors tells us that their ATP role improves their own professional development and job satisfaction.

Recruiting newly qualified nurses: ATPS Practices can post job vacancies on a Facebook page accessible to all student nurses.

Improved relationship and understanding with Universities-collaboration and influence over curriculum and placement requirements

Collaborative working with CCGs to promote visibility of and support for the scheme

Presentations at RCN and RCGP conferences.

Overall outline of the service/project/programme:

The Advanced Training Practice Scheme provides student nurses with accredited, high quality substantive placements (6-14 weeks) attached to practice nurse teams. Currently 200 nurses a year are placed across 130 participating practices, but with a growth strategy to reach 700 placements a year by 2016, resulting in 40% of all student nurses in the region will gain GP experience and experience of interprofessional learning in GP practice settings.

Added value of the service/project/programme

Massive shift in career intentions: Outcome audits show a shift from 30% student nurses considering Practice Nursing as a first career choice prior to GP placement to 88% after placement. This is a reflection of the high quality

and close supervision students get in their GP settings. Of those who have graduated since going through the ATPS more than 10% have been employed directly into Practice Nurse roles in GP.

Considerable interest from LETB's across the country in our modelling and success.

For further information visit :

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

AA19 Hambleton, Richmondshire and Whitby CCG

Organisational Information

Name of organisation	**Hambleton, Richmondshire and Whitby CCG**	Name of service/ project	**Integrated working GP and Yorkshire Ambulance Service**
Address	**Civic Centre, Stone Cross Northallerton, DL6 2UU**	Email	**john.darley@nhs.net**
Contact Person Name and Position	**John Darley**	Type of organisation	Profit ☐ / Not for Profit x
Have you consulted with the site?	**YES** √ / NO ☐	Type of organisation	**Commissioner** √ / Provider ☐

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

Yorkshire Ambulance Service (YAS) has for some time worked with a GP practice in the Dales where the Paramedic has become an integral part of the service offered to the patients within that area by both YAS and the GP practice. This has recently been repeated at Pickering utilising an Emergency care Practitioner.

To assist with the management of Red 1 & 2 calls and reduction in transport rates within the CCG, the placement of a skilled ambulance clinician into the area is being piloted. This pilot involves the deployment of a Paramedic Practitioner (PP).

Added value of the service/project/programme

The aim of this procedure is to provide a clear pathway that can be followed by the PP and the GP's within the group when working in partnership.

The expectation is that response to Red 1 & 2 calls will improve in the local area.

It is anticipated that referral to a PP may avoid inappropriate attendance at emergency Departments, and a more timely response for patients, with the GP support in place to provide an appropriate care pathway outcome.

YAS will monitor and audit:

- Total number of referrals from GP's to YAS PP by area and time of day
- Numbers of patients requiring a GP visit following PP assessment
- Numbers of patients requiring ambulance transport following PP assessment
- Proportion of patients seen by the PP and treatment regime commenced (i.e. 'see, treat & refer')
- Number of Red 1 & 2 attended and the impact upon the 8 minute standard
- Number of ambulance clinician referrals
- Proportion of non-transport following PP intervention
- Impact on crew referral within the locality
- Impact on cross border mutual aid requests
- Impact on red standard within the locality

AA20 Bridlington

Organisational Information

Name of organisation	**Brid inc**	Name of service/ project	**Brid Inc**
Address	Dr M Hardman, Practice 2, Medical Centre, Station Avenue, Bridlington YO16 4LZ Tel 01262 670690/ 07736 799595	Email mike.hardman@nhs.net	
Contact Person Name and Position	Dr Mike Hardman: lead GP	Type of organisation	Profit x / Not for Profit ☐
Have you consulted with the site?	**YES** x / NO ☐	Type of organisation	Commissioner ☐ / Provider x

Outline below the service/project/programme that you would like the Commission to visit. Please state why the

Commission should visit this site. (Maximum 500 words)

Brid Inc was formed in early 2014 in response to one of the five practices in the town being threatened with closure after 4 of its 5 GPs left. We were concerned that there would be a domino effect on the remaining practices. We now work collaboratively, following the work-streams on our Business Plan: Prescribing initiative with the CCG, developing a new model for access for patients, developing our partnership board, a hub-model over-75s service, Education and Research Department and combining back-office functions across the practices. The tide of GPs leaving the town has turned, and numbers will improve further as we are about to appoint our first GP researcher together with the University of Hull Medical School (HYMS). The Vice-Dean of the medical school, Dr David Pearson, came to work in Bridlington as a GP in October to help develop these plans.

We have brought together stakeholders in the local Health & Social Care environment on our Partnership Board. This comprises the local Council, CCG, Community Care provider, HYMS, Brid Inc, the voluntary sector and patient group. It is chaired by the local Health Trainers lead and provides Brid Inc with a legitimacy and social direction previously absent. Our first main project is with the EASYCare organisation, undertaking an economic evaluation project of their interventions in the over 75 age group; work which will be used to inform national and international policy in this area.

Overall outline of the service/project/programme:

Working with Hull York Medical School, we have created the UKs first Academy of Primary Care, committed to moving undergraduate and postgraduate medical education into the more deprived areas of the University's locality, with the intention of improving healthcare, testing new models of care, improving training and teaching and ensuring good quality research into our initiatives. We are working towards ATP status, and have had advanced talks regarding starting training nurses and pharmacists through this scheme. We are negotiating with the council and MacMillan to set up our own not-for-profit NHS carers scheme, providing carers with a pensioned post to encourage retention, HCA training to encourage career progression (ultimately linking to nurse training), and improved care for our patients

through developing long term relationships with these important members of staff.

With York Foundation Trust, we are developing our Acute General Practice Service, aligning it with the local Minor Injuries Unit, to offer accessible, appropriate care when needed, and reducing onward escalation to secondary care. We also aim to increase the number of GPSI posts in the town, to improve careers for established colleagues, encourage new colleagues, improve liaison with secondary care, and more efficient use of its resources.

With the council, we have advanced plans for a new building in which all health & social care staff can co-locate. We are rolling out in April our over-75s accountable-care organisation model, This will unite geriatrician, GP, modern matron and social worker into a unit, using care-navigators as patient advocates, able to respond on a daily basis to any crisis which may otherwise lead to an unplanned hospital or care admission.

Added value of the service/project/programme

Mitigation of workforce risk by shared action across primary carfe providers, intergration of service provision and collaborative working with other key stakeholders including: Health Education Yorskhire and the Humber, East Riding CCG, NHS England Area Team

AA21 Leeds Community Healthcare NHS Trust

Organisational Information

Name of organisation	**Leeds Community Healthcare** **NHS Trust**	Name of service/ project	**York Street Health Practice**
Address	68 York Street, Leeds, LS9 8AA	Email john.walsh@nhs.net	
Contact Person Name and Position	John Walsh Practice Manager 0113 - 2954840	Type of organisation	Profit / Not for Profit x
Have you consulted with the site?	**YES** tentative expression of interest by e-mail	Type of organisation	Commissioner ☐ / Provider x

Outline below the service/project/programme that you would like the Commission to visit. Please state why the

Commission should visit this site. (Maximum 500 words)

People who are homeless or temporarily housed often need support from a broad mix of services from a variety of organisations. It's in their best interests if those services work closely together to ensure that all their needs can be met, and information and signposting is as consistent as possible. York Street Practice, a wellbeing centre for people who are homeless and those seeking asylum, draws together health and social care support, counselling, physiotherapy, benefits, housing and legal advice to offer people a tailored, co-ordinated approach.

The Commission should visit this site because Simon Stevens in his NHS five year forward view describes a mixed economy of practices working together at scale and in some areas, primary care services delivered by NHS Trusts. This practice is run by an NHS Community Trust, has an innovative model of delivery with integration between health and social care services and provides services to hard to reach populations who often experience difficulty accessing timely care to meet significant needs.

Added value of the service/project/programme

Although the NHS scores highly by international comparison in the domain "access to health care", we know that hard to reach populations can experience difficulty accessing good quality primary care. The increased costs of service usage in secondary care settings is well documented. Integrated delivery of health and social care in a GP setting can improve outcomes and reduce costs and service pressures in secondary care.

Through involvement in education and training the practice is able to offer contextual training to doctros, nurses and other care workers in training, many of whom have learning needs around delivering care to hard to reach populations.

AA22 Fisher Medical Centre

Organisational Information

Name of organisation	**Fisher Medical Centre**	Name of service/ project	**Physicians Associates**
Address	Millfields, Coach Street, Skipton, North Yorkshire BD23 1EU	Email	**James.Thomas@yh.hee.nhs.uk**
Contact Person Name and Position	James Thomas General Practitioner	Type of organisation	Profit ☑ / Not for Profit ☐
Have you consulted with the site?	**YES** ☑ / NO ☐	Type of organisation	Commissioner ☐ / Provider ☑

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

The practice employs 4 Physicians Associates and is transforming its workforce using new types of primary care worker

Overall outline of the service/project/programme:

Fisher Medical Centre is a semi rural practice covering a population of 14k.

Like many practices we faced the issue of retirement of partners, leaving 11 clinical sessions to be covered by a depleted workforce. In addition to reducing income, increasing workload and managing partner's expectations of work-life balance we needed to work in a different way and look at a different workforce.

We had been considering the role of the Physician Associate (PA) in primary care after some having experienced them in other countries. After a poor response to a salaried GP advert we sought further information on PAs and Advanced Nurse Practitioners (ANP's) looking at models within the UK and the USA.

As a result of our investigations the practice moved forward with advertising and recruitment.

Recruitment of ANP's proved difficult, and salary levels high. The practice therefore decided to employ PA's. The practice now employs four PA's, two trained in the UK and two directly from the USA.

Integerating these PA's required changes to our way of practice as we continue to strive to manage expectation and provide good quality clinical care. It also resulted in change for our patients and the community. This necessitated an assessment and overcoming of challenges and potential barriers, which has been helped with our active PPG.

By corresponding with patients, and through use of the local press we conveyed the changes we were

planning. This resulted in patients being clear of what the role was and what they could expect from PA's.

Added value of the service/project/programme

The practice now works a Same Day Service system, with patients booking on the day.

Three PAs work with one GP in a "team approach" in order to provide the required level of supervision, maximise productivity and maintain quality. The GP triages calls whilst working with PA's. They also provide some clinical time with GPs involved with advanced care planning and chronic disease management. The other PA has been working with local care homes in an initiative with other practices to provide proactive care and education for care homes, working with an ANP.

PA's now see 21 routine appointments per day each, equivalent to 315 appointments per week or 13860 per annum (including annual leave).

Previous routine GP appointments were equivalent to 165 per week, or 7260 per annum.

A proportion of appointments are pre bookable, and telephone consultations are also available.

The PA role has been well received by patients who rapidly warmed to the role. At the same time patients have appreciated access to GP's is available and forms part of the team based approach.

The practice has found that the PA's are clinically very good, with well developed communication skills. They have fitted into the Primary care team easily and are keen to learn and develop their skills. We are currently perfoming a PSQ.

We believe the approach we have implemented at Fisher Medical Centre is one that can be replicated in other parts of the country. We also believe this approach to the provision of primary care could be one to help alleviate some of the pressures being experienced in primary care at present.

AA23 Haxby Group Practice

Organisational Information

Name of organisation	**HaxbyGroup Practice**	Name of service/ project	**Practice employed Pharmacist**
Address		Email	
Contact Person Name and Position		Type of organisation	Profit x / Not for Profit ☐
Have you consulted with the site?	**YES** ☐ / NO ☐	Type of organisation	Commissioner ☐ / Provider x

Outline below the service/project/programme that you would like the Commission to visit. Please state why the

Commission should visit this site. (Maximum 500 words)

In recognition of the challenges facing GP practices in terms of recruiting GPs, Haxby Group Practice in York looked at innovative ways to introduce non-medical practitioners into primary care. They recognised that pharmacists had skills that could be transposed into primary care and enable them to work alongside GPs. In 2012 they employed a pharmacist who had experience in secondary care and had completed a clinical diploma and an independent prescriber course. She was able to work alongside the GPs in practice carrying out roles such as reauthorisation of prescriptions and medicines management tasks. Very quickly she integrated into the practice and began to contribute to chronic disease management clinics in particular hypertension clinics. She also carried out a PGCE and was able to contribute to education within the practice; teaching medical students, GP registrars, and student nurses as well as qualified GPs and nurses. They discovered very quickly that not only did she deliver a quality product but she also delivered efficiencies. A time and motion study of practice activity revealed that we were spending 60 hours a week of GP time reauthorizing prescriptions (the practice has 20,000 patients over 4 sites). She was able to manage this workload in 35 hours a week. Of course her work was subject to a high level of governance. She was mentored by a GP and worked to protocols agreed across the practice. A visit to the site would enable an inspection of how she works and how she integrates with GPs, other health professionals and the administrative staff within the practice. She also operates remotely: working physically at two of the sites and authorising prescriptions at the remaining two electronically which again increases her efficiency.

Overall outline of the service/project/programme:

A primary care pharmacist working in general practice. The pharmacist has become part of the primary care team working alongside GPs reauthorising prescriptions, medicines management and chronic disease management. This has successfully shown that non-medical practitioners can integrate into primary care seamlessly and work hand in hand with GPs to deliver a quality primary care product.

Added value of the service/project/programme

1. Improved medicines management – saving on prescribing costs, reduced wastage
2. Improved turnaround time for reauthorisation of prescriptions
3. Synchronisation of prescriptions to provide better customer service to patients.
4. Additional capacity to carry out medicines management audits and improve overall quality of care.
5. Additional experience added to the primary care in terms of inter-professional learning.
6. Replaced 60 hours of GP time with 35 hours of pharmacist time releasing GPs to focus on more complex medical problems and as a consequence the practice introduced a multi-morbidity clinic into core practice hours in order to manage patients with complex problems more effectively.

AA24 Barnsley CCG

Organisational Information

Name of organisation	**Barnsley CCG**	Name of service/ project	**Primary Care Development ramme Programme Initiatives**
Address	**Hillder House 49-51 Gawber Rd, Barnsley, S75 2PY**	Email	**v.peverelle@nhs.net**
Contact Person Name and Position	**Vicky Peverelle**	Type of organisation	Profit ☐ / Not for Profit ☐
Have you consulted with the site?	**YES** √ / NO ☐	Type of organisation	**Commissioner** √ / Provider ☐

Outline below the service/project/programme that you would like the Commission to visit. Please state why the

Commission should visit this site.

Background

NHS Barnsley Clinical Commissioning Group in conjunction with its member practices has an ambitious strategy for the further development of primary care in Barnsley over the next five years.

The Primary Care Development Programme Group is proud of progress to date on the implementation of the Primary Care Strategy and proposed new developments and would like to showcase these. A site visit by the Primary Care Workforce Commission provides an ideal opportunity to do this and to influence the Commission's thinking and Report.

The range of initiatives to cover is;

Excellence in General Practice Innovation Fund

A new initiative has been introduced with projects successfully being awarded a maximum of £25,000 per project to help address the rising levels of demand to meet patient needs in General Practice and to create the environment that is needed for change. The Innovation Fund projects commenced in January 2015 and will support those who want to be creative and try something new, which can be tested and brought to other practices if successful.

Practice Delivery Agreements

One of the major developments for the CCG this year has been the design of the practice delivery agreement. The feedback from colleagues across the CCG member practices has been clear –investment and planning in workforce and primary care is key. Reducing health inequalities has also been one of the main drivers of this agreement, ensuring patients get the same access to the same level of high quality care, wherever they live in the borough.

Working with member practices has enabled a new model to emerge, seeing services grouped under one agreement. This allows additional investment to be brought forward to enable practices to invest in their workforce over a sustained period of time, helping to deliver a range of services. The feedback on this grouped approach to services has been extremely positive and is being viewed as an innovative way of working.

Primary Care Leadership

The CCG has strong leadership and a dedicated workforce which will be further enhanced through practices undertaking a Practice Engagement Programme, designed in collaboration with our practice members this is an engagement and leadership development programme designed to support practices develop the key skills required to take this ambitious agenda forward and to lead the next phase of the development of primary care in Barnsley. This programme commenced in January 2015.

GP and Practice Nurse Fellowships

A new model of care concept the CCG is keen to explore and is in Partnership with South West Yorkshire Partnership Foundation Trust (SWYPFT) is that of GP and Practice Nurse Fellowships which is seen as a possible key factor in attracting the clinical workforce to Barnsley. It is envisaged that this is an area that will take considerable attention and subsequent investment to achieve a sustainable primary care workforce for the future. There have been initial discussions with SWYPFT to look at a joint approach to this development to focus on key mutual priorities and health outcomes.

Overall outline of the service/project/programme:

As described above

Added value of the service/project/programme

Excellence in General Practice Innovation Fund

1. Supports General Practice to have the time and space to look at their business processes to identify solutions
2. Allows best practice that is showing positive outcomes to be shared and understood in a local context
3. Supports practices through an initial pump priming resource investment to test new ways of working

Practice Delivery Agreements

1. Invest in the Primary Care infrastructure to deliver high quality equitable services for Barnsley residents as close to home as possible
2. Support Primary care sustainability through a longer-term investment offer
3. Deliver a targeted approach to the demographic health challenges on a Barnsley footprint and on a local practice basis
4. Build a mutually accountable relationship that is centred on improving health outcomes in Barnsley

Practice Engagement Programme

1. Enable practices to make the most of the investment opportunity offered by the PDA
2. Enable practices to develop a deeper understanding of the CCG's purpose, ambition and values and agree how the CCG wants to work with and support its member practices
3. Establish new ways of working between CCG management and practices that underpin the ambition set out above
4. Develop the leadership skills and techniques at practice level required for successful clinical commissioning, leading wider primary care and developing primary care at scale through emerging federated models

GP and Practice Nurse Fellowships

1. Portfolio posts targeted to areas of greatest inequalities
2. Increase recruitment and retention of clinicians in Barnsley

AA25 Somerset CCG

Organisational Information

Name of organisation	**Somerset CCG**	Name of service/ project	**Integrated care pilots in Somerset**
Address	Wynford House Lufton Way Yeovil BA22 8HR	Email	**Michael.bainbridge@somersetccg.nhs.uk**
Contact Person Name and Position	Michael Bainbridge, Head of Primary Care Development	Type of organisation	Profit ☐ / Not for Profit ■
Have you consulted with the site?	**YES** ☐ / NO ■	Type of organisation	Commissioner ■ / Provider ☐

Outline below the service/project/programme that you would like the Commission to visit. Please state why the

Commission should visit this site. (Maximum 500 words)

Somerset CCG has been highly supportive of innovative new models of primary care provision. Our focus in Somerset has been primarily on the needs of patients with multiple long-term conditions, but we are now also according high priority to frailty, with many of our integration projects treating frailty as a long-term condition.

We have three large-scale integration pilots in Somerset, all with a strong primary care flavour. These are described briefly below, with particular emphasis on workforce issues and implications.

In addition, we are working closely with HEE SW and with both the deaneries covering Somerset on a number of innovative schemes, including supporting GPs in the first years of their careers. We also have a Practice Nurse development programme to which we are currently recruiting a senior practice nurse.

Taunton Deane

This service will enable primary care to deliver enhanced care for LTC patients. This model will support the development of "House of care "care co-ordination hubs that will increase capacity in primary care to manage patients with LTCs. The service will focus on LTC Nurses and non-medical care co-ordinators. This model will be supported by proposals to develop a Complex Care GP Service and other options for specialist medical and community input.

Mendip

The Mendip integrated care pilot builds on a highly successful pilot project delivering patient peer support to help patients with long-term conditions manage their own health. Across 12 practices serving 112,000 patients, there will be 8wte staff including 3 Health and Wellbeing Workers and 6 Health and Wellbeing Connectors, all based in general practice and employed by one practice on behalf of the others. These workers will receive referrals from GPs and take responsibility for connecting patients with community resources that empower them.

South Somerset

The South Somerset pilot is known as the Symphony Project, and is a nationally recognised integration beacon. The complex care model goes live in February 2015, with the opening of the first integrated care hub, based in the former day hospital at Yeovil Hospital, followed by two other hubs elsewhere in South Somerset in June and August. Ultimately the hubs will serve a population of 120,000 patients. Initially these hubs will pilot the care model with 1,500 patients with 3 or more conditions identified through our data set. The service will be jointly run and staffed by primary care, Yeovil Hospital and other partners. It will operate 8-8 on weekdays and 9-5 at weekends, greatly increasing access to primary care and associated services for the patients who need them most. In addition the team will proactively contact patients to ensure that they are well and review the current position.

Core hub staff include an experienced medical generalist (a GP or hospital doctor), clinically qualified care co-ordinators whose role is to negotiate and enact the single care plan with patients, carers and all the staff who need to be involved, as well as key workers who will act as health coaches, guiding patients and carers through the care planning process, helping them to access resources in the community, and maintaining routine contact.

AA26 HEKSS

Organisational Information

Name of organisation	**HEKSS**	Name of service/ project	**Community Education Providerr Network**
Address	Health Education Kent Surrey Sussex 7 Bermondsey Street London SE1 2 DD	Email	**atavabie@kss.hee.nhs.uk**
Contact Person Name and Position	Professor Abdol Tavabie Postgraduate Dean	Type of organisation	Profit ☐ / Not for Profit ☐x
Have you consulted with the site?	**YES** ☐x / NO ☐	Type of organisation	Commissioner ☐ / Provider ☐x

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

HEKSS has been leading a strategy to develop a network of Community Education Providers (CEPN): CEPNs being groups of primary and community care providers that come together with partner organisations such as HEIs to train and develop the workforce to collaborate with regard to workforce, education and training[1] and expansion of placements. All 20 CCGs in HEKSS have signed a Memorandum of Agreement to support and develop the model.

CEPNs offer placements for experiential learning for staff, students and trainees to support education and training tailored to the needs of local communities and more likely to be aligned to service commissioners. CEPNs offer further opportunities to develop multi-professional team based education. The CEPN has the ability to respond to requirements for training placements for emergent practitioner groups (such as Physician's Associates, Healthcare Navigators) and under-privileged groups such as community nurses and community pharmacists.

CEPNs have a key role in providing real time primary and community workforce data to inform decisions over how education and training funding should best be invested.

The development of the CEPN is predicated by the accreditation of the network as a single unit provider thus streamlining educational governance and commissioning arrangements. This offers further advantages of consistency of delivery of education for all professional groups based on national regulators requirements. Faculty development is enhanced and quality control processes harmonised.

We are working with a group of GP practices and a local university to come together to create a CEPN underpinned by a Social Enterprise model contract. The concept will facilitate for HEKSS to have a Learning Development Agreement with a legal entity in the community to train and supervise the future local workforce (GPs, Nurses, Pharmacy, Dentists and Optometrists) in Medway.

Primary Care Workforce Tutors (PCWTs) have been appointed within CCGs to promote the development of CEPNs, work with GP Tutors, and GP Programme Directors in facilitating multi-professional education and learning and to support initiatives for development of the current and future workforce. As CEPNs develop PCWTs working with GP

Tutors and GP Programme Directors will be pivotal in the local co-ordination of placements and programme development and promotion of team based working and learning.

Achievements to date:

- Development of 240 placements in primary care for undergraduate nurse students (currently less than 1% of nurses experience any training in primary care) in agreement with our 4 HEIs
- Development of a nurse mentor programme to support student nurse placements
- Development of a common practice nurse education pathway across the 4 HEIs
- Development of 40 paramedic practitioner placements in primary care working to support an educational programme developed in association with SECAMB

We are also developing placements in primary care for pre-registration community pharmacists and physician's associates

We would welcome the opportunity to share the CEPN model and could demonstrate this through visits to participating members of the CEPN who are supporting our range of learners

AA27 Oxford Health NHS FT and Oxford University Hospitals NHST

Organisational Information

Name of organisation	**Oxford Health NHS Foundation Trust AND Oxford University Hospitals NHS Trust**	Name of service/ project	**Emergency Multidisciplinary Unit**
Address	EMU, Abingdon Hospital, Marcham Road, Abingdon	Email	**Daniel.lasserson@phc.ox.ac.uk** **Jeanne.Fay@oxfordhealth.nhs.uk**
Contact Person Name and Position	Associate Professor Daniel Lasserson, Senior Trust General Practitioner, Oxford University Hospitals NHS Trust Dr Jeanne Fay, Senior Interface GP, Oxford Health NHS Foundation Trust	Type of organisation	Profit ☐ / Not for Profit X
Have you consulted with the site?	**YES**X / NO ☐	Type of organisation	Commissioner ☐ / Provider X

Outline below the service/project/programme that you would like the Commission to visit. Please state why the

Commission should visit this site. (Maximum 500 words)

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

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

how the EMU integrates knowledge and skillsets from nursing, therapists and social care professionals with interface

medical decisions in order to provide progressive, contemporary care.

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

Overall outline of the service/project/programme:

Patients with acute illness can be referred by paramedics, GPs (registered practice and out of hours primary care providers) and community nursing teams to the EMU. In addition, emergency department and on take medical teams can refer patients to EMU for those that have not been directly referred to EMU after making initial contact with healthcare. The unit runs over seven days and aims to provide an ambulatory treatment path for acutely ill patients, but is also able to undertake procedures that usually require out patient hospital attendance (e.g. blood and platelet transfusion, intravenous iron infusion). EMU is based in a community hospital site and uses innovations in point of care diagnostic technology in order to determine underlying diagnosis or impact on core physiological systems of acute illness. The unit staffing includes health care assistants, advanced practitioners, nurses, physiotherapists and occupational therapists, a social worker and senior medical cover provided by a consultant or Interface GP. Trainee doctors are also supervised on EMU including F2s, GP specialist trainees and elderly care specialist trainees. A dedicated patient transport service supports the EMU which radically improves the logistics problems of patient transport. For patients that are unable to be treated in their usual home environment, the EMU team are able to use up to six of the community hospital beds for short stays, predominantly to stabilise patients prior to moving to an ambulatory treatment path.

Added value of the service/project/programme

This nationally awarded innovative service sets the blueprint for future acute ambulatory care – a care model that is called for by national bodies (the Royal College of Physicians, British Geriatrics Society) and it demonstrates the critical elements of combining a general practice approach to illness and care with the hospitalist approach, in order to create a transformational yet deliverable model of care. It provides care that suits the needs and wishes of our growing complex older population and tells us how we should be training the clinicians of the future for a sustainable healthservice.

AA28 Health Education North West London

Name of organisation	Health Education North West London	Contact Number	**020 7863 1645**
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Contact Person Name and Position	Julia Whiteman, Postgraduate Dean	Number of attached evidence documents	**0**

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

PRIMARY CARE WORKFORCE COMMISSION SUGGESTIONS FOR SITE VISITS

Health Education North West London has developed a new educational infrastructure to enable the development of pathway-based multiprofessional networks. Our Community Education Provider Networks (CEPNs) model of healthcare brings together health and social care service providers, community groups and education providers focused around enabling the development of learning communities i.e. different parts of the health and social care workforce, patients and the public systematically improving services by learning with and from each other. The model promotes:
Facilitating integrated care through provision of educational projects and programmes across the whole workforce, both clinical and non-clinical, to help improve productivity, patient experience, and the quality of care.

- Acting as a catalyst for the adoption of best practice through the creation of learning communities across healthcare including social service and community groups
- Creating new innovative educational models to support local workforce transformation and enable service redesign through educational redesign along pathways
- Engaging patients and the public in the training and education of the healthcare workforce

In summary, the CEPNs comprise some combination of education providers, patient and community groups, primary care and community service providers along with those in secondary care, who individually or collectively form platforms to share their knowledge, skills and expertise in delivering healthcare. Within these networks, they deliver multi-professional education and training to healthcare workers. This results in improved patient experience and bringing care closer to home.

Of the seven networks HENWL is currently funding:

- The Brent and Harrow Narrative Education for Care homes project, is successfully introducing the Balint discussion approach to colleagues in care homes, creating and sustaining a culture of support, supervision and learning for the community of band 1-4 carers who provide the daily care for this challenging group of patients. It is raising the profile of narrative education to encourage emotional awareness and improved supervision and learning amongst care home workers. This CEPN has successfully promoted sustained leadership within the Brent and Harrow area amongst LAS, GP, Nurse, Care home HCAs, voluntary sector and social workers serving care home residents and frail elderly: it has embedded multiprofessional learning initiatives by training and creating a group of multi- professional facilitators in the Balint technique and founded a network of narrative-based reflective groups for carers across four nursing homes. These narrative-based groups, are evidence based and already utilised in training for other healthcare providers, particularly GPs and psychotherapists.

- Connecting Care for Children is focusing on building Child Health GP Hubs that connect secondary care and primary care paediatrics, creating practice champions, creating links with CAMHS services and Child Health GP Hubs, and enhancing patient experience and quality of care. Champions have been recruited, promoting information throughout the community and creating a peer support group for children with long term conditions. It is enhancing paediatric skills, confidence and competence across the system, reducing unscheduled care, inpatient admissions and paediatric outpatient referrals through improving capabilities in out of hospital care and enabling a greater ability for shared decision- making for patients, their families and professionals. Connecting Care For Children has been put forward by the King's Fund as a recommended model of specialist care with GPs

- Allied Health Professions Innovative Learning Network for Falls Management (ALIGN) - a CEPN for Allied Health Professionals to share learning, models and good practice in falls management. The education and learning model includes the development of an online learning platform, action learning, and a circle of innovation and innovation champions in falls care. Filming a falls simulation, webinar and face to face fall events are underway, as well as widening engagement with practice and district nurses.

- Perinatal Mental Health Education is addressing the poor perinatal mental health in London, addressing the educational deficit by providing a package for women and community and hospital based healthcare professionals, facilitated by healthcare experts and service users of maternity and mental health services. They have created packs, which GPs are circulating to patients, as well as promoting their services to as many services and public as possible, such as attending hospital open days, educating students at the University of West London, making connections with secondary services and teaching psychiatric colleagues and psychologists

The other three CEPNs are focusing on:

- PLACE (Pioneering Learning Across Community Education) is a CEPN focusing on End of Life, which offers students recruited from staff within bands 1-5 an opportunity to develop knowledge, skills and attitudes in end-of -life care in different settings, working with third sector partners and Trusts.

- The prevention and management of pressure ulcers – a CEPN to disseminate evidenced based educational materials, through a learning network, on pressure ulcer prevention enabling patients and carers to recognise who is at risk, when they are at risk, and their role in pressure ulcer prevention. They are working to provide access for patients and carers to co-created design solutions to pressure relief.

Quality Improvement Training - a CEPN created to deliver a multi-disciplinary, cross agency training programme staff at all levels with Quality Improvement skills to create a culture of continual improvement, focused on improvi hospital discharge processes. This will be achieved through targeted class-room teaching, broader Quality Impro 'sprint' workshops and spread through Quality Improvement Champions

AA29 Fakenham Medical Practice

Organisational Information

Name of organisation	Fakenham Medical Practice	Name of service/ project	The Fakenham Medical Practice
Address	Meditrina House	Email	David.bennett@nhs.net
Contact Person Name and Position	Dr David Bennett Managing Partner	Type of organisation	Profit ☐ ~~/ Not for Profit ☐~~
Have you consulted with the site?	**YES** ☐ / ~~NO ☐~~	Type of organisation	~~Commissioner ☐ /~~ Provider ☐
Outline below the service/project/programme that you would like the Commission to visit. Please state why the Commission should visit this site. (Maximum 500 words)			

Overall outline of the service/project/programme:

The Fakenham Medical Practice designed its new Surgery in 2008 with the aim of providing its 15,000 patient population with the highest standards of healthcare within the available resources. The seven partners' vision was for a new model of healthcare which provided as many services as possible on site and met the health care priorities of the Primary Care Trust.

Throughout the planning and construction phases Norfolk County Council Adult Social Care (NCC ASC) and Norfolk Community Health and Care (NCH&C) who are co-located, were closely involved to ensure that the facilities met their requirements. Both organisations have operatives co-located in one large working area within the same building.

The practice works closely with the two main hospitals in the area - the Norfolk and Norwich University Hospital and The Queen Elizabeth Hospital Kings Lynn as well as other providers including Anglia Community Eye Services and Global Diagnostics to provide consultant led outreach clinics and or operating sessions at the practice.

There is a built-in Operating Theatre for Day Surgery, and a mobile diagnostic pad capable of receiving mobile units to carry out Breast Screening as well as MRI scanning. The day surgery operating theatre with its hospital specification air exchange unit and back-up generator is used to perform day procedures such as Cataract Operations, as well as GPSWIs' led minor surgery.

More recently the practice has been forging a closer working partnership with Fakenham Gateway Sure Start Centre to ensure that our GPs are aware of the services and activities undertaken by them and enable the sharing of data where authorised about families in need.

As well as offering GP training it has also been an RCGP accredited research practice for many years.

The building also is used at weekends by Fakenham Weight Management Service (FWMS) and the East of England

Ambulance Service, currently the Out of Hours Provider.

In addition to its own dispensary there is also a 100 hour pharmacy which operates from within the same building.

The Practice played an important part in the set up of the GP Federation, Iceni Healthcare Limited established in April 2014 as provider organisation for all 107 member practices in Norfolk, Gt Yarmouth and Waveney and continues to be closely involved with the running of the Federation.

In line with its reputation for being an innovative and progressive practice under the direction and leadership of Dr Carly Hughes, working closely with NNUH and Public Health over the past 5 years, the practice has developed a Tier 3 service to manage obesity in Primary Care. The FWMS offers a management programme to people from all over Norfolk who are clinically obese (BMI >30) and who need to lose weight for medical reasons e.g. sufferers of diabetes, high blood pressure, heart disease and those with chronic mental illness.

Added value of the service/project/programme

We believe that the co-location of these facilities, agencies and organisations at the Fakenham Medical Practice has led to a significant improvement in the overall level of patient care offered to our patients.

AA30 Guys and St Thomas' NHS FT

Name of organisation	**Guy's and St Thomas' NHS Foundation Trust**	Name of serv project	**Integrated Care Clinical Pharmacist (ICP) for frail older people: Case management & Enhanced Rapid**
Address	Gracefield Gardens Health Centre 2-8 Gracefield Gardens London SW16 2ST	Email	**Lelly.oboh@gstt.nhs.uk**
Contact Person Name and Position	Lelly Oboh Consultant Pharmacist Care of People	Type of organ	Profit / Not for Profit
Have you consulted with the site?	**YES** / NO	Type of organ	Commissioner / Provider

The ICP is an innovative community based role where pharmacists lead medicines optimisation within various health and social care multidisciplinary teams for frail older people. In addition to the traditional pharmacist's role they

- Receive referrals from GPs, nurses, therapists and geriatricians to undertake domicilliary medication reviews for patients with complex therapeutic needs during vulnerable periods (i.e peri or post discharge, when a rapid response is needed to prevent a hospital admission) or patients with frequent hospital admissions
- Attend and present complex cases at geriatrician led community multidisciplinary team meetings and safeguarding meetings
- Actively support community pharmacists, community health and adult social care providers to deliver personalised interventions and care packages that support older people/their carers with medicines taking
- Actively integrate the role of the community pharmacist (named) into the patient care pathway by bridging the gap and facilitating collaborative working between local community pharmacists and GPs.

Evaluation of data from 143(n>350) reviews from community matrons caseloads show that patients had an average of 7 LTCs and 14 medicines. Cardiovascular, respiratory, pain and diabetic conditions were the most prevalent and over 60% patients were prescribed drugs linked with high risk of hospital admissions, anticholinergics, analgesics and inhaler devices. The emerging picture is that of very vulnerable patients, mainly over 75 years, with complex therapeutic needs, frequent hospital admissions, dynamic health status, living alone in the community and struggling to manage their medicines independently as a result of a combination of functional impairments, health and psychosocial needs.

The ICP role has been developed to cater for this vulnerable group, recognising that current disease-focused therapeutic approaches are often ineffective and positive outcomes result from addressing the interactions of the whole rather than discrete aspects of medicines use. In line with growing evidence of what works in this group, care provided by the ICPs is organised around the patient's holistic needs and integrated within the care pathway. They take the lead to identify, resolve and co- ordinate **all** aspects of medicines use, aiming to

- Reduce inappropriate polypharmacy (Deprescribing) and adverse effects.
- Improve adherence and patients' understanding of medicines
- Reduce utilisation of emergency services through better therapeutic control of multiple morbidities
- Increase knowledge and skills to optimise medicines use among community health and social care providers
- Facilitate partnership working across agencies to tackle barriers and improve medicines use during care transitions
- Investigate and develop methods of collaboration with community pharmacy to improve care

The ICP input is time limited, once the identified complex medicines need or acute crisis has been resolved. So a model which utilises a named community pharmacist to provide ongoing support identified in the care plan and reduces reliance on unplanned or emergency services is being explored. These community pharmacists will work closely with the GP and other generalist health and social care practitioners to support and monitor adherence, promote self management and independence, monitor drug effects and patient response and reduce wastage. The community pharmacist will refer and access specialist support from the ICPs and other specialists as needed

Overall outline of the service/project/programme:

The ICPs are integrated into the Southwark and Lambeth Integrated Care (SLIC) program for frail older people which aims to improve patient independence and experience through personalised and co-ordinated care, early identification and unnecessary hospital admissions

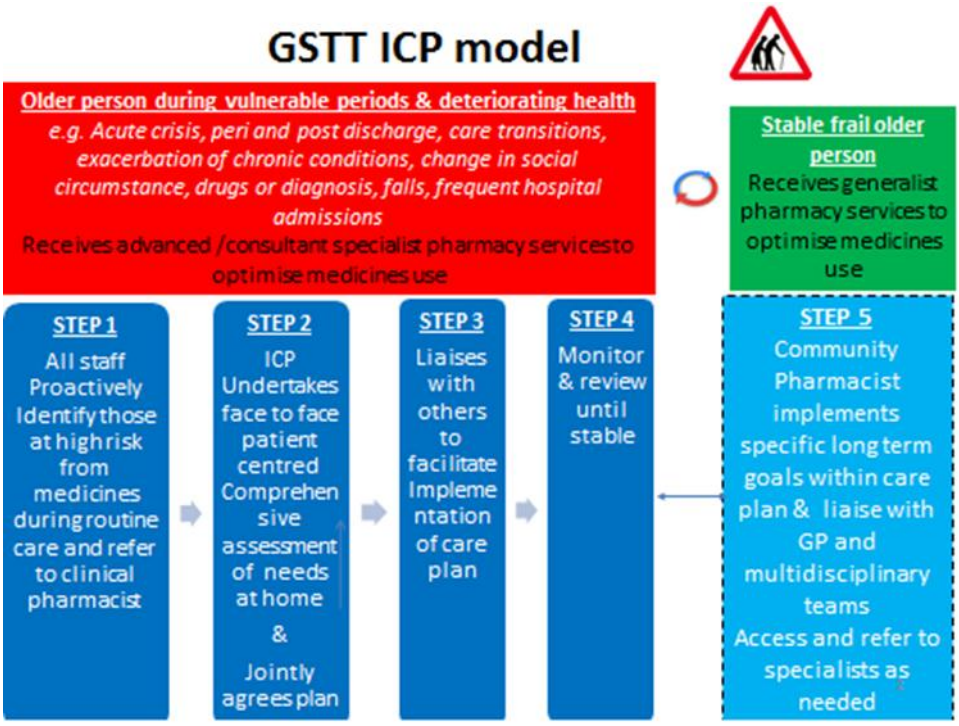
This ICP model is based on local 'community clinical pharmacy teams' first mentioned in the *Pharmacy White Paper 2008* ; A team of advanced and consultant level pharmacists in the care of older people, supporting and mentoring generalist practitioners to deliver sustainable high quality routine clinical pharmacy services to the most vulnerable in the community. In the GSTT model a consultant pharmacist oversees the project and provides strategic direction, professional leadership, clinical support and supervision to the ICPs.

The first element of the project the ICP addresses complex pharmacy needs through active **case finding, undertaking person centred medication reviews/assessments and jointly developing a care plan with the patient or their carers to meet the needs identified.** The care plan details the practical support and therapeutic interventions needed as well as finely tuned medicines regime to suit.

The second aspect, is the development of long-term strategies which enable the provision of appropriate support within the community for this patient group,s particularly enhanced roles for community pharmacists and care workers.

The diagram below outlines the patient pathway for older people identified as having medicines related needs

http://www.rpharms.com/models-of-care/models-of-care-in-action.asp



Step 1
Using locally developed screening or assessment tools community health service staff (mainly community matrons, therapists and nurses within enhanced rapid response teams) proactively identify patients that have a real or high risk of medicines related problem and refer to the ICP. The ICP also proactively case find patinets from matrons caseload and receive referrals via the CDMT, GPs and geriatricians in certain localities. (Comittment from CCG to commission enough posts for full coverage)

Step 2
Prior to the patient visit, the ICP gathers information from a range of sources including community services health records (RIO), hospital based electronic prescribing record, discussions with the referer and by accessing the clinical letters/records at the GP practices.
The ICP undertakes an in depth medication assessment using a locally developed Tool focused on 4 areas of medicines related needs; access, adherence and clinical issues. The pharmacist discusses these needs with the patient, taking into account their values, beliefs and experience from taking medicines. They jointly formulate a care plan to achieve the desired outcomes. Adherence issues and solutions are discussed with the patient to jointly determine practical ways to resolve the challenges they face, with appropriate follow up when necessary.

Step 3 & 4
The pharmacist coordinates the implementation of the various aspects of the plan by liaising with the referrer, GP, community pharmacist and a range of other health and social care professionals (including district nurses, occupational therapists, speech and language therapists, physiotherapists and carers) and informal carers as appropriate. Suggestions are negotiated and solutions agreed with all parties, and appropriate follow up monitoring and assessment arranged.
The ICP will follow up with telephone calls and further visits to ensure that agreed changes are actioned and the patient is responding and coping appropriately, until they are safe and stable to be removed form the ICPs active caseload

Step 5 (Work in progress)
The evaluation showed that 95% of patients regularly used a named community pharmacy for medicines supply and support with needs relating to access and adherence with medicines. The project has identified a role for a named community pharmacist to actively lead medicines optimisation in the stable frail older person following input from the ICP

Added value of the service/project/programme
Evaluation data revealed that the ICP identified an average of 3.8 medicines related problems per patient. Aside from improving proxy measures such as medicines reconcillation, reducing polypharmacy, drug interations, drug errors, duplication etc there is evidence of breaking the cycle of unscheduled episodes of care, improving patient experience, reducing adverse effects and wastage

Patients have benefited from the ICP input project in the following ways:

- Improved quality of life, health and emotional well-being e.g improved functionality, symptom control
- Improved personal dignity e.g ability to perform personal care and simple tasks, resolving incontinence problems
- Holistic approach to care referral and improved access to other services e.g dietetics, OT, home repairs/adjustments
- Improved co-ordination of care and reducing gaps in service provision e.g medicines supply and delivery
- Greater understanding of medication regimen, enabling greater patient choice and control e.g improved adherence, supporting and safe-proofing the existing innovative and bespoke ways to self manage medicines

- Improved patient experience- reduced anxiety about medicines running out or side effects, feeling listened to
- Reduction in adverse drug reactions e.g. postural hypotension, dry mouth, constipation
- Reduction in unplanned emergency admissions and unscheduled episodes of care e.g. resolving hyperkaemia, uncontrolled BP, acute decompensation in CHF
- Reduced medicines waste and cost effective prescribing e.g decluttering and disposal of unwanted/expired medicines
- 20 (n32) respondents to the patient satisfaction surveys (n35) found the pharmacist's visit either very helpful (75%) or helpful (25%). 90% of patients were satisfied with the outcome of the visit. 45% of the respondents felt that their health had improved following the pharmacists visit. 95% of patients felt their views and opinions about their medicines were taken into consideration and 80% felt involved in decisions about their medicines. 90% of patients felt that they had a better understanding of their medicines following the discussion with the pharmacist.

Staff have benefited from this project in the following ways:

- More effective joint working between different agencies and teams
- Increased knowledge of medicines issues amongst Community Matrons, GPs and the wider primary care team
- Encouragement to develop holistic approach to patient care
- ICPs are now an integral and valued members of the community multi-disciplinary team with referral requests being received from other healthcare providers and social care providers.

Wider NHS has also benefited
This model has been adapted and successfully replicated by other NHS organisations Learning has been widely shared and disseminated across NHS and the profession
Case studies from the project have been used for facilitated peer support meetings and clinical supervision for other community based clinical pharmacist across SE and East of England NHS

*****Several case scenarios that demonstate improved patient outcomes are available if needed.**

AA31 Bolton Community Practice

Organisational Information

Name of organisation	**Bolton Community Practice** **CIC**	Name of service/ project	**Bolton Community Practice**
Address	Waters Meeting Health Centre Waters Meeting Road Bolton BL1 8TU	Email	**Anne.talbot2@nhs.net**
Contact Person Name and Position	Dr Anne Talbot GP Clinical Director	Type of organisation	Profit ☐ / Not for Profit ☐x
Have you consulted with the site?	**YES** ☐ x/ NO ☐	Type of organisation	Commissioner ☐ / Provider ☐x

Outline below the service/project/programme that you would like the Commission to visit. Please state why the

Commission should visit this site. (Maximum 500 words)

Bolton Community Practice Community Interest Company is a Social Enterprise Organisation providing Primary Care for 11 500 patients across the Borough of Bolton at 4 sites. The Practice also delivers Bolton's Safehaven Scheme, providing safe care for violent patients unsuitable for usual General Practice services. The Practice's index of multiple deprivation is 32 and 25% of their registered population are from the BME community. The practice works closely with Urban Outreach, a charity supporting the needs of vulnerable adults.

The organisation was formed in 2011 from the merging of 5 separate small GP practices, now working as one integrated practice with a clear vision to provide exemplary care and achieve best outcomes and experience for their registered population. The development of the organisation has focused on achievement of this vision, recognising that a key requirement for success was an integrated workforce and effective and integrated IT and administrative systems. As a Social Enterprise, all staff are shareholders and are actively involved in the development of the practice and it's services.

The Practice has developed an innovative model of primary care delivery. It has no Practice boundary and patients who are registered at the practice are welcome to attend any site to receive their care. The practice highly values and encourages continuity of care, but also recognises that this flexibility:

- gives patients more choice and control over their healthcare
- enables increased access to care over extended hours
- facilitates access to a wider range of healthcare professionals and specialist skills
- improves staff satisfaction by improving working lifes

In order to deliver this innovative model of primary acre, the practice has developed a multidisciplinary workforce, recognising the key skills of different professional groups. The clinical team has grown to encompass GPs, Advanced Practitioner, practice nurses, pharmacist, physiotherapist, health care assistants and assistant practitioners. The team

also work closely with local neighbourhood community nursing teams to provide co-ordinated care to their frail elderly population. As shareholders within the organisation, all staff have owned and developed the workforce plans and flexible working arrangements key to the success of the model.

The team recognises the role of the learning environment in creating an effective integrated team and to foster the culture of multi-disciplinary working. The practice runs a weekly learning and development programme where staff across all professional groups and including non-clinical staff, receive education and training together.

The practice also recognises the importance of a learning enviroment in 'growing the workforce of the future'. The practice hosts apprentice staff in collaboration with Joint Learning, supporting local young people in gaining administative and reception placements and achieving NVQ qulaification. A number of apprentices have gone on to achieve permanent positions within the organisation. The practice also supports medical undergraduate and FY2 placements and has recently trialled a physician associate placement.

Bolton Community Practice would welcome the opportunity to demonstrate to the Commission an innovative and responsive model of primary care delivery, using the skills of a wider range of professions in a primary care setting, with flexible working arrangements, to meet the needs of a challenging population.

Overall outline of the service/project/programme:

The practice delivers services, between 8am and 7.30pm Monday to Friday and 9am to 12.30pm Saturdays. By virtue of clinical staff working a flexible shift pattern, a range of surgeries with staggered timing is provided throughout an extended day. The model is underpinned by an integrated IT and administative system with a central reception centre, and wide use of online patient services for appointment booking, prescription ordering and text messaging.

As an integrated practice, registration is accepted of any patient residing within the Borough of Bolton. Whilst generally patients would choose to obtain continuity of care at the practice site nearest to their home, an integrated IT and telephone system enables patients to choose to attend any site. Access is enabled close to a patient's place of work or to a clinician with the gender, language or clinical skills of their choice - giving patients more choice and control over their healthcare. Across the large clinical team specialist skills are provided in dermatology, gynaecology, joint injection, palliative care and physiotherapy. The practice staff also includes a pharmacist. The innovative model delivered by the practice facilitates access to a greater range of specialist skills.

The Advanced Practitioner led non-medical team provides a range of choices for patients to access responsive care throughout the extended day including a telephone advice service, minor illness clinics and a daily Rapid Access evening clinic with walk-in availability. Our Advanced Practitioner led team receive extremely high levels of patient satisfaction in relation to their experience of the service and the practice as a whiole has lower than average A&E attendance and ambulatory care sensitive condition admissions despite the challenges of the practice demographics.

Added value of the service/project/programme

Bolton Community Practice has successfully implemented an innovative model of Primary Care delivery to provide extended and responsive access to core primary care services and specialist skills. This has been delivered by the development of a multi-professional team, working within a learning environment where the team learns and develops together. The model has been enhanced by the staff delivering the service owning and developing flexible workforce plans and working arrangements that benefit both the patients they serve and their own working lives.

AA32 Cuckoo Lane Health Care

Organisational Information

Name of organisation	**Cuckoo Lane Health Care**	Name of service/ project	**Nurse Led General Practice**
Address	20 Church road Hanwell W7 1DR	Email	**Julie.belton@nhs.net**
Contact Person Name and Position	Julie Belton Director	Type of organisation	Profit ☐x / Not for Profit ☐ Social enterprise
Have you consulted with the site?	**YES** ☐ / NO ☐x	Type of organisation	Commissioner ☐ / Provider ☐X

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

In 2005 a tender became available for a GP practice in Hanwell. The Bid for Cuckoo Lane Health Care to become a Nurse-led practice was submitted, by staff that had been working at the practice for some time, and successful against 12 other bids (GP's and private organisations). The bid highlighted the staff structure rationalising Nurse Practitioner appointments and GP appointments identifying the 3 key groups of patients visiting General practice: those with long term conditions, those acutely ill and those with basic health needs such as travel health advice or well women. The aim was for highly skilled Nurse Practitioners and Practice Nurses to see two thirds of patients and thus the GP's time would be available to deal with more complex patients.

The practice has been running for 10 years and is now led by 2 Nurse Practitioner Directors. The practice employs 26 staff including: 6 Nurse Practitioners, 4 Practice nurses, 1 Health care assistants and 4 hours of a sessional GP per day. In addition admin staff including a Practice Manager and an IT lead. We are also a training practice for Practice Nurses, student nurses and we are part of the National Apprentice scheme.

The practice provides all the usual General Practice services as well as a number of specialist services including; heart disease and Hypertension management clinics, diabetic clinics, commuter clinics, well woman clinics, baby clinics and routine childhood immunisations, travel clinics, inhaler/asthma, lung function clinics, NHS health checks, anticoagulation monitoring. We also offer paediatric phlebotomy and the insertion of ring pessaries for the locality. One of our purposes is to work alongside patients to keep them healthy in their own homes thus preventing unnecessary hospital admissions.

Systems and processes have been carefully created to ensure everyone works in a consistent way – putting patient's in the centre and making sure records capture suitable information to enable the patient's journey to be as streamlined as possible.

Some evidence of the effectiveness of our approach to providing nurse led care are: the list size has steadily grown over the last 10 years and continues to do so; patient feedback and satisfaction is consistently been reported as excellent and on 'Friends and Family' National feedback the feedback is almost 100% positive; our benchmark against the other 79 practices in Ealing indicates that the clinical care provided is above the average in Ealing. In addition the practice takes an active role in local General Practice Issues and one Practice Nurse is a board member of the Ealing CCG and one Nurse Practitioner is a board member of the Ealing GP Federation. The IT lead is on the borough IGM & T steering group. Three practices have been selected to pilot the Whole Systems Integrated Care

approach to case management and Cuckoo Lane is one of them. The practice is committed to providing integrated care and in part of a local network which has monthly Multidisciplinary team meetings with consulatants, social services and local practices.

One of the practice key missions is to continually improve everything we do –and this requires excellent communication. With this in mind, as a practice, we have introduced a '5 point Communication Huddle' this happens for 5 minutes twice a day and key messages are immediately emailed to all members of the team.

A Nurse-led General Practice has definitely been successful and Cuckoo Lane would love to support other Practices to emulate a similar model.

We could offer advice on how to deal with some of the barriers to change that we have successfully overcome. This includes peoples understanding of what a Nurse Practitioner does.

- Patients needed to be reassured that they were being treated by a competent clinician.
- Secondary care needed to be reassured that they could accept referrals from Nurse Practitioners.
- Pharmacies and patients needed to told that Nurse Practitioners were allowed to prescribe as far as their competencies would allow. This can be the entire BNF excluding controlled drugs.

Overall outline of the service/project/programme:

Cuckoo Lane Practice in a Nurse Led General Practice

Added value of the service/project/programme

This service provides an alternative model of Primary care.

The core of the model is Mutual participation, which means that care provided to patients is planned and delivered with the patient at the centre.

AA33 Leeds West CCG

Organisational Information

Name of organisation	**Leeds west CCG**	Name of service/ project	**Enhanced access in Primary Crae**
Address	Wira House LS16 6EB	Email	**Susanrobins@nhs.net**
Contact Person Name and Position	Susan Robins Director of commissioning	Type of organisation	Not for Profit - NHS
Have you consulted with the site?	**YES** ☐ / NO ☐	Type of organisation	Commissioner - CCG

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

<u>You are invited to visit the Leeds West CCG enhanced primary care access pilot.</u>

Leeds west CCG have made significant progress in the delivery of seven day services in Primary care.

We have 38 GP practices in Leeds West with 37 currently delivering enhanced primary care and GP practices opening until 8pm weekdays.

In addition 17 of those practices have now opened their doors on a Saturday and a Sunday offering routine primary care. The CCG has made significant investment to deliver this 18 month project and invested in robust evaluation that we are confident will demonstrate the models sustainability long term. This is not a walk in or a see and treat service- but the expansion of core primary care over seven days.

The HEE should visist us in Leeds to learn about the great work being delivered, but also to have discussion with us around the future models for a primary care workforce. We are fully aware there are not enough GPs in the UK to deliver the model we are developing..and indeed that it's the workforce issues that may hinder our future expansion. We are very interested in associate practitioners and indeed the future roles of nurses and emergency care practitioners in urgent primary care. We are significantly further ahead that most CCG's in delivering seven day primary care services- and that includes the Challenge fund sites who have only 5 or 6 prcatices, we have 37 delivering this now. We would value a discussion with you.

Overall outline of the service/project/programme:

The CCG board approved £8.25 Million in September 2014 to establish seven day services in primary care. The clinical engagement and clinical leadership has been exelempary with practices working collaboratively in hubs. To date over 6000 additional primary care appointments are being offered.

The workforce issues have been addressed through open discussion between practices. To date the practices have

recruited extra capacity from General Practitioners, pharmacists, physiotherapists and nurses. We have stressed to practices that we do not want an army of Locums or sessional staff- but we want this to be delivered by core employed staff in primary care.

In addition the CCG has invested £350K in a practice nurse preceptee programme- where 10 trainee practice nurses are employed centrally by the CCG then placed in practices for their training.

This is working really well and we hope to expand to a further 10 nursing posts in 2015.

The community nursing model in leeds is delivered through neighboyurhood teams- that closely mirror our GP practice hubs- we therefore have the groundwork for Multispeciality provider models in the future and this is our next development for 2015.

We have expressed interest in the national Vanguard status.

We have also now applied for challenge fund second wave- being ready now to expand the IT and connectivity of our practices.

Added value of the service/project/programme

Improved access for patients- better patient satisfaction

Better health outcomes for patients – particularly those with LTC.

Earlier home visits during the day

Reduction in OOH visits and accident and emergency visits

Increased input and support to care homes

Deliver seven day services

Provide primary care at scale through hub working

AA34 ULK Association of Physician Associates

Name of Organisation: Swiss Cottage Surgery

Name of Service/Project: Physician Associates working within General Practice

Swiss Cottage surgery is a 12k patient practice in north London. It introduced it's first PA in 2013 when struggling to address the requirements of several new locally enhanced services and difficulties hiring a salaried GP. Due to the success of the role the surgery hired a second newly qualified PA in Oct '14. The two full time PAs work 37 hours a week each and work across the working day and extended hours to ensure PA appointments available during all working hours. The lead PA sees patients in 15 minute appointments and the newly qualified PA in 20 min appointment at the present time.

The PAs see a mixture of patients and have different responsibilities. The surgery runs a walk in service in the morning, so mornings occupy seeing any patients that walk in, there is no triage system, unless patients specifically request to see a particular person they will be assigned to a PA or Doctor according to availability. This has significantly improved daily access and ensures the majority of patients are seen on the day. In the afternoon the PAs have booked appointments which patients can book themselves or PAs/Drs/Nurses use to follow up patients or book into for the particular QOF, LTC, LES areas that they individually look after. The surgery also runs a warfarin monitoring service at lunch times 2 days a week for patients from their own and local practices, which the PAs run independently.

Raj Gill Lead PA at the surgery has a special interest in Respiratory diseases, so is LTC/QoF lead for Asthma/COPD. He also leads on Hypertension (and manages 24 hour BP service), Anticoagulation and Sexual Health.

Samira Esmeiliafar is responsible for the assisted living centre attached the surgery and is the LCS lead on Complex care and Admission Avoidance.

Swiss Cottage Surgery is an excellent example of how PAs can function in Primary care; their supervision needs, the relationship between PA and GPs, how they negotiate prescribing issues and the difference between a newly qualified and more experienced PAs.

AA35 Waltham Forest CCG

Organisational Information

Name of organisation	**Waltham Forest CCG**	Name of service/ project	**1. Integrated Care** **2. Transforming Services Together** **3. Primary Care Strategy** **4. CEPN – workforce support**
Address	Kirkdale House 7 Kirkdale Road Leytonstone E11 1HP	Email	anwar.khan@nhs.net
Contact Person Name and Position	Anwar Khan, chair of Waltham Forest CCG	Type of organisation	Profit ☐ / Not for Profit ■
Have you consulted with the site?	**YES** ☐ / NO ☐	Type of organisation	Commissioner ■ / Provider ☐

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

We value the opportunity to present a range of progarmmes and workforce-related intiatives that Waltham Forest CCG along with Tower Hamlets and Newham CCGs have been investing in and actively progressing over the last 12-18 months.

In particular, we would like the commission to explore the following aspects of the work conducted so far:

1. WELC Integrated Care programme
2. WEL-wide programme of transformation, Transforming Services Together (TST) with a specific focus on workforce workstream which aims to address system-level issues and align and support on-going workforce initiatives across commissioning and provider organisations
3. Workforce initatives that are driven by the implementation of the Waltham Forest CCG's Primary Care strategy
4. Projects driven by the CEPN that complement and align with other WEL-wide work

The primary care workforce is an essential enabler to the delivery of several CCG strategies including the IM&T, Urgent Care, Community Nursing and Integrated Care Strategies.

Ultimately the development of the workforce is the responsibility of each provider but the CCG believes that in collaboration with Local education and Training Boards (LETBs) and Public Health England, that we have a significant role to play in the on-going professional development and professional support for of all employees from admin to practice managers, HCAs to nurses, allied health professionals to GPs, and Opticians through to Pharmacists.

WELC Integrated Care programme

Waltham Forest CCG recognises and fully supports the Integrated Care approach and works in partnership with Tower Hamlets and Newham CCGs to progress this work.

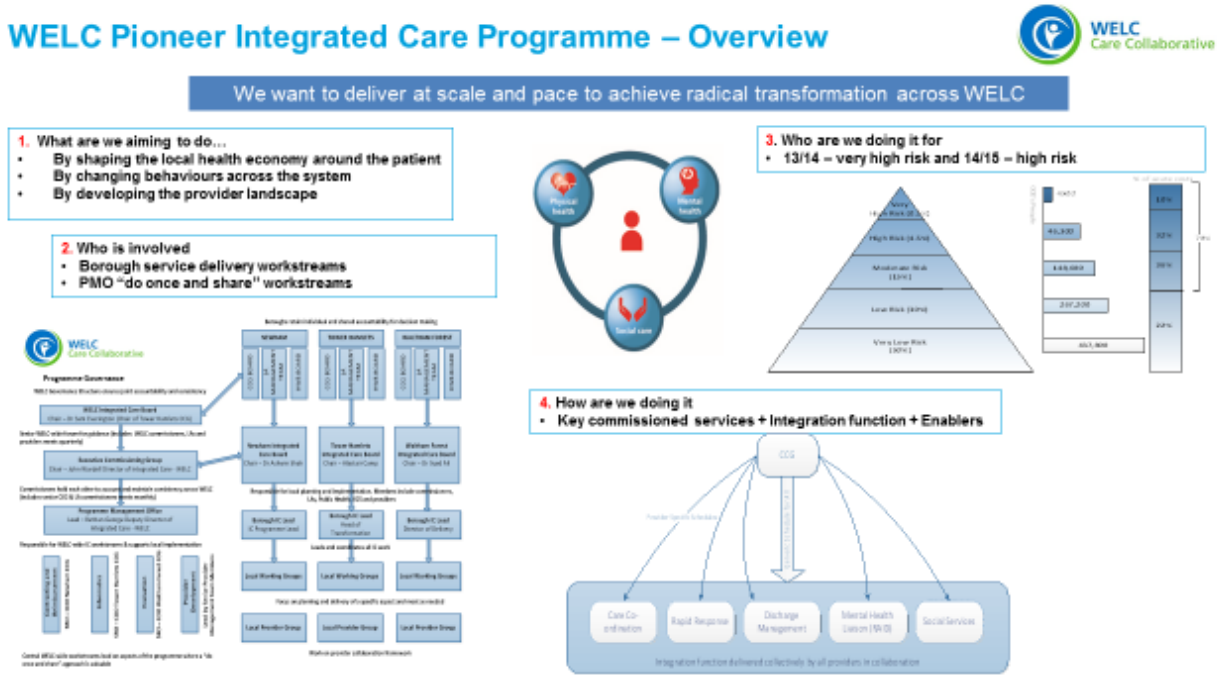
Waltham Forest introduced Integrated Care Management as a key transformational programme in October 2011. The programme targets the elderly, vulnerable patients, those with long term conditions or complex physical or mental health needs, who are at high risk of hospital admission or readmission.

The Waltham Forest model is focused around patient-centred care and looks at the whole person – their physical health, mental health and social care needs and delivers early interventions and diagnosis.

There are a number of active work streams in the integrated care programme, these are:

1. Care Co-ordination
2. Rapid Response
3. Mental Health: Developing enhanced primary care
4. Mental Health: Psychiatric Liaison

Care Co-ordination – a team of health and social care professionals including a nominated Community Matron and integrated Care Liaison Officer supported by nursing, therapy staff and Social Workers. Their main aim is enabling adults to remain in their own homes, maximise their independence and improve health and social care outcomes and quality of life. (a detailed model is provided as a seprate attachment)



Transforming Services Together (TST)

East London CCGs (Newham, Tower Hamlets and Waltham Forest) have together developed a five-year strategic

commissioning plan, which seeks to resolve strategic issues facing the region. At the centre of this is partnership working between commissioners, hospitals, community and mental health providers and primary care.

The five-year strategic commissioning plan brings together the aspirations of the three CCGs, NHS England, primary care and specialised commissioning teams to improve the health of residents and visitors to the three boroughs.

The Transforming Services Together programme currently has 14 workstreams: nine clinical workstreams, and five enabler workstreams (which support all the clinical workstreams.)

Clinical workstreams	Enabler workstreams
• Diagnostic services • Maternity and newborn • Children and young people • Surgery • Pathway redesign • Urgent and emergency care coordination • Primary care • Integrated care • Mental health	• Population health informatics • Workforce • Organisational development/clinical leadership • Estates • Long-term financial management

The Transforming Services Together programme was launched in September 2014 to deliver this five-year plan.

CEPN projects

The CCG has also been piloting a Community Education Provider Networks (CPEN) which is a network which brings together primary and community care stakeholders to collaborate in regard to strengthening workforce, education and training in the borough.

Some of the key objectives of this group are:

- Increase nursing in general practice
- Analyse the current health and social care workforce within Waltham Forest (identifying skills mix any skills shortages)
- Scoping what training is currently available for Long term conditions
- Promotion of Continuing professional development (CPD) for the workforce in the locality
- Improving education and training around long term conditions
- Improving the education and training within the community particularly around Pharmacy and Optometry

We suggest the following agenda for the 27th February visit:

	Agenda item	Key discussion participants	Time
1.	**Integrated Care**	**Caroline Gilmartin, Deputy Director of Commissioning**	**30 mins**
2.	**Transforming Services Together – workforce workstream**	**Jane Mehta, Workforce workstream Executive,** **Beata Malinowska, TST workforce workstream lead**	**30mins**
3.	**Primary Care Strategy – workforce**	**Anwar Khan, CCG chair**	**30mins**

4.	**CEPN – workforce initiatives**	**Neil Suttie, Head of Research, Development & Education Projects** **Maureen Dods, Associate Director, Organisational Development at NELFT (North East London Foundation Trust)**	**30mins**

Overall outline of the service/project/programme:

Added value of the service/project/programme

The added value and the return on investment are being monitored and measured by each project and workstrem. We can supply further details for each area on the day of the Commission's visit.