Supporting evidence

Contents page

Prime Minister's Challenge Fund:
Improving Access to General Practice

Wave Two Application Form

Gateway reference: 02356

Section A. About you

Information about the area, providers and commissioners involved.

1. Pilot project title:

GP Extra

2. Are you a member of the existing Challenge Fund Associate Network?

❑ Please tick

3. Lead contact details:

Proposal on behalf of:	Southport & Formby CCG
Project Lead:	Dr Niall Leonard
Job title:	GP Principle /Vice Chair SFCCG
GP Practice/Organisation:	Fox & Leonard Partnership
Email:	niall.leonard@nhs.net
Telephone:	01704 228439

4. Practices involved:

Please indicate which GP practices are covered, where they are located and approximate population size for each.

PRACTICE CODE	PRACTICE NAME / Postcode	List Size	Total No. of 75 and Over
N84005	I.M.HUGHES & PARTNERS PR8 6PG	9156	914
N84006	JACKSON & PARTNERS	8038	1312

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	L37 4DL		
N84008	UNWIN & PARTNERS PR9 7EG	8948	947
N84012	RUSSELL & PARTNERS PR8 3HW	12563	1748
N84013	BOND & PARTNER PR8 6PL	4862	548
N84014	SMITH P PR8 3LB	2940	346
N84017	FIRTH & PTNRS PR9 7LT	10953	1602
N84018	REDDINGTON & PARTNERS L37 4AW	9565	1488
N84021	HEDLEY & PTNRS PR9 0TZ	15738	1616
N84024	KILSHAW & PARTNERS PR8 2AD	9755	1558
N84036	FRESHFIELD SSP HEALTH LTD L37 3NU	2997	210
N84037	GANA PR8 4PR	2105	237
N84611	FOX & LEONARD PR9 7PN	2467	328
N84613	MULLA & PARTNERS PR9 9XL	3832	422
N84614	WAINWRIGHT & CAUDWELL PR9 9XL	2624	282
N84617	OBUCHOWICZ H PR8 6RG	3671	222
N84618	ELDRIDGE & PARTNERS L37 4AD	4649	453
N84625	NAIDOO K R PR8 4DB	4045	206
Y02610	TRINITY-SOUTHPORT HEALTH CENTRE PR9 0PQ	4016	554
	Total population covered	**122924**	**14993**

5. Other providers involved:

Please give details of any other providers with whom you will be collaborating (eg community services, pharmacies, 111, etc).

In the development and delivery of this scheme, there are a number of organisations who we will be collaborating with. These include: Southport & Ormskirk Integrated Care Organisation – integrated approach with

A&E and wrap around support from community service teams
Go To Doc – Out of Hours provider
Care Homes across Sefton
iMersey – IM&T partner
NHS111
Community pharmacies serving the population of Southport and Formby

6. CCGs covered:
Please indicate which CCGs are involved in this application.

NHS Southport & Formby CCG

7. NHS England Area Team:
Please indicate your NHS England Area Team.

Merseyside and CWW

8. Patient satisfaction:
Latest position on patient experience of access[1] across your proposed pilot area.

The feedback from the national General Practice patient survey demonstrates that the general scores and experience in Southport & Formby is largely in line with the England average.

Satisfaction with opening hours (% satisfied) and Overall experience of making an appointment (% good) score 77% and 76% respectively and are common with the England average.

Able to get an appointment and Convenience of getting an appointment both score slightly better in Southport & Formby compared to England average, whereas Ease of getting through on the phone scores slightly lower.

However, these overall figures do not demonstrate the variability of scores across the practices.

Satisfaction with opening hours ranges locally between 65% and 88%. The variation of scores when considering Overall experience of making an appointment is even greater with a low score of 56% and a high score of 91%.

[1] See breakdown of access related questions from the latest GP Patient Survey results (by practice) in the supporting documents section on the PMCF web page.

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There are also significant variations at a practice level for Able to get an appointment and Convenience of appointment:

Able to get an appointment (% saying no) ranges from 4% to 19% and Convenience of appointment ranges from 1% to 12%.

The important aspect with this is for practices to share their approaches and systems for appointment management with each other and to create a learning culture and to adopt the best practice across the towns.

The approach outlined in this proposal is designed to generate even more capacity in General Practice, offer additional times of opening and a greater choice of services. We will be closely monitoring the satisfaction and experience of patients using the existing and new services and forecast a positive reflection in both the local and national survey results throughout 2015/16 and beyond.

Section B. What you propose to deliver

Information about the proposed service innovations.

9. **Project overview -** Please give an overview of the proposed project. Please focus on what changes will be made to services.

Max 1000 words:

General Practice in Southport & Formby recognise the need to provide alternative services to its diverse population. This opportunity provides a real catalyst to the practices working towards a collaborative model of service delivery and a more integrated and collaborative approach to how additional primary care capacity will be accessed by the patients themselves and also the local Accident & Emergency department, and NHS111. Like all parts of the NHS, Southport and Formby has significant and increasing demand on the existing general practice capacity, coupled with substantial urgent care demand, pressures and challenges. The local GPs believe that this scheme is as an innovative and alternative approach to address both issues on a sustainable basis.

In summary, this scheme has been developed to provide extended general practice capacity and access to the population of Sefton. All 19 practices from Southport & Formby CCG will collaborate in their approach to offering a town-wide service to run additional clinics every evening and weekend, providing approximately 948 additional general practice appointments every week.

The majority of this additional capacity will be available and protected for patients to book into and is in addition to the existing general practice capacity. This is designed to directly address the challenges faced around accessing general practice.

We know through our engagement work that continuity of care is of vital importance to our patients and therefore, the service will be run by local clinicians to support this. This does not necessarily mean that every patient will be able to see their registered GP. However, they will be seen by a GP who works in the Southport and Formby area, who will have full access to the patient's complete record and who has a complete understanding of local services. Due to the demographics of the population, and the high number of older patients (Southport and Formby is 25 years ahead of the rest of England and Wales in terms of population profile) with multiple co-morbidities, the local GPs have developed an expertise in managing complex consultations. As a consequence levels of unplanned care historically

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have been lower than expected.

The service will operate from a single site, co-located within the same grounds as the local acute hospitals A&E department, utilising out patient clinic facilities.

Using agreed pathways and referral criteria, patients presenting at the A&E department who are considered clinically appropriate to be seen by general practice will have the opportunity to be diverted into this service using bookable appointments.

An audit of type 1 attendances at Southport and Ormskirk Hospital during the proposed GP Service (18.30 – 20.00 Mon to Fri and 08.00 – 12.00 Saturday and Sunday) between April 2013 and October 2014 shows that 60% of patients potentially could have been diverted to a GP service, although this level of data does not provide detail on each attendance.

Discharged – did not require any follow up treatment	2290
Discharged – follow up treatment to be provided by General Practitioner	900
Left Department before being treated	109
Left Department having refused treatment	28
Other	11
Total	3338

This service will be operating in the evenings at a time when A&E departments are often experiencing their peak demand. By co-locating the service with the A&E department, we are optimistic a number of patients will be booked into this new service and thereby help alleviate pressure on the A&E department. The out patient department is in close proximity of A&E, approximately 100 metres.

We will undertake a dual approach to advertise and raise awareness of this new service. Firstly, all participating practices will clearly advertise the service within the practice and receptionists will offer the service as an option when a patient makes contact. We will also be asking all local providers of health services to advertise the service in its waiting areas. Secondly, we will run a publicity campaign in the weeks leading to the opening of the new service to ensure the entire population is made aware of its location, opening times and purpose. We will then monitor the uptake of the service on a practice by practice basis so we can undertake additional marketing and advertising of the service where needed.

Also included within the scheme is a ‘roving’ GP for frail elderly patients identified at

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risk of admission. The demographic of our population is quite unique with 25.1% of our residents over 65 (compared to 17% nationally) and 12.6% over 75 (compared to 8% nationally). Therefore, we have a high numbers of care homes resulting in 959 nursing beds and 1177 residential beds. We know that within this cohort of our population are some of the most vulnerable people who require a lot of support and intervention from the health services. From local audit we know that care home staff can feel unsupported in dealing with ill patients and that the traditional roles of OOH, 999 and 111 can lead to unnecessary attendances at AED. This part of the scheme is designed to offer an additional layer of resilience to this population and to offer greater continuity and support to the care homes. At present, too many of these people are identified at risk of hospitalisation during the working day who subsequently get admitted into hospital in the early evening during the period of handover from general practice to community teams and/or out of hours provision. The roving GP will be proactively informed during the day of any resident who is considered 'at risk' of hospital admission. They will then work with care homes staff to continue to assess the health and well-being of the individual and, where needed, go out to see the patients and organise the necessary support and wrap-around packages. It is believed this will really target a reduction in emergency admissions at the local hospital.

In addition the scheme will extend to frail elderly individuals and their carers living in their own homes (non care homes) that have been identified by their own GP as at risk of hospitalisation. This emphasis on managing the frail and elderly in their own homes links with the CCG proposed 2nd year of the Local Quality Contract (due to start on 1st August 2015), which will focus the identification and proactive management of this cohort of our population.

Developing our existing IT systems is fundamental and we will work closely with our IT partner to benefit from a digitally mature health and social care economy wide informatics solution. Utilising existing informatics capabilities the service will benefit from a discrete solution with interoperability capabilities across primary & community care.

Throughout the life of the scheme, we will work closely with the PPGs to ensure we develop a coordinate approach to monitoring patient experience. This will need to include whether the additional capacity is meeting the needs of our population, whether the site of the new service is sufficiently accessible and whether our patients feel that the new services offer a genuinely improved general practice service.

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10. **Project outputs -** Please describe the expected benefits for patients as a result of the project. Include expected service benefits and how this will support practices in delivery of core primary care[2].

Max 1000 words

By September 2015:

- Additional general practice capacity will be available 7 days each week.
- General Practice will operate from 8am to 8pm Monday to Friday and from 8am to noon on Saturday and Sunday
- Approximately 948 additional general practice appointments will be available every week for local people
- All GPs and care homes will be aware of the 'roving' GP and systems will be established that result in proactive management of the most vulnerable and 'at risk' patients
- A comprehensive media and advertising campaign will have been undertaken to raise awareness of the population of Southport & Formby of the new services.

In turn, this will:

- Reduce the number of patients presenting at A&E because there is greater general practice capacity for them to access;
- Improve the experience and satisfaction of our patients who access general practice;
- Result in some patients, where clinically appropriate, being diverted from A&E and booked into the new general practice slots;
- Result in more of our most vulnerable and 'at risk' patients being cared for in their usual place of residence and not being admitted into hospital
- Reduce the number of patients accessing OOH services
- Increase use of community pharmacists for advice and help with self care.

[2] We would expect successful applications to also make reference to how the proposed scheme will achieve the wider range of benefits given in Section 6 of the wave two invitation.

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11. Describe how patients will receive some form of **extended access** outside of core opening hours above what is already provided. Please specify how many extra hours by practice the pilot will offer on weekdays and weekends (and number of consultations if available). Demonstrate that patients will be able to access general practice services from 8-8 on weekdays (or equivalent) and improved access at weekends*. This will be a minimum condition for receipt of funding.*

Max 1000 words:

The main element of this scheme is extending access and capacity of general practice. The service will operate from 6:30pm to 8:00pm from Monday to Friday and from 8:00am to 12:00 noon on Saturday and Sunday.

Our CCG wide Local Quality Contract already requires practices to have an open door and no phone divert policy from 8.00am to 6.30pm Monday to Friday.

The service will be run from a single site with all Southport and Formby practices working in a collaborated way. They will share the responsibility of the clinical input required and will see patients from other local practices. Sharing the care records is fundamental to enable the most effective and efficient use of each appointment. The clinicians will be required to manage and close each appointment; not simply ask the patient to return to see their own GP in the next day or so. They will refer to diagnostics and other services as appropriate.

Each session will operate with 8 GPs, 2 healthcare assistants and 2 pharmacists. Each appointment will be bookable and will provide a mixture of appointment types. Therefore each week there will be an additional 116 hours of GP, and 58 hours of additional clinical operating time. This equates to approximately 948 additional appointments weekly.

The model of consultation in addition to dealing with the present problem will include two further elements

- Health promotion – smoking cessation, alcohol, weight management etc.
- Self care advice – use of pharmacist / NHS choices etc. with appropriate supporting literature.
-

Although our contact figures are based on 10 minute consultation slots, there will be the facility to vary these times typically telephone consultations are shorter than

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face to face, and dealing with multiple or psychological problems takes longer.

In addition to traditional face to face consultation we will be offering bookable telephone and video consultations with GPs with the ability to arrange face to face consultations within the service

The healthcare assistants will support the GPs and have the ability to undertake tests including blood tests, spirometry tests and ECG examinations, urinalysis and arrange diagnostics available to the same level as normal hours primary care.

The pharmacist will support any medication reviews or respond to specific queries pertaining to patient queries about their medication.

Each session will be supported by two receptionists.

Patients residing in the area who present at A+E and are currently not registered with a GP can be signposted to this service to register at a Southport and Formby practice. The reception team will have access to information on practice boundaries, and services provided by contractors.

We anticipate the service being fully operational from 1st August and to run for the rest of 2015/16. The costings are based on a full 12 months activity.

The proposed bid will benefit from a digitally mature health and social care economy wide informatics solution. Utilising existing informatics capabilities the service will benefit from a discrete solution with interoperability capabilities across primary & community care. Utilising EMIS Web, the implementation will initially support the deployment of functionalities:-

- Access to primary care information
  - Via a proven, integrated data sharing connection, the service will have direct access to a patient's full primary care record.
  - The data sharing model is based upon explicit patient consent governance control with full audit capabilities.
  - Clinical information will be to the same quality level/standard as if the patient had been seen by their own practice
  - Cross-organisation tasks provide the capability to add, assign and receive tasks or messages between staff and services across primary, community and extended service.
  - Cross-organisation appointments provide a facility to book, receive and cancel appointments from the existing primary care system directly into the extended service EMIS web service, allowing primary care to proactively

book patient appointments in the extended service seamlessly from their existing system. Access to the appointment book would be provided to the A&E department to allow booking.

- Cross-organisation warnings improve safeguarding visibility
- Outbound documents allow a discharge summary or document outlining clinical intervention with the extended service to be electronically transmitted back to GP practice.
- Managed referrals will allow the service to refer electronically directly from the extended services system into local community services (e.g. Therapy, DN's)
- Mobile access to information will be facilitated utilising different technologies depending upon the service use. Mobile application access to elements of an individual's record will be provided via EMIS Mobile app which supports disconnected working

The proposed bid will benefit from Informatics Merseyside's strategic pathfinder partnership with EMIS Group to pilot newly developed functionalities to support collaborative working across primary care. As part of the proposed bid, it is planned that a Proof of Concept will be initiated between S&F CCG, Informatics Merseyside and EMIS, working in partnership to deploy innovative clinical federated functionality across the system

A clinical federated functionality will enable a collaboration of primary care practices to work in a more integrated way, with access to patient clinical information and practice system clinical workflow in a more holistic approach. Collaborating practices will be able to access patient's full primary care records from other GP practice's, and record intervention as if the patient was a member of their existing practice. The system will record the consultation within the collaborative system as well as the patients normal GP practice system.

This newly developed functionality will have the capability to transform the availability, and recording capabilities of multi-practice primary care.

The second key element of this service is an additional general practice service that will focus on some of our most vulnerable residents. The 'roving' GP will proactively target and support residents who have been previously identified by their own GP and, where appropriate, organise for additional services to be commissioned and provided on an individual basis. In addition there will be access to consultant geriatrician support, in the form of next day bookable slots in to geriatrician OPD and the ability to get rapid (24hr) email advice. This service is being commissioned by the CCG and is due to commence in April 2016.

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During the working day, GPs are often in discussion with care homes about specific residents or patients in their own homes, and will visit patients as and when required. During these visits, packages of care are agreed and, for example, patients may start a course of medication. One of the key aims of this scheme is to provide additional support to both the individual patients and care homes staff as the 'roving' GP service will continue to operate when general practice close and continue until 10:00pm in the evening. This is a period of the day where a high number of this particular cohort of residents can be admitted to hospital as a result of their reaction (or not) to particular medication or packages of care that has been prescribed that day. This service will see the patient's own GP proactively inform the 'roving' GP of any treatment or interventions that have been prescribed and administered and to flag up that there may be concerns or a need to closely observe the individual into the evening period. The 'roving' GP will then be in close liaison with the carers to monitor the progress of the individual and, where necessary, visit the patient.

Whilst this is not a bookable service for patients offering additional appointment capacity, it is additional capacity for the professionals to access. It is focusing on a highly vulnerable cohort of the population and it will have a significant impact on the number of patients from this cohort who are subsequently admitted to hospital, without there being a particularly acute need for them to be there.

Two roving GPs will provide an additional 51 hours capacity per week.

12. **Sustainability** - Describe how your project will lead to sustainable improvements once the non-recurrent funding is no longer available (including whether your CCG will support the scheme with supporting funding).

Max 1000 words:

The majority of this scheme is reliant upon the non-recurrent funding a successful bid would generate. The one area that is not reliant upon this are the IM&T developments given the great foundations already in place. All practices use the same system (EMIS) and, working with our IT partner, we will able to develop shared records and joint booking of the additional capacity being generated, supporting the collaborative approach underpinning this scheme.

The services described above will require the non-recurrent monies to fund:

- Staffing time to run and manage the services. This will be both clinical and non clinical staff;
- Diagnostic costs. We would anticipate an increase in the number of requests for diagnostics to run in parallel to the increase in appointment capacity;
- Estates costs. We will be using existing NHS premises but will be required to pay a lease/rent to incumbent owner
- Advertising and media campaign costs. There will be an initial high cost as the service is widely advertised and then a minimal amount required thereafter to continue to advertise in the practices and other provider premises
- Overhead costs. This includes support from the CCG to provide analytical, governance and finance support.

Other than the advertising and media campaign costs, we forecast that the level of expenditure will remain relatively static from when the services commence. This is set out in further detail in section 22 below.

Therefore, we anticipate that we will need to identify an income stream from 2016/17 that will cover this cost.

The actual impact of the services is not yet known and until all services are fully operational, coupled with raised patient and public awareness of the new services, will the full impact be realised. That said, there are currently three key funding streams where the income needed to support this on an on-going basis can be realised:

1) A reduction in the acute contract service levels, with a particular focus on A&E attendances and emergency admissions/re-admissions;
2) A reduction in the Out of Hours contract service levels, working on the assumption that these services will have a direct impact on a reduced demand for the current Out of Hours services;
3) A review of the current local Enhanced Services and local Quality Contracts to ensure they are delivering maximum value for money and to consider if there are alternative ways these can be used.

It is also considered that the real potential of this service approach is the delivery across a whole CCG footprint, as all Southport and Formby practices are participating. Delivering this approach across such a large footprint will optimise the greatest impact.

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13. How does the project **link to the local strategy for the health and care system** including its contribution to improving care for older people, promoting continuity of care, improving overall quality and productivity of local NHS services, and reducing health inequalities?

Max 500 words:

This scheme completely aligns with the local health and care strategy. The CCG for Southport and Formby and Health and Wellbeing Board have identified a number of priorities and these include:

- Support people early to prevent and treat avoidable illnesses and reduce inequalities in health
- Support older people and those with long term conditions and disabilities to remain independent and in their own homes
- Promote positive mental health and wellbeing
- Build capacity and resilience to empower and strengthen communities

These fit with SFCCGs strategic aims around:

- Improving services for frail elderly
- Primary care development
- Reducing unplanned care

Furthermore, there are a number of system objectives that have been agreed across the health community and this scheme directly supports the development and delivery of two of these:

- System objective 3 – reducing the amount of time people spend avoidably in hospital. Reduce emergency admissions by 20%
- System objective 5 – improve patient experience of GP and out of hours care by 30% (% reporting poor care to reduce)

The principle of continuity of care is so important to both the local population and the local clinicians. This is why we are focusing on employing only local GPs and local nurses to run these services. Whilst the patients may not be able to see their own GP every time in this service, they will be seen by a local clinician who understands the local health economy, who understands the services available and understands the local population. The development of the access to shared records will also avoid the much criticised 'repeat history' scenario for both the patients and professionals where the same questions are asked and the same answers are given each time a new episode of care commences. This approach will remove that and provide more time for the clinician to focus on the real needs of the patient.

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The named practices in this bid all collaborated in the successful Southport based out of hours collaborative from the mid 90's till the new GP contract. There is history of collaborative working to produce high quality patient services with a focus on access, and admission avoidance. The operational experience has been retained in the local primary care community.

The integrated approach and co-location of the service with the local A&E department is seen as a significant opportunity to make a real impact in the productivity of the urgent care system. It has the potential to ensure that patients are seen in the most appropriate care setting, by the most appropriate clinician. This is seen as an area of potential expansion based on the success of the scheme as it is fully rolled out.

Finally, the 'roving' GP service is completely committed and focused on improving the care provided to our most vulnerable and 'at risk' patient group. Southport has an ageing population anyway and as a result, there are already a range of services in place to provide the appropriate levels of care. This service will add to these existing services and have a focus to keep as many of our population in their usual place of residence and reduce inappropriate and unnecessary emergency admissions.

14. How do you think your pilot might influence current patient pathways out of hours, linking to 111, GP out of hours and diverting people from A&E?

Max 500 words:

One of the key aims of the service is to provide additional capacity and choice for the local population. It is forecast that this additional capacity will have an impact on both the demand on the GP Out of Hours service and also the level of support that Primary Care can provide to the local A&E department, especially at times of peak demand.

The service will also provide an additional choice for patients who call the 111 service.

As well as providing additional General Practice capacity, one of the real benefits of this approach is the ability to divert patients from A&E who can, and probably should be seen by a GP. The decision to co-locate the service on the same site as the A&E is designed to maximise the potential gain of this approach. Given the

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A&E is part of an Integrated Care Organisation, there are additional opportunities to consider further integration of the service with community based services.

Furthermore, the ‘roving’ GP service, supporting care homes and their vulnerable residents, will also result in a reduced demand on the OOH provider as there will be additional General Practice capacity in place to focus on this particular cohort. In turn, it is forecast that this service will result in a reduced demand on the A&E department both in terms of attendances and potential admissions.

We will work with the key partners (the ICO and the OOH provider) throughout the duration of the service to closely monitor and consider the impact and influence it is having on the closely associated services.

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Section C. How will it happen

Information about your strategy for leading this programme.

15. **Engagement -** Describe how local people and practices have been involved so far in designing this programme. Outline the methods by which organisations and professionals involved will continue to be engaged.

Max 300 words

The development of this scheme has been undertaken with significant input and consideration from all local practices. The fact that all 19 practices have committed to supporting and contributing to the approach is testament to their involvement and enthusiasm to finding creative solutions that will have a positive impact on the local population.

The practices considered a number of options and solutions and unanimously favoured a single site model and were equally in favour of an approach that would deliver equity of service for every resident.

The practices also considered what services the local population want. The CCG regularly facilitate 'Big Chat' events with local people which presents an ideal opportunity to debate key issues and themes and to gain valuable insights about their views. This insight has been critical in developing this approach. Direct feedback / questions that have been used includes:

- Patient support for the option to work as a group of GPs to offer 7/7 working
- One group mentioned that a walk-in GP practice is required in the area
- How will access to GP appointments be improved?
- Access to GP surgeries: Is there any work underway regarding telephone/email consultations? There needs to be promotion to online access to services, such as appointments/repeat prescriptions.

As we prepare to implement these services, we will continue discussions with the public via the PPG forums to ensure our communications, use of language and accessibility of the services are carefully considered and co-produced with PPG members.

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We will also be monitoring patient satisfaction, as well as professional satisfaction (for those delivering the services), throughout the duration of the service so we can monitor the experience of users and, where needed, quickly intervene to make improvements should the need arise.

16. Demonstrate that you have the **capacity and capability for rapid implementation** and technical deliverability, with tangible benefits for patients being demonstrated during 2015/16.

Max 300 words:

A successful application and the securing of funds will support a rapid implementation of the services described. Either directly, or through partnerships, we have the necessary capability within Southport & Formby to deliver the services to an excellent standard.

Our IT partner, Informatics Merseyside, bring the expertise and capacity to rapidly implement the solutions outlined earlier. The rapid implementation is possible because of the excellent IT foundations already in place across the area.

We have also involved the local acute trust/ICO to discuss the provision of the facilities to run part of the service on the same site as the A&E department and the development of appropriate referral criteria into the bookable service.

We will continue to actively engage with the local Care Homes and practices to ensure full awareness of the 'roving' GP service and will develop appropriate guidelines amongst our practices to ensure the service is fully aware of those patients and residents who will benefit the most from this new service.

The funding we have outlined will also secure a full time operational manager to run and manage the services and it will also secure a part time clinical director to support the additional capacity service.

The clinical lead will be responsible for overseeing training and staff development, oversee patient care and managing and supervision.

We are confident of rapid implementation with all services being fully operation from August 2015 and we forecast that the benefits to patients – in terms of additional access, improved experience, reduced A&E demand – will be seen within weeks of the 'go live' date.

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17. **Leadership** - Can you demonstrate both clear leadership for the proposed work programme and strong commitment from all the practices involved (eg signatures of support).

Max 300 words:

There is very strong local leadership and commitment to this service and this is demonstrated clearly by the number of practices from the CCG who are taking part. The development of the services has been done with local GPs, practice nursing staff and practice managers.

The leadership to develop the approach, canvas opinion and engage with colleagues has been led by Dr Niall Leonard, Vice Chairman of Southport & Formby CCG. Dr Leonard, is a former chair of SFCCG, progressed smoothly through the national assessment centre which was required of all potential CCG Chairs, ahead of the CCG Authorisation process. This demonstrates the calibre of clinical leadership involved in the development of this programme.

The approach will also see the establishment of a full time operational manager and part time clinical director. These two people will bring focused leadership and dedicated support to the successful implementation and delivery of the services.

There is long history and a breadth of excellent clinical leadership in within Southport and Formby, with many GPs and other primary care clinicians having significant experience in leadership roles for priority clinical areas and in lead commissioning roles.

The proposed lead practice for this proposal is led by a GP who has over twenty years of experience of leading programmes to improve the commissioning and provision of local services, including the development of relationships across health and social care and into the voluntary sector to improve health and wellbeing in its fullest sense.

There has been wide engagement with all GP practices in Southport and Formby, and a developing locality structure within the area which enhances opportunities for discussion and involvement in the implementation of the plans.

Finally, the CCG is fully supportive of the approach and delighted by the federated and integrated nature of the services. The CCG is providing any governance input and expertise required and will support the appointed leaders as required to ensure successful implementation and delivery.

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18. How will you develop your GP community to ensure **sustainable leadership** after pilot funding ceases?

Max 300 words:

In Southport and Formby there are many GPs with significant experience of leadership roles which include clinical and service transformation in mental health, CVD, respiratory, diabetes, children's services, medicines management, acute and community commissioning. A number of these leaders have taken opportunities presented by the North West Leadership Academy to enhance their leadership skills. This breadth of leadership provides a great platform for the development of succession plans and the identification of future leaders for long term sustainability of the programme.

There is also a strong track record of education, training and development e.g. Protected Learning Time - GPs from the area meet regularly for educational events both at large venue sessions and in-house with the wider practice team. Learning and development can be shared via this route to enhance the implementation and long term sustainability of the programme.

19. **Improvement methodology -** Outline the means by which you will redesign services and undertake testing and refinement of innovation ideas.

Max 500 words

The service with use the NHS Change Management Tool as the framework of principles in which to bring about robust change.

Specifically regarding improvement methodology we will be utilising a combined approach from the Institute of Health Improvement (Model for Improvement) and lean methodology (lean culture, flow and focus on reducing the 7 forms of waste) to bring about dynamic change and efficiency to ensure equitable access. In short the main areas include preparation, testing and measurement.

The approach will include the following

PROJECT TEAM

1. An integrated team will be formed that includes the following Vice Chair S&FCCG, Primary Care Quality Lead, Finance, Governance, Data Analyst, A&E Clinician, Trust manager, Care Homes Representative,

Healthwatch Representative, Local Area Team Representative.

2. The team will meet early March to develop the mobilisation plan and outcome measures.

PROJECT PREPARATION

1. Prework regarding the “Chamberlain 10 P’s approach” ensuring the following are covered:

Passion for the service, unified purpose of the team, understanding the population the service is aimed at, understanding the needs from specific patients perspectives, ensuring the right professionals are on the team, linking with other partners and organisations as stakeholders, visualising and mapping current and planned patterns and processes. Such system diagnostics and research outside of the service will inform the next stages. This grant is part of ensuring provision and payment

2. Formulation of a driver diagram and measurement mechanisms.

3. Formulation of change concepts using the IDEA approach to innovation

4. Set up of a project QI tracker

TESTING

The team will set up the service and use ongoing live Plan Do Study Act cycles aligned to project drivers to continue to incrementally improve the outcome for patients. Such cycles will move through development, live testing, implementation and scale up phases. PDSA cycle size will be governed by a) potential risk b) readiness of to change and c) degree of belief.

MEASUREMENT

We have sought to align the measures according to outcome, process and balancing measures while focussing on quality domains including (e.g. equity, timing, effectiveness etc.).

Our measurement unit will be one week and we will use transparent real time time series as part of the learning system.

The team will utilise a quality improvement advisor

20. **Measurement -** The nine national metrics for wave one are:

A. Patient contact, as a direct result of the change in access
- The change in hours offered for patient contact;
- The change in modes of contacts;
- The utilisation of additional hours offered; and
- Impact on the 'out of hours' service.

B. Patient experience/satisfaction, including patient choice
- Satisfaction with access arrangements; and
- Satisfaction with modes of contact available.

C. Staff experience/satisfaction
- Satisfaction with new arrangements.

D. Wider system change.
- Impact on the wider system attendances; and
- Impact on emergency admissions.

List any additional metrics you would like to see included as part of the evaluation
Data collection plans (include costs in finance plans): Bookable slots • Activity number of slots available / slots filled • Source of bookings – GP practice / A+E / GTD/111 • Patient behaviour following appointment – ie do they seek further advice with own GP • Impact on access to GPs in core hours • Average wait time • Patient satisfaction Roving GP • Activity • Whether a patient is admitted following intervention or remains in own home Impact on other providers • A+E activity by time band • OOH activity by time band • Unplanned admissions • Preferred place of death • Usage of Local Authority managed health promotion schemes Weekly run charts/ set up dashboard

21. **Commitment from CCG(s) -** Please attach a statement from your CCG setting out their views on the proposals. Success and sustainability of new approaches to primary care are partly dependent on the commitment of the CCG.

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Section D. Programme planning

22. **Estimate of funding needed -** Please include an estimate of the funding that you would need to support your proposal, including:

- how the investment will be funded (clearly indicating what funding is coming from PMCF and what from other sources – including matched / supplementary funds from partner organisations, recognising that PMCF has been identified as a revenue budget and funding is only available for the 15/16 financial year)
- a breakdown of all capital and revenue costs of the proposed investment.

Please note: Final decisions on funding will depend on the number of pilots selected and following dialogue between NHS England and applicants to help gauge the level of financial support they require.

Max 500 words:

In total, we will require £1.746 million of revenue / capital costs to support and drive the implementation for each project outlined in Section B. We are looking to fund this entirely from the Prime Ministers Challenge Fund.

	Costs for 122,000 population (annual costs)
Revenue	
Pay	
General Practitioner	£748,800
Roving General Practitioner	£270,400
Healthcare Assistant	£31,824
Pharmacist	£74,880
Receptionist	£44,928
Manager	£48,800
Medical Director 0.5	£78,000
	£1,297,632
Non-Pay	
Premises	£93,600
Prescribing	£100,000
Recruitment costs	£10,000
Training	£10,000
Consumables	£15,000
Interpretation Services	£50,000
Equipment	£20,000
IPLATO text messaging	£40,000

Miscellaneous (clinical waste / insurance/CQC registration/ accountancy etc, travelling expenses roving GPs)	£60,000
	£398,600
Capital	
I.T	£50,000
Total	**£1,746,232**

23. Please indicate the organisation to which you would wish funding to be awarded (eg lead practice or registered CIC).

Lead Practice - N84611 Fox & Leonard

24. **Timetable** - Please provide a high level programme plan, indicating key lines of work, dependencies and milestones. Where possible, include this in both tabular and graphical (Gantt) form. Please assume that funds will be available from 1 April 2015.

25. **Attachments:**

- ❑ Attach map of geographic area covered
- ❑ Attach letter setting out views of CCG(s)
- ❑ Include (as a minimum) high level month by month programme plan

Further information|:
If you have any queries about the application process, please contact the relevant NHS England area team.

Application submission:
Please send your completed application to the following mailbox by 5pm on 16 January 2015 to: England.challengefund@nhs.net *and copy in your area team*

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FF27 South Sefton CCG

NHS
South Sefton
Clinical Commissioning Group

Service	**Virtual Ward System – Integrated Community Care**
Commissioner Lead	**Dr. Peter Chamberlain** **South Sefton Clinical Commissioning Group**
Commissioning Group	**South Sefton Clinical Commissioning Group**
Provider	**Liverpool Community Health**
Period	**1st April 2013 – 31st March 2015**

1.1 Aims and overview

Our primary goal is to maintain happy independence for frail and older people.

Key objectives to this aim include preventing the need for an unplanned admission and therefore averting a crisis of care. The headline objectives three years from full roll-out of the whole system include:

1. Reduction in unplanned care admissions for medical patients 65 years of 20%. This equates to a total reduction of 8% across all unplanned care admissions.
2. Reduction in A&E attendances patients 65 years of 15%

Other objectives may be found below under section 1.5 – Expected Outcomes

There are two key strategies to achieve this – both with aim to coordinate care around the patient:

a) Horizontal integration of clinical community services through Virtual Wards
b) Vertical integration of clinical Information Technology systems to enable an integrated care record.

This specification focuses on (a) - the formation and function of Virtual Wards. Key documents to support this specification will include the South Sefton Virtual Ward Project Strategic Outline and the South Sefton Virtual Ward System Operating Framework.

Underpinning clinical integrated working will require a step up in the use of information technology, including streamlined cross system communication, a common referral pathway, mobile staff working and work towards a cross sector shared electronic care plan that is accessible to patients.

The four essential pillars of the Virtual Ward System are:

1) **Integration of teams, services and systems**

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a. A change from current 'Silo' working into defined multi-professional teams
b. Inclusion of Health, Social and Voluntary sectors within multi-professional teams
c. Coordinated care reducing the need for inter-professional referral
d. Ensuring gaps of care are closed at every opportunity

2) Pro-active focus on long term conditions

a. Bringing care closer to home
b. Shared Care Planning for key groups of patients
c. Increased screening for dementia and falls
d. Long term condition reviews for specified conditions
e. A platform to connect specialist teams
f. Use of assistive technologies in selected areas agreed by commissioners

3) Streamlined use of Information Technology

a. Use of population risk stratification to assist in identifying patients for pro-active intervention
b. Streaming of key measures for quality improvement process
c. Mobile working and online templates to enable screening and enrich patient data
d. Improved communication through cross-sector access to patient brief summary, specified discharge and communication templates, viewing of community record
e. Cross sector shared care plan

4) Empowering self care and patient responsibility

a. 12 week Pro-active care programme focussing on self care, goal setting, behavioural change and appropriate use of services
b. Limited access to electronic patient record
c. Focus on education, empowerment to patients, carers and families
d. Involvement in care planning
e. Enable patients to make appropriate choices about use of services and reduce inappropriate use
f. Linking patients with community support groups and third sector services

'Mrs Sefton' will be involved in decisions about her care as a partner. Goals within care plans will be based on 'Mrs Sefton' as an individual and aim to increase her knowledge of her conditions and how to identify and manage changes to her condition. Where appropriate this will include communicating choices and decisions about when not to undertake active treatment and about where she would like to be cared for at the end of her life.

The Virtual Ward Model requires the re-organisation of specified staff into multi-disciplinary and multi-provider teams that wrap care around the patient such as 'Mrs Sefton'. These teams will be based around specified GP Practice populations in four localities; Bootle, Crosby, Maghull and Seaforth & Litherland. These teams will be known locally as Virtual Wards.

The reasoning for 'Virtual Ward' relates to the following key attributes, all of which must be present and functioning within each Virtual Ward:

1. A multi professional team working in unison to provide patient care negating the need for inter-professional referrals
2. All Virtual Ward Staff to have access to a Common Patient Record and IMT system
3. Weekly 'Virtual Ward Round' multi-disciplinary team meeting
4. Administrative oversight through a Ward Manager and Ward Coordinator
5. Time limited 'stay' on the Virtual Ward for each episode up to 12 weeks
6. Specified discharge summary information
7. Specified physical boundary

1.2 Evidence Base

This specification is developed in line with current best evidence, specifically:

- Integrating health and social care in Torbay. Improving care for Mrs Smith. The Kings Fund (March 2011)
- An overview of integration in the NHS. What is integrated care? The Nuffield Trust (June 2011)
- A report to the Department of Health and the NHS futures forum. Integrated care for patients and populations: improving outcomes by working together. The Kings Fund and The Nuffield Trust (Jan 2012)
- The Integration of Health and Social Care. The Health Policy Economic Research Unit (June 2012)
- Caring for people with chronic conditions – A Health System Perspective, European Observatory on Health Systems and Policies Series, 2008
- OECD (2011), Health Reform: Meeting the Challenge of Ageing and Multiple Morbidities, OECD Publishing
- A Guide to the Implementation of the Long Term Conditions Model of Care, LTC QIPP, Sir John Oldham

1.3 General Overview

Integrated Care

The Virtual Ward system is an integrated model of care. This means that different professionals, teams and organisations are linked together and work alongside each other in a seamless way to wrap care around the patient.

Integration therefore closes the gaps in care by enabling aspects of care to fit together like a jigsaw. In addition communication, collaboration and coordination of care mean for a much more responsive and efficient service.

No one organisation therefore owns the model as it is the product of collaboration with a shared aim and vision. The main emphasis is that the power of team comes from a cohesive variety. Overlapping and understanding adjacent professional's role is therefore key to its success.

The Model

The model includes three interlocking clinical teams bound together through an information technology spine and Single Point of Contact. These three aspects include:

1) Virtual Ward Urgent Care Team (covering all four Virtual Wards)
2) Pro-Active Nursing Teams (one per Virtual Wards)
3) Re-ablement (Specified individuals attached to each Virtual Ward)

Given the integrated nature of the model, patients may receive the input of all three aspects at one time and there will be a cross over in roles. The key major roles of each of these three aspects however are stipulated below:

1) Virtual Ward Urgent Care Team (CCG patch)

a. Acute admission prevention
b. Two hour rapid response medical, nursing, re-ablement, social assessment
c. Hospital at home for specified presentations

2) Pro-Active Nursing (locality based)
   a. District Nursing Care
   b. Administration of pro-active care programme
   c. Medication assistance
   d. Support for goal setting, behavioural change
   e. Linking patients with voluntary services across the area
   f. Long Term Condition assessment and monitoring
   g. Contribution to and assistance with care planning including advanced care planning
   h. Palliative Care

3) Re-ablement
   a. Specified/ named individual professionals to be attached to each locality based Virtual Ward
   b. Focussed rehabilitation for pre and post hospital patients
   c. Support for independent living
   d. Domiciliary OT and PT assessment and treatment
   e. Assessment and coordination of social care and housing adaptations
   f. Linking patients with voluntary services across the area

In addition to working together much more closely, Virtual Ward staff will need to have access to and draw in support from more specialist community teams which should be seamless. Stop-gap short term care packages will be made available to Virtual Ward staff.

1.4 Objectives

The service objectives are to:

- Prevent unplanned hospital attendance or admission where appropriate by virtual ward coordination of care across multiple health and social care providers, improved communication and MDT optimisation of patients at greatest risk of admission and readmission

- Prevent unplanned hospital attendance or admission where appropriate through virtual ward patient engagement, patient education and improved self-management of patients with long term conditions.

- Reduce patient length of stay by pro-active transfer of care to the virtual ward and coordination of health and social care providers within the MDT and communication with partners.

- Reduce the proportion of re-admissions to hospital through providing a robust community safety net to support patients deemed high risk of re-admission.

- To provide care for patients without increasing the use of community unplanned activity at the walk-in centre, out of hours and hospital outpatient activity by virtual ward coordination and optimisation across multiple health and social care providers, improved patient engagement, patient education and improved self-management of patients with long term conditions at highest risk of crisis.

- To increase the number of frail and older people, especially those with long term conditions, who at the end of their life die in their preferred place of care.

- To improve the experience for frail older people like Mrs Sefton so that the receive care that they are involved in planning, is tailored to them and improves their confidence in managing their own conditions or illnesses.

- To assist patients to continue living in their own home for as long as possible and prevent the need for a large increase in nursing home requirements on both patients and the council.

- To be able to 'reach in' to the acute Trust to support either admission avoidance or fast track discharge.

1.5 Expected Outcomes

Measures have been aligned to the Institute of Health Improvement 'Triple Aim'* and therefore cover the following areas:

A. Population Health*
B. Experience of Care*
C. Per Capita Cost*

D. Measures of Integration
E. Patient activity data

Measure	Target (2012 baseline)	Data responsibility	Type of Measure	Responsible Organisation
A. Population Health*				
1. 30 day readmissions rate	16% > 10%	MCSU	Outcome	System

- Total - Age ≥ 65 years, medical				
2. Dementia diagnosis rate	53% > 75%	Alzheimers Society	Outcome	System
3. Dementia screening rate aged ≥ 65 years new patients	90%	Liverpool Community Health	Process	Liverpool Community Health
4. % of patients ≥ 65y requiring permanent residential/ nursing care	Flat line	Sefton Council	Outcome	System
5. % of patients ≥ 65 y remaining in their own home 6 months after admission	Flat line	Sefton Council	Outcome	System
6. Admission rate to permanent residential/ nursing care (council funded)	Flat line	Sefton Council	Outcome	System
B. Experience of Care*				
1. LTC-6 questionnaire (care coordination & self care)	90% completed 0 and 12w	Liverpool Community Health	Outcome	Liverpool Community Health
2. % of patients who die in their registered place of residence	36% > 66%	Public Health	Outcome	System
3. Bed days (Length of Stay) -Total -Age ≥ 65 years, Medical Specialities)	Reduction 10%	MCSU	Outcome	System
C. Per Capita Cost*				
Hospital				
1. Unplanned admissions -Age ≥ 65 years, Medical Specialities	Reduction 20%	MCSU	Outcome	System
2. A&E attendance age - ≥ 65 years	Reduction 15%	MCSU	Outcome	System
Balancing Measures				
3. OPD appointment rate - Age ≥ 65's	Flat line	MCSU	Balancing	System
4. Walk In Centre activity - Age ≥ 65's	Flat line	Liverpool Community Health	Balancing	System
5. Out of Hours activity - Age ≥ 65's	Flat line	Liverpool Community Health	Balancing	System
D. Measures of Integration				
1. Staff attendance at Virtual ward	6 LCH types	Liverpool	Process	Liverpool

rounds (CQUIN)	professionals	Community Health		Community Health
2. WM/ CM – GP monthly liaison meeting	100% (35 practices/ month)	Liverpool Community Health	Process	Liverpool Community Health
3. Pre/ post change frontline staff integration survey (AQUA)		Liverpool Community Health	Process	Liverpool Community Health
4. System integration tool (AQUA)		South Sefton CCG	Process	Steering Group
E. PATIENT ACTIVITY				
1. Demographics (including Name, DOB, **NHS number**, GP surgery)		Liverpool Community Health	Activity	Liverpool Community Health
2. Timing of referral, intervention, discharge		Liverpool Community Health	Activity	Liverpool Community Health
3. Type of intervention a) Short term intervention b) Integrated Care **c)** Pro-Active Care Programme		Liverpool Community Health	Activity	Liverpool Community Health
4. Types of professionals involved in care		Liverpool Community Health	Activity	Liverpool Community Health

In addition to the above streaming measures a **cohort of patients will also be evaluated** covering:

1. Use of health services:
    a. Unplanned Admissions
    b. A&E attendances
    c. GP practice attendances
    d. GP practice home visits
    e. WIC attendances
    f. OOH attendances
    g. OPD attendances

2. Financial review following patients through the health system coordinated by the London School of Economics

Data Reporting for Quality Improvement and Contracting

The provider will report the above specified measures to the Quality Improvement Stream

The provider will also report activity through the contract route activity according to the following:

Given integrated working means that multiple professionals work seamlessly together some contractual reporting requirements will need to change. This will apply to the following disciplines:

- Community Matrons (CM)
- District Nurses (DN)
- Community Physiotherapists (PT)
- Community Occupational Therapists (OT)

Reports will be presented by the following for each of the four locality based Virtual Wards respectively:

A. Monthly reporting on total new referrals, contacts and caseload.

B. Breakdown on the numbers of types of Virtual Ward patient care as per:
   a. Short term interventions with single professional involved in care
   b. Integrated care (two or more types of professionals directly involved in patient care)
   c. Pro-active care programme (specified 12 week programme)

C. Number of patient face to face contacts per discipline ie CM/ DN/ OT/ PT

Virtual Ward Managers will be responsible for collation of Virtual Ward activity and feeding into the above data streams via LCH managers and CCG representatives.

2. Scope

2.1 Service Description

The Virtual Wards are a community based service, delivering care within the patient's home environment and community settings. The Virtual Ward will work with patients registered with the respective cluster of locality GP Practices or patient's resident within the locality boundary.

Each Virtual Ward will comprise of staff from pro-active nursing and re-ablement and include:

- Ward Manager (LCH)
- Virtual Ward Coordinator (LCH)

- Community Matrons (LCH)
- District Nurses (LCH)
- Patient Centred Medicines Management (South Sefton CCG)
- Health and Wellbeing Trainer (Sefton CVS)
- Physiotherapist (LCH)
- Occupational Therapist (Community Provider and Local Authority)
- Social Worker (Local Authority)

Other staff may be added depending on the needs of the local population. This may include speech and language therapists, drug and alcohol worker etc.

In addition the above will supported by the **Virtual Ward Urgent Care Team** comprising:

- Community Geriatrician (Clinical lead) – (UHA)
- Urgent Care Nurses (LCH)
- Social Worker
- Physiotherapist
- Occupational Therapist
- Health Practitioner Assistants
- Technical Instructors
- Administration support

2.2 Accessibility/acceptability

- The Virtual Ward system will accept all patients over the age of 18 years of age. The main focus however will be on those aged 65 years and older

- All patients, regardless of place of residence, will be eligible for Virtual Ward input. Patients in their own homes however will require a different facet of care from those in e.g. a nursing home.

The service will be delivered in a model that ensures that it is acceptable to all members of the population. The service will utilise interpreting services for patients as required, and all literature will be provided in languages and format appropriate to patient need.

2.3 Whole System Relationships

The service cannot work in isolation and as such strong working relationships with partners to deliver safe, effective clear pathways of care will be established. Partners will include:

- Patients Family and Carers
- General Practitioners
- Practice Nurses
- Acute Trust Consultants – and in particular Acute medicine and Geriatrics
- Specialist Community Teams
- Single Point of Contact
- Hospice
- Intermediate Care Service
- Community Mental Health Team
- Psycho-geriatrician Service
- Social care providers and re-ablement service
- Voluntary and faith sector organisations
- Pharmacies
- South Sefton Clinical Commissioning Group
- Sefton Council
- Informatics Merseyside
- Informatics Providers

2.4 Interdependencies

The service delivery is interdependent upon care provision from the following, all of whom should be invited to weekly Virtual Ward round Multi-disciplinary meetings to discuss specific patients when deemed necessary by the Virtual Ward manager or Community Matron. Such attendances will count towards professionals attended for CQUIN targets.

Non Community Provider Interdependencies

- General Practitioner and Practice Nurse
- Community Consultant Geriatrician
- Hospice and Hospice at Home Service
- Community Mental Health Team
- Psycho-geriatrician Service
- Social care providers and re-ablement service
- Voluntary and faith sector organisations
- Pharmacies

Community Provider Interdependencies

- Community Heart Failure Team

- Community Diabetes Team
- Community Respiratory Team
- Community Equipment Services
- Community Phlebotomy
- Intermediate Care Bedded Unit
- IV Therapy Team
- Palliative Care Team
- Podiatry
- Nutrition and Dietetics

2.5 Relevant Screening Programmes and Clinical Networks

One of the powers of integrated care is that each member of the team may identify and screen for a problem on behalf of another more experienced or specialised colleague. This enables early detection of problems and enables staff to prioritise and decide on interventions.

All staff will be required to be able to complete brief screening tools including:

a. Common Assessment Protocol (CAP)
b. Dementia Screening
c. Falls assessment
d. Healthy Living Reviews
e. Provide information and understand the aspects of a social needs assessment

a. The Common Assessment Protocol is designed to enrich patient information which may be used to enhance the patient's brief summary and use inter-operatively. All patients should have a CAP completed other than those receiving care for a short term/ brief intervention by one professional. This will only be required once in electronic format. Many of the parameters will therefore self- populate.

b. The Virtual Ward will undertake dementia screening on all patients aged 65 years and over who have consented as per the Virtual Ward Dementia Screening Protocol.

c. Patients deemed at risk of falls ie those referred with mobility problems or noted to be living within an 'at risk' environment should be screened for falls risk

d. Healthy Living Review is a tool requested by the GP for assessing patients aged 65 years and over who are not attending the practice but whose health is deemed at risk.

e. Non-social care staff are not required to undertake social care needs assessments. However, in being able to provide and understand ratified information this rate limiting step may be reduced in arranging suitable support

Front line staff and managers should be encouraged and enabled to attend local regional and national training and work stream forums to increase both their own knowledge and support service development of the model. This would include organisations such as Advancing Quality Alliance, North West Leadership Academy, Kings Fund, Nuffield Trust and Department of Health QIPP work streams.

2.6 Sub-contractors

Community Geriatrician

The leadership component of the Virtual Ward Urgent Care Team may be sub-contracted to the Community Consultant Geriatrician at UHA. UHA will work in partnership to ensure the leadership role is fulfilled and that adequate community cover is provided for the following:

1. Oversight of the Urgent Care Team including review of patients, investigations and support for urgent care nurses. During out-of hours when a community geriatrician is not available support should be made available through a hospital geriatrician or acute medical consultant.
2. Leadership, development and roll out of care planning
3. Receive referrals from Virtual Wards via community matrons
4. Receive referrals from GPs
5. Attendance to Virtual Ward rounds when required for specified cases (see 3)
6. Engage with Nursing Homes on the development and roll-out of the nursing home strategy and advanced care planning/ best interest decision making.
7. Visiting patients in their own residence when required.
8. Hot clinics for patients at risk

No other element of the service would be expected to be sub-contracted. Should the provider wish to sub-contract any component of this service, agreement must be sought with the Commissioner.

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3. Integrated Working and Service Delivery

The model of service is one where a Virtual Ward multi-disciplinary, multi-provider team will deliver coordinated care to the defined GP registered population using agreed communication pathways, screening and evaluation tools. The service will provide care from community and coordinate transfer of care from secondary care acute settings.

Central to the delivery of effective care is the development of effective working relationships with primary and secondary care clinicians.

3.1 Type of patients

Within each Virtual Ward patients will be classified for activity purposes into three categories:

a) **Single professional input, short term intervention** e.g. District Nurse wound dressing

b) **Integrated Care: Two or more professional input in one episode of care** Such patients will require discussion at the weekly Virtual Ward Round

c) **Pro-Active Care Programme:** 12 week programme coordinated by the community matron but involving other virtual ward professionals as required. Patients for this programme will be identified through population risk stratification through GP practices. Patients should therefore be co-invited by their GP practice and Virtual Ward

3.2 Virtual Ward Manager and Coordinator

These roles are critical to effective integrated care. Aspects of these jobs will include:

- Appropriate delegation and oversight of patient visits, tasks and care.
- Dissemination of common referral form as required
- Responsibility for the preparation and facilitation of weekly ward rounds
- Set up and management of honorary contracts of all specified internal non- Liverpool Community Health staff to enable access to the IT based community care record. This will also include Urgent Care Team staff.

- Collation of Virtual Ward activity and feeding into the above data streams via LCH managers and CCG representatives.
- Coordination with health professionals outside of the Virtual Ward for input into patient care and attendance to Virtual Ward Rounds.
- Management of incidents and complaints according to the Operating Framework
- Ensure smooth running of the respective Virtual Ward
- Facilitate quality improvement and service development
- Forge relationships with discharge planning teams to develop effective acute trust in-reach and streamlining of patient discharge
- Ensure communication with General Practices meets the required standard

Please see the Strategic Outline and Operating Framework for details of the roles of other healthcare professionals within each Virtual Ward and Urgent Care Team.

3.3 Ward Rounds

- Virtual Ward Rounds are so named as:
- Virtual Ward rounds should occur weekly in each respective Virtual Ward.
- Be chaired by the Virtual Ward Manager
- Have access to the electronic common case record (projected)
- Discuss a range of patient cases
- Have in attendance a variety of health and social care professionals spanning a variety of sectors
- The minimum facility for this should be a confidential room with a table, chairs and access to the NHS N3 network.
- Attendance will be recorded for monitoring as per the respective Integrated Care CQUIN
- A full complement or 'quorate' Virtual Ward Round should include nine different types of professionals. The LCH CQUIN specifies 6 of these types of professional to come from LCH.

Patients to be discussed will include:

1. All Pro-Active Care Program patients following initial visit by Community Matron and Health & Wellbeing Trainer
2. Patients requiring two or more types of professionals inputting into an episode of care
3. New re-ablement patients
4. Complex patients including those under the community mental health and psycho-geriatrician service
5. Palliative patients
6. Patients being handed over from the urgent care team or secondary care
7. Prior to a decision on 'discharge' from the Virtual Ward

3.4 Communication

1) Internal

Nominated staff within each Virtual Ward will communicate internally outside of meetings.
The Ward Manager will ensure all staff have access to each other's work mobile and work email

2) External

a. Patients

Patients will be provided with the relevant contact details of the respective Virtual Ward. In addition they will be given a pack including an explanation of the Virtual Ward, incident, complaint and compliment feedback form and a copy of any patient specific and general educational/ support materials.

b. General Practice

Please refer to the Communication and Continuity aspect within the Operating Framework (Virtual Ward Communication and Continuity Specification) for full details on this area.

Key aspects within this that will be adhered to include:

1) Continuity of Relationship and Patient Care

1. Each practice to have one named district nurse caseload holder to be responsible for allocated tasks until closure of care.

2. Mobile phone number for community matron, ward manager and district nurse caseload holder to be made available to GP practices.

2) Communication

1. Requests for home visit according to stipulation in above specification

2. Face to Face communication with GP practices:

a. The district nurse caseload holder should visit the GP practice(s) under their care on a weekly basis

b. The community matron and / or the Virtual Ward manager will meet monthly with each practice to improve relationships, refer patients proactively, review complex cases and hand back patients being discharged.

3. Written Communication

There are two communication forms which should be used regularly to update the GP practice on patient's progress:

a) Virtual Ward Communication Form – to be used for feedback and update of the patients care

b) Virtual Ward Discharge Summary

The specified discharge summary form should be completed within two working days of the patients episode of care finishing for all:

1. Integrated Care patients (those requiring the direct input of two or more professionals)
2. Patients undergoing the pro-active care programme

c. Other Community Teams

i) The Virtual Ward Manager/ Coordinator will copy in key personnel involved in a patients care when disseminating a discharge summary for:

1. Integrated care patients
2. Patients undergoing the pro-active care programme

ii) Onward Referrals: Signposting and formal referrals to other community services will be in keeping with the 1st line/ services of choice as specified within the South Sefton Directory of Services when available.

3.5 Pro-Active Care Programme (PACP)

The aims of this specific programme are to improve long term condition secondary disease prevention, medication concordance, patient self-care, facilitate appropriate use of services (and reduce inappropriate use) and link the patient with third sector services.

It may be seen as a step up from practice nurse intervention and indeed the practice nurse should be involved and informed of patients stepping up and down from the pro-active care programme and provide vital information to assist the development of the patients care plan.

Patients may be referred pro-active through risk stratification and also directly from clinicians. The main focus should initially be on those patients in the top 5% of risk. Practices may start referring from the top. A record should be kept of the patients referred. Instead of re-visiting the very-high risk patients (top 0.5%), the objective should be to work down through the high risk patients (top 5%) through sequential 12 week PACP cycles.

Only patients with clearly no modifiable potential or are resident in nursing homes may be excluded from the PACP on clinical grounds. Carers may still benefit from the program so this should not be done lightly. No patients should not be excluded from applicable advanced / shared care planning.

All patients who complete the PACP should over the 12 weeks have:

1. Common Assessment Protocol completed
2. Pre and post LTC-6 questionnaire completed
3. Relevant screening (dementia, falls)
4. Minimum of three visits by the community matron and two by the health and wellbeing trainer
5. Interventions by other Virtual Ward staff or specialist teams as deemed necessary
6. Clear goals regarding self-care
7. Education for patient and carers
8. Signposting and linking to voluntary sector and carer support
9. Written action plan
10. Once in place – Advanced Care Plan / Shared Care Plan including NWAS pathfinder for suitable cases where admission may be avoided by linking up with other community staff (e.g. OOH, community teams)

3.6 Care Planning

The provider will be committed to support care planning for patients and assist in the coordination thereof across all relevant services. This will include Virtual Wards, Specialist Teams, GP OOH.

This will involve commitment to populate and contribute towards a 'Shared Care Record'. Aspects of this will involve:

1. Advanced Care Planning (patient centric, requiring capacity)
2. Best interest decision making (clinician centric, capacity not required e.g. DNAR decision)
3. Personalised care planning for specific long term conditions ie. Diabetes, Heart Failure, COPD, Chronic Renal Failure
4. Sharing with NWAS Pathfinder to divert unnecessary attendance and admissions to the acute trust

3.7 Linking with specialist teams

Virtual Ward staff will actively seek to involve other community teams and professionals. Direct referral may be undertaken from specific professionals without GP involvement as stipulated in the operating framework. This will be in accordance with the prioritised services of choice within the South Sefton Directory of Services when available. Specialist teams will be encouraged to be involved and invited to attend Virtual Ward rounds and work closely alongside Virtual Ward staff where and when required.

3.8 Pathways

The following pathways will be functional within the Virtual Ward system:

1. Referral process including electronic common referral form
2. Assessment process including common assessment protocol and screening
3. Discharge process including common electronic discharge letter
4. Pro-Active Care Program

Deviation from such processes will require commissioner involvement.

3.9 Urgent Care Team Pathways

The Urgent Care Team will perform to agreed pathways. These will be collaboratively designed and ratified by both LCH unplanned care and UHA Geriatrics department prior to rollout. The input of GPs and other acute trust consultants will be sought to input where required.

All pathways will be focussed on:

- Primary Care / Community Referrals
- Admission avoidance
- Taking patients through a crisis
- Early detection and intervention of disease and illness
- Enabling a hospital at home function
- Patient Safety and Monitoring
- Provision of treatment within the home
- Clarity on when and how to involve other urgent care services/ specialists both in the community and acute trust
- Innovative and developing philosophy of care

Pathways will include the following and may be added to over time:

1. Falls and mobility issues
2. Social crisis
3. Urgent therapies input
4. Re-ablement within the home
5. Heart Failure
6. Fast AF in the absence of any complication
7. COPD
8. Cellulitis
9. Gastroenteritis and dehydration
10. DVT (screening)
11. Pneumonia and lower respiratory tract infection
12. Urinary Tract Infection
13. Urgent Palliative Care

14. Minor injury
15. Urgent monitoring of bloods

For such pathways to be viable the Urgent Care Team will be provided the necessary training and equipment. As a minimum this will include provision of and **training** to **enable competency** within the team of the following :

1) Equipment for full observations including pulse oximetry, urinalysis, glucometer, thermometer, BP
2) Mobile electronic health record and internet (EMIS Web Community)
3) ECG with remote sending capability via wireless transmission
4) Point of care blood testing with upload network capability to EMIS Web including the following: D-Dimer, pH, PC02, Po2, Na, K, Cr, Ur, iCa, Glu, Hct , HC03, TC02, Base Excess, s02, Hb (Consider Alere D-Dimer and Alere Epoc)
5) Cannulation/ needles/ syringes / IVI equipment for fluid administration
6) Venepuncture and agreed protocol for rapid delivery and prioritisation at UHA laboratory
7) Nebulisers and respective drugs
8) Catheterisation and urine monitoring
9) Mobile Ultrasound for DVT exclusion
10) Ability to prescribe and provide limited oral drugs, injections and IV fluids
11) First Aid equipment for limited minor injury
12) Limited resuscitation equipment
13) Relevant protective clothing, equipment and disposal equipment
14) Relevant navigation support
15) Relevant telephone and stationary support

3.10 Capacity and Patient Flow

There is a stipulated maximum time frame for each Virtual Ward episode. The rationale for this is:

a) prevent clogging of the system
b) enable the team to focus on active intervention as opposed to mere observation
c) prompt clinicians for a definitive review
d) enable on-going assessment of capacity
e) assist the Virtual Ward in reaching patients with the greatest potential for modifiable change as opposed to being stuck with a small but very high risk caseload with minimal modifiable potential

'Maximum Length of Stay' under:

a. Urgent Care Team = 72 hour: Target 90%
b. Virtual Ward (pro-active nursing/ re-ablement) = 12 weeks: Target = 90%

The following have been calculated on the full staffing complement of the Virtual Ward system using

current activity data and targets of the model. The provider will work towards the following capacity:

1. Number of patients under the Urgent Care Team at any one time = 50 (turnover 100 / month)

2. Per locality based respective Virtual Ward:

    a. Number of patients completing the pro-active care programme = 100 / 12 week period
    b. Number of patients on case load receiving integrated care (including PACP) = 400 / month
    c. Number of patients per month facilitated to get a shared care plan* or advanced care plan* = 50

*May be completed by GP, Virtual Ward or Consultant. Aim to cover 5% (high risk) patients in 3 years.

Capacity will be increased through mobile working. All specified Virtual Ward and Urgent Care Team staff should be supplied with a mobile device capable of read/ write to EMIS Web Community.

3.11 Governance

An integrated governance framework will be developed. Summary of key aspects:

1) Oversight

The provider will provide directors, managerial and clinical staff to attend and be functional upon key work streams, quality improvement, governance group and steering group.

The above groups will be accountable to the commissioner through the clinical performance group and contract meetings.

The roles of staff and processes laid out in this document will be supported by the Strategic Outline and Integrated Care Operating Framework.

2) Clinical Governance

Overall clinical governance while patients are under each respective Virtual Ward will continue to remain with the General Practitioner (GP).

The Virtual Ward Manager and Community Matron will be responsible for administration and clinical delegation to fulfil the requirements following referral by the General Practitioner or other health care professional.

Clinical governance of patients under the care of the Urgent Care Team will rest with the Community Geriatrician for the clinical reasons of care until discharged to the GP. Patients may still receive input from the Virtual Ward Core Team until deemed necessary.

Clinical governance of patients referred by the GP or Community Matron will rest with the Community Geriatrician for the clinical reasons of care until discharged to the GP. Patients may still receive input from the Virtual Ward Core Team until deemed necessary.

Virtual Ward staff will involve, coordinate and communicate with specialist nursing teams, falls coordinator and other community services involved in the patients care directly. Virtual Ward and Urgent Care Team staff may refer directly to a host of professionals as stipulated in the Virtual Ward Operating Framework.

3) Incidents and complaints

Incidents and complaints and compliments (ICC) will be dealt with by the Virtual Ward Manager as per the providers protocol. A common form and email must be set up and ratified. An appropriate CCG representative must be copied into the email stream.

If a complaint cannot be dealt with internally within a Virtual Ward, the Manager will forward this on to the respective clinical leads for each discipline and line manager. All incidents, complaints and compliments will be collected and forwarded to the Quality Improvement work stream as a means of transparency and dissemination of learning.

Complaints and issues that require more senior input will be passed to the Virtual Ward Steering Group and Clinical Performance Group. All tiers of governance below the specified level must be informed of the outcome for development and learning purposes. On the occasion of 'whistle blowing' the event must be discussed at the minimum level of Virtual Ward Steering Group at the earliest opportunity and the specifics passed to the Quality Committee and Clinical Liaison Forum

All patients receiving urgent care team input, integrated care and pro-active care programme must be informed of how to feed-back and provided with either the common ICC form. It is suggested that this be included with any initial information provided to the patient and carers

All staff within the Virtual Ward System must be given easy access to both the form and / or email

All GP practices should be provided with paper forms and the email address.

A culture where transparency and submission of forms for quality improvement purposes should be encouraged as opposed to staff feeling that completion of a form will result in negative comeback.

4) Operating Framework

An integrated operating framework including governance umbrella structures, procedures and protocols will be required and reviewed annually. The following will be included. Note this is not an exhaustive list.

1) Clinical Governance

2) Staff Roles

3) Day to day working

4) Performance: Targets, Capacity, CQUINS

5) Specific Virtual Ward Processes

6) IMT operation and function of honorary contracts

7) Incident, Complaint and Compliments procedure

8) Assessment and Screening Protocols

9) Urgent Care Team: Patient Pathways

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries and location of service delivery

Urgent Care Team: The Urgent Care Team will cover all four localities (Maghull, Seaforth & Litherland, Crosby, Bootle) comprising South Sefton Clinical Commissioning Group

Pro-Active Nursing: Based permanently in each respective locality and therefore covering each specified locality as a Virtual Ward.

Re-ablement: Named individuals will work alongside pro-active nursing staff in their respective locality/ virtual ward and build up their case load to reflect this area. It is understood that at present re-ablement staff will still require a professional base and will therefore work between this base, the respective Virtual Ward hub within each locality and the patients living within the specified Virtual Ward.

4.2 Location(s) of Service Delivery

Each *Virtual Ward* will have a permanent hub based within each respective locality. Each Virtual Ward must have access to a weekly meet room with a table, sufficient space and access to the N3 NHS network.

The *Urgent Care Team* will be based at Litherland Town Hall

4.3 Days/Hours of Operation

The *Urgent Care Team* is the *unplanned* element of the service and will be delivered between 9am and 9pm, 7 days a week for the whole year, including bank holidays.

New referrals will therefore be accepted up to 7pm for same day assessment. Patients referred after this time will be assessed the following working day or alternative arrangements will be facilitated.

Pro-active nursing and Re-ablement aspects of the model account for the *planned care.* Delivery will be undertaken Monday to Friday, 9am – 5pm (excluding bank holidays).

Out of hours district nursing hours of operation will remain the same.

4.4 Referral criteria & sources

Referral criteria should be in line with the specified options on the common referral form as stated in the operating framework.

Referral to a locality based Virtual Ward may occur through the following:

a. Risk Stratification - Identification of high risk patients (top 5%) through Merseyside Shared Intelligence Portal Risk Stratification tool following verification by the patient's general practice
b. Direct referral from a GP, practice nurse or community based clinician
c. Intermediate Care Ward 35
d. Acute trust in-reach and identification of high risk patients through the discharge planning process

Patients may therefore be referred by the following:
GPs & Practice nurses, Community Speciality Nurses, Psycho-Geriatricians, Intermediate Care (Ward 35), Accident & Emergency, Medical Assessment Bay, Discharge planners, Social Workers.

Referral to the Urgent Care Team

Referrals will be facilitated by the Single Point of Contact with details sent to a nominated Virtual Ward Urgent Care Team duty clinician

Referral to the Virtual Ward Urgent Care Team may occur through the following:

b. General Practitioners (priority)
c. GPs working with Out of Hours service (priority)
d. Other community clinicians and specialist nurses
e. Intermediate Care (for transfer of re-ablement to the home situation)
f. Acute Trust to facilitate early discharge

The ratio of referrals from the community:acute trust should exceed 75:25

Patients may also be referred to the Urgent Care Team by the ambulance service once a ratified community care pathway is set up.

4.5 Referral Route

a. Planned Care: Directly to the respective Virtual Ward via merged common referral form sent directly to the respective Virtual Ward

b. Unplanned Care (Urgent Care Team) through the Single Point of Contact. This will require a phone call and follow up of a common referral form or letter and brief summary.

4.6 Exclusion Criteria

a. Patients whose observations deem them too ill to remain in the community setting as per the intermediate care toolkit

4.7 Response times

A response time refers to the time between receiving the referral to seeing the patient by the specified team.

1) Urgent Care Team:
   a. Patients in the community: 2 hours
   b. Patients in the acute trust: 24 hours

2) Pro-active nursing and Re-ablement:

1. Short term/ brief intervention (e.g. BP, wound dressing)
   a. Urgent: Less than 4 hours
   b. Routine: 24 hours

2. Integrated Care
   a. Assessment within 48 hours of referral

3. Pro-Active Care Programme
   a. Commence within two weeks of referral

5. Discharge and Criteria Planning

5.1 Urgent Care Team

A standardised discharge summary will be sent to both the *General Practice* and respective *Virtual Ward Manager* within 24 hours of completion of care. This should be sent electronically once the facility is available via either an nhs.net email, directly through EMIS or other third party data transfer software.

Diagnosis, interventions, medication used during the episode, any permanent medication changes and any action required of the General Practice must be clearly stipulated.

Urgent Care Team staff should whenever possible speak directly to Virtual Ward staff to facilitate handover of care. Attendance at the Virtual Ward round by a member of the Urgent Care Team should be encouraged and facilitated.

5.2 Locality based Virtual Ward

A standardised discharge summary will be sent the *General Practice* within 48 hours of completion of care. This will include a brief resume of each relevant professional input. This should be sent electronically once the facility is available via either an nhs.net email, directly through EMIS or other third party data transfer software.

Any actions required or suggested of the General Practice should be kept to a minimum and clearly stipulated on the form

6. Self-Care and Patient and Carer Information

Increasing patients and carers ability to self-care one of the four pillars of the Virtual Ward System

The provider will provide a structure delineating how self-care is being promoted within normal interactions and in addition how specific self-care approaches are to be taken.

Areas to focus on include:

1. Empowerment and responsibility for monitoring long term conditions and step up in treatment where applicable
2. Improve of self-management of minor illness
3. Improve understanding of how best to use the health care system appropriately

Specific areas to ensure include:

1. Use of holistic common assessment process and identification of gaps in patients knowledge
2. Assessment of ideas, concerns and expectations of patients regarding their conditions and use of the health care system
3. Education and provision of both written and electronic resources in enabling patients and carers to better understand their condition, medications, how to monitor long term conditions and what to do when symptoms occur
4. Assist patients in participation of shared decision making and holding health professionals to account and reason regarding decisions taken
5. Personalised action plan for specific long term conditions following the production of a guidance template e.g. Exacerbation of COPD, viral illness, monitoring blood pressure.
6. Specific goal setting with support and oversight and review in a cyclical fashion
7. Clear navigation and linking patients with relevant third parties, voluntary organisations and community support groups across the South Sefton area.
8. A self-care champion within each Virtual Ward to be nominated. Such an individual will be enabled to be trained to a higher level and attend service development activities both locally and regionally regarding self-care
9. Support and facilitation of a health-care navigators network to buddy with patients going through the health care system
10. Self-care aspects to be mandatory sections within all pathways involving long term conditions

The provider will develop self-care guidance and tools for specific conditions along with University Hospital Aintree, LCH specialist community teams, Merseycare, South Sefton CCG, specific disease

support organisations and self-care and shared-decision making support groups in the following areas:

1. Minor illness
2. Medication compliance
3. Falls and mobility issues
4. Diabetes
5. Heart Failure
6. COPD
7. Chronic Renal Disease
8. Hypertension and primary cardiovascular disease prevention
9. Angina
10. Atrial Fibrillation
11. Asthma
12. Anxiety
13. Depression
14. Smoking Cessation
15. Alcohol Misuse
16. Other clinical areas deemed relevant by staff

7. Quality and Performance Standards

Quality and Performance Standards

Quality Performance Indicator	Threshold	Method of measurement	Consequence of breach	Report Due
HCAI Control	The Provider must ensure compliance with the Health and Social Care Act 2008: Code of Practice for the Prevention and	In accordance with the Provider contract monitoring schedule and via contract meetings.	*An action plan (if required) to be agreed with the lead commissioner.*	

	Control of Healthcare Associated Infection in all provider services identified in the contract for acute services			
Service User Experience	Submission of Incidents, Complaints and Compliments	Collation via Quality Improvement Work stream	*An action plan (if required) to be agreed with the lead commissioner.*	
Outcome – improvement in Self Care	90% LTC completed at 0 and 12 weeks for integrated and pro-active care patients	Provider	*An action plan (if required) to be agreed with the lead commissioner.*	
Outcomes – Reduction in hospital admissions	20% reduction medical unplanned admissions in patients > 65y at 2015 from 2012	SUS data	*System measure – Address trends and improvements through Quality Improvement and collaborative working at senior level.*	
Outcomes – Reduction in 30d Readmission rate (> 65y)	16% > 10%	SUS data	*System measure – Address trends and improvements through Quality Improvement and collaborative*	

			working at senior level.	
Outcomes – Reduction A&E attendance by > 65y	Reduction 15% from 2012 data	SUS data	*System measure – Address trends and improvements through Quality Improvement and collaborative working at senior level.*	
Outcomes – Reduction in bed days	Reduction 10% from 2012 median at 2015	SUS data	*System measure – Address trends and improvements through Quality Improvement and collaborative working at senior level.* .	
Outcomes – Number Patients Dying at Home	Increase in proportion patients dying at home to 66% at 2015	Public Health data	*System measure – Address trends and improvements through Quality Improvement and collaborative working at senior level.*	
Integration – Average	6 / VW round	Provider	*Action plan (if required) to be*	

attendance at weekly VW meetings by types of LCH professional			*agreed with the commissioner.*	
Integration – Planned monthly meetings between CM / VWM and GP practice	1/practice per month across the CCG	Provider / CCG	*An action plan (if required) to be agreed with the lead commissioner.*	
Additional Measures for Block Contracts:-				

8. Activity

Activity Performance Indicators	***Target***	***Method of measurement***	***Consequence of breach***	***Report Due***
Total caseload of patients under each locality based Virtual Ward at any one time	*Work towards 400*	*Coordination of VW Managers and / or intelligence team*	*An action plan (if required) to be agreed with the lead commissioner.*	*As per contract data*
Total caseload of patients undergoing PACP across the CCG at any one time	*Work towards 4x100=400*	*Coordination of VW Managers and / or intelligence team*	*An action plan (if required) to be agreed with the lead commissioner.*	
Total caseload of patients under Urgent Care Team at any one time	*Work towards 50*	*Coordination of Urgent Team Lead and / or intelligence team*	*An action plan (if required) to be agreed with the lead commissioner.*	*As per contract data*

Dementia screening rate aged ≥ 65 years (New patients)	90%	*Dementia Screening Protocol*	*An action plan (if required) to be agreed with the lead commissioner.*	
Collation and presentation of the following:	**Demographics** (including Name, DOB, NHS number, GP surgery)	*Coordination of Urgent Team Lead and / or intelligence team*		
	Timing of referral, intervention, discharge	*Coordination of Urgent Team Lead and / or intelligence team*		
	Type of intervention a. Short term intervention b. Integrated Care c. Pro-Active Care Programme	*Coordination of Urgent Team Lead and / or intelligence team*		
	Types of professionals involved in episodes of care			

9. Continual Service Improvement Plan

The provider will engage with commissioners regarding the stipulated on-going quality improvement process and respective work-streams (Steering Group, Pro-Active Nursing, Re-ablement, Information Management & Technology)

10. Prices & Costs

See Virtual Ward Busiisness Case and relevant CQUINs

FF28 Leeds North & South East CCG

See next page

Nursing Update
Leeds North and South and East CCG

Ellie Monkhouse

Director of Nursing and Quality.

The Vision and Strategy for Nurses, Midwives and Care Staff

6 Areas of Action

1. Helping people to stay independent, maximise well being and improving health outcomes.
2. Working with people to provide a positive experience of care.
3. Delivering high quality care and measuring the impact.
4. Building and strengthening leadership.
5. Ensuring we have the right staff, with the right skills in the right place.
6. Supporting positive staff experience.

http://www.e-lfh.org.uk/programmes/compassion-in-practice/

National Picture

- Safer Staffing has identified and highlighted the ongoing concerns about nursing shortages across all specialties
- NMC 'shake up'
- Revalidation for qualified and non qualified nurses
- Francis et al, whistle blowing, staff satisfaction, staff F@F test- review of recruitment and nurse training/induction/CPD
- Style and delivery of nurse training?
- Alot to do about development of roles for the future
- Focus been on HV and not on profession as whole
- Particular concern around DN and PN's
- National leadership taking action?

Local Picture

What do we know about Leeds?

- Workforce issues
- Transformation
- Clarity of roles?
- Validation
- Sustainability of new ways of working
- Right skills in the right place?
- Leadership skills

Getting students to experience practice nursing

Advanced Training Practice model (ATP) providing placements for student nurses in primary care, City Wide Venture.

- Supported by Health Education Yorkshire and the Humber
- Hub and Spoke model, hub hosted in Leeds West Practice after selection process with LETB.
- Hub must be a training practice – 8 spokes
- Practices paid for having students
- Hopefully taking students from this academic year.
- Nurse mentors must have up to date mentorship qualifications

Vocational Training Scheme for GPNs

- Scheme links to ATP using the hub and spoke model
- Gives mentorship and training for secondary care nurses and newly qualified nurses who would like to work in practice nursing
- The proposal will establish a workplace learning model that will provide training in essential clinical skills, support and supervision for the induction and role development for registered nurses new to nursing in general practice.
- Working with experts in educational field, to develop this as a sustainable model with universities across Y&H in the future.

- Work started on this in October

Mentorship Scheme

From some initial scoping work identified that this was a gap on provision to support educational incentives

Develop a PN Education Support system
to assist individual Practices for protected study time to gain a recognised NMC mentorship qualification.

Working with colleagues who are experts in providing this support and as educational supervisors to be to support practices.

Target Education

- Aim is to make nurse and HCA target session more relevant to each group.
- Sessions have been based on feedback from nurses and HCAs.
- Separate sessions are being organised for different knowledge levels.
- Working with other 2 CCG lead nurses to ensure citywide learning as much as possible

PN Leadership Development Programme

- An incentive from last year was the leadership programme, includes nurses from LN and LSE
- Working with an independent leadership/coach with a nursing background to support the development and role of leaders within primary care
- Nurses work in groups to develop a project, of their choice, working in groups, deliver at PN Conference
- Given mentorship by Practice lead nurse
- Have support from CCG staff with the project
- Working with Leeds Beckett University for year 2 to deliver a mix of practical skills and theroy

Nurse Network at Councils

- Lead nurse from each practice attends meeting
- Opportunity to network with other practice nurses
- Meetings based on 6Cs of nursing, with indepth work on each of the 6C's built into meetings
- Contribute to the CCGs plans and learning in primary care
- Discuss strategic and operational delivery

Leadership

Senior Nurse Forum: led by Director of Nursing and Quality.

•Consists of nursing leaders, in nursing posts, across Leeds North and Leeds South and East.

•Discuss local and National nursing agenda and issues that affect our practice and profession

•Contributing to the Nursing strategy for LN and LSE, with a supporting strategy for Primary Care.

•Working on issues within commissioning and how to relate these to the 6C's national strategy

•Contributes towards clinical supervision and revalidation requirements

•Developing commissioning nursing leaders for the future

- Collaboration across working areas

•Development of visibility of nurses within the commissioning cycle, Transformation agenda and organisations in general.

New Innovations

Currently being worked up or about to start.....

- Guidance for recruitment, competency levels, ongoing assessment and roles and responsibilities for practice nurse, for practices
- Clinical skills website for practice Nursing, which will support revalidation, training, competency and induction requirements. This has been designed in partnership with a company by LN CCG and LSE CCG to meet the needs of practice nurses, we hope that this will also support some work for the care certificate.
- Clinical Supervision role to support PDR process and revalidation requirements around supervision, and to provide support as autonomous practioners, outside of practice.
- New leadership course, with 2 phases, and operational course and a higher level around leadership and coaching skills to support the development of leaders, in conjunction with Leeds Beckett University.
- C Diff project nurse, with LCH to support individual cases and care homes
- Care home Support nurse project role with LCC, particularly focusing on professional standards within care homes and knowledge of skills of nurses within these homes to be able to contribute and support the transformation agenda.
- Head of Nursing role across LSE and LN to be recruited to, to help operationalise this work and support DoN
- To start to develop a clinical leadership model with primary care to support the management and expertise of LTC
- Pilot site for Care makers within CCGs
- Start Planning for the 3rd Practice Nurse Conference for Leeds
- Start to map the clinical skills and expertise across Leeds and look at locality working across practice nurses to share knowledge and expertise.

Leeds North and Leeds South and East CCG's The Nursing Voice

A vision for the future of nursing from a commissioning perspective 2014 to 2017

Introduction/Forward from DoN

Complete after document written, taking in to account any new publications and developments within nursing and NHS.

Include Francis, Berwick, 6c's , 5 year forward plan etc...

Leeds North and Leeds South and East CCG

Nursing Vision

Our Vision was created by nurses, for nurses.

" Nursing will be delivered in a co-ordinated and collaborative approach with patients, families and other Health Care Professionals to reduce health inequalities across our communities."

This vision for nursing will support nurses to:

- Provide high quality, equitable, accessible care
- Provide person centred care
- Ensure the changing needs of individuals are identified and met within their local community
- Provide a framework to achieve self management and well being
- Develop nursing leadership and professional development to support a nursing workforce that will be able to innovate in the delivery of patient care
- Focus on the care and experience of the patient to enhance their journey
- Work in partnership with patients and healthcare professionals to empower patients to be involved in decisions around their care
- Treat all patients with dignity and respect
- Raise the profile of nurses working with different healthcare settings and encourage collaborative working

Nursing will be delivered in a co-ordinated and collaborative approach with patients, families and other Health care Professional to reduce health inequalities across our communities

Who has the vision been written for?

- Individual nurses
- Organisations that employ nurses, this includes NHS, private and voluntary sectors
- Commissioners of any care provision, including social care
- Education and Training organisations

What does this mean for your nursing voice?

- This will allow nurses to innovate and review their own practice
- Ensure that organisations and employers are investing in the development of nursing, and the voice of nursing within their organisations
- Ensure that nurses are involved in the planning and identification of health services and pathways
- Support the provision and development of the nursing workforce
- Look at ways to innovate and develop the role of the nurse and profile of the profession for the future
- Set professional standards that patients and users will expect when they come into contact with a member of our profession.
- We can provide support with the NMC revalidation process
- Integrate the role of the nurse into the shift of care from secondary to primary care and promote the role of the nurse in the importance of this
- Look to develop new roles and enhanced skills for nurses

To achieve our vision, we need to invest in the nursing workforce, and individuals to ensure a sustainable , clinically credible and viable educated nursing profession, with the right skills, for the right patient. We need to ensure that the voice and contribution of the nursing profession is heard in the provision and transformation of patient care in the future. The role and development of the nurse is key to the success of the transformation of services and sustainability of high quality care for the future.

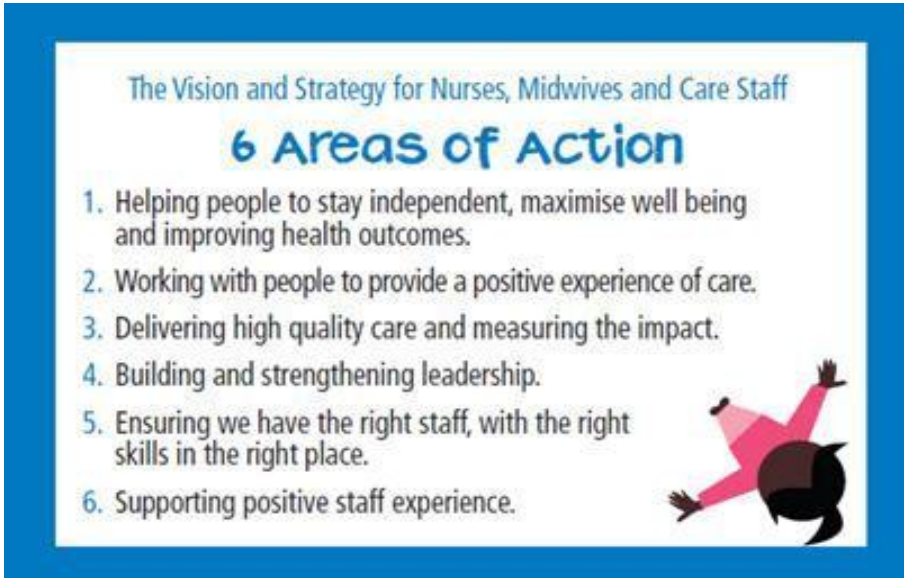
What is the role of the Nurse in Commissioning?

How will we do this?

- Ensure that the voice of the nurse and the nursing profession is key to the delivery and success of the CCG 2 and 5 year plans
- Invest in collaborative working across health, Social care, voluntary sector and private companies
- Support ways to encourage and commission interproffessional working
- Enhance and develop the skill set of nurses across organisations and sectors
- Ensure that there is a provision for the education and continued development of nurses
- Contribute and influence the national agenda on nurse education and workforce development, as well as locally.
- Invest in the development and ongoing provision of clinical leadership
- Encourage the development of nurse led pathways, to maximise the benefit of making every contact count, and utilising the skills and knowledge of nurses
- Invest and encourage people to join our profession
- Ensure that the nursing voice is heard across all health and social care organisations, at all levels.


workforce
responsibilities
competence standards
professional listening
shift compassion quality
provision skills patient leadership
Every story management
counts respect contact nursing
patients roles investment
courage voice
new dignity
education
self
innovation
communication
commitment
experience
care
WordItOut

Compassion in Practice: 6C's



The National Nursing and Midwifery Strategy, 2013.

The 6C's underpin the values and culture of nursing. Leeds North and Leeds South and East are committed to the values and actions of the 6C's, to ensure that people are treated with care and compassion throughout their contacts with the nursing profession. The continued development of the nursing Profession through the embedding of the 6 C's will strengthen the role of the nurse and enhance the experience of our patients. The Leeds North and Leeds South and East Vision for Nursing, will be based around each of the action areas. We will also embrace the use of the 7th C, known as Celebration, its very important to recognise the work that is going on across Leeds to support the delivery of the Leeds North and Leeds South and East CCGs Nursing vision.

Leeds North and Leeds South and East CCGs are embracing the 6C's within the nursing vision, to ensure that the local population of Leeds receive high quality nursing care.

Care

Care is our Core business across commissioners and providers. The care that we deliver helps the individual person and improves the health of the while community. Caring is key to our role as nurses, and we should provide care that is right for the individual.

We will achieve this by:

- Treating people as individuals, person centred
- With dignity and respect
- Allowing yourself time to listen to the needs of your patient

Communication

Communication is central to successful caring relationships and the effective team working. Listening is as important as what we say and do, with patients being involved in decision making. Communication is also key to a successful workplace and team.

We will achieve this by:

- Good, clear communication in a timely and responsive manner
- Keeping patients and colleagues informed
- Recognising non verbal communication

Compassion

Compassion is how care is given through relationships based on empathy, respect and dignity

We will achieve this by:

- Listening
- Understanding how actions impact on others
- Showing support and understanding

Courage

Courage enables us to do the right thing for the people we care for, to speak up when we have concerns and to have personal strength and vision to innovate and embrace new ways of working .

We will achieve this by:

- Speak up on behalf of those you are caring for and each other
- Embrace innovation and change, and make suggestions
- Overcome barriers and challenges through working with others

Competence

Competence means having the ability to understand the individuals health and social care needs with the clinical and technical knowledge and expertise to deliver effective care and treatments based on research and evidence

We will achieve this by:

- Keeping our knowledge and skills up to date
- Being confident and sharing knowledge with others
- Explaining things clearly to our patients and carers

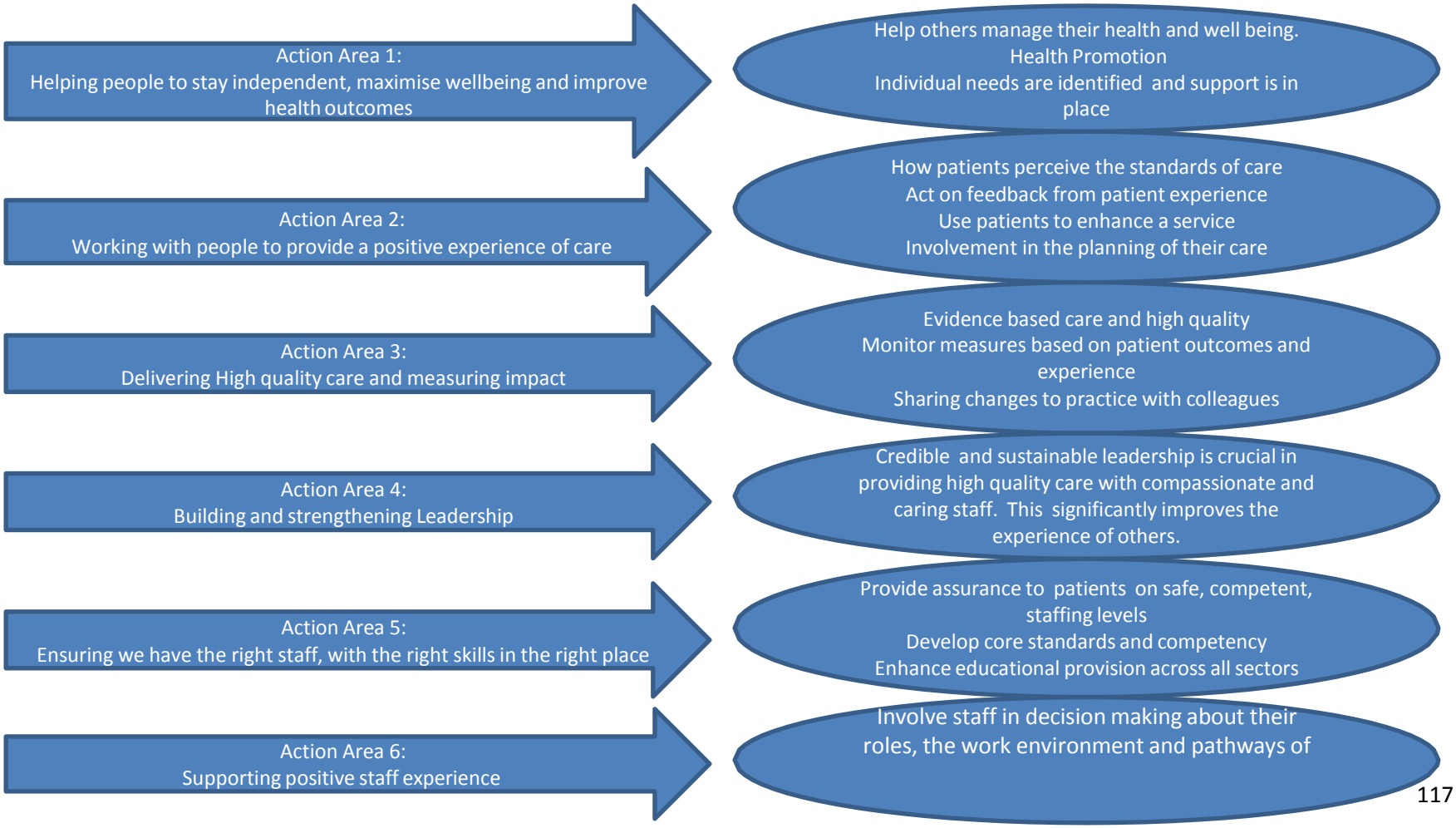
Commitment

A commitment to patients and local populations is fundamental to what we do. We need to build on our commitment to improve the care and experience of our patients, to take action to make this vision and strategy a reality for all and meet the health, care and support challenges ahead.

We will achieve this by:

- Continuing to develop our knowledge and skills
- Support the development of nurse led care and self directed care
- To implement the Nursing Voice and Vision for Leeds North and Leeds South and East CCGs

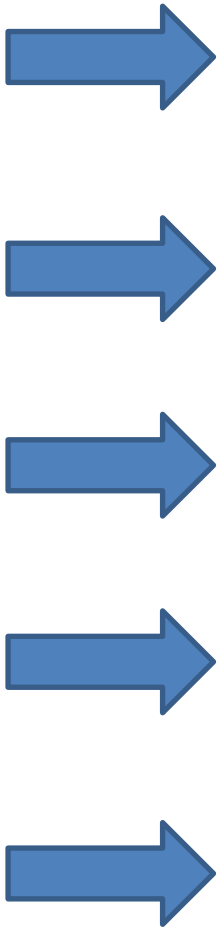
This is how all nurses across Leeds can contribute to the following actions to ensure that Compassion in practice is embedded across all of our organisations.



Implementing the vision

" Nursing will be delivered in a co-ordinated and collaborative approach with patients, families and other Health care Professional to reduce health inequalities across our communities."

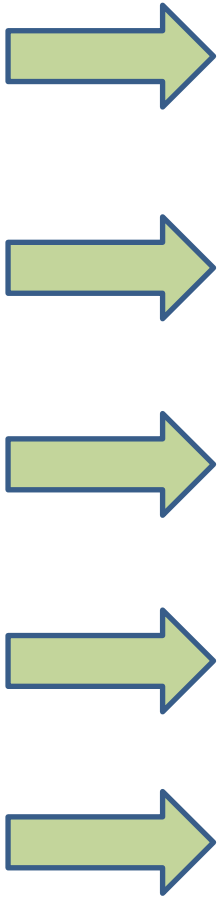
Action Area 1: Helping people to stay independent, maximising well- being and improving health outcomes



Improving access to, and uptake of Health Checks for people with learning Disabilities	Community Learning Disability nurses will work with GP Practices to identify potential people of GP registers requiring health checks, support with reasonable adjustments to facilitate access and provide specialist knowledge and expertise in LD care to practice staff to improve care and experience.
Leeds Autism Diagnostic Service	A specialist nursing role will contribute to the assessment and post diagnosis follow up. This role will provide support to nursing colleagues across all providers, and support patients and cares with a diagnosis of Autism
Learning Disability Community Nursing Teams	Staff will be trained to be able to support social care providers and families to be able to work within a more defined multi- disciplinary framework. Best interest assessors will work with health and social care colleagues
Deprivation of Liberty safeguards(DoLS) Safeguard those who lack the capacity to decide where to receive care and treatment.	This is a focus for the safeguarding team who will monitor the response of provider organisations to ensure they are meeting their requirements. The training delivered by the team on this will be adjusted to include the implications from the supreme court ruling.
'Early help' 'Think Family, Work Family' An approach to safeguarding and co-ordinating the support to families where parenting capacity is impacted.	The safeguarding team will continue to embed these models of care across the health economy, and continue to be involved in the development of the multi agency frameworks to support this.

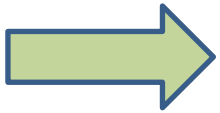
Personalised Health Budgets A pilot project hosted by Continuing Health Care until March 2015.	→	This has allowed eligible individuals to take control of their health care needs budget. Initial reviews suggest that people have seen benefit from shaping and contributing to their package of care. This project will continue to provide positive partnerships across other agencies.
Enhancing the role of the community nurse/matron	→	*This needs adding to, conversations with GPs and LCH in progress as to what their vision maybe*
Hybrid specialist practioner and support workers	→	*As above, looking through workforce plans in Primary care to identify gaps, and scope for development*

Action Area 2: Working with people to provide a positive experience of care



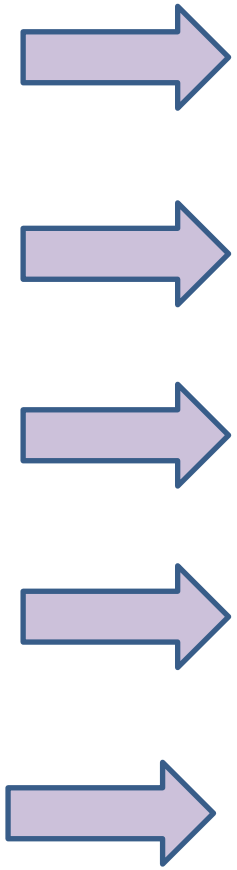
Support and roll out of Friends and Family Test across all providers	Support the introduction of this across all providers, and ensure that feedback is acted upon to improve services.
Therapy Measurements outcomes scale	A process to support Learning Disability service users and carers to be able to measure the outcomes of a agreed intervention with a Health Care Professional, and provide feedback on this.
Review of complaints policy to ensure that children and young people can make complaints	Ensure that the views of children are reflected and that they are able to contribute and influence their experience of care
Year of Care	*This needs adding*
Practice Nursing and community nursing	Look at the role of the practice nurse and the role that they can play in the future of providing consistency and continuity of care. Work with community nursing providers to look at integration and collaboration of workforce, to reduce duplication.

Young Carers



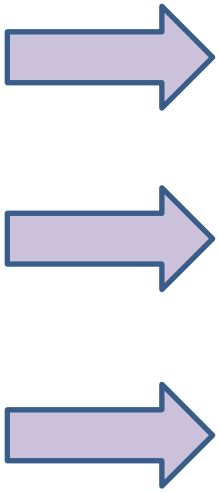
I would like us to commission some work on this, but need to test this out with you

Action Area 3: Delivering High Quality care and measuring impact

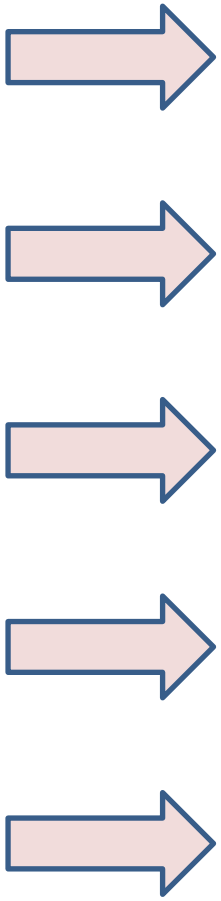


C Diff Project Nurse	To support the HCAI agenda across community care, working with providers. This role will provide extra support to care homes and small providers on education and training in relation to CDiff cases
Practice Nurse conference	We have now had 2 Leeds practice nurse conferences, this year it focused on Leeds innovations. We will continue to monitor the impact that these events have on , and support the development of a conference for next year, possibly with other community professionals .
Leeds Quality Institute	The Leeds Quality institute is supporting the review and redesign of priority areas across the city. Lead nurses and allied Health care professionals are working together to influence changes to the patients pathway. We will continue to ensure we are involved .
Commissioning the development of the ward health check across non acute providers	Support the development of ward health check models within our non acute providers, as a way of identifying early risk in nursing metrics
Working with all providers to support the High quality care Metrics for nursing	Identified priority areas are HCAI, Pressure Ulcers, Falls, Complaints and Medicines Management, we will look to use mechanisms such as CQUINs, KPIs and Service improvement clauses within contracts to support this.

Clinical Skills Net	Development of a web based facility, for practice Nurses, to ensure they have up to date guidance on clinical skills. This will support revalidation, and provide them with evidence. We will extend this to incorporate support Workers
Implementation of the Contracture Risk assessment to Care Homes	Roll out across care homes in Leeds, and audit what impact this has had on individuals outcomes and knowledge of nurses.
Minimum standards for safeguarding of children and adults	A mechanism for us to gather assurance from providers on how they are meeting these minimal standards for safeguarding.



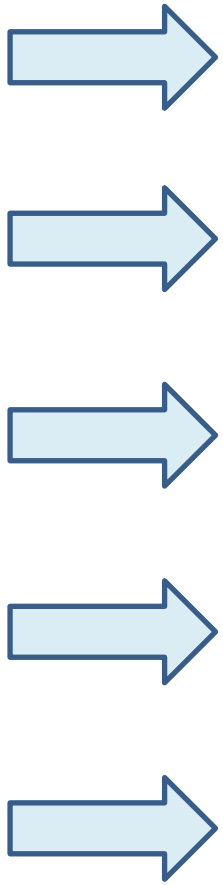
Action Area 4: Building and Strengthening Leadership



Practice Nurse Leadership Bespoke Course	Further development of the Leadership course, which will incorporate management and leadership skills. We are developing this in conjunction with Leeds Beckett University
Lead Practice Nurse Role	LN and LSE both employ Lead Practice Nurses to support development within Practice Nursing, and to provide representation of the workforce. This role will be developed further to enhance the role and profile of Practice Nursing
HCA Forum	Working with HCA's in primary care, in a dedicated forum, to support their role and competencies, through the development of a competency framework
Nurses Involvement in the commissioning process	Ensure the voice of the nurse is embedded within the commissioning process through sharing commissioning values and intentions. This will also be done through the profile of the nurse forum, who should be asked to comment on commissioning intentions as a profession.
Continued investment in nursing leadership	Support innovation and continue to invest and commission programmes that strengthen nursing leadership across commissioning and providers

Nurses integrated into council Meetings	To integrate nursing leaders into council meetings, to help make decisions and influence the development of primary care and co commissioning
CCG Senior Nurse Forum	Continue to develop the senior Nurse Forum for Leeds North and Leeds South and East. The forum will take on developmental roles and ensure the 6C's are embedded across the organisations and take on key roles for the implementation of the nursing strategy
Ensure our providers are investing in nurse leadership and sustainability of leadership	Encourage and support providers to develop and sustain leadership development and programmes, and ensure that it is key to their own nursing strategies.
Leeds Nursing Senate	Continue to develop our role and integrate with the work of the clinical senate, but also start to nurture future nurse leaders, and promote collaborative working across organisations with an emphasis on the nursing profession.

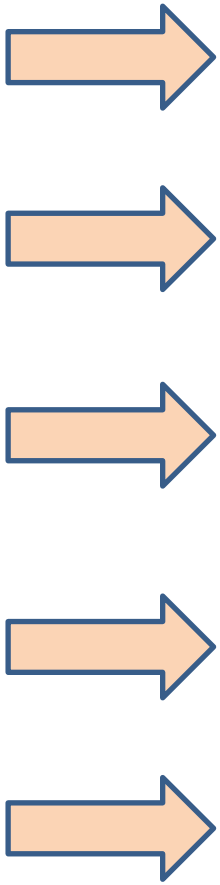
Action Area 5: Ensuring we have the right staff, with the right skills, in the right place.



CCG Safeguarding Training Strategy	Implementation of the training strategy across health care professionals to ensure they have the underpinning knowledge and competencies to protect vulnerable children and adults
Pre and Post Qualification investment into Primary Care Settings and provision of Mentors within Primary Care	Pre registration Students placements into GP Practices Training scheme to support post qualification or nurses wanting to move into the primary care sector Mentorship Programme, to support to pre and post registration schemes
Care Home Professional Standards Project Nurse	A project to map the skills and competencies of nurses in nursing homes, with the aim to conduct a gap analysis of what skills are needed, set minimal professional standards and commission education to be able to support the Transformation agenda.
Apprentice schemes for Support Workers	Needs adding
Looking at alignment of skills and competencies across areas of increased need across organisations and health care sectors	To develop workforce tools and skill matrix to identify the skills and expertise we have across primary care, community care , social care and acute providers, to ensure we have the correct skills and roles in the right places for the future.

Work with providers to ensure that they are working to the requirements of safer staffing	Work with providers to set agreed thresholds and support organisations to implement the guidelines as they are produced. To continue to monitor this as part of the contractual process, but also ensure that staff are supported to raise concerns about staffing.
Individuals working across organisations	Individuals should be able to move across organisations and nursing more easily, to support their knowledge, skills, career aspirations and knowledge base and experiences.
Primary care competency Guidelines	To support the profile and skill of practice nurses, and to support career development and opportunities we are developing guidance around competencies. This will incorporate a consistency of standards for practice nurses.
Investment in Community Nursing	Investment needs to continue in the provision of Community nursing to support increase in resource, but education and extension of skill for the community nursing workforce, this includes mental health.

Action Area 6: Supporting Positive Staff Experience



Prepare the primary care and CCG's workforce for Nurse revalidation	The lead practice nurses will promote and educate Practice Nurses in preparation for revalidation in 2015. The senior nurse forum will promote and educate nurses who work within the CCG organisations.
Clinical supervision	All nurses will be encouraged and expected to take part in clinical supervision to enhance their practice and understanding. Clinical supervision should be supported and valued by employers and managers in enhancing staff experience and performance.
Money and time set aside for nurse development and investment in workforce	Encourage all of our providers, employers of nurses and our own organisation to continue to invest in nurse development and Continued Professional development of nursing.
Recognising innovation and good practice	??? wording
Commit to working with providers to improve experience in the workplace	Through processes such as safer staffing, Staff Friends and family Test and Staff satisfaction surveys, alongside ability to whistle blow will we monitor the experience of nurses within providers and within our own organisations.

Encouraging community partners and commissioners to embrace the use of technology to innovate practice.	Encourage the use of the National Nurse Technology fund to develop new ways of working through the use of technology, support them with funding and applications if needed.
Nurse revalidation for nurses in commissioning	The senior nurse forum will support nurses within commissioning for revalidation. For nurses we will adapt organisational apprasial documentation to ensure it incorporates the needs of the revalidation process based on the 6 C's.
Work with providers in the development of their strategies	Encourage all providers to develop a nursing strategy to ensure there is a clear vision within each organisation that can be joined up across the city, and services can be commissioned to meet the needs of the strategy.
Nurses consulted with on changes services and pathways	Nurses need to be involved at all stages of any pathway changes or redesign, and they play a key part in managing patients through pathway journeys and could champion the seamless journey of the patient

Action Area 7: Celebration

This page will describe some highlights of what we have done so far.....

Practice Nurse conference
Senior nurse forum developed and expanded to include senior nurses working in commissioning across LSE/LN.

Awaiting to see if we will be one of the first commissioning organisations to work with the CNO Caremakers?
Contributed to Shape of care review
Contributed to the NMC review of revalidation
Use of social media to highlight our work
Some stuff from the practice nurse project work
Closer working with primary care
Care Maker

How will we monitor and evaluate our progress?

- Implemented into LSE and LN Strategic Plans
- Core work of Senior Nurse Forum
- Preparation for nurse revalidation
- Development of Nursing infrastructure to support his work across CCG and Primary care
- Included within professional Standards Action plan for LN and LSE CCG

NHS
Leeds North
Clinical Commissioning Group

BUSINESS CASE REVIEW:

GENERAL PRACTICE NURSE MENTORSHIP SCHEME

JUNE 2014

Leeds North CCG Business Case for Non-Recurrent Funding Request

Proposal Title: General Practice Nurse Development Programme
Transformation Workstream: Nursing
Accountable Lead Officer/ Lead Director: Ellie Monkhouse
Lead Clinician: Ellie Monkhouse
Lead Finance Officer: Martin Wright
Theme: To develop a sustainable practice nurse education support system Our proposal is to develop a practice nurse education support system to assist individual practices to free one of their practice nurses for protected study time to gain a recognised NMC Mentorship qualification. This will provide a group of nurses who can support and mentor registered nurses who would like to move into this specialised field , providing them with expert advice and guidance
Responsible Transformation Workstream or CCG Programme as applicable:
Approval Group:
Business case Author: **Catherine Gill, Nurse Partner Caritas Group Practice** **Cath Johnson, Lead Nurse Leeds North** **Andrea Mann, Lead Nurse Leeds South and East**

Recurrent or Non Recurrent funding required?

Non Recurrent

Description of Proposal:

The total funding required for 2014/15 split by CCG is:

Leeds North	£22,845
Leeds South and East	£22,845

This Business case has been developed on behalf of the 2 CCGs with their input from Clinical leads. 2014/15 then recurrently for 2015/16.

Introduction

- Traditional GP consultations are not considered sustainable and the demand for consultations will double in the next ten years.[3,2] Even if this demand has been overestimated, the number of retirements (22% of GPs and 20% of Practice Nurses are over 55) will mean GP practices will not have enough qualified clinical staff to manage this ageing population with increasingly complex health needs.

- This project proactively aims to address the current and future predicted gaps in patient access by building a workforce which is not only fit for purpose but provides training and education in the environment that the majority of care takes place – in primary care.

- Currently 90% of all patient contact is in primary care and at this point of contact, primary care clinicians are expected to provide a level of care which is set to increase not only in terms of clinical outputs but include working towards reducing inequality and disadvantage in protected characteristic groups.

- The scale of reorientation of nurse undergraduate training that is necessary to prepare nurses to meet these future challenges is such that there must be an a 80% increase in mentorship in general practice than is currently available.

- The vocational training scheme will establish a workplace learning model that will provide training in essential clinical skills, support and supervision for the induction and role development for registered nurses new to nursing in general practice. The proposed GPN VTS programme will focus on learning which is patient centred & encompasses learning in the wider aspect of primary care. The model proposed will be a service led workforce development programme in partnership with higher education and the GP Specialist Training programme. The model takes into account the need to enhance integrated teams & develop a skill mix approach to delivery of care.

- This robust long term approach which is phase one of a two to three year project will ensure a fit for purpose workforce who are properly supported through an accredited scheme developed and led by experts in their field.

Gaps Identified

Problem: Lack of capacity to support Practice Nurse Mentor training
Interest in enrolling as an ATP Spoke is very good however we are already hitting critical constraints in delivering our training plans because of existing workforce pressures many GP practices are experiencing. Many recent surveys have shown shortfalls in practice nurse numbers due to an aging workforce and in conjunction with this increasing amounts of care is required for patients with long term conditions.

Practices are willing but not able to release their practice nurses in the face of the unprecedented efficiency drives facing the NHS. Practices see their main priority as ensuring their clinical staff are released for mandatory clinical CPD training and are unable to further release their PNs from their clinical care responsibilities for mentor training.

We need to encourage and support a culture of learning by teaching clinical skills using consistently high quality standards and up to date clinical guidelines which are vital in supporting the future nursing workforce which will lead to increased patient safety and improved job satisfaction.

Leeds North

Practice nurse mentor survey

20% of nurses support students in practice
38% of nurses have an out of date mentor qualification
38% of nurses do not have a mentor qualification
55% of nurses said they would like to mentor students/junior staff if they had the time and support to do so.

Leeds South and East

The Lead Primary Care nurse identified that within LSE practices, that only 10/43 (23%) practices were recorded on the healthcare placement website in Jan 2014 and 5 of these were out of date with their annual audit. Only 11% of practices within LSE were actively taking student nurses at the start of 2014.

In October 2013, Practice Nurses were consulted on mentorship training and 13/100 (13%) reported that they were due an annual update. In addition, 5/100(5%) reported that they were keen to train as a mentor. A mentor training session was delivered at the January TARGET session for LSE. The session was a success that 57/100 (57%) of practice nurses attended the session for either an update on their current status or for information on mentorship.

The project worker for Leeds University has started to work with practices who have expressed an interest to take students and to update practice audits for those who were out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of date or have completed their mentorship update.

Increasing the number of practice nurses trained as mentors and willing to take students will contribute to the workforce planning and ATP implementation across the city.

Proposal

The proposal from Caritas Group Practice is to develop a PN Education Support system to assist individual Practices to free one of their PNs for protected study time to gain a recognised NMC Mentorship qualification.
This in turn will create sustainability for the future, and create a culture of training which at the moment is sadly lacking.
The first step would be to compile a Bank/Register of local experienced PNs who are willing and able to provide support to other practices. These PNs will be paid an AfC grade 6 top scale fee to provide practice nursing services to individual Practices. At the same time as undertaking this initial scoping exercise to create an Education Support Register we will work with the newly established ATP HUB to establish current numbers of qualified mentors within Leeds CCG's and produce a Mentor Register. During this initial phase we will also communicate to practices the rationale and outputs expected from this proposal and the benefits to their practice and their patients.

Aims of the project

1. 12 PNs are provided with protected time to train as mentors during the duration of the year-long project and a year on year duplication of these number in future years

2. 24 Student Nurses experience general practice during the duration of the project

3. At least 2 Student Nurses choose practice nursing as a first destination career with 30% of retiring PNs' posts to be filled by new graduates

4. Establish and accelerate HUB and spoke development across 3 Leeds CCG's in 2014/2015

Involving service users in the planning, delivery and monitoring the outcomes of the project

Service users will not be directly engaged in the planning delivery and monitoring of outcomes. PNs however will be actively involved in all aspects of the project through establishing the network of registered mentors, supporting practical activity in practice, monitoring qualifications obtained and future student contact. Feedback from PNs will be used to evaluate the success of different delivery models for Mentors training ie APL, online


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courses, Blended learning and Face to Face University programmes. Trainee mentors also require supervision by a qualified Mentor (we have 4 in Caritas) who will regularly monitor progress of the trainee mentors.

Monitoring the impact of the project

Close working relationships are developed with ATP Spokes by our Training and Education Administrator who usually makes contact at least 2 weekly. She not only speaks to Practice Managers about their views but makes contact with the individual PN undertaking Mentorship training and the allocated student nurse (Mentor training is apprentice style and involves course work and learning “on the job” with a student). Trainee mentors also require supervision by a qualified Mentor (we have 4 in Caritas) who will regularly monitor progress of the trainee mentors and student nurses. Students views are sought throughout their placement and completion evaluations are undertaken. This function will be taken on by the new Leeds ATP training and education administrator.

Evaluating the impact of the project.

The project will be evaluated at the 3, 6 and 12 months stage.

The scoping function and Register production of the number of PNs available to provide Practice Support and those who currently hold a NMC Mentor qualification will be completed by the 3 month point.
This will ensure ample time for the twinning of PNs who are to undertake mentor training with those PNs available to provide practices with support.

Further data can be analysed as necessary i.e. failure to complete training, why and what can be learned.

Promoting the project

The Project will be promoted directly to each individual Practice in Leeds in collaboration with the Leeds CCGs Practice Nurse Leads Gil Ramsden, Andrea Mann and Cath Johnson. Net working at events and sessions and at GP VTS Trainer workshops (held 2 monthly) will enable promotion by “word of mouth”.

Assisting in CCGs legal obligations to eliminate discrimination, promote equality or foster good relations for equality groups.

One of the core differences of Advanced Training Practices to traditional GP Training Practices is the provision of an Inter-professional learning and teaching environment. Inter-professional education (IPE) is born of the recognition that the complex and often intricate needs of patients usually exceed the expertise of one healthcare discipline. All healthcare practitioners need to have the knowledge, skills, and abilities not only to practice their own craft, but also to work effectively and collaboratively with other professionals, community members, and families. IPE has considerable merits (the evidence base is growing); notwithstanding the fostering of equality values between healthcare practitioners but also


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influencing the behaviours of practitioners towards different patient groups.[6,] The project impacts both implicitly and explicitly on patients; without a workforce fit for purpose and in the right numbers then CCGs legal obligations cannot be achieved.

Benefits for patients

It is reasonable to extrapolate that the direct impact and benefit for patients will be a workforce of sufficient numbers of appropriately trained healthcare professionals.

In the 12 months of the project 24 undergraduate nurses will benefit from experiencing General Practice who likely may not if this project is not supported. Practices may realise benefits within the year if 3rd year students choose Practice Nursing as a first destination career.

Managing risks

Potential risks in the main are mitigated by the proposal; those not as clearly moderated are those related to:

1. A lack of PNs available or willing to provide Practice Support and
2. GP Practice buy-in and ownership after pump priming funding support ceases.

Risk may be diminished by:

1. Clear communication regarding rationale for the project at the initial stages to increase understanding that workforce planning in individual GP practices is currently not a priority but will be in the future.
2. Ensuring this is a joint venture with Leeds South and East CCG and not a stand alone project.

Project Costs

Description	**Information**	**Hours**	**Cost**
Total Capital costs	**No capital costs**		
Revenue costs Salaries, NI and Pension Costs	Project Lead – Overall supervision Project Admin Support Mentor Support Provision (PN support for 12 mentors – 60 Hrs per mentor)	8 hrs/wk 10 hrs/wk	£16640.00 £5980.00 £20160.00
General Running Expenses	Post 500 communications Telephony Liaison (12 months)		£250.00 £220.00
Producing information, education and promotional materials	Promotion materials customised to local needs to cover Leeds (12 months) Website promotion		£2200.00


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Travel Expenses	Admin staff travel 50 miles /month x 12		£240.00
Total Costs of project (including VAT)			£45690.00
Individual CCG costs	Leeds North Leeds South		£22,845 £22,845

References:

1. Centre for Workforce Intelligence (2012) *Workforce risks and opportunities practice nurses education commissioning risks summary from 2012* [online] Available at*:* http://www.cfwi.org.uk/intelligence/shape-of-the-non-medical-workforce/general-practice [Accessed April 2013].

2. King's Fund (2011) *Improving the quality of care in general practice. Report of an independent inquiry commissioned by The King's Fund.* [online] Available at: http://www.kingsfund.org.uk/document.rm?id=9040 [Accessed April 2013].

3. Deloitte UK Centre for Health Solutions (2012) *Primary Care: Today and Tomorrow - Improving general practice by working differently. New Directions - Innovation that drives quality.* [online] Available at: http://www.deloitte.com/view/en_GB/uk/research-and-intelligence/deloitte-research-uk/deloitte-uk-centre-for-health-solutions [Accessed April 2013].

4**.** Health Education England: Our Strategic Intent (2013) *Developing people for health and healthcare.* [online] Available at: *http://hee.nhs.uk/wp-content/blogs.dir/321/files/2013/01/Our-Strategic-Intent-web-Feb20131.pdf* [Accessed April 2013].

5. Change Through Partnership (2009) *Review of Development Approaches for the non medical workforce in Primary Care*. [online] Available at: http://www.oxforddeanery.nhs.uk/about_oxford_deanery/primary_care/primary_care_taskforce/the_primary_care_team.aspx [Accessed April 2013].

6. Kings Fund (2012) *Improving GP services in England: exploring the association between quality of care and the experience of patients.* [online] Available at: http://www.kingsfund.org.uk/publications/improving-gp-services-england [Accessed April 2013].


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June 2014


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FF31 Leeds North & South and East CCG

Non Recurrent Funding Request Cover Sheet, 14-15

NHS
Leeds South and East
Clinical Commissioning Group

1. Scheme Name	Vocational Training Scheme (VTS) A project to develop a consistent strategic framework to enable the planning and development of a sustainable Practice Nursing workforce.		
2. Lead Commissioner	**Clinical:** Ellie Monkhouse	**Manager:** Andrea Mann Lead Primary Care Nurse	
3. Accountable Director	Ellie Monkhouse		'Y'for as many that apply
4. Investment Setting	**Primary Care** (direct investment in general practice)		Y
	Primary Care Wrap Around (community phlebotomy, debt/housing advice, based in primary care setting/working with GPs)		
	Community Health Care		
	3rd Sector not in primary/community setting		
	Mental Health or Learning Disabilities		
	Secondary or Specialist Health Care		
	Adult or Children's Services in Local Authority		
	Corporate Development		
	Other		
5. Investment Category	**Addressing a Performance Concern**		Y
	Delivering Operational Plan (if yes then please complete strategic aims section below)		Y
	QIPP		
6. Strategic Aims Please state 'Y'for as many that apply and reference the relevant work stream.	**To improve the health of the whole population and reduce inequalities in our communities**		Y
	To secure continuous improvement in the quality and safety of all services commissioned for our population		
	To ensure that patent, public and carer voices are at the centre of our health care services from planning to delivery		
	To deliver continuous improvement in health and social care systems within available resources		Y
	To develop and maintain a healthy organisation to underpin the effective delivery of our strategy		
7. Full or Part Year Cost	**Pay Costs:**	**Non Pay Costs:** The total funding required for 2014/15 split by CCG is: **Leeds North** £28,803 **Leeds South & East** £28,803	
8. Profile of Costs if not to end in March 2015	Sept 2014 – Sept 2015		
9. Exit Strategy	Non pay costs are one off		

10a. Activity	**Does the scheme have an impact on a core contract?** (in the second column state whether activity is expected to go up or down on the core contract)	Y/N	
	LCH	N	
	LTHT	N	

	LYPFT	N	
10b. Comments on activity			
10c. Communication of activity change	**Have you informed the Commissioning Lead?** Ellie Monkhouse	Yes	
11. Workforce Plan	The programme aims to address the workforce planning for newly qualified nurses and nurses new to practice nursing.		
12. Procurement Plan			
13. Risks and Mitigation	Risk of not proceeding with the VTS model after the preparation work is undertaken and addressing the predicted reduction in the practice nursing workforce. Lack of professional standards inconsistencies of care developing a workforce able to support Transformation and integration agenda, raise the profile of Primary care nursing. The CCG can't wait for a national development strategy that will take several years to develop.		

14. Evaluation Plan	This Project has been developed jointly with Leeds North CCG with the Lead Practice Nurses. A request is made for each CCG to fund non-recurrently as shown above. Each CCG is asked to gain approval through their Governing body for the funding. The business case will prepare and develop a vocational training scheme for nurses new into practice nursing over a 12 month period. The training scheme will continue to develop over a 2 to 3 year period to create a sustainable approach in the future and contribute to the workforce planning and leaving a legacy of training. The preparatory period will allow for adaptation to the changes currently facing primary care and in line with the transformation agenda. Using experts in education and training to develop the VTS ensures a training scheme is created that supports and transforms how we plan for the future nursing workforce and bring a new dimension to the practice nursing profession. The VTS scheme will support practices to develop and recruit nurses into general practice in the future. Providing a robust training scheme in general practice should encourage students, newly qualified nurses and nurses from secondary care to consider practice nursing as a career and it will aim to address the predicted 22% reduction in the practice nursing workforce over the next 5 years. Measures: • The project will be evaluated at 3,6 and 12months • The proposed objectives will be achieved with the proposed timescales. • The project will work with key leads who are experienced to inform the project. (Catherine Gill, Fran Mead, Christine Peake, Andrea Mann, Cath Johnson) • Include recommendations from national bodies where appropriate.

Leeds South and East Commissioning Group
Leeds North Clinical Commissioning Group

General Practice Nurse Vocational Training Scheme (GPN VTS)

Date: June 2014.

Paper prepared by: Andrea Mann Lead Practice Nurse (LSE) & Cath Johnson Lead Practice Nurse (North CCG

1. Introduction

Workforce planning

Workforce planning is essential to ensure practices have a sustainable workforce to meet the needs of the patients and ensure a viable and efficient practice nurse workforce is established. Health Education England (HEE) needs to ensure the NHS will meet the needs of patients both now and in the future. Commissioning of under and post graduate education should aim for a workforce in the right numbers, with the right skills, values and behaviours to respond to the current and future needs of patients.

The LETB workforce plans for primary care include addressing predicted future deficit in the General Practice Nurse (GPN) workforce as well as that of GP's. Current analysis of the practice nurse workforce has identified that 50% are over 50 years old highlighting a significant risk to the workforce. Practices are reporting difficulties at CCG level to recruit experienced, skilled and competent practice nurses into their vacancies and therefore investment into this workforce is essential.

Advanced Training Practice Project

The Advanced Training Practice (ATP) project has a clear strategic aim and was initiated in Yorkshire and Humber in 2009 to encourage inter-professional learning and create a model for integrated commissioning of primary care training for learners at different stages of learning. The project is expanding into a Hub and Spoke model with the additional aim to substantially increase the number of undergraduate nurses experiencing general practice and therefore the number who may consider Practice Nursing as a career option. Hub practices provide undergraduate teaching/education whilst other GP Training Practices enrol as a Spoke and offer workplace based experience. Implementation of ATP's is planned for April 2014. This model also promotes partnership working with Higher Educational Institutions (HEI) and provides opportunities to influence training curricula.

One of the ATP project aims are to increase the number of newly qualified nurses choosing practice nursing as a first career path following their completion of undergraduate training. Historically, practice nursing has generally been considered for experienced nurses from secondary care and different healthcare backgrounds. Over the past decade, the role of the practice nurse has expanded and nurses have taken on more advanced roles. Nurses wanting to make the transition into practice nursing have found it difficult to meet the requirements of the practice nurse role. There is a lack of courses available that provide suitable training to nurses new into practice nursing and the majority of alternative courses available have a requirement to be in post already. There is no national structured training for nurses in general practice compared to GP's who undertake a 3 year GP training programme.

2. Proposal for Vocational General Practice Nurse Training Scheme

During the last decade there has been a number of successful scoping and planning programmes commissioned by PCTs/SHAs across England. Despite this there is still no consistent strategic framework in place to enable the planning for and the development of the Practice Nursing workforce across England.

A coherent approach is needed locally, regionally then nationally to ensure that important scoping data is brought together and CCGs can share expertise. Caritas Health Partnership has proposed to undertake a project to pull together all previous work and ventures and develop a vocational training scheme (VTS) for GPN's. They propose to align this with the established GP VTS network with plans to expand the model within the Y&H and then undertake an exercise to roll out nationally. They plan to build on the progress already made through the General Practice Foundation Nursing Subgroup (GPFNS) (Joint venture Royal College of Nursing and the Royal College of General Practitioners) and their peer reviewed Nurse Competencies and Nursing Standards for General Practice Nursing in 2012.

The proposal provides an opportunity for the CCG's to work in partnership with Caritas Health Partnership to build on the ATP project and plan for a sustainable practice nursing workforce. It is essential to develop sustainable and credible programme of development with recognised education people. Catherine Gill is an expert in her field who will be integral in the development of the VTS not only locally but nationally in the future.

CCG investment

The proposal requires investment from CCGs initially and will start as a pilot project with the aim that it will become a LETB mainstream project with potential top slicing from each GP practice core funding by year one point. The implication of the HEE workforce plan is that this initiative needs to be funded by the service, because it is required to replenish the service.

3. Gaps identified

90% of all patient contact is in primary care and GP's and Nurses are expected to provide a level of care which is set to increase and work towards reducing inequality. Traditionally, undergraduate nurses spend the majority of their training in secondary care and the nurse. Recommendations set out in **A High Quality Workforce, NHS Next Stage Review** (DOH, 2008a, p19) to prepare nurses to meet future challenges with a greater amount of registered nurses beginning their careers in primary care. There is an understanding that newly qualified Registered Nurses will benefit from 'foundation periods of preceptorship at the start of their careers which will help them begin the journey from novice to expert' (DOH, 2008b, p72).

General Practice needs to ensure they can attract qualified and newly qualified nurses into the profession. Setting core standards and ensuring nurses develop a skill set fit for purpose after training will ensure practice nurses of the future can manage the wide range of complex conditions within general practice now and in the future. We need a sustainable practice nursing workforce in the future.

Leeds South and East

Current analysis of Leeds South and East GPN workforce estimates the number of GPN's over 55 years who are at due to retire is at 22%. Data collected highlights that 4% of the nurses are new into practice nursing. This group will not have the experience or the skills to manage the aging population with increasing complex needs. Therefore this project aims to address the current and future predicted gaps in patient access by building a workforce to meet the demands but also providing training and education in a primary care environment where the majority of care takes place.

Leeds North

The most recent analysis of GPNs over 55 years is 26.5%, more worryingly the amount of nurses who are due to retire in the next 5 to 10 years is 44.1%.

4. **Objectives**

- To review past PCT and new CCG models of general practice workforce development plans within Leeds, Calderdale, Kirklees, Bradford and Sheffield and draw on existing academic research to inform the project.
- To work with the LETB and ATP leads to engage with other similar task and finish groups and make links, share best practice and implement recommendations from national bodies where appropriate (NMD, Cavendish, Francis)
- To produce a General Practice Nurse Vocational Training Scheme Programme Proposal.

Additional Objectives with HEE support and funding

- Recruitment of GP practices to provide a minimum of 10 practical training places at GP practices in Leeds CCG's which an additional aim to increase to 20 practices joining the VTS programme in year two.
- Production of a GPN VTS job description / role specification, advertise and plan for interviewing for 10 one year GPN VTS posts. Recruitment would be a combination of graduate and experienced registered nurses from secondary care to general practice.
- Coordination of the Project to continue for the following 2 years and the key worker to work with other LETBs for a possible roll out nationally. Aim to have GPN posts locally and within the Y&H filled with vocationally trained GPN's by 2018.

5. What does this mean for CCG's?

- Establish a workforce learning model that will provide training in essential clinical skills, support and supervision for the induction and role development for registered nurses new to nursing in general practice.
- Support a proposed GPN VTS programme that will focus on learning which is patient centred and encompasses learning in the wider aspect of primary care and priorities general practice clinicians face.
- Work in partnership with Higher Education and the GP specialist Training Programme to provide a service led workforce development programme.
- Integrate teams and develop a skill mix approach to deliver of care within CCG practices.

6. Considerations

- Year one will have little impact on patients.
- Newly qualified nurses will receive training in an ATP Hub or Spoke which encompasses an inter-professional learning and teaching environment.
- The project impacts both implicitly and explicitly on patients. Without a workforce fit for purpose and in the right numbers then CCG's legal obligations cannot be achieved.
- To develop a city wide approach in workforce planning for the future of general practice nursing.

7. Proposed benefits for patients

- A future workforce of sufficient numbers of appropriately skilled healthcare professionals to meet the demands of an ageing population with complex needs.

8. Involving service users in the planning, developing and monitoring the outcome of the project.

- The project will ask the General Practice Foundation Nursing Subgroup (GPFNS) and Joint Venture Royal College of Nursing and the Royal College of General Practitioners patient involvement group for their comments on the proposal.

9. Monitoring and Evaluation

- The project will be evaluated at 3,6 and 12months
- The proposed objectives will be achieved with the proposed timescales.

- The project will work with key leads who are experienced to inform the project. (Catherine Gill, Fran Mead, Christine Peake, Andrea Mann, Cath Johnson and Gil Ramsden)
- Include recommendations from national bodies where appropriate.

10. Promoting the project

- The Practice Nurse Leads in Leeds (Andrea Mann, Cath Johnson, Gil Ramsden) will directly promote the project city wide across the CCG's.
- The Director of Nursing and Quality Ellie Monkhouse will promote the project city wide and nationally.

11. References

1. Centre for Workforce Intelligence (2012) Workforce risks and opportunities practice nurses education commissioning risks summary from 2012 [online] Available at: http://www.cfwi.org.uk/intelligence/shape-of-the-non-medical-workforce/general-practice [Accessed April 2013].

2. King's Fund (2011) Improving the quality of care in general practice. Report of an independent inquiry commissioned by The King's Fund. [online] Available at: http://www.kingsfund.org.uk/document.rm?id=9040 [Accessed April 2013].

3. Deloitte UK Centre for Health Solutions (2012) Primary Care: Today and Tomorrow - Improving general practice by working differently. New Directions - Innovation that drives quality. [online] Available at: http://www.deloitte.com/view/en_GB/uk/research-and-intelligence/deloitte-research-uk/deloitte-uk-centre-for-health-solutions [Accessed April 2013].

4. Health Education England: Our Strategic Intent (2013) Developing people for health and healthcare. [online] Available at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2013/01/Our-Strategic-Intent-web-Feb20131.pdf [Accessed April 2013].

5. Change Through Partnership (2009) Review of Development Approaches for the non medical workforce in Primary Care. [online] Available at: http://www.oxforddeanery.nhs.uk/about_oxford_deanery/primary_care/primary_care_taskforce/the_primary_care_team.aspx [Accessed April 2013].

6. Kings Fund (2012) Improving GP services in England: exploring the association between quality of care and the experience of patients. [online] Available at: http://www.kingsfund.org.uk/publications/improving-gp-services-england [Accessed April 2013].

Financial Costs

- The following costs relate to the cost of the project for a 12 month period to set up the VTS scheme

Description	Information	Hours	Cost
Total Capital Costs	**No Capital Costs**		
Revenue Costs	**Project Education Lead @ £40.00 per hour**	**12hrs per week**	**£24960.00**

Salaries, NI and Pension costs	**Nurse support testing/evaluating materials training content @ £24 per hour for 12 month period**	**85hrs**	**£2040.00**

	General Practice Nurse (GPN) VTS Key coordinator AfC Scale 3 plus on costs Pension for 12 month period	**£265(00**
General running expenses	**Postage 1500 communications (12 months) @0.50p**	**£750**
	Phone cost apportioned over 12 months	**£220.00**
	Website development	**£400.00**
Producing information, education and promotional materials	**GPN VTS Programme proposal/materials – University Accreditation/validation links**	**£126(00**
Travel expenses	**Project Lead/Coordinator Travel costs (12 months) 120 miles per month @ 0.40p/pml**	**£576.00**
Recruitment costs	**Appointment of key co-ordinator**	**£900.00**
TOTAL cost of the project (including VAT)		**£57(00**
Total cost per CCG		

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1. Drivers of Future Service Demand

Changing population and patient needs

Growing and ageing population

According to current projections, there will be more than 6 million people with a long-term, limiting illness or disability by 2030. Physiotherapy can help to prevent hospital admissions, reduce bed days and individuals' dependence on complex care packages, and decrease the need for residential home placements.

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

We have an increasingly frail elderly population. Each year, 35 per cent of over-65s experience one or more falls. Based on 2009/10 costs, each hip fracture avoided saves approximately £10,170. Physiotherapy-led falls prevention services, reduce the number of falls and fractures, improve outcomes, keep people living independently and reduce hospital admissions and GP appointments[i].

Increasing demand

Effective rehabilitation is fundamental to patient outcomes as well as the efficient delivery of services and effective pathways of care. Physiotherapy provides a key contribution to productivity and cost containment. The profession is underpinned by a strong evidence base and the workforce is skilled in evaluating, monitoring and reviewing services to reduce waste and to ensure that skills and resources are put to best use and to meet local patient needs.

Capability to focus on patient needs and to streamline interventions is essential with such widespread and increasing pressure on services. There are a number of examples such as rehabilitation following hip replacement, where protocol-driven care and optimal use of the physiotherapy workforce yield patient and service benefits. Other examples include assistant practitioner roles in areas such as adult cystic fibrosis which have improved exercise training effects and outcomes for patients, freeing up advanced and expert physiotherapist time for enhanced levels of input to acute ward and ICU stays.

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Previous high levels of demand on orthopaedic clinics have resulted in very successful substitution of traditionally medical roles with physiotherapy roles in clinical assessment services. Similarly, expert physiotherapists provide not only a holistic solution but also a cost-effective one in teams such as critical care outreach services. The levels of demand for GP services and the widely reported shortfall in GP trainees highlights a potential future area where physiotherapists, with their particular knowledge base, whole-person approach and assessment, diagnostic and treatment skills as autonomous practitioners can be a key part of the solution to providing effective, accessible and timely services in affordable ways.

Increasingly complex needs
The age profile of the population, the prevalence of long-term conditions and medical and technological advances mean that patients will live with and access services as a result of increasingly complex needs. Pre-registration physiotherapy education prepares physiotherapists for working with patients with complex needs.

Physiotherapy students learn how to work with and enable people with combinations of acute and chronic respiratory, neurological and musculoskeletal disorders and other pathologies within academic and a wide range of practice settings. The knowledge and skills required to work with complex cases is further developed throughout professional practice, meaning that the profession is excellently placed to meet increasing demand for meeting increasingly complex needs and patients presenting with co-morbidities.

In addition, physiotherapists build strong working relationships with other professionals across health and social, private and voluntary sectors. They are therefore excellently placed to optimise the integration of services, to smooth the pathways of care, and to enhance patient experience and outcomes in cost-effective ways.

Key pathologies and patient groups
Enhanced survival rates from a number of pathologies and growth in elderly population indicate the need to ensure that future rehabilitation demand can be met. No matter what care setting, in what sector, or for which group of patients, physiotherapists enable people to live longer and to live well.

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

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Falls: Costing the NHS over £4.6 million each day (= £1.7 billion per year), falls in later life represent a major burden on the health and social care systems. Prevention is better than cure. Physiotherapy is proven to prevent falls, reduce hospital admissions and restore independence. NICE guidance requires all older people with recurrent falls, or at increased risk of falling, to be considered for an individualised intervention including evidence based strength and balance training.

Dementia: By 2039, there will be 1.4 million people with dementia in the UK. Physiotherapy interventions reduce the risk of developing dementia and promote a delay in the progression of both cognitive and functional decline[iii].

Working age population: Keeping people fit to remain in work and facilitating return to work is a priority. Musculoskeletal (MSK) conditions are the biggest cause of absence from work in the UK, causing 27% of total days lost to sickness absence. Rapid access to good occupational health services, including physiotherapy, gets people back to work quicker and reduces the risk of MSK conditions and stress as they become older. A county council's introduction of a rapid access physiotherapy service and saved £100,000 per month from reduced sickness absence levels among their staff.

From a workforce perspective, we anticipate that demand for health care professionals with the expertise to act as assessors for personal independence payments, and similar schemes, will increase significantly in line with current Department of Work & Pensions policy and its contractors' projections.

Shifting the focus to prevention and well-being
Being physically active can help prevent and/or manage over 20 medical conditions including coronary heart disease, type 2 diabetes, cancer, obesity, back pain, osteoarthritis, and depression. As experts in movement, Physiotherapists have an invaluable contribution to make to the promotion of health and wellbeing and the prevention of ill health. Physiotherapists are increasingly working with good effect in public health roles and innovatively incorporating prevention and health promotion into every day clinical practice.

Physiotherapy Works
The CSP has produced a series of evidence-based briefings that demonstrate the effectiveness of physiotherapy for treating patients with a range of conditions. The series covers Cancer Survivorship, Cardiac Rehabilitation, Chronic Pain, COPD, Critical Care, Cystic Fibrosis, Dementia Care, Fragility Fractures and Falls, Lymphoedema, Multiple Sclerosis, Musculoskeletal Disorders, Occupational Health, Parkinson's Disease, Rehabilitation, Social Care, Stroke, Urinary Incontinence and Vestibular Rehabilitation. More information can be accessed via the following link: www.csp.org.uk/physiotherapyworksbriefings

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The CSP also has a corporate programme of activity (running to 2016), with the same name. This is focused on demonstrating the effectiveness of physiotherapy for meeting changing population and patient needs, with a particular focus on 'living longer, living well'. It is as part of this programme that the CSP is progressing a project on workforce data modelling.

Public and patient expectations

Information sharing: Further progression in the scale of demand for health and wellbeing information is anticipated. Patients and carers can expect physiotherapy communications to be professional, caring and compassionate and person-centred as this is core to the profession. Physiotherapists provide information to service users in a variety of formats. For example, a patient-owned folder of information about treatment and self-management is helping to improve the services of a community neuro-rehabilitation team (CSP Frontline May 2014) and expectant mothers can access a video explaining the benefits of physiotherapy for pelvic floor problems (www.csp.org.uk/publicatrions/pelvic-floor-muscles).

Service accessibility: The CSP supports the principle that physiotherapy services should be available to patients where and when they need it, and that changes to existing service organisation should be introduced to have a positive impact on patient care and to improve the quality, timeliness, accessibility and efficiency of service provision. It is possible for patients to self-refer for physiotherapy but also to access support and advice by phone (CSP Frontline Feb 2013) A breadth of developments such as flexible service hours and seven-day service operation are embedded within physiotherapy to ensure a focus on the requirements of service users. Close attention and responsiveness to user feedback is integral to physiotherapy care. The profession is fully engaged with the importance of delivering services that engage people effectively in decisions about their care and ensure they have the information required to make the choices that work for them.[iv]

Technological advances

Physiotherapists will continue to make best use of technological advances to improve patient care and services. Current developments include people with dementia using the Wii as part of a physiotherapy balance and strengthening exercise programme (CSP Your Health web page: http://www.csp.org.uk/your-health/conditions/dementia) and people with neurological disorders using interactive rehabilitation aids (CSP Frontline Sept 2013).

Current developments to improve the accessibility of services includes an NHS Foundation Trust's delivery of physiotherapy via telehealth to prisoners. This has been in place since 2006 and is now being extended to other service users (CSP news April 2014). Physiotherapists are already devising strategies to improve the

health and well-being of people who use tablets, computers, etc., in prolonged sitting positions (CSP Frontline, July 2013).

2. Future Service Models
Physiotherapy is continually evolving to deliver services through new models of care, with the workforce at all levels being experienced and capable of flexibly delivering quality patient care in a variety of settings and across an increasing plurality of service providers.

Primary and community care: There were nearly one million acute bed days lost due to delayed discharges in 2012/13. It is imperative that sufficient and appropriately located physiotherapy resources are in place in primary care to ensure efficient use of secondary care resources. Pulmonary rehabilitation is a good example. Pulmonary rehabilitation programmes for people with COPD are proven to reduce the length of hospital stay and to reduce the number of hospital re-admissions. For these reasons, it is recommended by NICE for all appropriate patients with COPD. However, in spite of this recommendation, provision continues to be patchy for patients.

We agree with the King's Fund that the current location of the workforce is not well matched to where the care is most needed, and that there is a strong need for more 'specialist-generalist' skills in primary and community care, and for shifts in workforce to be made to achieve this, with appropriate underpinning opportunities for workforce development at all staffing levels[v].

Physiotherapists have responded to the demand for advanced practice skills in primary and community care settings and delivered positive results. For example, a specialist and physiotherapy-led falls prevention programme in Scotland sees nearly 175 patients a month in their homes to assess risk factors and intervene to modify these. Between 1998 and 2008 there was a reduction in admissions due to falls in the home by 32 per cent, falls in residential institutions by 27 per cent and falls in the street by nearly 40 per cent. Over the same period, the number of hospital admissions for hip fractures decreased by 3.6 per cent.

Physiotherapists are also well-placed to respond to current and projected shortfalls in GP trainees, with the assessment and diagnostic and treatment skills to make a significant and valuable contribution to the delivery of patient care, including in ways that reduce hospital admissions and provide person-centred care closer to home.

3. Future Workforce Models
Physiotherapists are excellently placed to act in leadership and management roles, including to achieve the integration of services, patients' access to smooth

and timely care throughout the care pathway, and to optimise the scope for service improvements in the interests of meeting individuals' needs in person-centred, holistic ways.

Physiotherapy's distinctive contribution

Physiotherapy is ideally placed to provide solutions to current healthcare challenges. It can play a strong role in addressing current health and social care and public health priorities in a rapidly changing health and well-being economy, maximising productivity and efficiency whilst providing high-quality care.

Physiotherapists support self-management, promote independence and help to minimise episodes of ill health developing into chronic conditions requiring hospital admissions. They have a central role to play in enabling people to remain healthy at work and to support individuals' return to work, thus reducing current levels of sickness-related work absence and incapacity benefit claims, both major policy objectives.

Physiotherapists develop and focus their practice to optimise their clinical- and cost-effectiveness, recognising the increasing imperatives attached to this in a context of rising demand and tightening financial constraint. They are excellently placed to assume even greater responsibility for managing complex, non-routine caseloads, taking on activity previously undertaken by medical colleagues and overseeing the delivery of care by others.

Physiotherapy enables people to move and function as well as they can, maximising quality of life, health and well-being. Physiotherapists use manual therapy, therapeutic exercise and rehabilitative approaches to restore, maintain and improve movement and activity and to support people in managing their own condition, maintaining their independence and preventing future episodes of ill health. Physiotherapists work with a wide range of population groups (including children, those of working age and older people), across sectors, and in acute, community and workplace settings.

Physiotherapy delivers high-quality, innovative services in accessible, responsive, timely ways. It is founded on an increasingly strong evidence base, an evolving scope of practice, clinical leadership and person-centred professionalism. As an adaptable, engaged workforce, physiotherapy has the skills to address health care priorities, to meet individual needs, and to develop and deliver services in clinically- and cost-effective ways. With a focus on quality and productivity, it puts meeting patient and population needs, and optimising clinical outcome and the patient experience, at the centre of all it does.

Physiotherapy is excellently placed to provide solutions to current challenges. It

can play a strong role in addressing health care priorities in a rapidly changing health and well-being economy, recognising the imperative of delivering high-quality services and maximising productivity within difficult financial times. Its distinctive mix of diagnostic and assessment skills, holistic approach and developed communication and educative skills means that it can facilitate early intervention, support self-management and promote independence, and help to minimise episodes of ill health developing into chronic conditions.

Physiotherapists have particular skills and make particular contributions in the areas identified below.

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

The physiotherapy workforce is receptive to the need to adapt and develop. It recognises that this needs to have various dimensions: what it delivers, how and where it delivers services, and to whom it delivers services to maximise long-term benefits for individuals, society and the economy.

Physiotherapy is excellently placed to help to meet specific identified health care priorities and to facilitate change in how individual needs are met through the integration of care across sectors and settings and through the promotion of self-management. It is developing and using its knowledge and skills to meet changing, projected and unmet needs in rapidly shifting environments. Building on its expanding evidence base and strong professional values, physiotherapy can make a strong contribution to addressing increasingly diverse and complex health needs by leading and delivering high-quality, research-informed care.

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The physiotherapy workforce uses its skills, interventions and approach to deliver high-quality, timely and cost-effective care. It demonstrates real value in terms of quality outcomes and quality of experience for individuals and society's health and well-being. It is also represents value for money and a sound investment for the benefits it brings.

Physiotherapy services are focused on meeting user need, enhancing clinical outcome, strengthening service integration, and optimising the quality of the patient experience. Services are delivered via open access services, including through self-referral, and by optimising use of new technologies to enhance access and support to individuals (e.g. in engaging with self-management and behavioural change programmes). It is also delivered in ways that minimise hospital admissions and reduce length of hospital stays, with the real scope for physiotherapy to strengthen its contribution to early intervention and enhanced recovery programmes.

In developing its services, the physiotherapy workforce is able to do the following:

- Respond to the growing significance of individual choice and decision-making in accessing and purchasing health care and rising public expectations about speed of access to services and the quality of services received
- Acknowledge this cultural shift sits alongside significant fiscal constraint and the imperatives this creates for optimising use of available resources
- Deliver holistic care to meet individuals' increasingly complex needs
- Optimise use of its expert assessment, diagnostic and treatment skills (including through leading triage and through managing patient caseloads through risk stratification)
- Promote patient self-referral to services wherever appropriate
- Optimise access and delivery of services to all individuals and groups (including through developing services that provide extended hour and 7-day access where this enhances the quality of clinical outcome and patient experience)
- Address health inequalities, including by providing services between and across agencies and organisations (including schools and charities)
- Optimise its provision of occupational health and vocational rehabilitation services to initiate, lead and sustain 'fit for work' schemes
- Progress clinical leadership as an integral component of physiotherapy roles (as appropriate to career stage and job profile).

The broad scope of physiotherapy and the variety of settings in which the profession practises are significant for its capacity to contribute to meeting the changing needs of populations in increasingly challenging times. One example of

the significance of the scope of physiotherapy is the newly-granted right to prescribe independently (subject to fulfilment of HCPC education requirements and annotation on the regulator's register), allowing for the provision of more streamlined, cost-efficient and effective care for patients.

Physiotherapists' use of diagnostic ultrasound for treatments such as injection under image guidance and for joint working with radiology colleagues in musculo-skeletal diagnostic services are further examples of how the scope of the profession can facilitate enhanced care to patients. Physiotherapists' role in such care pathways has a financial benefit and physiotherapists' accurate diagnostic and image interpretation skills alongside their knowledge base mean they are ideally placed to fulfil enhanced roles in an increasing range of service areas and to develop their roles in primary care.

Workforce development
A commitment to the development of all parts of the workforce is essential for service development and delivery and achieving innovation, sustainability and continuous improvement in the interests of patients. The CSP would like to see support and opportunities for workforce learning and development more evenly distributed across staff groups to maximise workforce potential, service improvements and the quality of patient care. Information relating to pre-registration, post-registration and support worker physiotherapy education is provided below, with some key issues highlighted.

Pre-registration education - Quality assurance & enhancement
Pre-registration physiotherapy education in England (as well as the rest of the UK) is subject to robust regulation and quality assurance and enhancement arrangements. Processes ensure that programmes are measured and kept under review against high standards set by the HCPC, CSP, QAA and host higher education institution.

The CSP asserts its expectations of UK qualifying physiotherapy programmes through its Learning & Development Principles and accreditation processes. The L&D Principles help programme providers develop learning and teaching opportunities that prepare physiotherapy students for changes in population and patient needs, role and service delivery reconfigurations, and an increasing plurality of providers within health and social care and public health and therefore career development opportunities.

Pre-registration educational outcomes
Both the HCPC and CSP take an outcomes-based approach to physiotherapy education, with their focus on the knowledge, skills and attributes that students achieve on graduation, registration and entry to the profession.

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The CSP's Physiotherapy Framework (2013) defines the behaviours, underpinning values, and knowledge and skills required for contemporary physiotherapy practice at all levels, including entry-level graduate level. The CSP's Code of Members' Professional Values and Behaviours (2011) sets out expectations of all its members (including students, support workers, graduates and more experienced and advanced practitioners in all occupational roles), with a primary emphasis on person-centred professionalism.

The CSP encourages and supports flexibility, innovation and diversity in evidence-based programme design and delivery. This allows programme delivery teams to respond to changing local, national and global.

Through undertaking their pre-registration education, physiotherapists develop the following knowledge, skills and attributes:

- High standards of professionalism and an understanding of the need for a caring and compassionate approach towards service users at all times
- The knowledge, skills and attributes to practise autonomously
- An understanding of their obligations to equity and diversity
- Subjective assessment and interviewing skills, and the ability to apply these in a range of settings
- Objective assessment and handling skills, and the application of these in a range of settings, and to a range of pathological presentations
- Strong clinical reasoning skills
- An understanding of pathologies of a range of conditions and the resultant impact on individuals
- An understanding of the service user's perspective and person-centred practice
- A range of techniques to deliver safe and effective physiotherapy.
- Skills to enable and empower service users to lead as independent and fulfilling lives as possible
- The ability to modify and adapt skills, approaches and behaviours (including communication) to the needs of individual service users and within multi-professional teams
- Skills to support patients to self-care
- The ability to work with others to meet the responsibilities of professional practice
- The ability to delegate work to others (including support workers and carers)
- Leadership skills
- An understanding of the roles of other team members in service provision
- Team-working skills to enhance patient care and experience
- Skills to learn in multi-professional teams
- An understanding of current and future health and social care contexts and policies

- High standards of record-keeping
- Reflective practice skills and the skills to evaluate practice
- An understanding of the need for practice to be evidence-based and skills in critically evaluating research literature and applying research skills
- Skills for lifelong learning and CPD
- Problem solving skills
- Skills to help others to learn
- A basic knowledge of pharmacology.

These abilities are supplemented through post-registration practice and learning.

Value for money
Pre-registration physiotherapy programmes in England represents value for money and an excellent return on investment. Attritions rates form physiotherapy programmes are currently at 2.8% across the UK (see Part 2 of our response), while there is a very high translation of physiotherapy graduates into members of the health care professions workforce. This is across an increasing plurality of service providers, but with the majority of physiotherapists continuing to work within the NHS and NHS-funded services.

Post-registration education
Our future workforce will primarily comprise of those already working with in the profession. Sufficient financial support is therefore required to ensure that the workforce remain sufficiently skilled and adept at delivering quality physiotherapy services. The CSP is therefore concerned that a suitable and more equitable level of resource is allocated to support post-registration education. In line with the King's Fund *Time to Think Differently* initiative, the CSP urges HEE to provide assurance that a more balanced allocation of support will be achieved[vi].

Changing health and social care contexts provide opportunities for new roles to allow physiotherapists to use and develop their considerable skills and qualities in order to improve services and patient care.

Research-engaged workforce
Creating research capacity must be built into the workforce. With the necessary support, development and facilitation, physiotherapists can use their research skills to evaluate physiotherapy and multi-professional services, including integrated health and social care provision. As indicated in HEE's draft research & innovation strategy, the whole workforce needs the opportunity to strengthen engagement in research and innovation as a key way of achieving service improvements, affordability and enhancing patient care.

The particular place of clinical academic careers should be factored into workforce

planning, and their place within workforce and professional development process and structures should be overt. The value and impact of clinical academic careers for enhancing the quality, outcomes and cost-effectiveness of patient care must be recognised.

Role development
Physiotherapy recognises its need to continue to develop and evolve as a workforce to optimise its capacity to meet changing needs within changing structures. It is receptive to the following:

- Taking up more advanced and flexible roles to meet patient/population and service needs
- Acting as the primary assessors of individual need (building on the profession's assessment and diagnostic skills)
- Developing its leadership roles to promote wellness and prevent ill-health
- Its role as a profession often being to educate and support others in delivering services to individuals and groups
- Providing services and care traditionally provided by medical practitioners
- Extending its role in triage services
- Ensuring its education sustains the safe and effective integration of new areas and approaches into its scope of practice
- Adapting its practice and roles to the different environments in which individual and group needs can most effectively be met
- Delivering services in increasingly diverse settings (including within inter-professional and inter-agency teams and across care pathways), supported by strong continuing professional development [CPD] and peer review structures.

Physiotherapy is able to rise to new challenges and opportunities, while putting safety, quality and productivity to the fore. It is committed to optimising how it works with support staff, recognising the increasing knowledge and skills base of those in assistant roles and support workers' capacity to deliver hands-on care within some models of provision to enhance the timeliness, sustainability and accessibility of care. It is also committed to ensuring that those whom it recruits to the profession have the potential to develop excellent problem-solving and communication skills and to take a genuinely holistic approach to working with individuals.

Skill mix
Physiotherapy recognises and embraces the need for change in how it provides services as a workforce, in order to optimise its rich skills mix to meet individuals' needs in the most productive and effective ways. There is increasing value in physiotherapy support staff, with appropriate training and supervision, taking on greater responsibility for delivering routine aspects of care. In turn, qualified

physiotherapists are able to extend their roles at advanced levels, acting as first-contact practitioners, assuming greater responsibility for complex, non-routine caseloads, taking on activity previously undertaken by medical colleagues, and overseeing the delivery of care by others.

Setting

The physiotherapy profession recognises the increasing need and value of shifting where care is delivered, so that this happens more heavily in primary care settings. Physiotherapy also recognises the appropriateness of its contributing to meeting individuals' health and well-being needs in more diverse sectors and settings (in private, independent and voluntary organisations), including through maximising the value of its role in health promotion, illness prevention (including by leading initiatives relating to 'fit for work' and supporting individuals in engaging in self-management relating to obesity and smoking cessation) and secondary prevention.

[i] The Chartered Society of Physiotherapy, Physiotherapy Works for Social Care, June 2014. URL: http://www.csp.org.uk/publications/physiotherapy-works-social-care

[ii] The Chartered Society of Physiotherapy, Physiotherapy Works for Social Care, June 2014. URL: http://www.csp.org.uk/publications/physiotherapy-works-social-care

[iii] The Chartered Society of Physiotherapy, Physiotherapy Works for Social Care, June 2014. URL: http://www.csp.org.uk/publications/physiotherapy-works-social-care

[iv] Centre for Work force Intelligence, Big Picture Challenges: The Context, Oct 2013. URL: http://www.cfwi.org.uk/publications/big-picture-challenges-the-context-1

[v] The King's Fund, NHS and social care workforce: Meeting our needs now and in the future? July 2013. URL: http://www.kingsfund.org.uk/time-to-think-differently/publications/nhs-and-social-care-workforce

[vi] The King's Fund, NHS and social care workforce: Meeting our needs now and in the future? July 2013. URL: http://www.kingsfund.org.uk/time-to-think-differently/publications/nhs-and-social-care-workforce

FF33 RCGP

PRIMARY CARE WORKFORCE COMMISSION

Submission of evidence by the Royal College of General Practitioners

Thursday 2nd April 2015

Contents

Executive summary

Introduction and background

1. The Royal College of General Practitioners (RCGP, or 'the College') welcomes the opportunity to respond to the Primary Care Workforce Commission. The RCGP is the largest membership organisation in the United Kingdom solely for general practitioners (GPs). We gratefully acknowledge the contributions of our members in formulating this response.

2. Primary care, and specifically general practice, faces numerous challenges in delivering care. These challenges cover changes in population demographics, complexity of care, workforce demographics and funding constraints. In order to sustain the delivery of care to primary care, new models of care need to be invested in and implemented. A selection of novel approaches is presented below. For ease of examination, a distinction between 'new models of care' has been made. New 'clinical' models of care pertain to changes in the approaches and ways of working by the primary care workforce in delivering patient contacts. New 'structural' models of care relate to changes in the organisational design of primary care and their potential relationship to financial and contractual arrangements which may underpin different models. The RCGP strongly believes that knowing the number of GPs and other health care professionals required to provide an effective workforce is essential to delivering new models of care. Therefore we have submitted some evidence regarding this as part of this submission.

New clinical models of care

3. New clinical models of care can be viewed according to four dimensions: access; continuity of care; care planning and coordination of care; and, comprehensiveness of care. These are expected to achieve the composite goal of good quality care.

4. 'Access' is both an objective and subjective term – whether it is satisfactory depends on both experience and on an individual patient's priorities, which vary from proximity and availability of care to timeliness of care. Absolute appointment availability, both in clinic and at home, can be increased by additional workforce, and not all clinical contacts need a GP. New approaches to achieve proximity and availability of care use technology in the form of telephone, Skype and email consultations. The modernisation of home visits by use of technology and new clinical professionals has been key in providing care to isolated patients. Increased access to diagnostic testing in the community, to allow earlier diagnosis and routine monitoring, can also assist new ways of working.

5. Continuity is operationalised as relational, informational, and managerial. In the context of a multidisciplinary primary care team, who have to offset acute access against planned care, and use skills appropriately, continuity can be lost, and the challenge is to retain continuity where it is needed. This is often when a patient has complex diagnostic and management needs, or a serious illness. One of the measures to ensure continuity of care is to make sure that patients have a named GP and practice nurse for 'usual' contact; this can be extended to a 'usual team' model, which allows the practice some flexibility in allowing a patient to see a health professional with whom they have a prior relationship. Effective outcomes from continuity are of course also dependent on having sufficient time and skills.

6. Care planning and co-ordination of care is increasingly important as the proportion of the nation suffering from long-term conditions increases. A wide range of health professionals have been piloted as having a role in the co-ordination of care, for example, practice nurses and community matrons. This also involves the time, ability, and technology to link and co-ordinate with other services and professionals, where necessary. Care planning is a current approach that is being proposed to allow informational continuity and personalised care. It is important to note that the inclusion of 'non-health' professional carers in the design of any care plan is vital. The use of patient data can also be a very useful tool in the co-ordination of care for various patient cohorts. The co-ordination of care can also require significant alteration to non-clinical organisational processes – for example, records access and appointment allocation. In addition, significant investment may be required before any benefits are realised.

7. Comprehensive care is a core feature of expert medical generalism – seeing a GP who can tackle all aspects of health need. There is an important role for general practice to act as a hub, signposting patients to other services available across the health and social care system and the third sector. Comprehensiveness of care at this level can only be achieved through joint working. Development and evaluation of networked and collaborative models of care is required.

New structural models of care

8. Structural models of care can be viewed in terms of their governance and management structure; economic conditions; workforce personnel; and, infrastructure, technology and data.

9. Federated structures enable practices to share resources and to focus more on the delivery of a high quality service, extend opening hours and to co-operate in developing a local general practice workforce through shared investment and shared use of existing training capacity. To reflect the growing multidisciplinary nature of the primary care workforce, there should be opportunities for non-GPs to co-lead these structures via boards or partnerships.

10. The modern primary care workforce already offers a range of skills in the community, and this needs both consolidation and further development. GP federations can co-ordinate extended opening hours, with larger federations of practices combining to deliver extended clinical and integrated out of hours (OOH) services. Different approaches to practice staff mix would be required in different areas and training of all primary care workforce personnel will have to be expanded and altered.

11. To fully integrate services and to prevent fragmentation of healthcare in the community, patients should be able to access a range of multidisciplinary services via the general practice surgery. However, significant investment in general practice surgeries will be required to ensure that the infrastructure of the practices is able to support multidisciplinary services. A large challenge in multidisciplinary working is ensuring that patient records can be shared effectively between different members of the extended team. Another challenge for this is Information Technology (IT) infrastructure and ensuring that different systems are able to interact. The collection of effective medical data can drive improvements in the quality and use of patient data.

Quantitative workforce planning

12. To deliver any of the above models of care, it is of utmost importance that Health Education England (HEE) addresses the current shortfall in GPs and ensures that there is sufficient supply of GPs in the future. It is vital that HEE or an independent body works with interested parties to conduct detailed quantitative analysis. There are numerous methods to estimate if there is a shortage of GPs in England.

13. The College estimates current GP shortage using extrapolations of GP vacancy rate data. The College uses the Centre for Workforce Intelligence (CfWI) estimate of a 3,000 GP shortfall by 2020. However, the CfWI also model the impact of two probable supply shocks: decrease in median GP retirement age and increased emigration from the UK workforce. All of these estimates suggest a shortage of GPs in England of approximately 7,700. It is also important to note that the CfWI report itself states that its forecast baseline most likely underestimates future patient demand for GP services. Investment in the recruitment of GPs is needed to ensure delivery of new models of care and to address significant workforce issues including workload, patient safety and recruitment.

Recommendations

14. Key recommendations that the College believes are essential to design a primary care workforce that is able to deliver the new models of care and ways of working include:
    - **a) Workforce planning**
        i. Increased collection of workforce data
        ii. Quantitative forecasting of workforce numbers
        iii. Evaluation of the relevant competencies for different health and care roles
    - **b) Recruitment**
        i. Cultural change to encourage recruitment to general practice
        ii. Stabilisation of GP careers
        iii. Greater exposure to general practice at undergraduate and foundation school level
        iv. Review of incentives to attract locum doctors
        v. Review of underlying reasons why UK graduates emigrate to other countries
        vi. Incentivising practices to recruit / commission a wider variety of health care professionals in new roles
    - **c) Training**
        i. Increased GP training capacity, especially in our underserved areas
        ii. Increased nurse training capacity with co-ordinated structure and funding
        iii. Funded education and advanced training provision for current and new Allied Health Practitioners, Health Care and ‘Medical’ Assistants
        iv. Funded education and training provision for administrative and practice manager roles
        v. Review of funding for GP training
        vi. Review of training content for health professionals who will have a more active role within the future delivery of primary care
    - **d) Retention**
        i. Invest in occupational health and GP morale
        ii. Establish clearer workload management guidelines
        iii. Career structures for non-GP primary care workforce members
    - **e) Innovation**
        i. Funding for research at frontline practices

Introduction

1. The Royal College of General Practitioners (RCGP, or 'the College') welcomes the opportunity to respond to the Primary Care Workforce Commission. The recommendations from the Commission will form a key part of NHS England (NHSE) and Health Education England (HEE)'s responses to the challenges faced by primary care in responding to changing patient demand. The RCGP is the largest membership organisation in the United Kingdom (UK) solely for general practitioners (GPs). Founded in 1952, it has over 50,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. We maintain close links with other professionals working in primary care, such as practice managers, nurses and physician assistants. We gratefully acknowledge the contributions of our members in formulating this response.

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

Background

3. Primary care, and specifically general practice, faces numerous challenges in delivering care. These challenges cover changes in population demographics, complexity of care, workforce demographics and funding constraints.

4. The UK population is projected to grow by approximately seven per cent between 2012 and 2022. The greatest relative expansion in the UK population is the growth of patients aged over 80 years old. Patients aged over 80 consult four times more often than the average patient and have more complex needs. There is also strong evidence that the overall care general practice is required to deliver is becoming more complex. The number of people living with more than one long term condition is expected to rise from 1.9 million in 2008 to 2.9 million by 2018. There is evidence that around 65 per cent of those over 65 are living with multiple morbidity.[1]

5. The general practice workforce is also ageing. Deloitte's Centre for Health Solutions argued that the greatest supply challenge facing primary care is the average age profile

[1] Department of Health (2012) *Long term Conditions Compendium of Information. (Third Edition).* Accessed at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

of GPs.[2] The proportion of GPs aged 55 and over rose from 17.5 per cent in 2000 to 21.9 per cent in 2014. It is also concerning that 54 per cent of GPs over the age of 50 are intending to leave direct patient care within five years.[3] Additionally, the practice nurse workforce is also ageing. A review in 2009 found that a disproportionate number of primary care nurses are expected to retire within five to ten years.[4]

Table 1: Proportion of GPs aged 55 years or over, 2014[5]

Country	Percentage of GPs aged 55 or over
England	21.9
Scotland	19.6
Wales	23.0
Northern Ireland	24.0

6. The proportion of GP posts filled is also an area of concern: 'the Health and Social Care Information Centre (HSCIC) GP vacancy survey was suspended in 2010. In the absence of centrally collected data the most useful proxy is a snapshot survey conducted in February 2013 of 220 practices, covering around 950 full-time positions. It suggested that the number of unfilled GP posts has gone up fourfold in the last two years: The results showed vacancy rates of 7.9 per cent of all GP posts in January 2013 – almost double the 4.2 per cent figure from the previous year's survey in January 2012, which itself was twice the Department of Health baseline figure of 2.1 per cent from the last survey in 2010.' [6] This is reflected in qualitative evidence from GPs and providers of GP services.

7. These challenges to workload and ageing workforce have also correlated with a decline of investment in general practice. Research undertaken by Deloitte shows that funding to general practice in England as a share of total NHS funding has decreased from 11.0 per cent in 2004/05 to 8.5 per cent in 2011/12.[7] Applying the same methodology as Deloitte, the College has estimated that funding for general practice has fallen further to 8.3 per cent in 2012/13.

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[2] Deloitte (2012) *Primary care: Today and tomorrow, improving general practice by working differently.* Accessed at: http://www2.deloitte.com/uk/en/pages/life-sciences-and-healthcare/articles/primary-care.html
[3] Health Education England (2014) *Securing the Future GP Workforce Delivering the Mandate on GP Expansion: GP Taskforce Final Report.* Accessed at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/07/GP-Taskforce-report.pdf
[4] Deloitte (2012) *Primary care: Today and tomorrow, improving general practice by working differently.* Accessed at: http://www2.deloitte.com/uk/en/pages/life-sciences-and-healthcare/articles/primary-care.html
[5] Health and Social Care Information Centre (2014) *General and Personal Medical Services, England - 2003-2013, As at 30 September.* Accessed at: http://www.hscic.gov.uk/catalogue/PUB13849
[6] Health Education England (2014) *Securing the Future GP Workforce Delivering the Mandate on GP Expansion: GP Taskforce Final Report.* Accessed at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/07/GP-Taskforce-report.pdf
[7] Deloitte (2014) *Under Pressure: The funding of patient care in general practice*. Accessed at: http://www.rcgp.org.uk/campaignhome/~/media/Files/PPF/Deloitte%20Report_Under%20Pressure.ashx

8. It is important to note that there are significant health inequality challenges in primary care. It is well-documented that the prevalence of multi-morbidity increases with deprivation, with people in deprived areas having the same prevalence of multi-morbidity as more affluent patients who are 10 to 15 years older. In particular, physical and mental health comorbidity has been shown to be almost twice as common in the most deprived compared with the most affluent areas.[8]

9. However, there is significant disparity in the provision of primary care workforce across the country. The Centre for Workforce Intelligence (CfWI) notes that 'health inequalities caused by the imbalance in the local and regional distribution of GPs and other primary care workers has been an enduring policy issue since the founding of the NHS.

> *'Prosperous rural and suburban areas may find it easier to recruit GPs than deprived urban or isolated, poorer rural areas. Poor local amenities, smaller practices and a higher workload generated by a disadvantaged population act as disincentives for GPs to work in such areas. Likewise, a National Audit Office report on health inequalities found: The number of GPs in areas with the greatest health needs has increased in recent years but GP levels, weighted for age and need, are still lower in deprived areas.'*[9]

10. In order to sustain the delivery of primary care, new models of care need to be invested in and implemented. The modern primary care workforce already offers a range of skills in the community, and this needs both consolidation and further development. A selection of possible approaches is presented below. For ease of examination, a distinction between 'new models of care' has been made. New 'clinical' models of care pertain to changes in the approaches and ways of working by the primary care workforce in delivering patient contacts. Alongside these, new 'structural' models of care relate to changes in the organisational design of primary care. To assist the analysis of these two distinct types of change, a modified version of the framework developed by Kringos has been used.[10] New clinical models of care are analysed according to four dimensions: access; continuity of care; coordination of care; and, comprehensiveness of care. Similarly, structural models of care are categorised in terms of governance and management structure; economic conditions; workforce personnel; and, infrastructure, technology and data.

[8] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. (2012) *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study.* Lancet 2012; published online May 10. DOI:10.1016/S01406736(12)602402.
[9] Centre for Workforce Intelligence (2014) *In-depth Review of the General Practitioner Workforce.* Accessed at: http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce
[10] Kringos D, Boerma W, Bourgueil Y et al. (2013) *The strength of primary care in European internal comparative study* Br J Gen Pract 2013; DOIL 10.3399/bjgp13X674422 http://bjgp.org/content/63/616/e742.full.pdf+html

New clinical models of care

Access

11. There is no single definition of good 'access' to general practice, nor a universal solution that all practices should implement. Access is a subjective term and is highly dependent on an individual patient's priorities. Absolute appointment availability, both in clinic and at home, can be increased by additional workforce, and not all clinical contacts need a GP. Within this section we analyse models that assist with two aspects of care:
    a) **Availability and proximity of care.** Some patients would prioritise being able to access general practice in the right location to suit their needs. For example, people with reduced mobility need their local practice to be physically accessible.
    b) **Timeliness of care.** Some patients would prefer to prioritise accessing GP services quickly or at a time most convenient to them, and would prioritise this over (for example) seeing a particular GP.[11]

Alternative use of technology

12. To assist the availability and proximity of care, a significant number of practices have introduced telephone triages. GP-led telephone triage is an example of demand management that is becoming increasingly used, including through a number of specific models such as 'Doctor First' and 'Patient Access'. In these models, typically a GP calls back all patients in the first instance, and then either offers a face-to-face appointment with a GP or nurse (usually on the same-day), gives advice over the phone, or issues a prescription for the patient to pick up. There is an ongoing debate (hampered by lack of sufficient evidence) about whether such systems do reduce workload. Evidence recently published from the ESTEEM study[12] (which focuses specifically on telephone triage of patients requesting same day consultations in general practice) found that the number of overall patient contacts increased, but noted a reduction in face-to-face GP contacts.[13]

13. Additionally, alternative forms of consultations have also been used such as web consultations. Compared to telephone consultations, web consultations can permit a richer interaction between a patient and their GP, as non-verbal communication can also be analysed. Also, some of these technologies could grant certain isolated groups a new means of accessing primary care services e.g. carers. However, there are limitations of the use of such technologies including information security, evidence base for reduction in workload and / or financial savings, and challenges in establishing and maintaining IT infrastructure. Furthermore, as the nature of consultations change, training methods must reflect the different skillset required for alternative forms of consultations.[14]

14. Another alternative form of patient contact can be with a specialist from secondary care. Tower Hamlets Clinical Commissioning Group designated community specialists as part

[11] Royal College of General Practitioners (2015) *Access position statement.* Unpublished paper, included in the Appendix.
[12] Prof John L Campbell et al (2014) *Telephone triage for management of same-day consultation requests in general practice (the ESTEEM trial): a cluster-randomised controlled trial and cost-consequence analysis*, The Lancet, 2014
[13] Royal College of General Practitioners (2015) *Access position statement.* Unpublished paper, included in the Appendix.
[14] Royal College of General Practitioners (2015) *Access position statement.* Unpublished paper, included in the Appendix.

of their diabetes 'Year of Care' pilot.[15] These community specialists were accessible to patients with complex diabetes via email for rapid advice regarding controlling their condition. Comparably rapid telephone advice with a designated specialist, generalist physician has also been piloted. This rapid access allows the control of complex problems without attendance to the health care system. However, provision of direct access to secondary care specialists coverall could potentially fragment overall medical care if it occurs on an ongoing basis, and requires co-ordination between the sectors that could have new implications for funding models.

Home visits

15. Home visits are an important aspect of access, as they allow patients to receive care in the convenience of their own homes. Working with district nurses and health visitors, home visits have been used by general practice to ensure that immobile patient groups are able to receive general practice care. Paramedic assessment of acutely unwell patients can provide speedy evaluation and avoid GPs having to leave surgery at short notice. For less urgent care situations, use of advanced nurse practitioners for home visits could prove useful. One solution to this challenge is closer joint working between district nurses and GP practices – for example through the use of technology to ensure that district nurses can remotely access and share information about patients with their practice. Models of direct patient to specialist services are emerging, however, these will need further analysis of cost and effectiveness.

Intermediate care

16. The provision of intermediate care is essential in our health care system to prevent unnecessary admissions and readmissions into hospital. This is of great importance to patients with long term conditions who prefer to be treated at home, as well as being economically significant. Home visits also have an important role in assisting intermediate care. There are some instances where GPs are being piloted in assisting ambulance services to make decisions regarding whether a patient can be left to stay at home or not. Additionally, step down care, provided by a multidisciplinary team, can be arranged to prevent readmissions in a variety of ways:
    a. Home-based intermediate care with nurses and other input for rehabilitation
    b. Home-based six week reablement care plans

17. One specific example of home-based intermediate care is 'Hospital@Home', a service designed to provide an alternative to hospital admission for patients who are acutely ill. Delivered by a team of GPs experienced in acute care, advanced nurse practitioners and staff nurses, this 24/7 service has resulted in almost 2,000 patients receiving their treatment in their own home, including care homes, rather than hospital. The main provider of Hospital@Home is Partners4Health, a GP-run organisation and NHS body. The name was chosen as it is fundamental to the culture of Partners4Health that effective services and support can only be delivered by providers working together and utilising the skills and resources of all providers in an integrated systematic way in order to improve care for patients.[16]

[15] Diabetes UK (2010) *Year of Care Pilot 2007 – 2010.* Accessed at: http://www.diabetes.org.uk/professionals/service-improvement/year-of-care/ 11/02/15
[16] Royal College of General Practitioners (2014) *Council Papers: Case studies – Integration of care*. Unpublished, included in Appendix.

18. Hospital@Home is a partnership between Partners4Health and:
    a. the local acute trust for diagnostics and consultant advice, enabling the development of condition specific care pathways,
    b. community providers for district nursing and therapies,
    c. the Local Authority for equipment and rapid response for personal care.

    The service has been independently reviewed and has been shown to be safe, effective and significantly less expensive than hospital care. Patient and carer feedback appears to be very positive with 793 out of 794 responders to the post discharge survey requesting Hospital@Home rather than admitted care in the future.[17]

19. Beyond home visits, general practice can also have a role in the organisation of standard intermediate care beds and transitional care. Historically, community hospitals (often run by GPs) provided this opportunity, but these have become less common in recent NHS investment. There are challenges in providing effective intermediate care, including working with Local Authorities who face budgetary challenges.

Diagnostics

20. Historically, the NHS has been good at reactive care i.e. responding to serious ill-health, rather than proactive care i.e. identifying and addressing conditions earlier. The delay in diagnostics has both financial and clinical consequences.[18] One of the barriers in diagnostics is both access to clinician time and access to diagnostic tests in the community. The introduction of physician associates for acute diagnostics of particular conditions could assist early confirmation of diagnosis. This coupled with point of care testing e.g. Hgba1c, d-dimer, C reactive protein and calcitonin precursors, would allow greater certainty in earlier diagnosis of conditions.

21. However, in order to deliver earlier diagnostics, significant investment in infrastructure to host point of care testing will be required. 'Scaling up' of such services to a larger population may be needed to justify the investment. Furthermore, training of staff so that they are able to make independent diagnostic decisions would also be required. There are also numerous other challenges in making earlier diagnostics a reality.[19]

Co-location of primary and secondary care services

22. An additional approach is to have both primary and secondary care services located in the same physical area. In particular there is an opportunity to provide secondary care services on-site at a GP practice. This has been piloted specifically for glaucoma where mobile units are able to temporarily provide screening and post-surgery follow-up services in order to reduce hospital visits.[20] This approach could also work for

[17] Royal College of General Practitioners (2014) *Council Papers: Case studies – Integration of care*. Unpublished, included in Appendix.
[18] Deloitte Centre for Health Solutions (2014) *Working differently to provide early diagnosis: Improving access to diagnostics.*
[19] *Ibid.*
[20] Royal College of General Practitioners (2014) *Co-Managing the Glaucoma Suspect in primary care.* Accessed at: http://www.rcgp.org.uk/~/media/Files/CIRC/Eye%20Health/RCGP-Comanaging-the-Glaucoma-Suspect-in-primary-care-December-2014.ashx

outpatients by the transferring of acute generalists and geriatricians into the community. It is important that specialists use practice Information Technology (IT) systems to avoid confusion and the redundancy of practice medical records. Similarly, outreach clinics by secondary care clinicians could provide referral opinions and advice in GP settings (by remote technology or by direct attendance), and this has the added advantage of strengthening collegial relationships and mutual understanding of clinical needs and best referral practice.

23. Furthermore, there are a number of examples of GPs providing expertise and value to the health care system by being attached to hospital emergency departments, particularly during the out of hours (OOH) period. This approach may reduce demand on accident and emergency (A&E) departments as it is estimated that between 15 and 26.5 per cent of A&E attendances could be treated by primary care physicians.[21] However, an issue with this approach is that patients could begin to treat A&E as a universal treatment centre perpetuating the NHS culture of reactive (and therefore more costly) care. For both co-location approaches there are cultural and organisational challenges in getting primary and secondary care professionals to work together in teams.

24. Beyond co-location, another model is multidisciplinary teams based at community hospital sites. One such example is the Emergency Multidisciplinary Unit (EMU) based in Oxford. Adult patients with acute illness can be referred by paramedics, GPs (in and OOH) and community nursing teams to the two EMU units. The units are open seven days a week and aim to provide an ambulatory treatment path for acutely ill patients, but are also able to undertake procedures that usually require day patient hospital attendance (e.g. blood transfusion). The EMUs use point of care blood tests, electrocardiograms and on site x-rays in order to determine underlying diagnosis or impact of acute illness. The EMU physiotherapists and occupational therapists can make same day assessment of the patients' mobility and safety, while the EMU social worker can access urgent crisis care packages, or respite care home placements if appropriate. EMU have very close links with the Hospital@Home service, the Integrated Locality Team, and community nurse specialists such as those for Neurology (Parkinson's Disease), Diabetes, Heart Failure, & Chronic Obstructive Pulmonary Disorder. The EMU approach emphasises the importance of transferable skills, development of advanced practice and novel GP training, the latter including GP trainee rotation in the multidisciplinary team training and a GP ST4 quality improvement fellow.[22]

Seven day services

25. Whilst there is political interest for seven day services by general practitioners, it is also important to note that there could be increased demand for other non-GP services at the weekend, for example chronic disease management clinics by nurses, physiotherapy, and phlebotomy. However, to provide this level of access additional clinical and administrative resource would be required. If these services are to be delivered by practices, there could be some challenges to align workforce timetables, IT infrastructure, appointments and patient records across different providers. Maintaining

[21] Deloitte (2014) *Spend to save: The economic case for improving access to general practice.* Accessed at: http://www.rcgp.org.uk/~/media/Files/PPF/2014-RCGP-Spend-to-Save-Deloitte-report.ashx
[22] Oxford Health Emergency Multidisciplinary Unit. Accessed at: http://www.oxfordhealth.nhs.uk/?service_description=emergency-multidisciplinary-unit. Downloaded on 11/02/15.

fairness in the allocation of appointments is also an important factor to consider. There are further considerations to be made with the formation of seven day services, for example, the potential of creating supply-induced demand and an undesirable distribution of patient contacts. It is important that the availability of seven day services should be aligned to local demand and supply.

Continuity of care

26. For the purposes of this submission, 'continuity of care' concerns the ability to see a preferred GP or nurse (relational continuity), as well as the transitions between traditional primary and secondary care services. For some patients, being able to see a GP or nurse of their choice takes priority over fast access; this may apply in particular to those with long term conditions, and within an episode of care, where continuity of care is an important factor.

27. Continuity is operationalised as relational, informational, and managerial. [23] In the context of a multidisciplinary primary care team, who have to offset acute access against planned care, and use skills appropriately, continuity can be lost, and the challenge is to retain it where it is needed. This is often when a patient has complex diagnostic and management needs, or a serious illness - including psychological vulnerability, where interpersonal dynamics over a period of time act as crucial enabler for engagement and therapeutic change. One of the measures to ensure continuity of care is to make sure that patients have a named GP and practice nurse for 'usual' contact; this can be extended to a 'usual team' model, which allow the practice some flexibility in allowing a patient to see a health professional with whom they have a prior relationship. Effective outcomes from continuity are of course also dependent on having sufficient time and skills to use the interpersonal relationship and diagnostic abilities to full effect – seeing the same doctor is an important building block, but if the patient and doctor do not have adequate time together to do the job it is not effective.

Care planning and co-ordination of care

28. Co-ordination of care is increasingly important as the proportion of the nation suffering from long-term conditions increases. Furthermore, as the prevalence of multi-morbidity rises, a more holistic approach to patient care is required. One approach to this focusses on person-centred assessments every six months, as opposed to separate reviews for individual diseases. This prevents multiple visits from patients, which can be beneficial for the patient and the practice. A wide range of health professionals have been piloted as having a role in the co-ordination of care, for example, practice nurses and community matrons. This also involves the telephone co-ordination of secondary care, where necessary. It is important to note that the inclusion of non-health professional carers in the design of any care plan is vital.

29. The use of data can also be a very useful tool in the co-ordination of care for various patient cohorts. Segmenting heterogeneous patient populations into clinically meaningful subgroups using data allows operational and core decision-making to be performed in advance. Multidisciplinary design of packages of care for these segmented patient

[23] RCGP Continuity of Care Toolkit. Accessed at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP%20CoC%20toolkit.ashx, downloaded 18/02/15

groups has both clinical and financial benefits. The defined packages of care reduce health inequalities and the use of the most cost effective competent member of staff optimises spend. Furthermore, establishing particular warning signs or data levels for individual patients can assist the management of conditions e.g. use of red flags in motor neurone disease.[24] In order to sustain effectiveness, case management practices must undergo monthly, multidisciplinary team review and challenge with relevant professionals from across the patient's treatment pathways.

30. The co-ordination of care requires significant alteration to non-clinical organisational processes. In addition, significant investment may be required before any benefits are realised. The modification of training of different health care professionals to undertake a care co-ordination role is important to ensure that it is conducted correctly. There can also be legal and financial challenges in co-ordinating care as people age and / or conditions deteriorate.

31. A specific example of continuity of care and care-planning is the 3D project run by the University of Bristol, supported by the College. The 3Ds are Dimensions of health, Drugs and Depression, which are the focus of the intervention. The intervention is designed to address the problems of illness burden (poor quality of life, depression), treatment burden (multiple uncoordinated appointments, polypharmacy, poor primary/secondary care co-ordination) and lack of patient-centred care (low continuity, disregard of patients' priorities) experienced by patients with multimorbidity. The intervention involves:

    a. Identification and prioritisation of patients with multimorbidity
    b. Improving continuity of care by having a named usual GP and practice nurse and longer appointment times
    c. Comprehensive 'person centred' assessments every six months as opposed to separate reviews for each condition. A 3D review will involve two appointments approximately a week apart. The first will be with their named practice nurse and the second with their named GP. These will follow the 3D assessment structure and bespoke computerised template.
    d. Integration with a designated general physician to provide telephone advice about complex problems and help co-ordinate hospital care

    The trial is still ongoing however its intended outcomes include: an economic evaluation to assess the cost effectiveness of the intervention; A mixed methods process evaluation to explore how and to what extent the intervention was implemented; the advantages and disadvantages of different models of care for patients with multimorbidity; and, how and why the intervention was or was not beneficial.[25]

32. In addition, effort must be made to generate patient and community activation. The promotion of self-care by patients and their communities was noted as crucial to overall

[24] Royal College of General Practitioners. Accessed at: http://www.rcgp.org.uk/clinical-and-research/circ-clinicians.aspx. Downloaded on 11/02/15.
[25] University of Bristol 3D project (2014). http://www.bristol.ac.uk/social-community-medicine/projects/3d-study/research/ Downloaded 11/02/15

better patient outcomes.[26] Public health professionals could have an important role within the primary care workforce to use their expertise to help increase patient and community activation.

Comprehensiveness of care

33. Comprehensive care is a core feature of expert medical generalism – seeing a GP who can tackle all aspects of health need. This dimension also denotes having a comprehensive service for first contact at one location (in the UK the local general practice). The 'third level' is having a full range of services available for referral and patient support. There is an important role for general practice to act as a hub, signposting patients to other services available across the health and social care system and the third sector. The co-ordination of services from secondary care and social care at primary care level is fundamental to deliver holistic care in the community – if different parts of the service are not confident of the roles and actions of others, there could be duplication and missed opportunity. Both informational continuity and health professional attitudes can be relevant here: professional training is often conducted in isolation, and one way to improve this is to ensure that training includes development of the skills and attitudes essential for collaborative working across organisational boundaries. Protected learning times for practice staff are essential for continuing professional development. There is literature on this topic and it shows that the outcomes depend, in part, on role models and work culture.[27]

34. Intermediate care focusses on two major patient flows: out of the acute bed services into community beds; and, the entry point from primary care and other health professionals to community services. One example of this model of care creates a single point of access (SPA) for primary care professionals to refer on their patient's needs. A GP can make one phone call for a needs assessment from a range of health professionals including social care, nurses, therapists, end of life care, reablement and care home support. There is no need for a GP to complete a referral form and call handling is performed by an experienced administrator or clinician. Following the call, the SPA then pass the information to the relevant team who pick up the work. This system has not replaced the GP's ability to directly refer to a team they know but it assists the GP's role as a navigator. The SPA has led to significant admission avoidance due to easier access to appropriate community services.[28]

35. The King's Fund conducted a review of case studies where specialists worked in out of hospital settings.[29] Four key interfaces for consultants working in the community it highlighted were:
    a. Consultant-run email and telephone helplines that provide advices for GPs, nurses and other health professionals

[26] Royal College of General Practitioners (2014) *An inquiry into Patient Centred Care in the 21st Century: Implications for general practice and primary care.* Accessed at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Inquiry-into-Patient-Centred-Care-in-the-21st-Century.ashx
[27] Evans J, Lambert T, Goldacre M. (2002) *GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice.* Occas Pap R Coll Gen Pract. 2002 Feb;(83):iii-vi, 1-33.
[28] Oxford Health NHS Foundation Trust. Accessed at: http://www.oxfordhealth.nhs.uk/resources/2013/04/CS-011.12-Single-Point-of-Access-leaflet.pdf. Downloaded 11/02/15
[29] Robertson R, Sonola L, Honeyman M, Brooke B, Kothari S (2014) *Specialists in out-of-hospital settings.* The King's Fund. Accessed at: http://www.kingsfund.org.uk/publications/specialists-out-hospital-settings

b. Consultant participation in multidisciplinary team meetings
c. Consultant-run education sessions
d. Consultants supporting staff to work in extended roles

New structural models of care

Governance and management structure

36. The benefits of federation (either formally or informally) with other practices is increasingly acknowledged. Federation enables practices to share resources and to focus more on the delivery of a high quality service, extended opening hours and to co-operate in developing a local general practice workforce through shared investment and shared use of existing training capacity. However, practices should maintain their individuality and clinical autonomy in order to retain workforce satisfaction, value for patients and to drive synergies that can result from being embedded in the community.[30] There are also some calls for the average practice size to increase.

37. Federations could allow the maintenance of partnership structures. To reflect the growing multidisciplinary nature of the primary care workforce, there should be opportunities for non-GPs to co-lead these structures. Non-GP members could be granted the opportunities for partnerships, or where federations occur, integrated boards could be established. These boards could include a range of healthcare professionals ranging from the following stakeholders: practice representatives; patient representatives; community nurses; mental health specialists; community geriatricians; community paediatricians; social care managers; public health specialists; financial directors; and, general managers. The optimal size of federation could range from 25,000 to 100,000 patients.[31]

Economic conditions

38. For federated practices there could be one core contract that covers the delivery of services that are currently funded through global sum, Quality Outcome Framework and Direct Enhanced Services. In addition, the owner(s) of the practice would receive additional rental payments and funding for their involvement in training. There could be a single prescribing budget, which would exclude high cost specialised drugs.

39. An additional delegated budget for community and secondary care budgets could be provided. Potentially, the federation should focus on the needs of the local population and should not compete with other organisations or providers to win contracts for the provision of services outside of their area.

[30] Royal College of General Practitioners (2014) *An inquiry into Patient Centred Care in the 21st Century: Implications for general practice and primary care.* Accessed at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Inquiry-into-Patient-Centred-Care-in-the-21st-Century.ashx
[31] Public Health Wales (2014) *Rapid review of primary care models and policy: Discussion paper for Wales.* Accessed at: http://www.gpone.wales.nhs.uk/sitesplus/documents/1000/Primary%20care%20models%20and%20policies-%20rapid%20review%20July%202014%20FINAL.pdf

Workforce development

Organisation of workforce

40. In order to develop the primary care workforce a range of skills in the community will be needed. The modern practice could have a range of skills that are currently reflected in the roles of GPs (medical generalists); nurse practitioners and practice nurses; health care assistant roles; phlebotomists; pharmacists; and, a full range of administrative staff and a high calibre practice manager. Innovative models also include care planning leads and community outreach workers. A GP federation would co-ordinate extended hours services, with larger federations of practices combining to deliver OOH services that are integrated with other urgent care services in the region.

41. Community and specialist services would be commissioned by each practice. In some instances, the individuals delivering community and specialist services could be shared between different practices. Examples of commissioned services include district nurses, community connectors, social workers, complex case managers, community matrons, health visitors, midwives, maternal and child health clinics, lifestyle coaching, speech and language therapists, community practice nurse with a mental health specialism, drug and alcohol workers, advice workers and physiotherapists. The community and specialism service provider would retain responsibility for the employment, HR and backfill of staff on leave.

42. A specific example of general practices delivering community services from general practice surgeries is the 'GPs at the Deep End' work with general practices serving Scotland's 100 most socio-economically deprived populations. This programme aims to assist GPs to find ways of tackling the inverse care law. The project has identified a range of measures to improve the care of, and outreach to, the most vulnerable and marginalised groups within GP practices' local communities. These include:

    a. targeted appointments for patients with most complex needs, combined with additional consultation time

    b. practice-attached community link workers, connecting practices and patients to community resources for health

    c. attached alcohol and mental health workers

    These ideas have been tested out through pilots such as the Glasgow Links Project, which explored opportunities to connect local citizens, primary care teams, the voluntary sector and other providers of support. Under this, 18 per cent of patients were identified as having a need for support, and in 50 per cent of cases this was for mental health or addiction services. Of those patients with an identified need, 75 per cent were signposted to a resource, and 70 per cent of those who made initial contact were still using the resource four to six weeks later.[32]

43. Given the increased complexity of federations and the opportunity to achieve efficiency savings, certain administrative and back office functions could be shared. New roles

[32] Royal College of General Practitioners (2014) *An inquiry into Patient Centred Care in the 21st Century: Implications for general practice and primary care.* Accessed at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Inquiry-into-Patient-Centred-Care-in-the-21st-Century.ashx

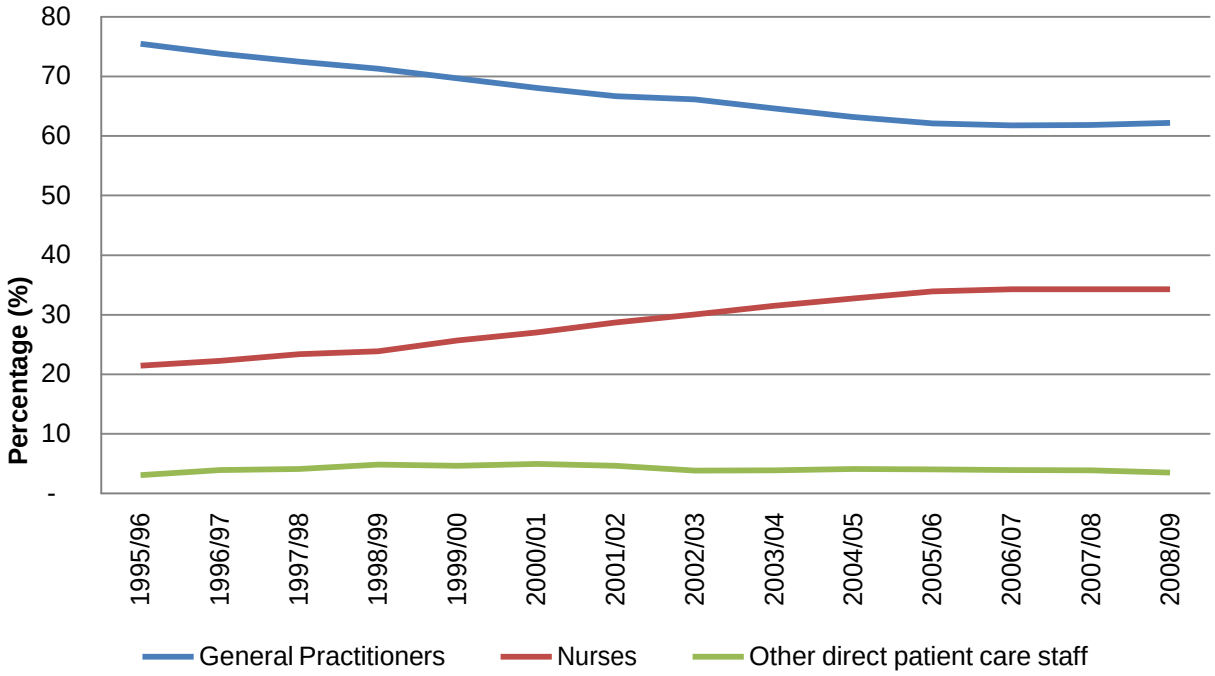
such as IT specialists and data analysts have emerged within federations in order to pool resources to drive new ways of working.

Practice skill mix

44. To resolve workforce staffing issues, there are many different models of staff mixes that have emerged. In the absence of medical professionals many practices have adapted and trained less qualified health professionals. Whilst there is a proportion of traditional GP work that can be done competently by other members of the practice team, there are questions regarding what is the ideal level of service and practice staff mix. There can be reasonable concerns about safety issues and substitution borne out of financial and recruitment constraints rather than clinically-led decisions. There is a lack of evidence regarding what the clinical outcomes of GP substitution are or will be in the future.

45. There can be no single, universal workforce solution regarding staff mix. Each locality will face different challenges due to variations in patient need, availability of health care professionals and infrastructure. Some practices in areas with lower retirements and healthy local recruitment to training pathways may choose to continue to configure their workforce to historical norms. We believe that most practices will find themselves under increasing workload pressure and will need to see their workforce skill mix evolve through necessity. A few practices could face significant challenges that will demand more radical workforce transformation and a complete redesign of primary care clinical pathways. However, whilst workforce pressures may be a stimulus for new thinking, we should be recruiting the workforce we need to deliver new models of care that are optimal for patients, not tailoring new models of care to current constrained workforce numbers. As presented in Figure 1, the practice skill mix contribution to direct patient care has changed significantly. Further evaluation of the impact this has had on clinical outcomes needs to be conducted.

Figure 1: Percentage of consultations conducted by practice staff type
1995/96 to 2008/09



46. Over the next few months, the College is conducting a workshop and developing a position paper about practice skill mix. The aim of this process is to articulate the challenges faced in this area and outline the range of potential solutions. The College is willing to submit the outcomes of this process to the Commission, if requested.

Training of workforce

47. There needs to be a multi-professional approach to training and workforce delivery. Looking at just one particular aspect of the workforce in isolation is not a realistic option. An approach that looks at the skill sharing in the workforce and skills development would appear to be the most sensible one. Clearly defined roles and standards of training for all working within primary care are essential to ensure high quality and safe care is provided to patients when they are often at their most vulnerable in locations best suited to them, though this could be used flexibly to meet the needs of the population.

48. Training capacity within general practice needs to be increased, with multidisciplinary training occurring within general practice. Nurse training capacity is an area that needs particular attention. Primary care workforce training at undergraduate and postgraduate levels can be limited by the poor availability of nurse supervisors. The process for becoming a nurse supervisor is fairly straight forward and funding is provided via the Learning Beyond Registration funding. However, the accreditation process doesn't limit the supply of nurse supervisors. A reported barrier to supply of nurse supervisors is that practices are reluctant to release nurses from patient contact time. Smaller practices in particular are less likely to release nurses. Locally practices can establish primary care

development centres to co-ordinate the facilitation of nurse training within primary care.[33] There needs to be enabling of training in general practice otherwise the volume and speed of training will not match demand.

Infrastructure, technology and data

49. To fully integrate services and to prevent fragmentation of healthcare in the community, patients should be able to access multidisciplinary teams via the general practice surgery. However, significant investment in general practice surgeries would be required to ensure that the infrastructure of the practices is able to support multidisciplinary services, and some of this may best be done at a 'community hub' level, linking with the local practices. Whilst the GP premises funding announced in the 2014 Autumn Statement is welcome, there should be co-ordination between this review and NHS England's new models of care programme to ensure that public finances are not wasted on infrastructure projects designed for traditional ways of working.

50. A large challenge in multidisciplinary working is ensuring that patient records can be shared effectively between different team members. A key challenge for this is IT infrastructure and ensuring that different systems are able to interact. It is essential that every practice within a federation uses a common IT system or systems that are compatible. Capability with the IT systems of other services e.g. community health, is also vital.

51. The collection of effective medical data can drive improvements in the quality of patient data. By using coding from EMIS, performance dashboards for the management of patient cohorts with long term diseases can be created. It is also vital that patient registration data is maintained up to date especially email and mobile telephone contact details as patients move away from postal communications.

[33] Primary Care Development Centre. Accessed at: http://www.pcdc.org.uk/about-us/standing-advisory-groups. Downloaded 11/02/15

Quantitative workforce planning

52. To deliver any of the above models of care, it is of utmost importance that the current shortfall of GPs is addressed and that there is a commitment to sufficient supply of GPs in the future. It is vital that HEE or an independent body works with interested parties to conduct detailed quantitative analysis, to allow the development of a consensus on the number of GPs needed to work within and deliver these new models of care. This section will outline the College's initial work in estimating what the shortfall in the number of GPs in England is and how many will be needed by 2020.

53. There are numerous methods to estimate if there is a shortage of GPs in England. To date, the College has segmented this approach into two time frames i.e. estimating the current GP shortage and estimating the long-term number of GPs required.

54. Short term estimates are generated using two key approaches:

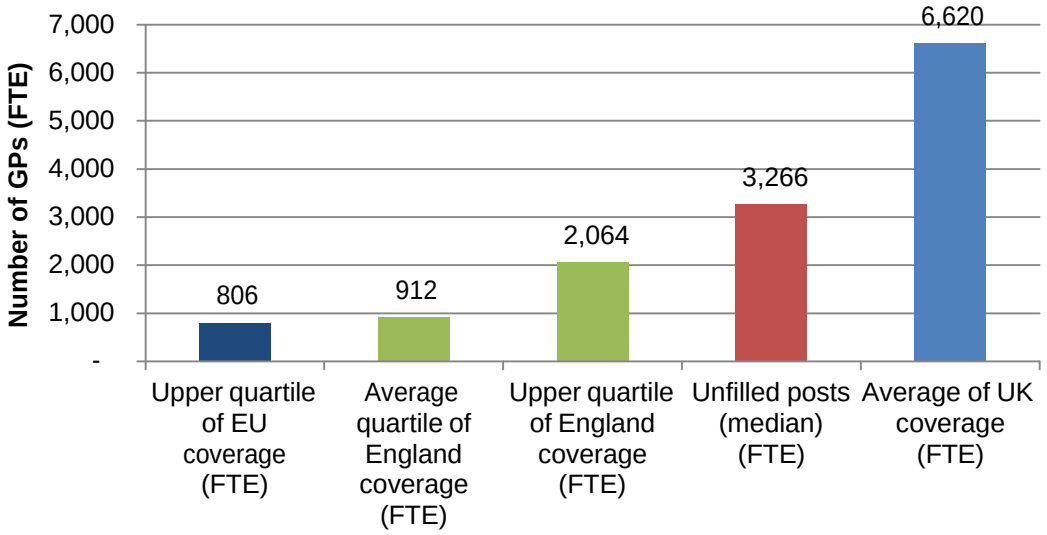
    a. **Approach A:** The current shortage in GPs is mainly driven by supply-side factors of attrition, unfilled posts and lack of trainee doctors
    b. **Approach B:** The current shortage in GPs can be attributed by benchmarking against different coverage levels e.g. vs. England, UK and Europe

55. To estimate the current shortage of GPs four methodologies have been used:
    a. Increasing England's coverage to the upper quartile of EU coverage
    b. Increasing England's coverage to the average and upper quartile of England coverage
    c. Estimating the current shortfall using estimates of vacancy data i.e. unfilled posts
    d. Increasing England's coverage to the average of UK coverage

56. The preferred estimate of current shortfall is using estimates of vacancy rate data because the other methodologies are normative and subject to change. Furthermore, comparisons against other European countries can be difficult due to the differences in primary care systems. HEE's GP Taskforce report states that vacancy rates have grown fourfold in the last three years – 'The results showed vacancy rates of 7.9 per cent of all GP posts in January 2013 – almost double the 4.2 per cent figure from the previous year's survey in January 2012, which itself was twice the Department of Health baseline figure of 2.1 per cent from the last survey in 2010.'[34] The College uses a reasonable estimate of 9.0 per cent vacancy rates in 2014, which results in a shortfall of circa 3,200 GPs.

[34] Health Education England (2014) *Securing the Future GP Workforce Delivering the Mandate on GP Expansion: GP Taskforce Final Report.* Accessed at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/07/GP-Taskforce-report.pdf

Figure 2: Estimated current shortfall of general practitioners, England, Full time Equivalent (FTE), 2013



57. To estimate the long-term shortfall is a complex question with the analysis of numerous supply and demand factors required. The College suggests using the Scenario 4 estimate by the CfWI to estimate the long-term need. The College believes that this is the best reflection of the current situation in general practice i.e. 'professionally driven workforce development and perceived decrease in the status and attractiveness of the GP profession'. The scenario forecasts a shortfall in 2020 of approximately 3,000. This is the same estimate used in the HEE Workforce plan.[35]

58. However, in the discussion the CfWI also model the impact of two probable supply shocks; decrease in GP retirement age and increased emigration from the UK workforce. Reduction in GP median retirement age from 59 to 58 creates an additional shortage of approximately 430 FTE in 2018. Whereas, increased emigration could create a further reduction of supply to about 1,000 by 2020. The evidence base for these supply shocks occurring is widely documented. Therefore if you add these estimates to the Scenario 4 total, the long term undersupply by 2020 could be in the region of 4,500. This long term estimate coupled with the short term estimate suggests a GP shortage of 7,700 in England shortage.

59. The inclusion of these supply shocks are supported by numerous sources of evidence:
    a. The reduction in retirement age is supported by a British Medical Association (BMA) survey, which 'found that that in the past year around 57 per cent of GPs responding said they had considered retiring early, 28 per cent had considered leaving the profession entirely, and 24 per cent had considered working overseas.'[36] It is also supported by evidence quoted by HEE's GP Taskforce, which states 'that the proportion of GPs expecting to quit direct patient care in the

[35] Health Education England (2015) *Workforce Plan for England. Proposed Education and Training Commissions for 2014/15.* Accessed at: http://nwl.hee.nhs.uk/files/2014/04/HEE-Workforce-plan-14-15.pdf
[36] Centre for Workforce Intelligence (2014) In-*depth Review of the General Practitioner Workforce.* Accessed at: http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce

next five years had increased from 6.4 per cent in 2010 to 8.9 per cent in 2012 amongst GPs under 50 years-old and from 41.7 per cent in 2010 to 54.1 per cent in 2012 amongst GPs aged 50 years and over.' [37,38]

b. The State of Medical Education and Practice report found that emigration is one of the two most common reasons for doctors leaving the workforce. It also highlights that proxy indicators suggest that the number of UK graduates leaving to work abroad is increasing. A key indicator for doctor emigration is the number of applications for Certificates of Good Standing. Applications for certificates have risen by 22 per cent since 2008, with doctors aged between 24 and 27 years old forming the majority of the applicants. In 2013, destinations were predominately to two countries – Australia and New Zealand (51 per cent). A further 9.7 per cent went to Canada, 8 per cent went to three countries in east Asia (Hong Kong, Malaysia and Singapore), 6.7 per cent went to Ireland and 4.9 per cent went to the United Arab Emirates.[39] Further research should be conducted.

60. It is important to note that the CfWI report itself states that its forecast baseline is probably underestimated: 'baseline demand for GP services is projected to increase by 10.75 per cent (or 0.6 per cent per annum) on a FTE basis between 2013 and 2030, based on two drivers: population growth and the changing age and gender composition of the population, particularly the increase in older people. However, as the baseline does not include changes in patient expectations, the rise of multiple morbidities and case complexity, or the potential impact of greater prevalence of non-age-related long-term conditions, such as obesity or diabetes, it most likely underestimates future patient demand for GP services.'[40]

61. There has also been a historical imbalance between consultant and GP recruitment. In 2014, there were 32,628 GPs (excluding retainers and registrars, full time equivalent) and 40,443 Consultants (including Directors of Public Health, full time equivalent) recruited. Compared to 2004, this represents an annual average growth of 1.7 per cent and 3.7 per cent respectively.[41] In addition to this, 'there were 2,814 level one entry posts for GP training compared to 4,143 level one entry posts for a Consultant medical career (i.e. other specialty training). The ratio of level one entry points to CCT holders suggest that we are replacing 7.9 per cent of the GP workforce annually compared to 10.3 per cent of the Consultant workforce replaced annually.'[42]

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[37] Centre for Workforce Intelligence (2014) In-*depth Review of the General Practitioner Workforce.* Accessed at: http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce

[38] Health Education England (2014) Securing the Future GP Workforce Delivering the Mandate on GP Expansion: GP Taskforce Final Report. Accessed at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/07/GP-Taskforce-report.pdf

[39] General Medical Council (2014) *State of Medical Education and Practice 2014*. Accessed at: http://www.gmc-uk.org/publications/25452.asp

[40] Centre for Workforce Intelligence (2014) In-*depth Review of the General Practitioner Workforce.* Accessed at: http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce

[41] Health and Social Care Information Centre (2014) *General and Personal Medical Services, England - 2004-2014, As at 30 September.* Accessed at: http://www.hscic.gov.uk/catalogue/PUB16934.

[42] Health Education England (2014) Securing the Future GP Workforce Delivering the Mandate on GP Expansion: GP Taskforce Final Report. Accessed at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/07/GP-Taskforce-report.pdf

62. Analysis to date is also limited because it has looked at general practice in isolation from staff mix. There could be shortages in other members of the primary care workforce team but data availability is poor. For example, there has been an overall downward trend in the number of nurse training places since 2010/11.[43] The CfWI's baseline projection for supply and demand demonstrates a possible shortfall of registered nurse headcount by 2016.[44] There is evidence to suggest that varying staff mix and roles of other professionals (clinical and other) could have a significant impact on the demand for GP services and therefore on the number of GPs required in the short and long-term. However, whilst different skill mixes have arisen, these should not necessarily be considered as ideals as in some localities they are consequences of a failure to have sufficient workforce planning and investment. Regardless, investment in the recruitment of GPs is needed to ensure delivery of new models of care and to address significant workforce issues including workload, patient safety and recruitment.

63. It is noted that HSCIC has made improvements to the collection of workforce data on other members of the practice team. Analysis on the number of full time equivalent practice nurses between 2013 and 2014 has shown a growth of 8.6 per cent in the number of advanced nurse practitioners and a reduction in the number of overall practice nurses of 2.1 per cent. Whilst growth in the number of advanced nurse practitioners is welcome the overall increase of 0.8 per cent in the number of nurses could be insufficient given the rise in general practice demand.[45] Furthermore, there is no consensus or clarity on the definitions between 'extended', 'advanced' or 'practice' nurses. Further work must be done to ensure clarity around definitions (potentially including career frameworks), with analysis of the impact this has on workforce planning. There is also a need to increase nurse training capacity with increased mentors and trainers and to standardise nurse training.

[43] Royal College of Nursing (2014) *Nurse training places creeping up after dire warnings of shortages.* Accessed at: http://rcnpublishing.com/doi/pdfplus/10.7748/ns2014.04.28.33.14.s16
[44] Centre for Workforce Intelligence (2013) *Horizon scanning – A strategic review of the future healthcare workforce: Informing the nursing workforce.* Accessed at: http://www.cfwi.org.uk/news/publications/horizon-scanning-a-strategic-review-of-the-future-healthcare-workforce-informing-the-nursing-workforce/
[45] Health and Social Care Information Centre (2014) *General and Personal Medical Services, England - 2004-2014, As at 30 September.* Accessed at: http://www.hscic.gov.uk/catalogue/PUB16934.

Key recommendations

64. This section outlines the key recommendations that the College believes are essential to design a primary care workforce that is able to deliver the new models of care and ways of working outlined above. These recommendations are organised into the following categories: workforce planning; recruitment; training; and, retention.

Workforce planning

a) **Increased collection of workforce data.** HSCIC are undertaking a review of primary care workforce data collection and the College looks forward to the results of this process. The outcome of this consultation is intended to be published in February 2015. We welcome the intention of the consultation, however, further comment cannot be made until it is published. There is an urgent need for better primary care data to underpin better understanding of workforce numbers and activity. To highlight the poor collection of primary care data, the last official collection of GP consultation rates in England was in 2008/09 and the last vacancy rate data was collected in 2010. This is in stark contrast to the weekly publication of secondary care activity data. The use of EMIS and other practice software as a source of accurate workforce and activity data should be explored and potentially funded. In addition, there needs to be analysis of the overall competencies for professional roles and any provisions that may be needed for innovation.

b) **Quantitative forecasting of workforce numbers.** Given the length of time it takes to train a GP and other healthcare professionals, quantitative analysis of workforce requirements in the future must be undertaken, based on new models rather than old.

c) **Evaluation of the relevant competencies for different health and care roles.** There is a lack of clarity regarding the distinctions between certain professional roles and evaluation of the relevant competencies and accreditations required would assist in workforce planning.

Recruitment

d) **Cultural change to encourage recruitment to general practice.** There is a body of evidence that highlights that some of the perceived deterrents to choosing general practice as a career were its portrayal, by some hospital-based teachers, as a second class career compared to hospital medicine.[46]

e) **Stabilisation of GP careers –** NHS England's Five Year Forward View set out a clear vision that put general practice at the centre of the health care system and outlined a new deal for general practice and primary care. Decisive action to implement the joint Action Plan by NHS England, HEE, BMA and the College is required to inspire confidence in training medics to choose general practice. In addition, building on HEE's work with the Royal College of Nursing and

[46] Evans J, Lambert T, Goldacre M. (2002) *GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice.* Occas Pap R Coll Gen Pract. 2002 Feb;(83):iii-vi, 1-33.

universities, we would welcome a programme that provides ready and easy access to conversation courses for GPs and other professionals who wish to switch from the acute sector to the community.[47] There also needs to be further clarity regarding the funding of training for non-GP health professionals.

f) **Greater exposure to general practice at undergraduate and foundation school level.** For example, in 2014, zero per cent of F1 doctors rotated through general practice in their training and 43.3 per cent of F2 doctors experienced general practice.[48] This is despite the findings that including general practice throughout medical education is the most effective way of making general practice more attractive.[49]

g) **Review of incentives to attract locum doctors.** There is a lack of data available on locum doctor usage and availability. However, usage is reported to have increased.[50] Further research should be done to evaluate the scale and cost of locum usage and also what incentives can be designed to encourage locum doctors to join the general practice workforce.

h) **Review of underlying reasons why UK graduates emigrate to other countries.** There is a urgent need to understand why UK graduates do not wish to practice in the UK and also what differences in work conditions keep them abroad. An anecdotal survey performed by an expatriate GP highlighted favourable comparisons for autonomy, stress and consultation length in comparing general practice in the UK and Australia.[51]

i) **Incentivising practices to recruit / commission a wider variety of health care professionals in new roles.** Incentives should be designed to promote practices to integrate different healthcare professionals into their practice teams. Examples of different staff members include district nurses, social workers, community matrons, health visitors etc.

Training

j) **Increased GP training capacity, especially in our underserved areas.** Delivering the number of GPs and/or primary care professionals will need significant expansion to training capacity. This may require increased incentive packages to potential GP trainers and a review of GP training models. The

[47] Department of Health (2014) *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the Government to Health Education England: April 2014 to March* 2015. Accessed at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/310170/DH_HEE_Mandate.pdf
[48] UK Foundation Programme (2014) *Annual Report 2014.* Accessed at: http://www.foundationprogramme.nhs.uk/index.asp?page=home/keydocs
[49] The characteristics of general practice and the attractiveness of working as a GP: medical students´ views 2014 Mar http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4207180/
[50] Centre for Workforce Intelligence (2014) In-*depth Review of the General Practitioner Workforce.* Accessed at: http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce
[51] GPs Down Under (2015). Accessed at: http://gpsdownunder.com/learning/forum-learning-gems/categories/listings/life-as-a-gp-in-australia-and-the-uk-a-comparison. Downloaded 11/02/15

geographical distribution of GPs is linked to regional training capacity and programmes, with most GPs taking their first job in their region of training.[52]

k) **Increased nurse training capacity with co-ordinated structure and funding.** Primary care workforce training at undergraduate and postgraduate levels can be limited by the poor availability of nurse supervisors. Central funding and co-ordination should enable sufficient training capacity.

l) **Funded education and advanced training provision for current and new Allied Health Practitioners, Health Care and 'Medical' Assistants.** Apprenticeships for health care assistant and business administration apprenticeship roles should also be included.

m) **Funded education and training provision for administrative and practice manager roles.** As the complexity of general practice care and organisation changes, it is vital that the back office functions are led by highly competent staff.

n) **Review of funding for GP training.** Whilst it is 'cheaper' to train a GP than to train a consultant, in terms of the cost per output; the annual cost of GP training is greater than the annual costs of training a trainee in a secondary care specialty. Training costs for secondary care are contained within service level agreements and it requires greater notice to vary the value of contracts than it does to extract savings from GP training. A review of the incentives and financial reimbursement (especially service level increment for training, 'SIFT') for becoming a training practice should be conducted to ensure that practices aren't financially discouraged from doing so.

o) **Review of training content for health professionals who will have a more active role within the future delivery of primary care.** Changes to ways of working will mean that health care professionals will work in non-traditional roles, which will require non-traditional skills. A review of the standards and content of training courses should be conducted to ensure that training is still fit for purpose.

Retention

p) **Invest in occupational health and GP morale.** There needs to be a dedicated programme to understand the drivers of GP attrition. In addition, access to greater occupational health programmes should be funded to assist doctors in managing their occupational health needs. Potentially, there should be encouragement and financial support for structured sabbaticals for at-risk doctors to prevent long-term attrition. The charity Royal Medical Benevolent Fund provides some funding towards financial support in addition to the central funding provided by NHS England. Better GP morale could also boost recruitment, the perception of low morale amongst current GPs was a key deterrent for graduates

[52] Centre for Workforce Intelligence (2014) In-*depth Review of the General Practitioner Workforce.* Accessed at: http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce

to choose general practice as a career. [53] Despite common perceptions, financial remuneration was low on the motivations for people to select general practice. [54]

q) Establish clearer workload management guidelines. This will prevent GP burnout and assist in the positive perception of general practice as a career. One of the most popular reason people choose general practice as a career was its perceived compatibility with a work-life balance.

r) Career structures for non-GP primary care workforce members. Professional practice management skills and flexible career structure. The Calderdale framework can help in identifying an appropriate skill mix and improved career structures.[55]

Innovation

s) Funding for research at practice paid from other funds. Novel models of care are continually created by frontline workers, however, additional funds should be provided for practices to have dedicated primary care based researchers that look at research across all of the professions.

[53] Evans J, Lambert T, Goldacre M. (2002) *GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice.* Occas Pap R Coll Gen Pract. 2002 Feb;(83):iii-vi, 1-33.
[54] Hamilton, W. (2011). Motivation and satisfaction in GP training: a UK cross-sectional survey. *The British Journal of General Practice*, *61*(591), e645–e649. doi:10.3399/bjgp11X601352
[55] The Calderdale Framework (2015) Accessed at: http://www.calderdaleframework.com/the-framework/ Downloaded 11/02/15

PRIMARY CARE WORKFORCE COMMISSION

Submission of evidence by the Royal College of General Practitioners

Thursday 2nd April 2015

Contents

Executive summary

Introduction and background

1. The Royal College of General Practitioners (RCGP, or 'the College') welcomes the opportunity to respond to the Primary Care Workforce Commission. The RCGP is the largest membership organisation in the United Kingdom solely for general practitioners (GPs). We gratefully acknowledge the contributions of our members in formulating this response.

2. Primary care, and specifically general practice, faces numerous challenges in delivering care. These challenges cover changes in population demographics, complexity of care, workforce demographics and funding constraints. In order to sustain the delivery of care to primary care, new models of care need to be invested in and implemented. A selection of novel approaches is presented below. For ease of examination, a distinction between 'new models of care' has been made. New 'clinical' models of care pertain to changes in the approaches and ways of working by the primary care workforce in delivering patient contacts. New 'structural' models of care relate to changes in the organisational design of primary care and their potential relationship to financial and contractual arrangements which may underpin different models. The RCGP strongly believes that knowing the number of GPs and other health care professionals required to provide an effective workforce is essential to delivering new models of care. Therefore we have submitted some evidence regarding this as part of this submission.

New clinical models of care

3. New clinical models of care can be viewed according to four dimensions: access; continuity of care; care planning and coordination of care; and, comprehensiveness of care. These are expected to achieve the composite goal of good quality care.

4. 'Access' is both an objective and subjective term – whether it is satisfactory depends on both experience and on an individual patient's priorities, which vary from proximity and availability of care to timeliness of care. Absolute appointment availability, both in clinic and at home, can be increased by additional workforce, and not all clinical contacts need a GP. New approaches to achieve proximity and availability of care use technology in the form of telephone, Skype and email consultations. The modernisation of home visits by use of technology and new clinical professionals has been key in providing care to isolated patients. Increased access to diagnostic testing in the community, to allow earlier diagnosis and routine monitoring, can also assist new ways of working.

5. Continuity is operationalised as relational, informational, and managerial. In the context of a multidisciplinary primary care team, who have to offset acute access against planned care, and use skills appropriately, continuity can be lost, and the challenge is to retain continuity where it is needed. This is often when a patient has complex diagnostic and management needs, or a serious illness. One of the measures to ensure continuity of care is to make sure that patients have a named GP and practice nurse for 'usual' contact; this can be extended to a 'usual team' model, which allows the practice some flexibility in allowing a patient to see a health professional with whom they have a prior relationship. Effective outcomes from continuity are of course also dependent on having sufficient time and skills.

6. Care planning and co-ordination of care is increasingly important as the proportion of the nation suffering from long-term conditions increases. A wide range of health professionals have been piloted as having a role in the co-ordination of care, for example, practice nurses and community matrons. This also involves the time, ability, and technology to link and co-ordinate with other services and professionals, where necessary. Care planning is a current approach that is being proposed to allow informational continuity and personalised care. It is important to note that the inclusion of 'non-health' professional carers in the design of any care plan is vital. The use of patient data can also be a very useful tool in the co-ordination of care for various patient cohorts. The co-ordination of care can also require significant alteration to non-clinical organisational processes – for example, records access and appointment allocation. In addition, significant investment may be required before any benefits are realised.

7. Comprehensive care is a core feature of expert medical generalism – seeing a GP who can tackle all aspects of health need. There is an important role for general practice to act as a hub, signposting patients to other services available across the health and social care system and the third sector. Comprehensiveness of care at this level can only be achieved through joint working. Development and evaluation of networked and collaborative models of care is required.

New structural models of care

8. Structural models of care can be viewed in terms of their governance and management structure; economic conditions; workforce personnel; and, infrastructure, technology and data.

9. Federated structures enable practices to share resources and to focus more on the delivery of a high quality service, extend opening hours and to co-operate in developing a local general practice workforce through shared investment and shared use of existing training capacity. To reflect the growing multidisciplinary nature of the primary care workforce, there should be opportunities for non-GPs to co-lead these structures via boards or partnerships.

10. The modern primary care workforce already offers a range of skills in the community, and this needs both consolidation and further development. GP federations can co-ordinate extended opening hours, with larger federations of practices combining to deliver extended clinical and integrated out of hours (OOH) services. Different approaches to practice staff mix would be required in different areas and training of all primary care workforce personnel will have to be expanded and altered.

11. To fully integrate services and to prevent fragmentation of healthcare in the community, patients should be able to access a range of multidisciplinary services via the general practice surgery. However, significant investment in general practice surgeries will be required to ensure that the infrastructure of the practices is able to support multidisciplinary services. A large challenge in multidisciplinary working is ensuring that patient records can be shared effectively between different members of the extended team. Another challenge for this is Information Technology (IT) infrastructure and ensuring that different systems are able to interact. The collection of effective medical data can drive improvements in the quality and use of patient data.

Quantitative workforce planning

12. To deliver any of the above models of care, it is of utmost importance that Health Education England (HEE) addresses the current shortfall in GPs and ensures that there is sufficient supply of GPs in the future. It is vital that HEE or an independent body works with interested parties to conduct detailed quantitative analysis. There are numerous methods to estimate if there is a shortage of GPs in England.

13. The College estimates current GP shortage using extrapolations of GP vacancy rate data. The College uses the Centre for Workforce Intelligence (CfWI) estimate of a 3,000 GP shortfall by 2020. However, the CfWI also model the impact of two probable supply shocks: decrease in median GP retirement age and increased emigration from the UK workforce. All of these estimates suggest a shortage of GPs in England of approximately 7,700. It is also important to note that the CfWI report itself states that its forecast baseline most likely underestimates future patient demand for GP services. Investment in the recruitment of GPs is needed to ensure delivery of new models of care and to address significant workforce issues including workload, patient safety and recruitment.

Recommendations

14. Key recommendations that the College believes are essential to design a primary care workforce that is able to deliver the new models of care and ways of working include:
    - **a) Workforce planning**
        i. Increased collection of workforce data
        ii. Quantitative forecasting of workforce numbers
        iii. Evaluation of the relevant competencies for different health and care roles
    - **b) Recruitment**
        i. Cultural change to encourage recruitment to general practice
        ii. Stabilisation of GP careers
        iii. Greater exposure to general practice at undergraduate and foundation school level
        iv. Review of incentives to attract locum doctors
        v. Review of underlying reasons why UK graduates emigrate to other countries
        vi. . Incentivising practices to recruit / commission a wider variety of health care professionals in new roles
    - **c) Training**
        i. Increased GP training capacity, especially in our underserved areas
        ii. Increased nurse training capacity with co-ordinated structure and funding
        iii. Funded education and advanced training provision for current and new Allied Health Practitioners, Health Care and ‘Medical’ Assistants
        iv. . Funded education and training provision for administrative and practice manager roles
        v. Review of funding for GP training
        vi. Review of training content for health professionals who will have a more active role within the future delivery of primary care
    - **d) Retention**
        i. Invest in occupational health and GP morale
        ii. Establish clearer workload management guidelines
        iii. Career structures for non-GP primary care workforce members
    - **e) Innovation**
        i. Funding for research at frontline practices

Introduction

1. The Royal College of General Practitioners (RCGP, or 'the College') welcomes the opportunity to respond to the Primary Care Workforce Commission. The recommendations from the Commission will form a key part of NHS England (NHSE) and Health Education England (HEE)'s responses to the challenges faced by primary care in responding to changing patient demand. The RCGP is the largest membership organisation in the United Kingdom (UK) solely for general practitioners (GPs). Founded in 1952, it has over 50,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient-centred generalist clinical care. We maintain close links with other professionals working in primary care, such as practice managers, nurses and physician assistants. We gratefully acknowledge the contributions of our members in formulating this response.

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

Background

3. Primary care, and specifically general practice, faces numerous challenges in delivering care. These challenges cover changes in population demographics, complexity of care, workforce demographics and funding constraints.

4. The UK population is projected to grow by approximately seven per cent between 2012 and 2022. The greatest relative expansion in the UK population is the growth of patients aged over 80 years old. Patients aged over 80 consult four times more often than the average patient and have more complex needs. There is also strong evidence that the overall care general practice is required to deliver is becoming more complex. The number of people living with more than one long term condition is expected to rise from 1.9 million in 2008 to 2.9 million by 2018. [1] There is evidence that around 65 per cent of those over 65 are living with multiple morbidity.

5. The general practice workforce is also ageing. Deloitte's Centre for Health Solutions argued that the greatest supply challenge facing primary care is the average age profile

[1] Department of Health (2012) *Long term Conditions Compendium of Information. (Third Edition).* Accessed at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

of GPs.[2] The proportion of GPs aged 55 and over rose from 17.5 per cent in 2000 to 21.9 per cent in 2014. It is also concerning that 54 per cent of GPs over the age of 50 are intending to leave direct patient care within five years.[3] Additionally, the practice nurse workforce is also ageing. A review in 2009 found that a disproportionate number of primary care nurses are expected to retire within five to ten years.[4]

Table 1: Proportion of GPs aged 55 years or over, 2014[5]

Country	Percentage of GPs aged 55 or over
England	21.9
Scotland	19.6
Wales	23.0
Northern Ireland	24.0

6. The proportion of GP posts filled is also an area of concern: 'the Health and Social Care Information Centre (HSCIC) GP vacancy survey was suspended in 2010. In the absence of centrally collected data the most useful proxy is a snapshot survey conducted in February 2013 of 220 practices, covering around 950 full-time positions. It suggested that the number of unfilled GP posts has gone up fourfold in the last two years: The results showed vacancy rates of 7.9 per cent of all GP posts in January 2013 – almost double the 4.2 per cent figure from the previous year's survey in January 2012, which itself was twice the Department of Health baseline figure of 2.1 per cent from the last survey in 2010.' [6] This is reflected in qualitative evidence from GPs and providers of GP services.

7. These challenges to workload and ageing workforce have also correlated with a decline of investment in general practice. Research undertaken by Deloitte shows that funding to general practice in England as a share of total NHS funding has decreased from 11.0 per cent in 2004/05 to 8.5 per cent in 2011/12.[7] Applying the same methodology as Deloitte, the College has estimated that funding for general practice has fallen further to 8.4 per cent in 2012/13.

[2] Deloitte (2012) *Primary care: Today and tomorrow, improving general practice by working differently.* Accessed at: http://www2.deloitte.com/uk/en/pages/life-sciences-and-healthcare/articles/primary-care.html
[3] Health Education England (2014) *Securing the Future GP Workforce Delivering the Mandate on GP Expansion: GP Taskforce Final Report.* Accessed at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/07/GP-Taskforce-report.pdf
[4] Deloitte (2012) *Primary care: Today and tomorrow, improving general practice by working differently.* Accessed at: http://www2.deloitte.com/uk/en/pages/life-sciences-and-healthcare/articles/primary-care.html
[5] Health and Social Care Information Centre (2014) *General and Personal Medical Services, England - 2003-2013, As at 30 September.* Accessed at: http://www.hscic.gov.uk/catalogue/PUB13849
[6] Health Education England (2014) *Securing the Future GP Workforce Delivering the Mandate on GP Expansion: GP Taskforce Final Report.* Accessed at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/07/GP-Taskforce-report.pdf
[7] Deloitte (2014) *Under Pressure: The funding of patient care in general practice*. Accessed at: http://www.rcgp.org.uk/campaignhome/~/media/Files/PPF/Deloitte%20Report_Under%20Pressure.ashx

8. It is important to note that there are significant health inequality challenges in primary care. It is well-documented that the prevalence of multi-morbidity increases with deprivation, with people in deprived areas having the same prevalence of multi-morbidity as more affluent patients who are 10 to 15 years older. In particular, physical and mental health comorbidity has been shown to be almost twice as common in the most deprived compared with the most affluent areas.[8]

9. However, there is significant disparity in the provision of primary care workforce across the country. The Centre for Workforce Intelligence (CfWI) notes that 'health inequalities caused by the imbalance in the local and regional distribution of GPs and other primary care workers has been an enduring policy issue since the founding of the NHS.

> *'Prosperous rural and suburban areas may find it easier to recruit GPs than deprived urban or isolated, poorer rural areas. Poor local amenities, smaller practices and a higher workload generated by a disadvantaged population act as disincentives for GPs to work in such areas. Likewise, a National Audit Office report on health inequalities found: The number of GPs in areas with the greatest health needs has increased in recent years but GP levels, weighted for age and need, are still lower in deprived areas.'*[9]

10. In order to sustain the delivery of primary care, new models of care need to be invested in and implemented. The modern primary care workforce already offers a range of skills in the community, and this needs both consolidation and further development. A selection of possible approaches is presented below. For ease of examination, a distinction between 'new models of care' has been made. New 'clinical' models of care pertain to changes in the approaches and ways of working by the primary care workforce in delivering patient contacts. Alongside these, new 'structural' models of care relate to changes in the organisational design of primary care. To assist the analysis of these two distinct types of change, a modified version of the framework developed by Kringos has been used.[10] New clinical models of care are analysed according to four dimensions: access; continuity of care; coordination of care; and, comprehensiveness of care. Similarly, structural models of care are categorised in terms of governance and management structure; economic conditions; workforce personnel; and, infrastructure, technology and data.

[8] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. (2012) *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study.* Lancet 2012; published online May 10. DOI:10.1016/S01406736(12)602402.
[9] Centre for Workforce Intelligence (2014) *In-depth Review of the General Practitioner Workforce.* Accessed at: http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce
[10] Kringos D, Boerma W, Bourgueil Y et al. (2013) *The strength of primary care in European internal comparative study* Br J Gen Pract 2013; DOIL 10.3399/bjgp13X674422 http://bjgp.org/content/63/616/e742.full.pdf+html

New clinical models of care

Access

11. There is no single definition of good 'access' to general practice, nor a universal solution that all practices should implement. Access is a subjective term and is highly dependent on an individual patient's priorities. Absolute appointment availability, both in clinic and at home, can be increased by additional workforce, and not all clinical contacts need a GP. Within this section we analyse models that assist with two aspects of care:
    a) **Availability and proximity of care.** Some patients would prioritise being able to access general practice in the right location to suit their needs. For example, people with reduced mobility need their local practice to be physically accessible.
    b) **Timeliness of care.** Some patients would prefer to prioritise accessing GP services quickly or at a time most convenient to them, and would prioritise this over (for example) seeing a particular GP.[11]

Alternative use of technology

12. To assist the availability and proximity of care, a significant number of practices have introduced telephone triages. GP-led telephone triage is an example of demand management that is becoming increasingly used, including through a number of specific models such as 'Doctor First' and 'Patient Access'. In these models, typically a GP calls back all patients in the first instance, and then either offers a face-to-face appointment with a GP or nurse (usually on the same-day), gives advice over the phone, or issues a prescription for the patient to pick up. There is an ongoing debate (hampered by lack of sufficient evidence) about whether such systems do reduce workload. Evidence recently published from the ESTEEM study[12] (which focuses specifically on telephone triage of patients requesting same day consultations in general practice) found that the number of overall patient contacts increased, but noted a reduction in face-to-face GP contacts.[13]
13. Additionally, alternative forms of consultations have also been used such as web consultations. Compared to telephone consultations, web consultations can permit a richer interaction between a patient and their GP, as non-verbal communication can also be analysed. Also, some of these technologies could grant certain isolated groups a new means of accessing primary care services e.g. carers. However, there are limitations of the use of such technologies including information security, evidence base for reduction in workload and / or financial savings, and challenges in establishing and maintaining IT infrastructure. Furthermore, as the nature of consultations change, training methods must reflect the different skillset required for alternative forms of consultations.[14]
14. Another alternative form of patient contact can be with a specialist from secondary care. Tower Hamlets Clinical Commissioning Group designated community specialists as part

[11] Royal College of General Practitioners (2015) *Access position statement.* Unpublished paper, included in the Appendix.
[12] Prof John L Campbell et al (2014) *Telephone triage for management of same-day consultation requests in general practice (the ESTEEM trial): a cluster-randomised controlled trial and cost-consequence analysis*, The Lancet, 2014
[13] Royal College of General Practitioners (2015) *Access position statement.* Unpublished paper, included in the Appendix.
[14] Royal College of General Practitioners (2015) *Access position statement.* Unpublished paper, included in the Appendix.

of their diabetes 'Year of Care' pilot.[15] These community specialists were accessible to patients with complex diabetes via email for rapid advice regarding controlling their condition. Comparably rapid telephone advice with a designated specialist, generalist physician has also been piloted. This rapid access allows the control of complex problems without attendance to the health care system. However, provision of direct access to secondary care specialists coverall could potentially fragment overall medical care if it occurs on an ongoing basis, and requires co-ordination between the sectors that could have new implications for funding models.

Home visits

15. Home visits are an important aspect of access, as they allow patients to receive care in the convenience of their own homes. Working with district nurses and health visitors, home visits have been used by general practice to ensure that immobile patient groups are able to receive general practice care. Paramedic assessment of acutely unwell patients can provide speedy evaluation and avoid GPs having to leave surgery at short notice. For less urgent care situations, use of advanced nurse practitioners for home visits could prove useful. One solution to this challenge is closer joint working between district nurses and GP practices – for example through the use of technology to ensure that district nurses can remotely access and share information about patients with their practice. Models of direct patient to specialist services are emerging, however, these will need further analysis of cost and effectiveness.

Intermediate care

16. The provision of intermediate care is essential in our health care system to prevent unnecessary admissions and readmissions into hospital. This is of great importance to patients with long term conditions who prefer to be treated at home, as well as being economically significant. Home visits also have an important role in assisting intermediate care. There are some instances where GPs are being piloted in assisting ambulance services to make decisions regarding whether a patient can be left to stay at home or not. Additionally, step down care, provided by a multidisciplinary team, can be arranged to prevent readmissions in a variety of ways:
    a. Home-based intermediate care with nurses and other input for rehabilitation
    b. Home-based six week reablement care plans

17. One specific example of home-based intermediate care is 'Hospital@Home', a service designed to provide an alternative to hospital admission for patients who are acutely ill. Delivered by a team of GPs experienced in acute care, advanced nurse practitioners and staff nurses, this 24/7 service has resulted in almost 2,000 patients receiving their treatment in their own home, including care homes, rather than hospital. The main provider of Hospital@Home is Partners4Health, a GP-run organisation and NHS body. The name was chosen as it is fundamental to the culture of Partners4Health that effective services and support can only be delivered by providers working together and utilising the skills and resources of all providers in an integrated systematic way in order to improve care for patients.[16]

[15] Diabetes UK (2010) *Year of Care Pilot 2007 – 2010.* Accessed at: http://www.diabetes.org.uk/professionals/service-improvement/year-of-care/ 11/02/15
[16] Royal College of General Practitioners (2014) *Council Papers: Case studies – Integration of care*. Unpublished, included in Appendix.

18. Hospital@Home is a partnership between Partners4Health and:
    a. the local acute trust for diagnostics and consultant advice, enabling the development of condition specific care pathways,
    b. community providers for district nursing and therapies,
    c. the Local Authority for equipment and rapid response for personal care.

    The service has been independently reviewed and has been shown to be safe, effective and significantly less expensive than hospital care. Patient and carer feedback appears to be very positive with 793 out of 794 responders to the post discharge survey requesting Hospital@Home rather than admitted care in the future.[17]

19. Beyond home visits, general practice can also have a role in the organisation of standard intermediate care beds and transitional care. Historically, community hospitals (often run by GPs) provided this opportunity, but these have become less common in recent NHS investment. There are challenges in providing effective intermediate care, including working with Local Authorities who face budgetary challenges.

Diagnostics

20. Historically, the NHS has been good at reactive care i.e. responding to serious ill-health, rather than proactive care i.e. identifying and addressing conditions earlier. The delay in diagnostics has both financial and clinical consequences.[18] One of the barriers in diagnostics is both access to clinician time and access to diagnostic tests in the community. The introduction of physician associates for acute diagnostics of particular conditions could assist early confirmation of diagnosis. This coupled with point of care testing e.g. Hgba1c, d-dimer, C reactive protein and calcitonin precursors, would allow greater certainty in earlier diagnosis of conditions.

21. However, in order to deliver earlier diagnostics, significant investment in infrastructure to host point of care testing will be required. 'Scaling up' of such services to a larger population may be needed to justify the investment. Furthermore, training of staff so that they are able to make independent diagnostic decisions would also be required. There are also numerous other challenges in making earlier diagnostics a reality.[19]

Co-location of primary and secondary care services

22. An additional approach is to have both primary and secondary care services located in the same physical area. In particular there is an opportunity to provide secondary care services on-site at a GP practice. This has been piloted specifically for glaucoma where mobile units are able to temporarily provide screening and post-surgery follow-up services in order to reduce hospital visits.[20] This approach could also work for

[17] Royal College of General Practitioners (2014) *Council Papers: Case studies – Integration of care*. Unpublished, included in Appendix.
[18] Deloitte Centre for Health Solutions (2014) *Working differently to provide early diagnosis: Improving access to diagnostics.*
[19] *Ibid.*
[20] Royal College of General Practitioners (2014) *Co-Managing the Glaucoma Suspect in primary care.* Accessed at: http://www.rcgp.org.uk/~/media/Files/CIRC/Eye%20Health/RCGP-Comanaging-the-Glaucoma-Suspect-in-primary-care-December-2014.ashx

outpatients by the transferring of acute generalists and geriatricians into the community. It is important that specialists use practice Information Technology (IT) systems to avoid confusion and the redundancy of practice medical records. Similarly, outreach clinics by secondary care clinicians could provide referral opinions and advice in GP settings (by remote technology or by direct attendance), and this has the added advantage of strengthening collegial relationships and mutual understanding of clinical needs and best referral practice.

23. Furthermore, there are a number of examples of GPs providing expertise and value to the health care system by being attached to hospital emergency departments, particularly during the out of hours (OOH) period. This approach may reduce demand on accident and emergency (A&E) departments as it is estimated that between 15 and 26.5 per cent of A&E attendances could be treated by primary care physicians.[21] However, an issue with this approach is that patients could begin to treat A&E as a universal treatment centre perpetuating the NHS culture of reactive (and therefore more costly) care. For both co-location approaches there are cultural and organisational challenges in getting primary and secondary care professionals to work together in teams.

24. Beyond co-location, another model is multidisciplinary teams based at community hospital sites. One such example is the Emergency Multidisciplinary Unit (EMU) based in Oxford. Adult patients with acute illness can be referred by paramedics, GPs (in and OOH) and community nursing teams to the two EMU units. The units are open seven days a week and aim to provide an ambulatory treatment path for acutely ill patients, but are also able to undertake procedures that usually require day patient hospital attendance (e.g. blood transfusion). The EMUs use point of care blood tests, electrocardiograms and on site x-rays in order to determine underlying diagnosis or impact of acute illness. The EMU physiotherapists and occupational therapists can make same day assessment of the patients' mobility and safety, while the EMU social worker can access urgent crisis care packages, or respite care home placements if appropriate. EMU have very close links with the Hospital@Home service, the Integrated Locality Team, and community nurse specialists such as those for Neurology (Parkinson's Disease), Diabetes, Heart Failure, & Chronic Obstructive Pulmonary Disorder. The EMU approach emphasises the importance of transferable skills, development of advanced practice and novel GP training, the latter including GP trainee rotation in the multidisciplinary team training and a GP ST4 quality improvement fellow.[22]

Seven day services

25. Whilst there is political interest for seven day services by general practitioners, it is also important to note that there could be increased demand for other non-GP services at the weekend, for example chronic disease management clinics by nurses, physiotherapy, and phlebotomy. However, to provide this level of access additional clinical and administrative resource would be required. If these services are to be delivered by practices, there could be some challenges to align workforce timetables, IT infrastructure, appointments and patient records across different providers. Maintaining

[21] Deloitte (2014) *Spend to save: The economic case for improving access to general practice.* Accessed at: http://www.rcgp.org.uk/~/media/Files/PPF/2014-RCGP-Spend-to-Save-Deloitte-report.ashx
[22] Oxford Health Emergency Multidisciplinary Unit. Accessed at: http://www.oxfordhealth.nhs.uk/?service_description=emergency-multidisciplinary-unit. Downloaded on 11/02/15.

fairness in the allocation of appointments is also an important factor to consider. There are further considerations to be made with the formation of seven day services, for example, the potential of creating supply-induced demand and an undesirable distribution of patient contacts. It is important that the availability of seven day services should be aligned to local demand and supply.

Continuity of care

26. For the purposes of this submission, 'continuity of care' concerns the ability to see a preferred GP or nurse (relational continuity), as well as the transitions between traditional primary and secondary care services. For some patients, being able to see a GP or nurse of their choice takes priority over fast access; this may apply in particular to those with long term conditions, and within an episode of care, where continuity of care is an important factor.

27. Continuity is operationalised as relational, informational, and managerial. [23] In the context of a multidisciplinary primary care team, who have to offset acute access against planned care, and use skills appropriately, continuity can be lost, and the challenge is to retain it where it is needed. This is often when a patient has complex diagnostic and management needs, or a serious illness - including psychological vulnerability, where interpersonal dynamics over a period of time act as crucial enabler for engagement and therapeutic change. One of the measures to ensure continuity of care is to make sure that patients have a named GP and practice nurse for 'usual' contact; this can be extended to a 'usual team' model, which allow the practice some flexibility in allowing a patient to see a health professional with whom they have a prior relationship. Effective outcomes from continuity are of course also dependent on having sufficient time and skills to use the interpersonal relationship and diagnostic abilities to full effect – seeing the same doctor is an important building block, but if the patient and doctor do not have adequate time together to do the job it is not effective.

Care planning and co-ordination of care

28. Co-ordination of care is increasingly important as the proportion of the nation suffering from long-term conditions increases. Furthermore, as the prevalence of multi-morbidity rises, a more holistic approach to patient care is required. One approach to this focusses on person-centred assessments every six months, as opposed to separate reviews for individual diseases. This prevents multiple visits from patients, which can be beneficial for the patient and the practice. A wide range of health professionals have been piloted as having a role in the co-ordination of care, for example, practice nurses and community matrons. This also involves the telephone co-ordination of secondary care, where necessary. It is important to note that the inclusion of non-health professional carers in the design of any care plan is vital.

29. The use of data can also be a very useful tool in the co-ordination of care for various patient cohorts. Segmenting heterogeneous patient populations into clinically meaningful subgroups using data allows operational and core decision-making to be performed in advance. Multidisciplinary design of packages of care for these segmented patient

[23] RCGP Continuity of Care Toolkit. Accessed at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP%20CoC%20toolkit.ashx, downloaded 18/02/15

groups has both clinical and financial benefits. The defined packages of care reduce health inequalities and the use of the most cost effective competent member of staff optimises spend. Furthermore, establishing particular warning signs or data levels for individual patients can assist the management of conditions e.g. use of red flags in motor neurone disease.[24] In order to sustain effectiveness, case management practices must undergo monthly, multidisciplinary team review and challenge with relevant professionals from across the patient's treatment pathways.

30. The co-ordination of care requires significant alteration to non-clinical organisational processes. In addition, significant investment may be required before any benefits are realised. The modification of training of different health care professionals to undertake a care co-ordination role is important to ensure that it is conducted correctly. There can also be legal and financial challenges in co-ordinating care as people age and / or conditions deteriorate.

31. A specific example of continuity of care and care-planning is the 3D project run by the University of Bristol, supported by the College. The 3Ds are Dimensions of health, Drugs and Depression, which are the focus of the intervention. The intervention is designed to address the problems of illness burden (poor quality of life, depression), treatment burden (multiple uncoordinated appointments, polypharmacy, poor primary/secondary care co-ordination) and lack of patient-centred care (low continuity, disregard of patients' priorities) experienced by patients with multimorbidity. The intervention involves:

    a. Identification and prioritisation of patients with multimorbidity
    b. Improving continuity of care by having a named usual GP and practice nurse and longer appointment times
    c. Comprehensive 'person centred' assessments every six months as opposed to separate reviews for each condition. A 3D review will involve two appointments approximately a week apart. The first will be with their named practice nurse and the second with their named GP. These will follow the 3D assessment structure and bespoke computerised template.
    d. Integration with a designated general physician to provide telephone advice about complex problems and help co-ordinate hospital care

    The trial is still ongoing however its intended outcomes include: an economic evaluation to assess the cost effectiveness of the intervention; A mixed methods process evaluation to explore how and to what extent the intervention was implemented; the advantages and disadvantages of different models of care for patients with multimorbidity; and, how and why the intervention was or was not beneficial.[25]

32. In addition, effort must be made to generate patient and community activation. The promotion of self-care by patients and their communities was noted as crucial to overall

[24] Royal College of General Practitioners. Accessed at: http://www.rcgp.org.uk/clinical-and-research/circ-clinicians.aspx. Downloaded on 11/02/15.
[25] University of Bristol 3D project (2014). http://www.bristol.ac.uk/social-community-medicine/projects/3d-study/research/ Downloaded 11/02/15

better patient outcomes.[26] Public health professionals could have an important role within the primary care workforce to use their expertise to help increase patient and community activation.

Comprehensiveness of care

33. Comprehensive care is a core feature of expert medical generalism – seeing a GP who can tackle all aspects of health need. This dimension also denotes having a comprehensive service for first contact at one location (in the UK the local general practice). The 'third level' is having a full range of services available for referral and patient support. There is an important role for general practice to act as a hub, signposting patients to other services available across the health and social care system and the third sector. The co-ordination of services from secondary care and social care at primary care level is fundamental to deliver holistic care in the community – if different parts of the service are not confident of the roles and actions of others, there could be duplication and missed opportunity. Both informational continuity and health professional attitudes can be relevant here: professional training is often conducted in isolation, and one way to improve this is to ensure that training includes development of the skills and attitudes essential for collaborative working across organisational boundaries. Protected learning times for practice staff are essential for continuing professional development. There is literature on this topic and it shows that the outcomes depend, in part, on role models and work culture.[27]

34. Intermediate care focusses on two major patient flows: out of the acute bed services into community beds; and, the entry point from primary care and other health professionals to community services. One example of this model of care creates a single point of access (SPA) for primary care professionals to refer on their patient's needs. A GP can make one phone call for a needs assessment from a range of health professionals including social care, nurses, therapists, end of life care, reablement and care home support. There is no need for a GP to complete a referral form and call handling is performed by an experienced administrator or clinician. Following the call, the SPA then pass the information to the relevant team who pick up the work. This system has not replaced the GP's ability to directly refer to a team they know but it assists the GP's role as a navigator. The SPA has led to significant admission avoidance due to easier access to appropriate community services.[28]

35. The King's Fund conducted a review of case studies where specialists worked in out of hospital settings.[29] Four key interfaces for consultants working in the community it highlighted were:
    a. Consultant-run email and telephone helplines that provide advices for GPs, nurses and other health professionals

[26] Royal College of General Practitioners (2014) *An inquiry into Patient Centred Care in the 21st Century: Implications for general practice and primary care.* Accessed at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Inquiry-into-Patient-Centred-Care-in-the-21st-Century.ashx
[27] Evans J, Lambert T, Goldacre M. (2002) *GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice.* Occas Pap R Coll Gen Pract. 2002 Feb;(83):iii-vi, 1-33.
[28] Oxford Health NHS Foundation Trust. Accessed at: http://www.oxfordhealth.nhs.uk/resources/2013/04/CS-011.12-Single-Point-of-Access-leaflet.pdf. Downloaded 11/02/15
[29] Robertson R, Sonola L, Honeyman M, Brooke B, Kothari S (2014) *Specialists in out-of-hospital settings.* The King's Fund. Accessed at: http://www.kingsfund.org.uk/publications/specialists-out-hospital-settings

b. Consultant participation in multidisciplinary team meetings
c. Consultant-run education sessions
d. Consultants supporting staff to work in extended roles

New structural models of care

Governance and management structure

36. The benefits of federation (either formally or informally) with other practices is increasingly acknowledged. Federation enables practices to share resources and to focus more on the delivery of a high quality service, extended opening hours and to co-operate in developing a local general practice workforce through shared investment and shared use of existing training capacity. However, practices should maintain their individuality and clinical autonomy in order to retain workforce satisfaction, value for patients and to drive synergies that can result from being embedded in the community.[30] There are also some calls for the average practice size to increase.

37. Federations could allow the maintenance of partnership structures. To reflect the growing multidisciplinary nature of the primary care workforce, there should be opportunities for non-GPs to co-lead these structures. Non-GP members could be granted the opportunities for partnerships, or where federations occur, integrated boards could be established. These boards could include a range of healthcare professionals ranging from the following stakeholders: practice representatives; patient representatives; community nurses; mental health specialists; community geriatricians; community paediatricians; social care managers; public health specialists; financial directors; and, general managers. The optimal size of federation could range from 25,000 to 100,000 patients.[31]

Economic conditions

38. For federated practices there could be one core contract that covers the delivery of services that are currently funded through global sum, Quality Outcome Framework and Direct Enhanced Services. In addition, the owner(s) of the practice would receive additional rental payments and funding for their involvement in training. There could be a single prescribing budget, which would exclude high cost specialised drugs.

39. An additional delegated budget for community and secondary care budgets could be provided. Potentially, the federation should focus on the needs of the local population and should not compete with other organisations or providers to win contracts for the provision of services outside of their area.

[30] Royal College of General Practitioners (2014) *An inquiry into Patient Centred Care in the 21st Century: Implications for general practice and primary care.* Accessed at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Inquiry-into-Patient-Centred-Care-in-the-21st-Century.ashx
[31] Public Health Wales (2014) *Rapid review of primary care models and policy: Discussion paper for Wales.* Accessed at: http://www.gpone.wales.nhs.uk/sitesplus/documents/1000/Primary%20care%20models%20and%20policies-%20rapid%20review%20July%202014%20FINAL.pdf

Workforce development

Organisation of workforce

40. In order to develop the primary care workforce a range of skills in the community will be needed. The modern practice could have a range of skills that are currently reflected in the roles of GPs (medical generalists); nurse practitioners and practice nurses; health care assistant roles; phlebotomists; pharmacists; and, a full range of administrative staff and a high calibre practice manager. Innovative models also include care planning leads and community outreach workers. A GP federation would co-ordinate extended hours services, with larger federations of practices combining to deliver OOH services that are integrated with other urgent care services in the region.

41. Community and specialist services would be commissioned by each practice. In some instances, the individuals delivering community and specialist services could be shared between different practices. Examples of commissioned services include district nurses, community connectors, social workers, complex case managers, community matrons, health visitors, midwives, maternal and child health clinics, lifestyle coaching, speech and language therapists, community practice nurse with a mental health specialism, drug and alcohol workers, advice workers and physiotherapists. The community and specialism service provider would retain responsibility for the employment, HR and backfill of staff on leave.

42. A specific example of general practices delivering community services from general practice surgeries is the 'GPs at the Deep End' work with general practices serving Scotland's 100 most socio-economically deprived populations. This programme aims to assist GPs to find ways of tackling the inverse care law. The project has identified a range of measures to improve the care of, and outreach to, the most vulnerable and marginalised groups within GP practices' local communities. These include:

    a. targeted appointments for patients with most complex needs, combined with additional consultation time

    b. practice-attached community link workers, connecting practices and patients to community resources for health

    c. attached alcohol and mental health workers

    These ideas have been tested out through pilots such as the Glasgow Links Project, which explored opportunities to connect local citizens, primary care teams, the voluntary sector and other providers of support. Under this, 18 per cent of patients were identified as having a need for support, and in 50 per cent of cases this was for mental health or addiction services. Of those patients with an identified need, 75 per cent were signposted to a resource, and 70 per cent of those who made initial contact were still using the resource four to six weeks later.[32]

43. Given the increased complexity of federations and the opportunity to achieve efficiency savings, certain administrative and back office functions could be shared. New roles

[32] Royal College of General Practitioners (2014) *An inquiry into Patient Centred Care in the 21st Century: Implications for general practice and primary care.* Accessed at: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Inquiry-into-Patient-Centred-Care-in-the-21st-Century.ashx

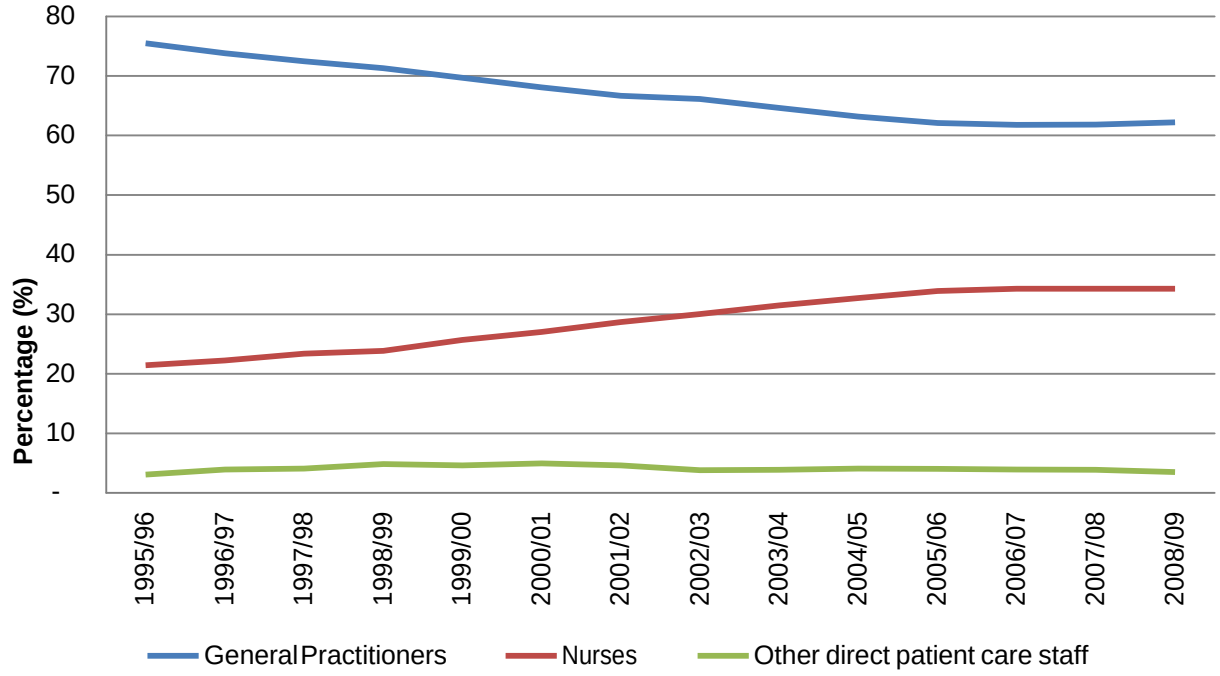
such as IT specialists and data analysts have emerged within federations in order to pool resources to drive new ways of working.

Practice skill mix

44. To resolve workforce staffing issues, there are many different models of staff mixes that have emerged. In the absence of medical professionals many practices have adapted and trained less qualified health professionals. Whilst there is a proportion of traditional GP work that can be done competently by other members of the practice team, there are questions regarding what is the ideal level of service and practice staff mix. There can be reasonable concerns about safety issues and substitution borne out of financial and recruitment constraints rather than clinically-led decisions. There is a lack of evidence regarding what the clinical outcomes of GP substitution are or will be in the future.

45. There can be no single, universal workforce solution regarding staff mix. Each locality will face different challenges due to variations in patient need, availability of health care professionals and infrastructure. Some practices in areas with lower retirements and healthy local recruitment to training pathways may choose to continue to configure their workforce to historical norms. We believe that most practices will find themselves under increasing workload pressure and will need to see their workforce skill mix evolve through necessity. A few practices could face significant challenges that will demand more radical workforce transformation and a complete redesign of primary care clinical pathways. However, whilst workforce pressures may be a stimulus for new thinking, we should be recruiting the workforce we need to deliver new models of care that are optimal for patients, not tailoring new models of care to current constrained workforce numbers. As presented in Figure 1, the practice skill mix contribution to direct patient care has changed significantly. Further evaluation of the impact this has had on clinical outcomes needs to be conducted.

Figure 1: Percentage of consultations conducted by practice staff type
1995/96 to 2008/09



46. Over the next few months, the College is conducting a workshop and developing a position paper about practice skill mix. The aim of this process is to articulate the challenges faced in this area and outline the range of potential solutions. The College is willing to submit the outcomes of this process to the Commission, if requested.

Training of workforce

47. There needs to be a multi-professional approach to training and workforce delivery. Looking at just one particular aspect of the workforce in isolation is not a realistic option. An approach that looks at the skill sharing in the workforce and skills development would appear to be the most sensible one. Clearly defined roles and standards of training for all working within primary care are essential to ensure high quality and safe care is provided to patients when they are often at their most vulnerable in locations best suited to them, though this could be used flexibly to meet the needs of the population.

48. Training capacity within general practice needs to be increased, with multidisciplinary training occurring within general practice. Nurse training capacity is an area that needs particular attention. Primary care workforce training at undergraduate and postgraduate levels can be limited by the poor availability of nurse supervisors. The process for becoming a nurse supervisor is fairly straight forward and funding is provided via the Learning Beyond Registration funding. However, the accreditation process doesn't limit the supply of nurse supervisors. A reported barrier to supply of nurse supervisors is that practices are reluctant to release nurses from patient contact time. Smaller practices in particular are less likely to release nurses. Locally practices can establish primary care

development centres to co-ordinate the facilitation of nurse training within primary care.[33] There needs to be enabling of training in general practice otherwise the volume and speed of training will not match demand.

Infrastructure, technology and data

49. To fully integrate services and to prevent fragmentation of healthcare in the community, patients should be able to access multidisciplinary teams via the general practice surgery. However, significant investment in general practice surgeries would be required to ensure that the infrastructure of the practices is able to support multidisciplinary services, and some of this may best be done at a 'community hub' level, linking with the local practices. Whilst the GP premises funding announced in the 2014 Autumn Statement is welcome, there should be co-ordination between this review and NHS England's new models of care programme to ensure that public finances are not wasted on infrastructure projects designed for traditional ways of working.

50. A large challenge in multidisciplinary working is ensuring that patient records can be shared effectively between different team members. A key challenge for this is IT infrastructure and ensuring that different systems are able to interact. It is essential that every practice within a federation uses a common IT system or systems that are compatible. Capability with the IT systems of other services e.g. community health, is also vital.

51. The collection of effective medical data can drive improvements in the quality of patient data. By using coding from EMIS, performance dashboards for the management of patient cohorts with long term diseases can be created. It is also vital that patient registration data is maintained up to date especially email and mobile telephone contact details as patients move away from postal communications.

[33] Primary Care Development Centre. Accessed at: http://www.pcdc.org.uk/about-us/standing-advisory-groups. Downloaded 11/02/15

Quantitative workforce planning

52. To deliver any of the above models of care, it is of utmost importance that the current shortfall of GPs is addressed and that there is a commitment to sufficient supply of GPs in the future. It is vital that HEE or an independent body works with interested parties to conduct detailed quantitative analysis, to allow the development of a consensus on the number of GPs needed to work within and deliver these new models of care. This section will outline the College's initial work in estimating what the shortfall in the number of GPs in England is and how many will be needed by 2020.

53. There are numerous methods to estimate if there is a shortage of GPs in England. To date, the College has segmented this approach into two time frames i.e. estimating the current GP shortage and estimating the long-term number of GPs required.

54. Short term estimates are generated using two key approaches:

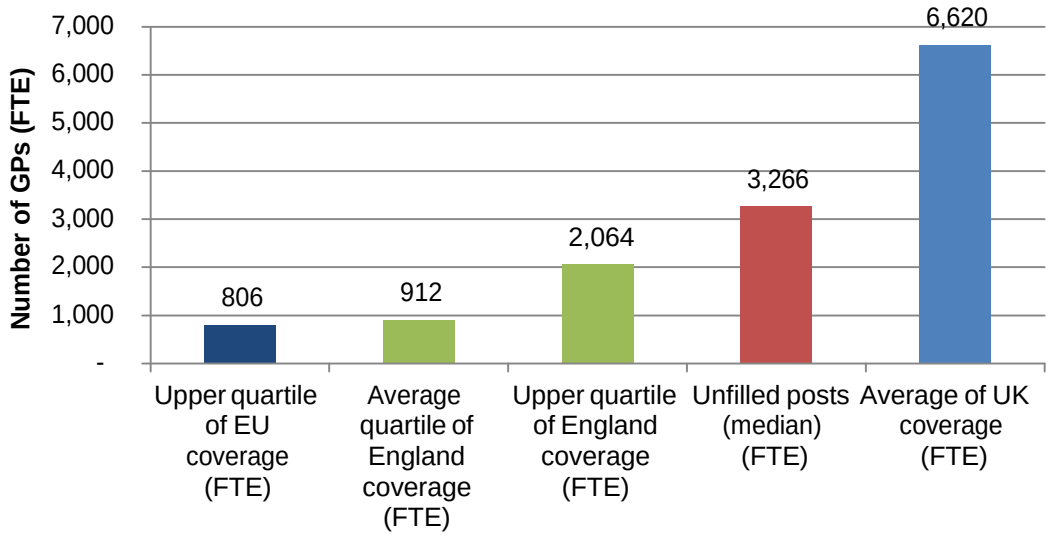
    a. **Approach A:** The current shortage in GPs is mainly driven by supply-side factors of attrition, unfilled posts and lack of trainee doctors
    b. **Approach B:** The current shortage in GPs can be attributed by benchmarking against different coverage levels e.g. vs. England, UK and Europe

55. To estimate the current shortage of GPs four methodologies have been used:
    a. Increasing England's coverage to the upper quartile of EU coverage
    b. Increasing England's coverage to the average and upper quartile of England coverage
    c. Estimating the current shortfall using estimates of vacancy data i.e. unfilled posts
    d. Increasing England's coverage to the average of UK coverage

56. The preferred estimate of current shortfall is using estimates of vacancy rate data because the other methodologies are normative and subject to change. Furthermore, comparisons against other European countries can be difficult due to the differences in primary care systems. HEE's GP Taskforce report states that vacancy rates have grown fourfold in the last three years – 'The results showed vacancy rates of 7.9 per cent of all GP posts in January 2013 – almost double the 4.2 per cent figure from the previous year's survey in January 2012, which itself was twice the Department of Health baseline figure of 2.1 per cent from the last survey in 2010.'[34] The College uses a reasonable estimate of 9.0 per cent vacancy rates in 2014, which results in a shortfall of circa 3,200 GPs.

[34] Health Education England (2014) *Securing the Future GP Workforce Delivering the Mandate on GP Expansion: GP Taskforce Final Report.* Accessed at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/07/GP-Taskforce-report.pdf

Figure 2: Estimated current shortfall of general practitioners, England, Full time Equivalent (FTE), 2013



57. To estimate the long-term shortfall is a complex question with the analysis of numerous supply and demand factors required. The College suggests using the Scenario 4 estimate by the CfWI to estimate the long-term need. The College believes that this is the best reflection of the current situation in general practice i.e. 'professionally driven workforce development and perceived decrease in the status and attractiveness of the GP profession'. The scenario forecasts a shortfall in 2020 of approximately 3,000. This is the same estimate used in the HEE Workforce plan.[35]

58. However, in the discussion the CfWI also model the impact of two probable supply shocks; decrease in GP retirement age and increased emigration from the UK workforce. Reduction in GP median retirement age from 59 to 58 creates an additional shortage of approximately 430 FTE in 2018. Whereas, increased emigration could create a further reduction of supply to about 1,000 by 2020. The evidence base for these supply shocks occurring is widely documented. Therefore if you add these estimates to the Scenario 4 total, the long term undersupply by 2020 could be in the region of 4,500. This long term estimate coupled with the short term estimate suggests a GP shortage of 7,700 in England shortage.

59. The inclusion of these supply shocks are supported by numerous sources of evidence:
    a. The reduction in retirement age is supported by a British Medical Association (BMA) survey, which 'found that that in the past year around 57 per cent of GPs responding said they had considered retiring early, 28 per cent had considered leaving the profession entirely, and 24 per cent had considered working overseas.'[36] It is also supported by evidence quoted by HEE's GP Taskforce, which states 'that the proportion of GPs expecting to quit direct patient care in the

[35] Health Education England (2015) *Workforce Plan for England. Proposed Education and Training Commissions for 2014/15.* Accessed at: http://nwl.hee.nhs.uk/files/2014/04/HEE-Workforce-plan-14-15.pdf
[36] Centre for Workforce Intelligence (2014) In-*depth Review of the General Practitioner Workforce.* Accessed at: http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce

next five years had increased from 6.4 per cent in 2010 to 8.9 per cent in 2012 amongst GPs under 50 years-old and from 41.7 per cent in 2010 to 54.1 per cent in 2012 amongst GPs aged 50 years and over.' [37,38]

b. The State of Medical Education and Practice report found that emigration is one of the two most common reasons for doctors leaving the workforce. It also highlights that proxy indicators suggest that the number of UK graduates leaving to work abroad is increasing. A key indicator for doctor emigration is the number of applications for Certificates of Good Standing. Applications for certificates have risen by 22 per cent since 2008, with doctors aged between 24 and 27 years old forming the majority of the applicants. In 2013, destinations were predominately to two countries – Australia and New Zealand (51 per cent). A further 9.7 per cent went to Canada, 8 per cent went to three countries in east Asia (Hong Kong, Malaysia and Singapore), 6.7 per cent went to Ireland and 4.9 per cent went to the United Arab Emirates.[39] Further research should be conducted.

60. It is important to note that the CfWI report itself states that its forecast baseline is probably underestimated: 'baseline demand for GP services is projected to increase by 10.75 per cent (or 0.6 per cent per annum) on a FTE basis between 2013 and 2030, based on two drivers: population growth and the changing age and gender composition of the population, particularly the increase in older people. However, as the baseline does not include changes in patient expectations, the rise of multiple morbidities and case complexity, or the potential impact of greater prevalence of non-age-related long-term conditions, such as obesity or diabetes, it most likely underestimates future patient demand for GP services.'[40]

61. There has also been a historical imbalance between consultant and GP recruitment. In 2014, there were 32,628 GPs (excluding retainers and registrars, full time equivalent) and 40,443 Consultants (including Directors of Public Health, full time equivalent) recruited. Compared to 2004, this represents an annual average growth of 1.7 per cent and 3.7 per cent respectively.[41] In addition to this, 'there were 2,814 level one entry posts for GP training compared to 4,143 level one entry posts for a Consultant medical career (i.e. other specialty training). The ratio of level one entry points to CCT holders suggest that we are replacing 7.9 per cent of the GP workforce annually compared to 10.3 per cent of the Consultant workforce replaced annually.'[42]

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[37] Centre for Workforce Intelligence (2014) In-*depth Review of the General Practitioner Workforce.* Accessed at: http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce

[38] Health Education England (2014) Securing the Future GP Workforce Delivering the Mandate on GP Expansion: GP Taskforce Final Report. Accessed at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/07/GP-Taskforce-report.pdf

[39] General Medical Council (2014) *State of Medical Education and Practice 2014*. Accessed at: http://www.gmc-uk.org/publications/25452.asp

[40] Centre for Workforce Intelligence (2014) In-*depth Review of the General Practitioner Workforce.* Accessed at: http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce

[41] Health and Social Care Information Centre (2014) *General and Personal Medical Services, England - 2004-2014, As at 30 September.* Accessed at: http://www.hscic.gov.uk/catalogue/PUB16934.

[42] Health Education England (2014) Securing the Future GP Workforce Delivering the Mandate on GP Expansion: GP Taskforce Final Report. Accessed at: http://hee.nhs.uk/wp-content/blogs.dir/321/files/2014/07/GP-Taskforce-report.pdf

62. Analysis to date is also limited because it has looked at general practice in isolation from staff mix. There could be shortages in other members of the primary care workforce team but data availability is poor. For example, there has been an overall downward trend in the number of nurse training places since 2010/11.[43] The CfWI's baseline projection for supply and demand demonstrates a possible shortfall of registered nurse headcount by 2016.[44] There is evidence to suggest that varying staff mix and roles of other professionals (clinical and other) could have a significant impact on the demand for GP services and therefore on the number of GPs required in the short and long-term. However, whilst different skill mixes have arisen, these should not necessarily be considered as ideals as in some localities they are consequences of a failure to have sufficient workforce planning and investment. Regardless, investment in the recruitment of GPs is needed to ensure delivery of new models of care and to address significant workforce issues including workload, patient safety and recruitment.

63. It is noted that HSCIC has made improvements to the collection of workforce data on other members of the practice team. Analysis on the number of full time equivalent practice nurses between 2013 and 2014 has shown a growth of 8.6 per cent in the number of advanced nurse practitioners and a reduction in the number of overall practice nurses of 2.1 per cent. Whilst growth in the number of advanced nurse practitioners is welcome the overall increase of 0.8 per cent in the number of nurses coul d be insufficient given the rise in general practice demand.[45] Furthermore, there is no consensus or clarity on the definitions between 'extended', 'advanced' or 'practice' nurses. Further work must be done to ensure clarity around definitions (potentially including career frameworks), with analysis of the impact this has on workforce planning. There is also a need to increase nurse training capacity with increased mentors and trainers and to standardise nurse training.

[43] Royal College of Nursing (2014) *Nurse training places creeping up after dire warnings of shortages.* Accessed at: http://rcnpublishing.com/doi/pdfplus/10.7748/ns2014.04.28.33.14.s16
[44] Centre for Workforce Intelligence (2013) *Horizon scanning – A strategic review of the future healthcare workforce: Informing the nursing workforce.* Accessed at: http://www.cfwi.org.uk/news/publications/horizon-scanning-a-strategic-review-of-the-future-healthcare-workforce-informing-the-nursing-workforce/
[45] Health and Social Care Information Centre (2014) *General and Personal Medical Services, England - 2004-2014, As at 30 September.* Accessed at: http://www.hscic.gov.uk/catalogue/PUB16934.

Key recommendations

64. This section outlines the key recommendations that the College believes are essential to design a primary care workforce that is able to deliver the new models of care and ways of working outlined above. These recommendations are organised into the following categories: workforce planning; recruitment; training; and, retention.

Workforce planning

a) Increased collection of workforce data. HSCIC are undertaking a review of primary care workforce data collection and the College looks forward to the results of this process. The outcome of this consultation is intended to be published in February 2015. We welcome the intention of the consultation, however, further comment cannot be made until it is published. There is an urgent need for better primary care data to underpin better understanding of workforce numbers and activity. To highlight the poor collection of primary care data, the last official collection of GP consultation rates in England was in 2008/09 and the last vacancy rate data was collected in 2010. This is in stark contrast to the weekly publication of secondary care activity data. The use of EMIS and other practice software as a source of accurate workforce and activity data should be explored and potentially funded. In addition, there needs to be analysis of the overall competencies for professional roles and any provisions that may be needed for innovation.

b) Quantitative forecasting of workforce numbers. Given the length of time it takes to train a GP and other healthcare professionals, quantitative analysis of workforce requirements in the future must be undertaken, based on new models rather than old.

c) Evaluation of the relevant competencies for different health and care roles. There is a lack of clarity regarding the distinctions between certain professional roles and evaluation of the relevant competencies and accreditations required would assist in workforce planning.

Recruitment

d) Cultural change to encourage recruitment to general practice. There is a body of evidence that highlights that some of the perceived deterrents to choosing general practice as a career were its portrayal, by some hospital-based teachers, as a second class career compared to hospital medicine.[46]

e) Stabilisation of GP careers – NHS England's Five Year Forward View set out a clear vision that put general practice at the centre of the health care system and outlined a new deal for general practice and primary care. Decisive action to implement the joint Action Plan by NHS England, HEE, BMA and the College is required to inspire confidence in training medics to choose general practice. In addition, building on HEE's work with the Royal College of Nursing and

[46] Evans J, Lambert T, Goldacre M. (2002) *GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice.* Occas Pap R Coll Gen Pract. 2002 Feb;(83):iii-vi, 1-33.

universities, we would welcome a programme that provides ready and easy access to conversation courses for GPs and other professionals who wish to switch from the acute sector to the community.[47] There also needs to be further clarity regarding the funding of training for non-GP health professionals.

f) **Greater exposure to general practice at undergraduate and foundation school level.** For example, in 2014, zero per cent of F1 doctors rotated through general practice in their training and 43.3 per cent of F2 doctors experienced general practice.[48] This is despite the findings that including general practice throughout medical education is the most effective way of making general practice more attractive.[49]

g) **Review of incentives to attract locum doctors.** There is a lack of data available on locum doctor usage and availability. However, usage is reported to have increased.[50] Further research should be done to evaluate the scale and cost of locum usage and also what incentives can be designed to encourage locum doctors to join the general practice workforce.

h) **Review of underlying reasons why UK graduates emigrate to other countries.** There is a urgent need to understand why UK graduates do not wish to practice in the UK and also what differences in work conditions keep them abroad. An anecdotal survey performed by an expatriate GP highlighted favourable comparisons for autonomy, stress and consultation length in comparing general practice in the UK and Australia.[51]

i) **Incentivising practices to recruit / commission a wider variety of health care professionals in new roles.** Incentives should be designed to promote practices to integrate different healthcare professionals into their practice teams. Examples of different staff members include district nurses, social workers, community matrons, health visitors etc.

Training

j) **Increased GP training capacity, especially in our underserved areas.** Delivering the number of GPs and/or primary care professionals will need significant expansion to training capacity. This may require increased incentive packages to potential GP trainers and a review of GP training models. The

[47] Department of Health (2014) *Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the Government to Health Education England: April 2014 to March* 2015. Accessed at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/310170/DH_HEE_Mandate.pdf
[48] UK Foundation Programme (2014) *Annual Report 2014.* Accessed at: http://www.foundationprogramme.nhs.uk/index.asp?page=home/keydocs
[49] The characteristics of general practice and the attractiveness of working as a GP: medical students´ views 2014 Mar http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4207180/
[50] Centre for Workforce Intelligence (2014) In-*depth Review of the General Practitioner Workforce.* Accessed at: http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce
[51] GPs Down Under (2015). Accessed at: http://gpsdownunder.com/learning/forum-learning-gems/categories/listings/life-as-a-gp-in-australia-and-the-uk-a-comparison. Downloaded 11/02/15

geographical distribution of GPs is linked to regional training capacity and programmes, with most GPs taking their first job in their region of training.[52]

k) **Increased nurse training capacity with co-ordinated structure and funding.** Primary care workforce training at undergraduate and postgraduate levels can be limited by the poor availability of nurse supervisors. Central funding and co-ordination should enable sufficient training capacity.

l) **Funded education and advanced training provision for current and new Allied Health Practitioners, Health Care and 'Medical' Assistants.** Apprenticeships for health care assistant and business administration apprenticeship roles should also be included.

m) **Funded education and training provision for administrative and practice manager roles.** As the complexity of general practice care and organisation changes, it is vital that the back office functions are led by highly competent staff.

n) **Review of funding for GP training.** Whilst it is 'cheaper' to train a GP than to train a consultant, in terms of the cost per output; the annual cost of GP training is greater than the annual costs of training a trainee in a secondary care specialty. Training costs for secondary care are contained within service level agreements and it requires greater notice to vary the value of contracts than it does to extract savings from GP training. A review of the incentives and financial reimbursement (especially service level increment for training, 'SIFT') for becoming a training practice should be conducted to ensure that practices aren't financially discouraged from doing so.

o) **Review of training content for health professionals who will have a more active role within the future delivery of primary care.** Changes to ways of working will mean that health care professionals will work in non-traditional roles, which will require non-traditional skills. A review of the standards and content of training courses should be conducted to ensure that training is still fit for purpose.

Retention

p) **Invest in occupational health and GP morale.** There needs to be a dedicated programme to understand the drivers of GP attrition. In addition, access to greater occupational health programmes should be funded to assist doctors in managing their occupational health needs. Potentially, there should be encouragement and financial support for structured sabbaticals for at-risk doctors to prevent long-term attrition. The charity Royal Medical Benevolent Fund provides some funding towards financial support in addition to the central funding provided by NHS England. Better GP morale could also boost recruitment, the perception of low morale amongst current GPs was a key deterrent for graduates

[52] Centre for Workforce Intelligence (2014) In-*depth Review of the General Practitioner Workforce.* Accessed at: http://www.cfwi.org.uk/publications/in-depth-review-of-the-gp-workforce

to choose general practice as a career.[53] Despite common perceptions, financial remuneration was low on the motivations for people to select general practice.[54]

q) Establish clearer workload management guidelines. This will prevent GP burnout and assist in the positive perception of general practice as a career. One of the most popular reason people choose general practice as a career was its perceived compatibility with a work-life balance.

r) Career structures for non-GP primary care workforce members. Professional practice management skills and flexible career structure. The Calderdale framework can help in identifying an appropriate skill mix and improved career structures.[55]

Innovation

s) Funding for research at practice paid from other funds. Novel models of care are continually created by frontline workers, however, additional funds should be provided for practices to have dedicated primary care based researchers that look at research across all of the professions.

[53] Evans J, Lambert T, Goldacre M. (2002) *GP recruitment and retention: a qualitative analysis of doctors' comments about training for and working in general practice.* Occas Pap R Coll Gen Pract. 2002 Feb;(83):iii-vi, 1-33.
[54] Hamilton, W. (2011). Motivation and satisfaction in GP training: a UK cross-sectional survey. *The British Journal of General Practice*, *61*(591), e645–e649. doi:10.3399/bjgp11X601352
[55] The Calderdale Framework (2015) Accessed at: http://www.calderdaleframework.com/the-framework/ Downloaded 11/02/15

Patient access to general practice – solutions and challenges from the front line

February 2015

Introduction – what does 'access' mean to patients?

1. Across the UK, GP practices are pioneering new approaches to providing patients with access to their services, despite the huge financial and workload pressures facing general practice. This paper explores some of the initiatives being tested and looks at what solutions and challenges are emerging. Its findings are relevant to individual clinicians and practices, but also have implications for commissioners and policy makers at both a national and local level.

2. Firstly, however, it is important to ask exactly what the term 'access' to general practice means to patients. GP access is a popular topic in public debate about the NHS – with politicians and the media often quick to call for initiatives to 'improve' access for patients. However, there is little agreement about what 'good' access to general practice looks like, and the term is often used to describe a range of quite diverse projects – from offering consultations via skype to providing extended practice opening hours.

3. The starting point for this paper is that there is no single definition of good access to general practice, and no one-size fits all solution that all practices should implement. In fact, 'access' can mean very different things to different people, depending on an individual patient's priorities. Many practices are already closely monitoring how patients access their services and implementing changes accordingly, and RCGP Scotland has recently published a Toolkit for practices to use for this purpose[1].

4. This paper focuses on the following three aspects of access to general practice[2]:

    a. **Availability and proximity of care.** Some patients would prioritise being able to access general practice in the right location to suit their needs. For example, people with reduced mobility need their local practice to be physically accessible.

    b. **Timeliness of care.** Some patients would prefer to prioritise accessing GP services quickly or at a time most convenient to them, and would prioritise this over (for example) seeing a particular GP.

    c. **Ability to see a preferred GP or nurse.** For some patients, being able to see a GP or nurse of their choice takes priority over fast access (this may apply in particular to those with long term conditions for whom continuity of care is an important factor).

5. This paper explores current initiatives focusing on each of these aspects of access to general practice, before considering what systems and processes underpin effective approaches to improving access for patients.

[1] RCGP Scotland, Treating access: a toolkit for GP practices to improve their patients' access to primary care: http://www.rcgp.org.uk/rcgp-near-you/rcgp-scotland/~/media/Files/RCGP-Faculties/Scotland/RCGP-Scotland/RCGP_Scotland_Treating_Access_Toolkit_2014.ashx

[2] Goodwin N, Dixon A, Poole T, Raleigh V (2011). *Improving the quality of care in general practice. Report of an independent inquiry commissioned by The King's Fund*. London: The King's Fund

Availability and proximity of care – bringing GP services closer to patients

6. The vast majority of people in the UK have at least one GP surgery close to where they live –almost all are able walk or take public transport to a practice within 30 minutes of their home[3].

7. However, practices face a number of challenges in ensuring that all those living in their local community are able to physically access the services they need. For example, practices in areas with a high population turnover may find that a significant proportion of their local population are not registered with the surgery. Even patients who are registered may find that work and family commitments make it difficult to be physically present at their local practice during the week. Carers, in particular, may feel that they are unable to take time out to visit their practice and as a result neglect their own health needs. In addition, a number of patient groups can face specific challenges with accessing their local surgery – including those who have a disability, those with mental health problems, and those who are homeless.

8. Alongside these challenges, the sheer volume of patients who seek care from general practice – with an estimated 420m consultations across the UK in 2014/15 – can act as a barrier to patients accessing services. Most individual practices have relatively small back office functions, which can potentially lead to long waits on hold for patients attempting to contact the surgery by telephone to book an appointment.

9. With limited resources at their disposal, practices are working to overcome or to some extent mitigate these problems. Some are using technology to provide patients with an alternative means of accessing services without having to be physically present at the practice. Others are finding new ways to bring GP services directly to patients, through outreach programmes and co-location with other parts of the health system. This section explores some of these initiatives.

Online booking systems

10. Practices are increasingly using online booking systems to provide patients with an alternative to contacting the surgery by telephone to secure an appointment. The Government in England has made this a priority, with the 2014/15 GMS contract requiring all practices to put systems in place to offer online booking systems, as well as repeat prescription services – with the intention of offering these services to 95% of patients by March 2015. In January 2015 NHS England reported that 91% of patients are now registered with a practice that offers online booking (compared to 64% the previous year) and 88% with a practice that offers repeat prescriptions (compared to 64% the previous year)[4].

11. The key advantages of this approach include:
    a. Reduced pressure on practice telephone systems
    b. Greater convenience for patients who prefer to book online. In England the GP Patient Survey found that 33.8% of patients say they would prefer to book appointments online[5].
    c. With 73% of people in the UK now having access to high speed broadband (higher than any other Western European country), there is clearly a large pool of people who would find it useful to have the option of booking online[6].

[3] Boyle S, Appleby J, Harrison A (2010). *A Rapid View of Access to Care*. London: The King's Fund.

[4] NHS England Board Papers, 29 January 2015: http://www.england.nhs.uk/wp-content/uploads/2015/01/item3-board-290115.pdf

[5] GP Patient Survey results, July 2014: https://gp-patient.co.uk/surveys-and-reports#july-2014 Note: this question has been dropped from the GP Patient Survey as of January 2015.

12. However, there are some disadvantages that need to be considered:
    a. It is far from clear that online booking systems will help practices reduce their administrative workload, with some reporting that the cost of employing staff to run their online presence is an added financial pressure. Even with relatively high take up from patients, telephone booking systems still need to be maintained and staffed.
    b. A significant minority of people in the UK do not have access to the internet, and there is a risk that shifting towards greater use of online services will exacerbate health inequalities.
    c. Some groups of patients – for example those who are visually impaired or those with learning disabilities – may find that their practice website is not fully accessible to them.
    d. Patients are free to book a slot that may be too short or long for their needs, which could be frustrating for the individual patient and a source of inefficiency for the practice. Often it is helpful for patients to speak to a receptionist at their practice to ensure they receive an appointment most appropriate for their needs – particularly because the patient and receptionist may have spoken before.

Case study: Online booking – individual practice

Granville House Medical Practice in Chorley, Lancashire, has instituted on online booking system for its patients. Patients request to be added to the system, and after providing their information and proof of identification are given a password for the online service through which they can view book directly available appointments. The surgery estimates that around a quarter of all their advance appointments are booked in this way.

These appointments are only available for GPs as the precise nature of the need for the appointment is often not known until the patient is present.

Granville house finds this system to work very well for their surgery by empowering patients. They have in particular found the system to be very popular with their elderly patients.

However, while the surgery itself is very positive about online booking, the implementation and upkeep of the system has associated staffing and administrative costs, which not every surgery may be able to afford. In addition, not all patients have access to the internet or feel comfortable using online services.

Case study: Online booking – Bury GP Federation

Bury GP Federation – which covers 30 of Bury's 33 GP practices – is implementing a dramatic increase in online access to booking systems for member practice patients. This will involve making it easier for patients to register with their local practice, which has been seen as a barrier to greater uptake of online bookings in the past.

The federation will also be rolling out a website allowing patients to more easily compare services and performance across member practices so that they can make informed choices about their care.

[6] Ofcom European Broadband Scorecard 2014: http://stakeholders.ofcom.org.uk/market-data-research/other/telecoms-research/bbresearch/scorecard-14

Two factors have made this initiative possible. Firstly, the pooling of resources across the federation makes designing and implementing online booking systems simpler and more efficient. Secondly, the practice has been able to access additional funding through the Prime Ministers' Challenge Fund to implement this scheme.

Smartphone apps

13. A small number of practices have gone further than simply offering online booking and have funded and developed their own smartphone app. Whilst there are some benefits to using this approach, an obvious limitation is that patients who do not use smartphones are excluded – it is currently estimated that at least 54% of the UK population use such devices[7]. Although there is very little evidence in this area at present, existing cases in which apps have been used suggest that they can help improve access in combination with other measures.

14. Whilst current examples of apps being developed appear to be on an individual practice level, it is highly unlikely that most practices would have the resources and time to pursue this on their own, and this would also lead to unnecessary duplication and a large number of different user interfaces. It seems likely, therefore, that any scaling up of the use of apps will be taken forward by federations of GP practices working together.

Case study: Practice smartphone app

The Robin Lane Medical Centre has developed a smartphone app through which patients can request appointments, send secure messages to clinicians and set appointment reminders.

The development of the app was funded by the practice itself and cost £5,000. In addition to the convenience the app offers to some patients, the practice has found that it has helped to reach patient groups who may not ordinarily interact with their GP – for example young people seeking confidential advice about sexual health.

Although a smartphone app inevitably will not reach some patients, the practice uses a number of other means to engage with the local community more widely – including setting up a local wellbeing centre next to the practice run in partnership with voluntary sector organisations.

Web consultations

15. The use of video conferencing in general practice – particularly the programme Skype – has received significant attention from politicians and the media in public debate about the future of access to general practice. The opportunities presented by the rapid growth of online video conferencing services for general practice are clearly worth exploring – and many practices are already doing so. Practices are also trying out other online services that often receive less attention, such as real time webchat consultations.

[7] ComScore analysis, November 2012: http://www.comscore.com/Insights/Data-Mine/15-5-percent-of-European-Smartphone-Owners-Have-a-Tablet

16. Whilst telephone consultations have been in use for some time, there are some clear advantages to patients being able to communicate with their GP from the comfort of their own home (or workplace) using web-based services:
    a. Video conferencing can facilitate a richer interaction between a patient and their GP as compared to speaking on the telephone – given the vital role that non-verbal communication plays in most consultations.
    b. Wider availability of these sorts of technologies could help break down some of the physical barriers that prevent groups such as long-term carers or the physically disabled from receiving care.
    c. Webchat services provide a more discreet method of communication, which may encourage some patients who wouldn't normally seek care to approach their GP.

17. There are some significant limitations that need to be considered carefully as use of these services increases:
    a. Online interaction between GPs/ nurses and patients should not be considered a replacement for face-to-face contact. Much of the value of general practice lies in the development of a trusted relationship over time between a patient and their GP, and it is more difficult to achieve a strong rapport when communicating remotely.
    b. There are legitimate concerns that have yet to be fully addressed about the security of information exchanged through third party programmes such as Skype – which routes its data through servers that are outside of the jurisdiction of EU information governance laws.
    c. Where practices have offered these services, they have felt it necessary to require users to register in person first – which may to some extent negate some of the advantages described above.
    d. There is little evidence at the moment that online consultations reduce workload or save practices money. They still require GP/nurse time and there are also costs associated with setting up and maintaining IT infrastructure. One pilot in Central London has reported that Skype consultations took up on average 10 minutes of practice time per patient compared to five for a telephone call[8].

Case study: Skype consultations

The South King Street Medical Practice in Blackpool has recently begun offering its patients consultations via Skype. When the local CCG revamped their computer systems to include computers with inbuilt cameras, the possibility of using Skype was introduced into the practice. As the service is free there are no associated technological costs, and the practice report that the user friendly nature of Skype has meant that no extra administration has been required.

The service has been taken up by a wide range of patients, but has proven to be particularly popular with the housebound elderly. While it can be a good alternative to home visits the service is primarily used as a means of increasing the types of access available. The service is advertised on the practice website and within the surgery. The patients will book an appointment in the normal way, and it is often suggested as an alternative to telephone consultations. Examples of consultations are district nurses using the service as part of their home visit service to involve the GP, examination of skin complains and eye complaints, or its use to involve relatives in another locality who have an interest in the patient's care. There are limits to the service as it cannot be used for a large number of examinations and

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complaints, however it is considered preferable to phone consultations and suitable for many situations.

There is no evidence that it is currently freeing up time for clinicians in surgery – however, if there were a greater use of the service across the healthcare system especially by district nurses then it is envisioned that this could be the case.

The feedback from clinicians and users has been very positive. However, the uptake has been limited by high levels of deprivation in the local area and therefore a lack of access to the associated technology. Indeed it should be noted that the use of this technology was only made possible due to an upgrade of the practices wider computer system.

Co-location of general practice with other services

18. An alternative approach is to physically move GP services into other settings within the health and social care system. In particular, there are a number of examples of GP services being attached to hospital emergency departments, particularly during the out of hours period.

Case study: Co-location of general practice with secondary care

North Manchester General Hospital has been rethinking the design of its busy A&E department, which sees almost 100,000 patients a year. The hospital has recruited GPs with a special interest in emergency medicine and integrated them directly into the team alongside hospital consultants. These GPs typically work for part of the week in a local GP surgery, providing a direct link between primary care the emergency department.

19. The merit of this approach is that with an estimated 15% of patients in England presenting at hospital emergency departments who could have been treated in primary care, the presence of a GP in this setting helps to reduce the burden on secondary care but also ensures that patients receive care that better fits their needs[9].

20. However, whilst some areas have found this approach to be helpful there are some important limitations that need to be considered. Many out of hours GP services such as those described in the case study above do not provide a walk-in centre, which may hamper the ability of secondary care to transfer patients directly into primary care. In addition, the presence of GP services in A&E may further encourage patients to see hospital emergency departments as a 'one stop shop', putting the NHS on a reactive footing when potentially a better approach would be to strengthen primary care so that more proactive services are delivered closer to patients' homes.

Home visits and district nursing

21. One effective means of ensuring hard-to-reach patients are able to access general practices services is to undertake more home visits and outreach services, including working in close collaboration with district nurses. Home visits have long been used by general practice for this purpose, but are becoming increasingly difficult to fit in alongside other demands on practices' time. Between 1995 and 2008 the number of

[9] College of Emergency Medicine, Press Statement: Emergency Departments: Emergency Departments - More useful than the official data suggests, May 2014: http://www.collemergencymed.ac.uk/CEM/document?id=7760

home visits conducted in England declined from 0.3 consultations per patient-year to 0.1 per patient-year (although to some extent this explained by changing patterns of out of hours care).

22. Inevitably, the time needed to properly arrange and conduct home visits can prove a barrier to increasing their use. One solution to this challenge is closer joint working between district nurses and GP practices – for example through the use of technology to ensure that district nurses can remotely access and share information about patients with their practice.

Case study – District nurses with remote access to patient information

A GP practice in South Yorkshire is piloting an initiative in which doctors and district nurses are given hand held Personal Digital Assistants (PDSs) enabling them to access and share information about patients they are visiting with the GP practice.

Benefits include improved efficiency and patient experience, with doctors and district nurses no longer required to return to record or access relevant information about the visit. The new approach has also reduced duplication of records, making it easier to manage and organise home visits.

23. Implementing this approach, however, requires investment in IT systems and hardware and in relevant training for staff. One potential further barrier to greater uptake of this model is the shortage of district nurses, of which there are an estimated 40% less than a decade ago[10].

Ensuring homeless people and other socially excluded groups can access general practice

24. In 2013/14 the number of households considered legally 'homeless' stood at 52,270 in England, 29,326 in Scotland and 5,115 in Wales. In Northern Ireland 9,878 households were considered homeless in 2012/13. This presents challenges for GPs across the UK – particularly those practicing in areas with high levels of deprivation[11].

25. Whilst tackling homelessness requires a multi-agency response, general practice has a vital role to play as a point of access to the NHS for those of no fixed address. GPs and their teams can build trust with socially excluded groups, working in partnership with other parts of the health and social care system as well as the voluntary sector.

26. In 2013 the RCGP published a paper on 'Improving access to health care for Gypsies and Travellers, homeless people and sex workers[12]', calling for radical changes in the way the needs of these patient groups are met, including:

    a. More 'one-stop' healthcare hubs where vulnerable groups can receive multiple services in one place at one time.
    b. Greater community engagement to allow vulnerable groups to have their voice heard and develop support networks.
    c. More localised decision making for commissioners, who should seek greater collaboration with vulnerable groups to deliver mutual health and financial benefits.

[10] National Nursing Research Unit at King's College London, District nursing – who will care in the future?, Policy +, Issue 40, September 2013
[11] http://www.scotland.gov.uk/Resource/0045/00453960.pdf
[12] Improving access to health care for Gypsies and Travellers, homeless people and sex workers, RCGP, 2013: http://www.rcgp.org.uk/news/2013/december/urgent-action-needed-for-sex-workers-gypsies-and-travellers.aspx

d. More communication and joined up working between health, social care and voluntary services targeted at marginalised groups.
e. Greater integration between health and housing services to identify and treat health problems associated with poor living conditions.

Case study: Homelessness GP services in Watford

The Meadowell surgery in Watford offers enhanced access to primary healthcare for homeless and disadvantaged people living in the local area. 'Homeless' in this context includes people in temporary accommodation, staying with friends or at risk of being made homeless, as well as those who find themselves sleeping on the street.

Having started as a direct PCT-provided service, Meadowell became a social enterprise when NHS Hertfordshire was forced to divest itself of the provision of community healthcare services. Subsequently, Meadowell submitted a successful bid for a block contract under the Alternative Provider Medical Services (APMS) framework, for a term of 5 years.

As a social enterprise, Meadowell is able to act in relative freedom, providing for the needs of more than 600 patients with a range of services.

Meadowell provides a holistic, 'one stop shop' service, and is able to address health problems together with housing departments.

As homeless people often find it hard to engage with health services, aside from a schedule of planned appointments, Meadowell offers daily drop-in sessions.

Besides full range of primary care services, Meadowell also provides:

- Specialist services for the treatment of drug and alcohol misuse in primary care
- Joint working with specialist services to help people recover from alcohol and drug abuse
- A hepatitis c treatment centre.
- Cognitive behavioural therapy (CBT) on site
- Alcohol home detox support
- Housing and welfare advice and support

Working with the voluntary sector to reach patient groups who typically report poorer levels of GP access

27. A number of patient groups often report difficulties and frustrations with access to general practice – including carers and those with physical or mental disabilities. Some practices are working with national or local voluntary sector organisations to improve access for these patients.

Case study: Improved access for patients with hearing loss in Northern Ireland

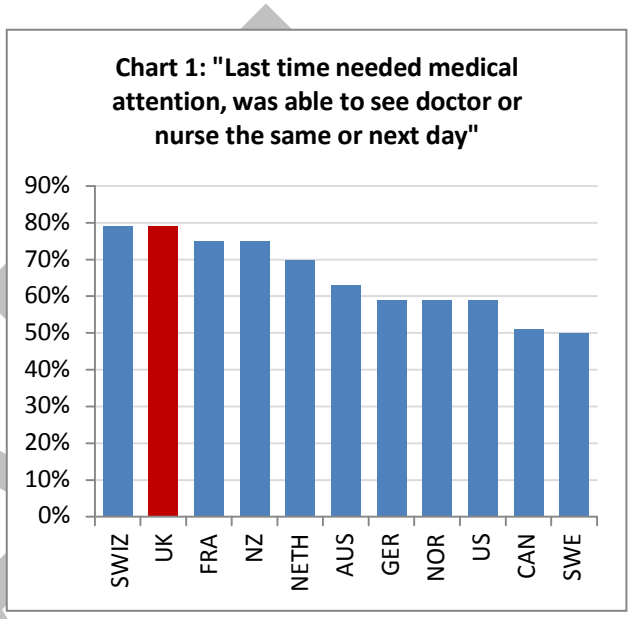
Action on Hearing Loss, a national voluntary sector organisation, have been working with GP practices to improve access for patients with hearing loss. The Hunter Family Practice in Northern Ireland have implemented a number of changes – including establishing a new protocol for booking a sign language interpreter, installing hearing loops and providing training to practice staff – designed to improve the experience of patients with hearing loss who visit the practice. The practice has used Action on Hearing Loss's 'Louder than Words'

benchmarking tool to ensure they fully meet the needs of this patient group.

The practice have reported that staff now feel more confident in helping patients with hearing, where in the past they might have felt unsure or embarrassed about how best to interact with these patients. Patients with hearing loss have reported that the changes have led to a more positive experience when they book an appointment and visit the practice.

28. In Wales, the RCGP has worked closely with EquIP Cymru to develop a set of tools that patients and practices can use to improve access to general practice for people with disabilities[13].

Timeliness of care



29. Ensuring that patients can access general practice at a time convenient to them is a growing challenge for the NHS, with practice capacity and resources failing to keep pace with demand for appointments.

30. A straightforward international comparison shows that the UK performs well in relation to short-term access to front line medical care. In a comparison of fourteen industrialised nations' healthcare systems carried out by the Commonwealth Fund in 2014, the UK was found to be a high performer in regard to short-term access to care (see Chart 1).[14] This is supported by the findings of various patient surveys conducted in England, Scotland, Wales and Northern Ireland, with relatively high proportions of respondents saying they are able to obtain an appointment quickly and at a convenient time.

31. However, there is evidence that patients are finding it increasingly difficult to access general practice at a time convenient to them. In England, the proportion of patients who report they were unable to secure an appointment has been creeping upwards, with patients unable to get an appointment within a week on an estimated 62.4m occasions in 2014[15]. In Wales, an estimated 658,000 patients found it "difficult" to get a convenient GP appointment in 2013 – and if trends continue this could rise to as many as 800,000 by 2017[16]. Patients in Scotland had to wait more than two days for an appointment with a doctor or nurse on an estimated 3.2m occasions in 2013/14.

32. Practices across the UK are exploring a number of different approaches to ensuring that patients can rely on timely access to their services with the limited resources at their disposal. Many practices are opening for longer hours to fit in more

[13] These resources are available on the RCGP website here: http://www.rcgp.org.uk/clinical-and-research/practice-management-resources/disabled-people-guidance-on-improving-access-to-gp-services.aspx

[14] Mirror, mirror, on the wall: How the Performance of the U.S. Health Care System Compares Internationally, Karen Davis, Kristof Stremikis, David Squires, and Cathy Schoen, Commonwealth Fund 2014: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

[15] New league table reveals GP shortages across England, as patients set to wait week or more to see family doctor on 67m occasions, RCGP, February 2015: http://www.rcgp.org.uk/news/2015/february/new-league-table-reveals-gp-shortages-across-england.aspx

[16] RCGP analysis based on data from the National Survey for Wales

consultations and offer patients greater access in the evenings and at weekends. Some are looking at what systems can be put in place to manage the flow of patients interacting with the practice – for example by having GPs speak to patients when they first call to request an appointment, or by offering 'walk in' sessions, in which patients can be seen by a GP on a first come, first served basis within the practice at specific times. Others are looking at what systems can be put in place behind the scenes to increase efficiency – for example by experimenting with different forms of 'skill mix' that allow GPs to focus on patient care. The following section analyses some of these different approaches.

Extended hours

33. One obvious tool practices can use to offer patients more timely access is to extend (or make more flexible) their opening times beyond core contracted hours. It is estimated that in England around 60% of practices currently provide some form of extended opening (outside 8am - 6.30pm), with 17% open over the weekend, and 53% providing extended opening during the week[17].

34. Whilst additional funding is available for practices who choose to open outside core hours, there are a number of barriers to increasing uptake of this additional service by surgeries:
    a. Problems with recruiting and retaining a GP workforce to staff extended hours provision is a frequently cited problem. There is a risk that attempting to provide longer hours will leave the practice overstretched, having a negative impact on care during core opening times.
    b. Lack of sufficient demand from patients. Some practices have found that services in the evenings and at weekends are not popular enough to justify longer opening times.
    c. In Northern Ireland (where several extended hours pilots are being implemented this year by the Health and Social Care Board) some practices have found the same patients are booking into evening slots as in the day – raising the question of whether it would be more effective to increase capacity during core hours[18].

35. One solution to the problems outlined above is for groups of practices to work together in federations or networks in order to share both resources (in terms of GP and non-GP workforce, and back office functions) and patient demand across a particular locality.

Case study: Extended hours shared across federated practices

Hambleton, Richmondshire and Whitby GP Federation is instituting eight to eight opening for GP services during the week and for four hours on Saturday and Sunday.

The service will be staffed on a rota system, operating on three sites, meaning that patients who have an appointment within this area in the extended time period will often be seen at a different surgery than their normal one, or the community hospital at weekends. By allowing doctors to access patient records across the locality through EMIS web the project aims to

[17] NHS Choices, Freedom of Information requests http://www.nhs.uk/aboutnhschoices/contactus/pages/freedom-of-information.aspx. Comparable information for Wales, Scotland and Northern Ireland not available.

[18] Hansard, Northern Ireland Assembly Committee for Health, Social Services and Public Safety session, 11th June 2014, GP Out-of-hours Framework: Department of Health, Social Services and Public Safety and Health and Social Care Boardhttp://www.niassembly.gov.uk/Assembly-Business/Official-Report/Committee-Minutes-of-Evidence/Session-2013-2014/June-2014/GP-Out-of-hours-Framework-DHSSPS-and-HSCB/

ensure a certain amount of continuity of care.

Patients can pre book appointments with the service in the normal way through their existing surgery. If they attempt to book an emergency appointment at their surgery in the out of hours period their call will be directed to the service.

This service operates in addition to existing out of hours services, and delivers routine GP care, in contrast to the out of hours service which only treats emergency or urgent medical concerns. The aim is to provide increased access to standard general practice services in the out of hours period.

However, despite the advantages of a system such as this it has only been possible to implement with the additional funding directed to the project via the Prime Minister's Challenge Fund. In addition, there have been problems with recruitment, leading to the creation of a rota system rather than the extended opening of every surgery in the local area.

Demand management systems

36. For many patients, the first person they speak to when contacting their local practice is a receptionist, who often has an important role in ascertaining whether enquiries are urgent or non-urgent. However, some practices are pursuing a different approach by placing GPs at the front-end of the service as a means of managing demand more effectively. Such systems help ensure patients receive more timely care by identifying those whose needs can be dealt with quickly, in theory freeing up time for the practice to focus on patients with more complex problems.

37. GP-led telephone triage is an example of demand management that is becoming increasingly used, including through a number of specific models such as 'Doctor First' and 'Patient Access'. In these models, typically a GP calls back all patients in the first instance, and then either offers a face-to-face appointment with a GP or nurse (usually on the same-day), gives advice over the phone, or issues a prescription for the patient to pick up.

38. Similarly, some practices offer 'walk in' sessions at specific times, with patients guaranteed an appointment if they visit the practice during these hours.

39. Such models have a number of potential advantages:
    a. Patients are able to see or speak to a GP on the same day, benefiting those patients who wish to prioritise speed of access to general practice.
    b. More efficient use of consultation time, with simple problems dealt with more quickly.
    c. Better continuity of care for patients. Whilst patients may not always see or speak to their 'usual GP', their interaction either via telephone or 'walk in' session is captured in the practices' systems and can result in any relevant follow up (e.g. an overdue check-up can be spotted and booked in for the patient). This level of continuity would not be achievable if the patient visited a stand-alone walk-in centre or a hospital emergency department.

40. However, although some practices using these models have reported encouraging results, others have been less positive. There is limited independent research on their effectiveness and it is therefore difficult to draw reliable conclusions about whether they could be implemented on a wider scale. There are a number of limitations to these models:

a. An obvious limitation of telephone consultations is the lack of visual information – such as non-verbal cues or a physical examination – as well as challenges around relationship building and communication.
b. A barrier to effective implementation of the 'Doctor First' model in some areas is that English may not be the first language for many of the population. Telephone consultations are also potentially less effective for certain groups of patients, such as those with learning difficulties.
c. There is an ongoing debate (hampered by lack of sufficient evidence) about whether such systems do reduce workload. Evidence recently published from the ESTEEM study (which focuses specifically on telephone triage of patients requesting same day consultations in general practice) found that the number of overall patient contacts increased, but noted a reduction in face-to-face GP contacts.[19]
d. Walk-in clinics can lead to a long queue of patients at the surgery who have been guaranteed a same-day appointment, meaning that the service could overrun (impacting on other aspects of care) or GPs could feel they have only limited time to see each patient.

Case study: GP-led telephone triage (using the Doctor First model)

Denburn Medical Centre in Aberdeen was formed when two smaller practices merged into one. Upon merging they struggled to meet demand so they decided to switch to the Doctor First telephone triage model. Under this system, patients can ring at any time and a doctor will call them back for a phone consultation. But if patients need – or still want to be seen – by the doctor or a Nurse Practitioner they can be offered an appointment that day or at a time which suits them.

The practice has found that in two out of every three cases the problem can be dealt with over the phone. Through the use of the system the practice has achieved the following:

- Saving of £20,000 in DNAs – equivalent of two to three GP sessions a week.
- Reduced emergency admissions
- Over 20% reduction in out of hours presentations between May-August 2012 and May-August 2013
- GPs much more accessible to patients and other members of the multi-disciplinary team
- Weekly patient contacts up by 100% meaning more people are being helped but there is no backlog

Ability to see a preferred GP or nurse

41. For many patients, access to general practice is as much about quality as it is about quantity (or speed). Being able to see a preferred GP or nurse is more highly valued by some patients than speed or convenience of access, and indeed general practice is often considered to work best when there is continuity of care between a patient and their doctor, facilitating an ongoing therapeutic relationship[20].

[19] Prof John L Campbell et al, Telephone triage for management of same-day consultation requests in general practice (the ESTEEM trial): a cluster-randomised controlled trial and cost-consequence analysis, The Lancet, 2014
[20] Freeman G, Hill A, Promoting Continuity of Care in General Practice, RCGP, 2011

42. There is evidence that it is becoming more difficult, in the face of rising workloads and falling resources, to offer patients the opportunity to see their preferred GP or nurse. Patient survey data across the UK supports this conclusion:

    a. In England a majority of patients have a preferred GP (54%), but there has been an increase in the proportion of patients reporting that they only see their preferred GP "some of the time" (31% in 2015 compared with 28% in 2012) or that they "never or almost never" see them (8% in 2015 compared with 6% in 2012)[21].
    b. In Northern Ireland 55% of patients who have a preferred GP said they "always or almost always" got to see them in 2011, down from 57% the previous year[22].
    c. In Scotland 76% of patients who have a preferred doctor said they were usually able to see their preferred doctor. This is a three percent point decrease compared to 2011/12[23].

43. In the face of this challenge, practices are pursuing a number of approaches to promoting continuity of care and ensure patients who wish to are able to see their preferred GP or nurse[24]. One model beginning to be explored in some areas is the setting up of GP 'micro teams' – groups of two or more doctors who work together to provide continuity of care to an allocated number of patients. Increasingly, however, practices are also seeking to proactively identify patients who would most benefit from improved continuity of care, and using a care planning approach – led from within general practice but in partnership with other professionals – to ensure these patients have access to more personalised, integrated care. This section explores initiatives being piloted in these areas.

GP 'micro teams'

44. GP 'micro teams' involve allocating a shared group of patients to a small number of GPs within a practice – usually two or more doctors and potentially involving a practice nurse. When patients contact the surgery to arrange an appointment, but their preferred GP is not available, they are assigned an appointment with another member of the micro team. Some of the advantages of organising care in this way include:
    a. Improved continuity of care for patients as compared to randomly allocating an alternative doctor where the preferred GP is unavailable. By being given access to a micro team patients are likely to see a smaller number of doctors over a period of time.
    b. Improved peer support amongst GPs, reduced isolation, and better processes for jointly reviewing the care of patients with complex needs.

Case study: GP micro teams in Tower Hamlets

Tower Hamlets CCG in London is currently piloting micro teams of GPs across the borough[25]. Receptionists first attempt to book a patient with their chosen doctor first and if that fails, with another member of the micro-team. Only if that fails would the patient be

[21] GP Patient Survey results, 2012-2015, Ispos Mori
[22] The GP Patient Survey in Northern Ireland 2010/11 Summary Report. http://www.dhsspsni.gov.uk/2010-11_gpps_in_northern_ireland_national_summary_report.pdf
[23] National Statistics for NHS Scotland. Health and Care Experience Survey 2013/2014. Volume 1: National Results. http://www.scotland.gov.uk/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey
[24] For detailed guidance on enhancing continuity of care aimed at practices, please see the RCGP's continuity of care toolkit: http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/Continuity%20of%20Care%20Toolkit.ashx
[25] Micro teams in general practice, NHS Tower Hamlets briefing note: http://www.towerhamletsccg.nhs.uk/gp/clinical-services/What%20is%20a%20micro-team%20v%201.0%20GP%20Internet.pdf

booked with a doctor from another team. Exceptions to this rule could be where certain doctors in the practice provide specialist services; women's health for example. Administration can also be streamlined and aligned to support the micro-teams.

One North London practice has reported that after implementing a micro team approach, the percentage of patients seen by their regular GP rose from 27% to 42%[26].

Proactive care planning and promoting self care

45. The College has long advocated for the implementation of a 'care planning' approach led from within general practice as a means of improving care for patients with long term complex care needs – particularly those living with multiple morbidities[27]. Embedding a 'care planning' approach into primary care stands out as a solution that has the potential to both improve quality of access for patients and help manage demand in general practice by empowering patients to become experts in their own care. This approach, based on the 'house of care' model, involves patients living with long term conditions co-designing their own care plan with a community-based team of health professionals led from within general practice. This approach is set to become increasingly prevalent throughout the UK in the coming years. The Government in England has made it a requirement that all patients over the age of 75 have a 'named GP' responsible for managing their care through a personalised care plan (based on a national template). Governments in Wales, Scotland and Northern Ireland are also implementing plans to promote care planning.

46. A full analysis of the benefits of care planning is beyond the scope of this paper, but it is worth noting that this approach can have the following specific benefits for patients in terms of access:
    a. Care planning improves continuity of care for patients and focuses on raising the 'quality' of the patients' interaction with their GP practice. It offers those with complex needs access to more person-centred care, taking into account the physical, mental and social background of the patient.
    b. Care planning puts access to general practice on a more 'proactive' footing. Rather than the onus being on the patient to approach their GP, the practice identifies patients in need of long term support and works with them to design their care according to their needs and goals.
    c. There is strong evidence that care planning leads to improved self-management by patients themselves, enabling that person to make more informed and personally relevant decisions about accessing health or social care resources[28]. As the number of consultations required by the patient decreases, this frees up practice resources that can be used to improve access for other patients.
    d. Care planning facilitates access to more than just general practice – it can provide a platform for multi-disciplinary team working, involving GPs and practice staff working alongside other professionals in the community or colleagues in secondary care.

Case study: Pooling practice resources to deliver planned care for care home residents in Cumbria

[26] Quality in General Practice in Tower Hamlets: Our strategy for change 2014/15 – 2017/18, NHS Tower Hamlets: http://www.towerhamletsccg.nhs.uk/gp/clinical-services/Quality_in_General_Practice_in_Tower_Hamlets_strategy_v3.0%20-%20for%20GP%20internet.pdf

[27] See for example the RCGP's work with the Coalition for Collaborate Care: http://coalitionforcollaborativecare.org.uk/

[28] Care planning: Improving the lives of people with long term conditions, RCGP 2010, Mathers et al.

An initiative called 'Better Together' has been launched in Wokington, Cumbria, combining five practices covering 33,900 patients. As a means of increasing access, these practices have banded together to establish a new team providing dedicated services for residents in local care homes, focusing on proactive (rather than reactive) care. This team will undertake scheduled visits in order to create proactive care plans for patients, as well as undertake end of life care and medication reviews. This project has been undertaken in response to local concerns around the level of access to GP services and historically poor health outcomes linked to levels of deprivation in the local area, and it is hoped that it will help mange demand for GP services in a proactive fashion alongside improving the overall health of their population. The project is being taken forward using additional funding from the Prime Ministers' GP Challenge Fund.

47. Whilst overall care planning can be cost neutral, the need to invest resources, time and energy into designing and implementing new systems to support it can act as a barrier to wider take up. There are also technical and regulatory barriers to sharing information about care plans between health and social care professionals.

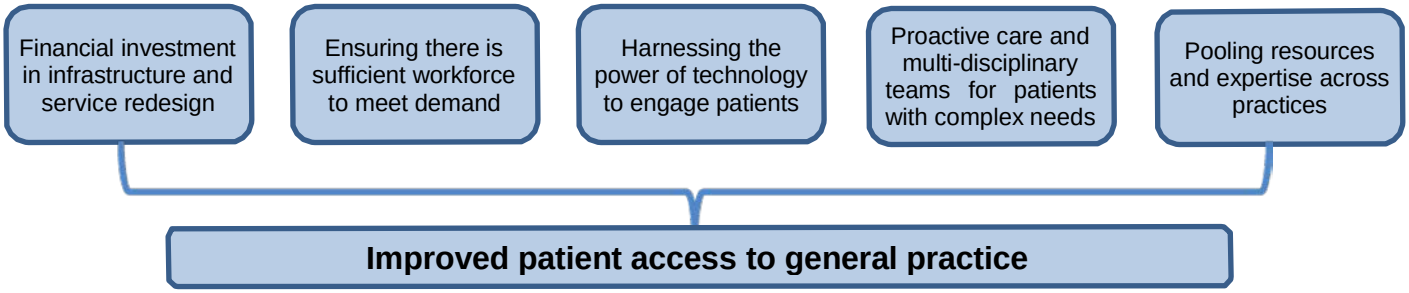
Case study: Overcoming barriers to sharing care plans in Wales

In Mid and West Wales local Councils and the Hywel Dda University Health Board are working together to implement a new approach to caring for older people with complex needs based on personalised care planning[29].

Having identified system constraints preventing the sharing of individual care plans across agencies, Carmarthenshire County Council and Hywel Dda are working together to develop an interface between the NHS' *Myrddin* system and the Council's *CareFirst* system. This will enable staff to access one system and transport data from the other through one access point, and is currently being piloted with multi-agency staff in Llanelli. Work is also underway to set up mobile working options for community teams and provide access to Wi-Fi at certain hotspots across the County including Council and Health buildings so staff do not have to return to their base of work to upload patient data.

The way forward – drivers of better access to general practice for patients

48. A central conclusion of this paper is that there is no one-size-fits-all solution to improving access to general practice. The ideas and case studies outlined are likely to work in some areas, but have a limited effect in others. However, some broad conclusions can be drawn about what factors are important to the successful delivery of high levels of access to general practice. Based on the ideas explored above, the following five key drivers of improved access can be identified:



[29] Delivering integrated health and social care to older people with complex needs, Caring for the future in Mid West Wales: http://www.carmarthenshire.gov.uk/English/socialcare/Documents/Statement%20of%20Intent%20Hywel%20Dda%20UHB%20region%20Final%20Iteration%2031%20March%202014%20(2).pdf

	COUNCIL November 2014 Case Studies – Integration of Care	REF: C/xxx	ITEM xx

CATEGORY

For discussion

SCOPE

UK

LEAD OFFICER(S)

Maureen Baker

LEAD DIRECTOR

Paul Rees

EXECUTIVE SUMMARY

1. Across the UK a number of different models of integrated care are being developed and tested. There is a growing consensus that there is no 'one size fits all' approach to integration that will work for patients in every area, and that local health economies will need to decide what works best for them from a relatively small number of potential models.

2. The College has consistently championed the leading role that GPs can play in redesigning services around patients. Council debated a paper in September 2014 outlining 'five tests' to be applied to different models of integrated care – which are currently being finalised to incorporate feedback from that discussion. However, alongside these high-level principles there is a need to collect and showcase concrete examples of integrated care and highlight the role GPs are playing both as providers and system leaders.

3. This document contains four case studies demonstrating the role that GPs are playing – working with patients and other health and social care professionals – in delivering integrated care. These case studies are intended to provide a starting point for local decision-makers who are considering how to design new integrated services that best meet the needs of patients in their local area.

4. The four case studies are:
   a. Hospital@Home, Western Cheshire
   b. Alliance contracting in Canterbury, New Zealand
   c. ~~Better Care Together~~, NHS West Leicestershire CCG
   d. The 'Torbay Model'

SUPPORTING ORGANISATIONS

N/A

PATIENT INVOLVEMENT/IMPLICATIONS

As a member of Council the Chair of the College's Patient Partnership Group (PPG) will have an opportunity to respond to the paper.

RESOURCE IMPLICATIONS (Financial, Legal, Personnel, IT etc)

Policy development in this area is being taken forward using existing resources.

DECLARATION AND CONFLICTS OF INTEREST

None

AUTHOR(S) :	**RECOMMENDATION**
Rachel Mawby Bronwen Franklin-Pierce Jonathan Ware	1. That Council debates and discusses the case studies outlined in this paper. 2. That Council provides ideas for further case studies that could be developed, submitting any written suggestions via email (policy@rcgp.org.uk) by 19th December.

Case Study 1: Hospital@Home, Western Cheshire

Hospital@Home was launched in December 2011 and is a service designed to provide an alternative to hospital admission for patients who are acutely ill. Delivered by a team of GPs experienced in acute care, ANPs and staff nurses, this 24/7 service has resulted in almost 2000 patients receiving their treatment in their own home, including care homes, rather than hospital.

Overview

The driving force behind setting up the Hospital@Home service was the desire to deliver care in a personalised fashion; not everyone who is acutely unwell needs to treated in hospital providing there are safe, accessible community options.

The main provider of Hospital@Home is Partners4Health, a GP-run organisation and NHS body. The name was chosen as it is fundamental to the culture of Partners4Health that effective services and support can only be delivered by providers working together and utilising the skills and resources of all providers in an integrated systematic way in order to improve care for patients.

Hospital@Home is a partnership between Partners4Health and:

- the local acute trust for diagnostics and consultant advice, enabling the development of condition specific care pathways,
- community providers for district nursing and therapies,
- the Local Authority for equipment and rapid response for personal care.

Each organisation plays an essential part in delivering a structured, seamless care service at home for patients who would otherwise require hospital admission.

The service has been independently reviewed and has been shown to be safe, effective and significantly less expensive than hospital care. Patient and carer feedback appears to be very positive, with 793 out of 794 responders to the post discharge survey requesting Hospital@Home rather than admitted care in the future.

Key features

Patients are referred to Hospital@Home by GPs and community matrons, and would otherwise need to be admitted to hospital. Although the service accepts patients aged 18 and above, the majority of patients are aged 75 and over.

The service provides 24/7 care, accepting admission from 08.00-20.00. Patients are assessed within two hours of referral and treatment commenced not more than four hours after referral, which compares favourably with admitted care. During an admission patients are clerked, investigations carried out and a care plan agreed with the patient. This care plan is delivered and monitored by the nursing team and overseen by the duty GP. On the day of discharge, after an average 3.8 day length of stay in the Hospital@Home scheme, a discharge report is sent to the GP.

Current conditions treated through Hospital@Home include

- pneumonia
- COPD
- heart failure
- severe cellulitis
- urospesis

- delirium
- dehydration
- End of Life medical emergencies such as sepsis and hypercalcaemia.

Available investigations include near patient arterial blood gasses and ECGs. X-rays and blood tests are fast tracked with results within 60 minutes. Treatments include IV fluids and therapies, oxygen and nebulised therapies as well as prescribed medication.

Outcomes and results

- Positive feedback from patients, carers and local GPs
- Recent audit of pneumonia treatment, compared with the BTS Community Acquired Pneumonia national hospital audit, showed better than expected outcomes and a faster referral to treatment time than admitted care.
- On track to deliver 1460 care episodes in 2014-15 and avoid 5000 in-patient bed days.
- CCG confirmed savings of £500,000 over the first two years of the service, and Hospital@Home is on track to save in excess of £1m in the 2014/15 financial year following expansion of the service. Assuming full utilization of available capacity this saving will ramp up to an annualised saving of £2.3m in 2016/17.
- Excellent CQC inspection report.

"… being treated at home gave mum some sense of control and self-reassurance at a time when she was physically and mentally very low. It is difficult to adequately say how grateful I am for the service you provided"
Family of a patient receiving Hospital@Home care

"It's wonderful. I don't know what I would have done without the service. I'm getting all the health care I need."
Patient quoted in the CQC inspection report

Case Study 2: Alliance contracting in Canterbury, New Zealand

The use of Alliance Contracting in Canterbury, New Zealand is an example of a local health economy adopting an innovative provider model as a means to integrate care and address previous difficulties within the health system.

Overview:

Alliance contracting is an innovative model that works on the assumption that multiple organisations can achieve better things by working together on agreed pain/gain contracts in which 'everyone wins, or everyone loses'. It involves a recognition that if one partner is struggling it is in the interest of all to help solve the problem. It involves a collective contract with pre-agreed gains and losses dependent on the overall performance of all the parties, rather than with penalties solely for whoever fails within it.

Key Features:

In 2006 Canterbury Hospital had to remove 5,000 patients from its waiting list to meet targets, and by 2007 Canterbury Hospital regularly entered gridlock**.** It was calculated that, if

nothing changed, Canterbury would need another hospital the size of the 500-plus bed Christchurch hospital by 2020, 20 per cent more general practitioners and a similar increase in practice nurses. It would need another 2,000 residential care beds for the elderly on top of the 4,500 already in existence. This was unaffordable.

A new health service plan was adopted with the following goals:

- Services should enable people to take more responsibility for their own health and well-being
- As far as possible people should stay well in their own homes and communities
- When people need complex care it should be timely and appropriate.

To achieve these goals a new way of working was essential. The key requirements were:

- Those in the health system – from primary to community to hospital to social care, and whether working as public employees, independent practitioners, or private and not-for-profit contractors – had to recognise that there was 'one system, one budget' in Canterbury
- Canterbury had to get the best possible outcomes within the resources available, rather than individual organisations and practitioners simply arguing for more money
- That the goal was to deliver 'the right care, right place, right time by the right person' – and that a key measure of success was to reduce the time patients spent waiting.

By working together under a unifying contractor model, Canterbury was able to address many of the problems that can stem from a lack of integration within the health and social care system.

However, even within the alliance contract, an element of competition remains as patients are, within certain constraints, still able to choose a provider – for example, GPs are able to decide which of the three providers they will refer to.

Outcomes and results

The adoption of this model has lead to the following improvements in the health care service:

- In 2008 'HealthPathways' was developed. This is an electronic health management system which helps GPs to understand which treatments can be managed in the community, what tests GPs should carry out before a hospital referral and where and how GPs can access such resources. It also includes a patient version (HealthInfo) to help patients manage their own care. Pathways are continuously reviewed and audited with input from local GPs.
- Reduced strain on the hospital and greater efficiency within it has prompted fewer cancelled admissions.
- Waiting times for elective surgery are down as GPs have been provided with direct access to a range of diagnostic tests and a range of conditions that once were treated purely or mainly in hospital are now provided in general practice – for example, the removal of skin lesions
- Extended GP access. The use of alliance contracting has lead to longer GP opening hours within Christchurch with two 12-hour surgeries currently in operation. Rural areas now have 24 hour and nurse cover. In addition, there is a dedicated 24 hours a day surgery/ care facility similar to Darzi centres now in existence.
- The creation of an Electronic Request Management System which GPs use to request tests, outpatient referrals, community assessments and specialist advice.

- The creation of an Electronic Share Care Record a Central Patient Database that is modular so it builds on existing systems instead of replacing them.

Case Study 3: Better Care Together, NHS West Leicestershire CCG

Better Care Together is an initiative being undertaken by NHS West Leicester CCG. It aims to radically transform care in Leicester, Leicestershire and Rutland into an integrated health and social care system with better results for patients by moving more care out of hospitals and into the community.

Overview

Better Care Together is a five year strategy to transform health and social care in Leicester, Leicestershire and Rutland, drawn up by local NHS organisations including NHS Cumbria Clinical Commissioning Group, University Hospitals of Morecambe Bay NHS Foundation Trust, and Lancashire North Clinical Commissioning Group.

The strategy aims to improve the health and experience for patients and service users by focussing on community-based prevention and care and looking at how hospital services linking to wider health services in the community and primary care will work together in the future.

Key Details

The *Better Care Together* strategy is based on a partnership of NHS organisations and local authorities across the area. It sets out clinicians' aims for how and where services could be delivered to meet the main challenges facing future care. These aims include:

- More resources in the community to support independent living
- Health and social care services which are joined up and create a better experience for the people using them
- A re-shaped General Hospital with community beds, a Diabetes Centre of Excellence, rehabilitation, psychological therapies and outpatient clinics
- Smaller hospitals and fewer acute beds, as a result of shifting workload and resource to the community

A key principle of Better Care Together is to provide the right levels of support for people who need it, close to or in their home. GPs, district nurses, therapists and social care professionals all have a role to play in this. They will be supported by specialist doctors running clinics in the community rather than in hospital. Working in this more co-ordinated way aims to keep people well, enabling them to lead healthier, productive independent lives without regular visits to hospital.

Work is beginning to re-design how services are delivered in key areas of healthcare; urgent care, long-term conditions, frail older people, and mental health. This work will involve direct input from doctors, other healthcare professionals, patients and carers from across the area.

Outcome and Results:

As the *Better Care Together* plans are still being implemented, it is not possible at this stage to fully quantify its results. However, a vision has has been agreed by all partner organisations and has six strategic objectives:

- ***System Objective One*** - to deliver high quality, citizen centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a reduction in the time spent avoidably in hospital.
- ***System Objective Two*** - to reduce inequalities in care (both physical and mental) across and within communities in LLR resulting in additional years of life for citizens with treatable mental and physical health conditions.
- ***System Objective Three*** - to increase the number of those citizens with mental and physical health and social care needs reporting a positive experience of care across all health and social care settings.
- ***System Objective Four*** - to optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system
- ***System Objective Five*** - all health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile where appropriate.
- ***System Objective Six*** - to improve the utilisation of our workforce and the development of new capacity and capabilities where appropriate, in our people and the technology we use.

Case Study 4: ‘‘The Torbay Model’, Torbay and Southern Devon Health and Care NHS Trust

Integration of the Health and Social Care in Torbay and Southern Devon was driven from the bottom up, inspired by a local team in Brixham who developed a patient-centred care model in 2004. The group started working with general practices in order to help older people most at risk, with a particular focus on enabling them to remain independent for as long as possible.

Overview
The ‘Torbay Model’ was based on care providers in Brixham questioning how care could be improved for ‘Mrs Smith’, a fictitious user of health and social care services in her 80s. People with long-term conditions and older people have needs which are rarely either just ‘medical’ or ‘social’, and for this reason integration of health and social care was deemed essential.

Key details

Torbay and Southern Devon Health and Care NHS Trust is an integrated health and adult social care organisation. The trust:

- Provides services to around 375,000 people.
- Runs 11 community hospitals.
- Employs almost 2,000 members of staff, including frontline health and social care staff, district nurses, physiotherapists occupational therapists, social workers and others to deliver care locally.

The service is based around five integrated health and social care teams organised in zones or localities, each of which is aligned with local GP practices. Each team has a single manager, a single point of contact and uses a single assessment process. Budgets are

pooled, meaning each team can commission whatever care they feel their patients need. Shared health and social care electronic records are also a key element of the model.

Integration of care has a long history in Torbay, and the Trust has become one of the most well-known examples of success in delivering joined-up care. The Trust formally came into existence as a statutory body on 1 October 2000, as Torbay Primary Care Trust. It subsequently became Torbay Care Trust on 1 October 2005 (taking on responsibility for social care in a partnership agreement with Torbay Borough Council from December 2005), and Torbay and Southern Devon Health and Care NHS Trust in April 2012.

The Trust is now exploring ways of achieving closer integration with local hospital services. This includes focusing more on prevention, bringing expertise on the care of older people into A&E, and strengthening the role of discharge coordinators in the hospital to reduce lengths of stay.

Outcomes and results

The results of integration include reduced use of hospital beds, low rates of emergency hospital admissions for those aged over 65, and minimal delayed transfers of care. Use of residential and nursing homes has fallen and at the same time there has been an increase in the use of home care services. There has been increasing uptake of direct payments in social care and favourable ratings from the Care Quality Commission.[1]

- The daily average number of occupied beds fell from 750 in 1998/99 to 502 in 2009/10
- Emergency bed day use in the population aged 65 is the lowest in the region at 1920 per 1000 population compared with an average of 2698 per 1000 in 2009/10
- Emergency bed day use for people aged 75 and over fell by 24 per cent between 2003 and 2008 and by 32 per cent for people aged 85 and over in the same period.
- Delayed transfers of care from hospital have been reduced to a negligible number and this has been sustained over a number of years.
- Since 2007/8 Torbay Trust has been financially responsible for 144 fewer people aged over 65 in residential and nursing homes.
- There has been a corresponding increase in the use of home-care services.[2]

[1] Conclusion taken from Thistlethwaite, Peter, *Integrating health and social care in Torbay: Improving care for Mrs Smith,* Kings Fund Report, March 2011: http://www.kingsfund.org.uk/sites/files/kf/integrating-health-social-care-torbay-case-study-kings-fund-march-2011.pdf

[2] Figures taken directly from the Trust's website: http://www.torbaycaretrust.nhs.uk/aboutus/Pages/TheTorbayModel-MrsSmith.aspx

FF36 RCGP

PART ONE: AN RCGP POSITION STATEMENT

tHe future of GP out of Hours Care

Royal College of General Practitioners

Executive Summary

General practice has a vital role to play in the delivery of effective patient care at all times of day, including outside normal working hours. Those seeking help from the NHS at this time are often at their most vulnerable, and for many of these patients general practice is best placed to provide the care they need.

Pressures facing the UK's urgent and emergency care services continue to be the subject of significant public debate. Although much of this debate has focused on A&E, there is a strong case for the skills of the expert medical generalist working in the community to be placed at the heart of our response to the challenges of meeting the needs of patients out of hours.

GPs already make a crucial contribution to the delivery of urgent and emergency care, making up a major part of the out of hours NHS workforce, with GP services of some form available 24 hours a day in most parts of the UK. Evidence indicates that patient satisfaction with the out of hours services GPs provide is relatively high and that the performance of these services is improving. However, too many patients are not aware that they can access these services, and the overall fragmentation of the out of hours care system can leave patients unsure as to where to seek help.

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The RCGP believes that to safeguard care for patients, future models of out of hours care provision should be based on the following principles:

- Patients should be able to gain timely access to the skills of an expert medical generalist[1] when they need it, including outside core surgery hours.
- Services must be developed from a patient perspective, delivering integrated, whole person care to individuals interacting with different parts of the health and social care system.
- Personalisation and continuity of care are key, with systems and processes put in place to facilitate the appropriate sharing of patient information and ensure smooth and timely handover of care.
- The quality and safety of care are paramount and all service delivery models must ensure that working patterns are safe and sustainable.
- Providers and commissioners should be responsive to their local context, tailoring services to the needs and priorities of their populations.
- Out of hours services must be adequately resourced. Proposals to enhance out of hours services should not be pursued to the detriment of the ability of general practice to provide patient access in hours.

To deliver on these principles and support general practice to provide high quality patient care outside of contracted working hours in future, political willpower and action from policy makers throughout the NHS will be needed. The RCGP recommends that decision makers:

- Remove barriers that prevent providers of out of hours services from developing more integrated services, such as current restrictions on patient record sharing.
- Make it easier for GPs who wish to 'opt in' to deliver out of hours care directly to do so.
- Ensure that proposals to enhance the provision of extended hours GP services are adequately funded, and that in England commissioning processes for out of hours services are made more transparent.
- Take steps to ensure the general practice workforce has the capacity to deal with demand for out of hours care — including implementing four year training for all GPs, improving the assessment system for GP out of hours competencies, boosting training and support in out of hours GP care and undertaking long-term workforce planning.

The Role of General Practice in the Provision of out of Hours Care

The provision of general practice outside its core contractual hours (8am to 6.30pm Monday to Friday) is fundamental to the effective operation of the NHS. Many patients who present during this 'out of hours' period are best dealt with in primary care and GPs play a vital role in responding to their needs. This includes both the provision of planned care (commonly known as extended services) and urgent and emergency care.

GPs bring not only generalist skills that are essential to the treatment of patients in the out of hours period but also a unique knowledge of the health needs of their patients and local populations. As such, they have an important role to play in leading efforts to enhance the quality of out of hours care, for example by ensuring continuity and enabling a more proactive approach to the management of complex patients.

At the same time, it is not realistic to expect that patients will be able to see the GP of their choice out of hours, nor that every practice will be in a position to deliver out of hours care. Instead, the focus must be on encouraging and enabling GPs to lead in the planning and provision of out of hours GP care, working in collaboration with other professionals across the whole of the health and social care system.

What General Practice Currently Provides

In April 2004, GP practices were given the opportunity to transfer responsibility for the provision of out of hours care to Primary Care Organisations[2], and this is an option which the vast majority of practices have taken up. However, this does not mean that GPs no longer provide out of hours care. GPs make up a major part of the workforce that staffs the organisations contracted to provide out of hours GP services, and also work in a variety of other settings such as urgent care centres.[3]

According to a 2014 report by the National Audit Office, in 2013-14 out of hours GP services in England handled around 5.8 million cases, 3.3 million of which were face to face consultations, including 800,000 home visits. In addition, other out of hours services in England which regularly employ GPs (such as urgent care centres, walk-in centres and minor injury units) see 7 million patients every year. This is in comparison to 14.8 million attendances at A&E each year both in and out of hours.[4]

As well as providing urgent and emergency care, many GPs also offer planned care in the evenings or over the weekend. Analysis of data from the NHS Choices website suggests that the majority of GP surgeries in England (60%) currently provide some form of extended opening (outside 8am - 6.30pm), with 17% open over the weekend, and 53% providing extended opening hours during the week.[5]

In England, 74% of respondents to the July 2014 GP Patient Survey said they felt it was easy to get through to their out of hours service, and 77% were happy with their GP opening hours.[6] In Scotland[7], the closest equivalent figures were 71% and 78%; and in Northern Ireland[8] 75% and 86% (figures are not available for Wales).

The Department of Health has commissioned the Primary Care Foundation to develop a benchmarking tool of out of hours GP services in England to support quality improvement. The latest summary benchmark report found that, although there are still some unexplained differences between services, the overall performance of out of hours care is improving.[9] In particular, access to out of hours services is good, with a definitive (final) clinical assessment taking place within 20 minutes in more than 80% of potentially urgent cases, compared to just over 60% when the previous benchmarking exercise took place. In addition, in a recent report on GP out of hours services the National Audit Office concluded that overall GP services are performing well against the standards set.[10]

There are three main ways in which out of hours GP care can be organised and delivered:

- **Practice based provision**. Practices provide out of hours care for their patients 'in house' utilising their own resources. Due to the pressure it puts on GPs, this form of provision has become increasingly rare, with only around 10% of all GP practices currently 'opted in' to this system.[11]
- **Collaborative models of provision**. Under this approach, groups of GPs or GP practices in a particular area come together to offer general practice services through a rota system. This may, for example, be achieved through the formation of a GP cooperative or a GP federation.[12]
- **Outsourcing**. This involves contracting out responsibility for the provision of out of hours GP services to a separate organisation, which may be a private provider, a social enterprise, or an NHS body.

According to the April 2014 Market Analysis carried out by Urgent Health UK, social enterprises (which are generally either GP led or run) account for 56.1% of the out of hours market in England, measured by population served (up from 49% in April 2013), and GP practice providers 2.4%. Commercial services accounted for 22.6% and NHS run services accounted for 20.2%.[13]

Out Of Hours GP Services And The Wider Healthcare System

The provision of out of hours GP services is just one part of a wider system that includes walk-in centres, urgent care centres, GP led health centres, A&E, as well as other services such as social care.

There has been much discussion of whether a lack of access to GP out of hours services is driving increased pressure on A&E departments. A recent large scale study by Imperial College London[14] found that the percentage of a practice's registered population able to see their GP within two weekdays – a measure of access to GP services – was associated with a lower rate of self-referred discharged emergency department visits per registered patient. However, this did not look specifically at the out of hours period, and it is important to note that there is much stronger evidence of a correlation between A&E attendance and both deprivation and location.

At the same time, evidence suggests that the rise in the number of patients going to A&E is not as sharp as it has been reported to be in some sections of the media. For example, much of the increase in A&E activity in England 2003-04 was due to a change in the data series to collect previously unrecorded attendances at walk-in centres and minor injury units.[15] RCGP analysis shows that attendances at major A&E units (type 1) in 2003-04 in England totalled 12,665,482[16], while in 2011-12 there were 14,013,922 attendances at major A&E departments.[17] This equates to a 10.6% increase over the 8 year period, or on average 1.3% per year. Over the same period England's population grew by around 6%, or 0.8% on average per year.[18] This would suggest that between 2003-04 and 2011-12 attendances at major A&E units increased at only 0.5% per year above the rate of population change. In contrast, the average number of GP consultations per patient in England increased by 41% over a 13 year period, from 3.9 per patient in 1995 to 5.5 in 2008 – a rate of 2.7% per year.[19] Over the same period England's population grew by 4.5% or at a rate of 0.34% per year. Indicating that GP workload has increased at a much higher rate than A&E workload in recent years.

Much of the public debate about out of hours care has focussed on the pressures on A&E. Whilst this is not to be dismissed, too little attention has been given to the fact that huge pressures are being felt across the urgent and emergency care system and are not confined to A&E. One of the drivers behind this is the rising number of frail elderly and people with multimorbidity. This means that people are more likely to need to attend A&E, more likely to be admitted, and more likely to stay for longer once admitted. For example, a survey of hospital chief executives undertaken by the HSJ in July 2013 cited an increase in the severity of illness as one of the key causes of A&E pressures.[20]

Problems with the discharge of patients from hospital at weekends are also perceived to be a factor behind pressures across the urgent and emergency care system. The National Audit Office's recent report on managing emergency hospital admissions[21] notes that the number of delayed discharges to social care is decreasing, while the number to other parts of the NHS are increasing – although it cautions that there are concerns that the data reported may not accurately reflect the scale of the problem.

It is likely that levels of patient awareness of GP out of hours services are also an important factor. According to the GP Patient Survey, 44% of people in England do not know how to contact their GP out of hours service.[22] In addition, patients may be confused by the varied nature and nomenclature of the community services on offer, whilst in contrast A&E has a high 'brand awareness' amongst the public. A survey undertaken by the National Audit Office found a correlation between lack of awareness of out of hours services (including NHS 111) and A&E attendance in England.[23] In addition in 2011, the Primary Care Foundation found that the proportion of A&E cases that could be classified as 'primary care' was between 10 and 30%.[24] A similar report by the College of Emergency Medicine from 2014 found that over a 24 hour period around 15% of attendees at A&E could be seen by a GP without the need for an Emergency Department assessment, with the largest sub group of these being young children.[25]

Models of Good Out Of Hours Provision

There is no 'one size fits all' model for the design and delivery of out of hours GP services. However, in deciding what approach to adopt, there are certain common principles which the College believes should be applied:

- Patients should be able to gain timely access to the skills of an expert medical generalist when they need it, including outside core surgery hours.
- Services must be developed from a patient perspective, delivering integrated whole person care to individuals interacting with different parts of the health and social care system.
- Personalisation and continuity of care are key, with systems and processes put in place to facilitate the appropriate sharing of patient information and ensure smooth and timely handover of care.
- The quality and safety of care are paramount and all service delivery models must ensure that working patterns are safe and sustainable.
- Providers and commissioners should be responsive to their local context, tailoring services to the needs and priorities of their populations.
- Out of hours services must be adequately resourced. Proposals to enhance out of hours services must not come at the detriment of the ability of general practice to provide patient access in hours.

Policy Recommendations

To support GPs in providing high quality services out of hours, it is essential that the right policy levers and incentives are put in place. Set out on the next pages are four key areas in which policy change is needed.

Integrated Care

The development of an integrated approach to the provision of out of hours care is vital to ensure that patients receive care from the right health professional, at the right time and in the right place, supported by the patient information necessary to provide the best possible treatment.

A single point of access for patients requiring urgent care during the out of hours period, such as NHS 111 is intended to provide, could offer significant benefits by simplifying access for patients and encouraging them to access services in ways that are most appropriate. However, the introduction of NHS 111 has not always been adequately aligned with the way in which GP out of hours services operate, generating incompatible processes and poor patient experience. For example, in some areas of the country where NHS 111 is not directly run by the out of hours service, a double layer of phone triage has emerged, with the time to clinical assessment being measured separately by the NHS 111 and the out of hours care provider. Similarly, there are discrepancies between the time to face to face consultations set out in the National Quality Requirements for the out of hours period, and the standards set out for NHS 111.[26]

In addition, the limitations which exist on the ability of different providers involved in out of hours care to share patient information continues to act as a significant barrier to continuity of care. In many cases, providers of out of hours GP services still routinely have to operate without access to patient notes. According to a survey undertaken in England by the Health and Social Care Information Centre, only 37% of urgent care centres were able to transfer data electronically to local A&E departments; only 20% of A&Es were able to receive electronic data from ambulance services; and only 30% of these services reported that all local GPs were able to receive summary information electronically about patients seen in their unit.[27]

Policy recommendations:

- Make integration between different parts of the health service a key consideration when developing new out of hours services.
- Remove barriers that prevent providers of out of hours services from accessing patient records.
- Review national standards and specifications for out of hours GP services and NHS 111 to ensure integration.
- Ensure that responsibility for promoting awareness of out of hours services rests with one body, so that a lack of understanding of the various forms of provision available can be adequately addressed.

Encouraging GP Led Models Of Out Of Hours Care

GP practices are uniquely positioned to lead the delivery of integrated, patient centred care out of hours, given the knowledge that they have of the patients registered at the practice, and the ongoing nature of the GP patient relationship. Given this, practices wishing to develop GP led models of out of hours care provision should be encouraged to do so. At present, however, legal and financial barriers can mean that the opposite can often be the case.

In England, there are concerns that the rules on commissioning may have the effect of preventing GPs who wish to opt back into the provision of out of hours services from doing so. For example, legal advice was given in December 2013 to a group of local GPs in Hackney, London, who wished to take back the provision of out of hours services within their area. In addition, small scale, locally based providers may struggle to compete for contracts against large scale commercial enterprises with greater experience of tendering and greater scope to undercut on price.

In addition, there can also be a financial disincentive for GPs to take back direct responsibility for out of hours care. GPs who remain opted in to out of hours care provision receive an extra 5.6% of their global sum entitlement. However, this is viewed by many as being inadequate and may not reflect the full range of factors that can drive the costs of provision, for instance the degree of rurality.

Policy recommendations:

- The Department of Health should clarify the legal position of GPs seeking to opt back into the provision of out of hours care, and make legislative changes if necessary to ensure that they are able to do so without the requirement to go through a competitive tendering process.

- Government in England, Wales, Scotland and Northern Ireland should work to review the payments received by practices that are opted into responsibility for the provision of out of hours services, to ensure that this does not act as a disincentive.

Workforce

The GP workforce is one of the major enablers of out of hours care. While the majority of out of hours services are fully staffed, there have been some high profile examples of out of hours services failing to recruit and retain enough GPs to provide adequate care; for example, Serco in Cornwall which was subject to a National Audit Office report due in part to concerns over the level of staffing.[28]

The GP workforce as a whole is already struggling to meet demand and the profile of those GPs engaged in out of hours work is ageing. Any increase in out of hours GP provision is therefore likely to require a significant increase in GP numbers over and above the current workforce.

If GPs are engaged in providing additional evening and weekend care, this will mean that they have reduced availability during weekdays, due to the need for rest breaks. This poses real practical challenges, especially for single handed practices. Although the number of these has fallen to 921 since 2002, 11.4% of practices in England still fall into this category.[29] Smaller group practices (e.g. 2-4 GPs) will also face significant logistical difficulties managing with fewer GPs available during the in hours period, especially rural and remote practices that need adequate numbers of GPs on duty to provide home visit and nursing home visit cover across a large geographical area.

A 2013 Scottish Workforce survey identified that older GPs were undertaking the majority of out of hours work in Scotland, with over 45s contributing 50% of the total hours input during the out of hours period in Scotland over the survey year.[30] Given this, it will be important to attract sufficient numbers of younger GPs to participate in the provision of out of hours care, although this may be challenging given the growing number of GPs balancing work and family commitments.

In addition, GPs may be discouraged from undertaking out of hours work by the high cost of medical indemnity (medical insurance purchased in advance of undertaking out of hours work). A marked increase in the cost to GPs of buying indemnity insurance has been identified by out of hours providers as a barrier to the recruitment of GP staff in a 2014 report by the National Audit Office.[31]

It is also important that newly qualified GPs are equipped with the skills they need to deliver out of hours care in an urgent care environment, including to patients not registered with their own practice. The RCGP believes that the current three year training programme for GPs does not include sufficient training in the skills required to provide the high quality out of hours services needed and rightly expected by today's more diverse and ageing population. Out of hours work (especially where it involves urgent and emergency care through a designated out of hours service) involves a key set of clinical, risk assessment and decision making skills. Urgent and emergency care in the out of hours period can involve providing care to more patients with immediate and severe conditions than are encountered in the in hours period, with reduced access to medical records, and a greater use of telephone consultations. It can also mean working in relative isolation, without the ability to liaise fully with secondary care, meaning that a GP in the out of hours period can find themselves with more responsibility to assess and manage medical risk while having access to less support and fewer resources.

There are many environments in which a GP trainee can develop competencies relevant to out of hours work. However, the current training system does not provide sufficient opportunity for the necessary training in an out of hours setting to integrate, further develop and assess these competencies in context. The current COGPED guidelines specify that GP trainees should do at least twelve sessions of between 4 and 6 hours in an out of hours service in their final year.[32] However, the interpretation of this has been left up to the local level, with many deaneries/Local Education and Training Boards, taking this to mean that GP trainees have to do a minimum of only 48 hours of out of hours training in total.[33] In addition, there are persistent problems around out of hours providers supplying sufficient sessions for GP trainees to allow them to develop their professional skills.

A properly skilled out of hours GP workforce is one of the outcomes that the College's proposal for an extended and enhanced four year GP training programme is intended to deliver. The introduction of a four year training programme for all GPs means that, for the first time, all GP trainees would receive specialist led clinical training in child health and mental health, plus enhanced training in drug and alcohol misuse, and the rehabilitation and care of older people, all of which include specific competencies needed for work in primary care services out of hours. All GP trainees would receive emergency care training during their primary care placements.

As a result of extending the training time to include a minimum of 24 months of general practice based training over the four years, GP trainees would gain a 33-50% increase in out of hours experience by working regular sessions with out of hours providers. In addition, as part of a four year training programme, GP trainees would have an opportunity to undertake innovative placements in unscheduled, urgent and out of hours care settings.

Policy recommendations:

- Implement four year training for all GPs as a means to produce a workforce with the correct competencies to provide good quality out of hours care.
- Improve the assessment system for GP out of hours competencies, by clarifying core competencies and enhancing elements of formative and summative assessment.
- Introduce a requirement to consider the ability of services to provide training sessions and supervision as part of the clinical commissioning process in England and according to other arrangements in the devolved nations.
- Plan to ensure that the capacity of the future GP workforce is adequate to meet future out of hours as well as in hours needs.
- Consider what appropriate financial support could be given to individual GPs where the cost of indemnity insurance has reached unsustainable levels.

Resources

Cost per case and per head of population of out of hours GP services is affected by a number of factors, including population age, levels of demand, and geography.[34] In general, higher cost out of hours services are more likely to be rated by patients as good or very good.[35]

Urgent Health UK's April 2014 Market Analysis of the out of hours market records a drop in average spend per head of the population, from around £9.00 per head in 2012 to £7.98 per head. The report notes that this reflects the fact that commissioners have been squeezing suppliers hard on price and have taken money from out of hours contracts to help pay for NHS 111.

In addition, the National Audit Office has estimated that the cost of delivering out of hours GP services in 2013-14 was around £400 million. This is real terms reduction from previous years, in part due to the introduction of NHS 111, and the consequent loss of call handling related income from individual GP services.[36]

This loss of income combined with an ongoing lack of investment in general practice[37] services has led to many providers facing financial difficulties, which in turn can lead to a lack of faith in the ability of the service to provide safe care, thereby driving GPs away from the service. This situation may be one of the underlying causes behind recent rises in the cost of medical indemnity.

Concerns have also been expressed that in some cases contracts for out of hours services may be awarded on the basis on price over and above quality. However, this is difficult to verify, due to the extremely limited nature of the data publicly available.

Alongside the funding of out of hours services for urgent care, there is also a need for adequate resourcing for extended hours services. Currently, there is considerable variation in the level of funding available between local areas and the four nations of the UK, and additional investment is needed if general practice is to be in a position to meet national policy aspirations in this area. In 2013, the Coalition Government announced a £50 million Challenge Fund to encourage longer opening hours for GP practices in England[38], and the Scottish Government has announced £4 million to support the health service to test innovative approaches to providing seven day care[39], with a further £1.5 million specifically for rural GP practices, including provision for extended opening hours.[40] However, whilst schemes such as these are welcome, the nature of the funding that they provide is one-off rather than recurrent.

Policy recommendations:.

- Ensure that proposals to enhance the provision of extended hours GP services are adequately costed and funded.
- Improve transparency regarding the basis on which out of hours services are awarded, and work with commissioners to ensure that cost is not prioritised over quality.

References

1 The concept of the 'Expert Medical Generalist' is defined in The GP 2022: A Vision for General Practice produced by the RCGP: "As career-long professional learners, GPs will use their self-directed learning skills to undertake structured, needs-based continuing professional development programmes that will enable them to develop from proficiency towards generalist expertise. Such expertise will be manifested, for example, through an enhanced ability to structure care plans that consider both individual conditions and multimorbidity, while also supporting self-care and enabling shared decision-making alongside delivering evidence-based interventions and managing limited resources."

2 Currently Clinical Commissioning Groups in England, NHS Boards in Scotland, Local Health Boards in Wales and Health and Social Services Boards in Northern Ireland.

3 BMA, (2011). *National Survey of GP opinion*. London: BMA, and College of Emergency Medicine (2013). *The Drive for Quality – how to achieve safe, sustainable care in our emergency departments?*. London: College of Emergency Medicine.

4 National Audit Office, (2014). *Out of Hours GP Services in England*. London: National Audit Office. Available at: http://www.nao.org.uk/wp-content/uploads/2014/07/Out-of-hours-gp-services-in-england.pdf.

5 NHS Choices website, Freedom of Information requests. Available at: http://www.nhs.uk/aboutnhschoices/contactus/pages/freedom-of-information.aspx (Accessed October 2013).

6 GP Patient Survey, (2014). *GP Patient Survey 2014 results*. London: GP Patient Survey. Available at: https://gp-patient.co.uk/ (Accessed October 2014).

7 2013/14 Scottish Health and Care Experience Survey: 71% overall positive rating for out of hours care and 78% happy with GP opening hours.

8 NI GP patient survey 2010/11: 75% of respondents said they felt that they had received care quickly from the out of hours service and 86% were happy with their surgery's opening hours.

9 Primary Care Foundation, (2012). *Benchmark of out of hours: an overview across the services*. London: Primary Care Foundation.

10 National Audit Office, (2014). *Out of Hours GP Services in England*. London: National Audit Office. Available at: http://www.nao.org.uk/wp-content/uploads/2014/07/Out-of-hours-gp-services-in-england.pdf.

[11] Ibid

[12] A cooperative is a non-profit organisation which is entirely owned and staffed by GPs from within the area in which it operates. GP federations are associations of GP practices that come together with the goal of sharing responsibility for developing high quality, patient focussed services for their local communities.

[13] Urgent Health UK Ltd, (2014). *Market Analysis Report – England*. London: Urgent Health UK Ltd.

[14] Cowling TE, Cecil EV, Soljak MA, Lee JT, Millett C, Majeed A, Wachter RM, Harris MJ (2013). Access to primary care and visits to emergency departments in England: a cross-sectional, population-based study. *PLoS One.* 12;8(6):e66699.

[15] The King's Fund, (2013). *Are accident and emergency attendances increasing?*. London: The King's Fund. Available at: http://www.kingsfund.org.uk/blog/2013/04/are-accident-and-emergency-attendances-increasing.

[16] Department of Health, (2011). *Total Time Spent In A&E*. London: Department of Health. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/ http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/ PerformancedataandstatisticsAccidentandEmergency/DH_087978

[17] NHS England, (2012). *Weekly A&E SitReps 2011-12*. London: NHS England. Available at: http://www.england.nhs.uk/statistics/statistical-workareas/ae-waiting-times-and-activity/weekly-ae-sitreps-2011-12/

[18] Office for National Statistics, (2011). *Population Estimates for England and Wales, Mid-2002 to Mid-2010 Revised (National)*. London: Office for National Statistics. Available at: http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-andwales/mid-2002-to-mid-2010-revised--national-/index.html and Office for National Statistics, (2011). *2011 Census, Population and Household Estimates for the United Kingdom*. London: Office for National Statistics. Available at: http://www.ons.gov.uk/ons/publications/re-referencetables.html?edition=tcm%3A77-270247

[19] The Health and Social Care Information Centre, (2008).*Trends in Consultation Rates in General Practice 1995 to 2008*: Analysis of the QResearch® database.

References

20 Health Service Journal, (2013). *Trust Chiefs See Sicker Patients as Key Cause of A&E Crisis*. London: Health Service Journal. Available at: http://www.hsj.co.uk/acute-care/trust-chiefs-see-sicker-patients-as-key-cause-of-ae-crisis/5060822.article (Accessed 11 July 2014).

21 National Audit Office, (2013). *Emergency Admissions to Hospital Managing the Demand*. London: National Audit Office. Available at: http://www.nao.org.uk/report/emergency-admissions-hospitals-managing-demand/

22 GP Patient Survey, (2014). *GP Patient Survey 2014 results*. London: GP Patient Survey. Available at: https://gp-patient.co.uk/ (Accessed October 2014).

23 National Audit Office, (2014). *Out of Hours GP Services in England*. London: National Audit Office. Available at: http://www.nao.org.uk/wp-content/uploads/2014/07/Out-of-hours-gp-services-in-england.pdf.

24 Primary Care Foundation and NHS Alliance, (2011). *Breaking the mould without breaking the system*. London: Primary Care Foundation and NHS Alliance.

25 Health Service Journal, (2014). *Beyond the official data: a different picture of A&E attendances.* London: Health Service Journal. Available at: http://www.hsj.co.uk/comment/beyond-the-official-data-a-different-picture-of-ae-attendances/5070973.article#.U4Nx53JdWSp (Accessed May 2014).

26 Department of Health, (2006). *National Quality Requirements in the Delivery of Out-of-Hours Services*. London: Department of Health. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4091215.pdf.

27 Health and Social Care Information Centre, (2008). *Not Just a Matter of Time, a review of emergency and urgent care services in England*. London: Health and Social Care Information Centre. Available at: http://image.guardian.co.uk/sys-files/Society/documents/2008/09/26/emergencyreview.pdf.

28 National Audit Office, (2013). *Memorandum on the provision of out of hours services in Cornwall.* London: National Audit Office. Available at: http://www.nao.org.uk/wp-content/uploads/2013/03/Out-of-hours-GP-services-Cornwall-Full-Report.pdf.

29 Health and Social Care Information Centre, (2012). *General and Personal Medical Services, England 2002-2012*. London: Health and Social Care Information Centre. Available at: https://catalogue.ic.nhs.uk/publications/workforce/numbers/nhs-staf-2002-2012-gene-prac/nhs-staf-2002-2012-gene-prac-rep.pdf.

[30] ISD Scotland and NHS Scotland, (2013). *Primary Care Workforce Survey 2013.* Edinburgh: ISD Scotland and NHS Scotland. Available at: https://isdscotland.scot.nhs.uk/Health-Topics/General-Practice/Publications/2013-09-24/2013-09-24-PCWS-Report.pdf.

[31] National Audit Office, (2014). *Out of Hours GP Services in England*. London: National Audit Office. Available at: http://www.nao.org.uk/wp-content/uploads/2014/07/Out-of-hours-gp-services-in-england.pdf.

[32] COGPED, (2010). *Out of Hours Training for GP Speciality Registrars*. London: COGPED. Available at: http://www.cogped.org.uk/document_store/1286375694vGnm_out_of_hours_position_paper_(revised_2010).doc.

[33] In the case of rural areas for example, where the number of patients seen in any given session could be quite small, this might mean that the trainee satisfies the requirement to undertake a certain amount of out of hours activity but nevertheless, in that time, has little direct patient contact and is less likely to adequately develop the required competencies.

[34] Primary Care Foundation, (2010). *Improving out of hours care: what lessons can be learned from a national benchmark of services*. London: Primary Care Foundation.

[35] Primary Care Foundation, (2012). *Benchmark of out of hours – an overview across the services*. London: Primary Care Foundation.

[36] National Audit Office, (2014). *Out of Hours GP Services in England*. London: National Audit Office. Available at: http://www.nao.org.uk/wp-content/uploads/2014/07/Out-of-hours-gp-services-in-england.pdf.

[37] Baker M, Ware J and Morgan K, (2014). Time to 'put patients first by investing in general practice'. *British Journal of General Practice,* 64(623): 268-269.

[38] Department of Health, (2013). *Seven day 8-8pm gp access for hard working people*. London: Department of Health. Available at: https://www.gov.uk/government/news/seven-day-8am-8pm-gp-access-for-hard-working-people. (Accessed October 2014).

[39] The Scottish Government, (2013). *Round the Clock Care*. Edinburgh: The Scottish Government. Available at: http://news.scotland.gov.uk/News/Round-the-clock-care-514.aspx (Accessed October 2014).

[40] The Scottish Government, (2013). *1.5m for Rural Healthcare*. Edinburgh: The Scottish Government. Available at: http://news.scotland.gov.uk/News/-1-5m-for-rural-healthcare-36d.aspx (Accessed October 2014).

Version Date: November 2014

Published by:

RC GP Royal College of General Practitioners	**Royal College of General Practitioners** 30 Euston Square, London NW1 2FB Telephone: 020 3188 7400 Fax: 020 3188 7401 Email: policy@rcgp.org.uk Website: www.rcgp.org.uk
Royal College of General Practitioners is a registered charity in England & Wales (No. 223106) and Scotland (No. SC 040430).	

Adopted by the Council of the Royal College of General Practitioners, June 2014

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PART TWO: CAse sTudies

Examples of GP Provided out of hours care


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Out Of Hours Service Stornoway, Isle Of Lewis

In Stornoway in the Isle of Lewis local GPs have developed an innovative solution to the problem of unsustainable pressures on the emergency care system. The local rural general hospital had experienced problems recruiting sufficient junior doctors to cover the out of hours period, and consequently local GPs stepped in to provide cover for A&E out of hours alongside their normal general practice duties.

This model is uncommon within the UK, with GPs taking a management and treatment role at the front end of hospital. It has led to better results in A&E with decreased overnight admissions and tests.

Overview

The out of hours GP service in the isle of Lewis (Outer Hebrides) has developed from a very traditional approach to an innovative model where GPs cover the local rural general hospital from 8pm to 8am, seven days a week.

The service is run through the Western isles Health Board, with ten GPs from local surgeries providing cover for the front end of the hospital on a rota system in the out of hours period, in addition to treating patients seeking help through NHs 24. This model evolved out of necessity as there were not enough junior doctors to cover the rota at the local hospital so, in order to save the service, GPs stepped in and filled the gap.

Authors:

> “Our out of hours model is an innovation that shows what we can do together”

dr Brian michie
stornoway out of hours service

Key Features

The essence of this system is that local GPs lead and coordinate a multidisciplinary team which controls the front end of the local hospital, in addition to dealing with the out of hours needs of the local population in the community, for example through home visits.

Within the hospital GPs trained in emergency medicine treat every patient who presents at A&e. The GPs admit patients as appropriate to the Acute Assessment unit or an appropriate ward or High dependency Area. At any point if the GP decides a patient is beyond their clinical skills the relevant consultant will be called in to take over management of the patient. Patients presenting at A&e with conditions that are best treated within general practice will be seen by a GP in A&e. in addition to GPs, this service is staffed by emergency Nurse Practitioners within A&e and Clinical support Nurses in the hospital.

Outside the hospital the team is comprised of ambulance service paramedics, some of whom have trained to practitioner level for unscheduled care, overnight nurses, who again have trained as unscheduled care practitioners, and a second on call GP.

Patients who do not present at A&e (via foot, car, ambulance or emergency helicopter) will access the service via NHs 24 (the out of hours health contact service for scotland).

OutcOmes And results:

- Reduction in the number of 999 calls coming to A&e by over 50%
- decrease in overnight admissions by 17%
- decrease in the number of out of hours tests and X-rays, reducing pressure on the relevant departments as these staff will then be available the next day
- improved resilience in night time hospital cover.

SELDOC, South London

SELDOC is one of the few remaining GP cooperatives in the UK. Cooperatives are a collaborative model of care designed to help GPs to provide services over large areas on a rota system. They depend on GPs being opted in to provide out of hours care. Given that many GPs chose to opt out after the 2004 contract change the majority of cooperatives ceased to exist. However, unlike most areas, the majority of GPs in Lambeth, Southwark and Lewisham remained opted in to provide out of hours care, which means that GPs in the area can continue to directly provide care through this traditional model.

Overview

seLdOC is a GP cooperative providing urgent and emergency general practice services to patients in Lambeth, southwark, Lewisham, and, since 2013, in sutton in the out of hours period (6.30pm till 8am on weekdays, and 24 hours at weekends and bank holidays). it also provides cover for patients of surgeries that have had to close for GP training or in emergency circumstances.

Before the 2004 GP contract change, all GPs had to provide some cover for the out of hours period, and many GPs banded together to form GP cooperatives which helped to spread the load within a local area. in 2004, GPs were given the opportunity to opt out of providing out of hours care, and the majority chose to do so, meaning many GP cooperatives ceased to exist. However, over 90% of all GP surgeries within Lambeth, southwark and Lewisham have opted to provide out of hours care, and choose to do so through seLdOC, meaning it remains a true cooperative that is run by elected local GPs. every GP surgery is strongly encouraged to contribute to staffing the service.

Key Features

seLdOC operates on a rota system staffed entirely by local GPs, except in exceptional circumstances, with around 120 GPs out of a total of 600 in the area signed up in any month. seLdOC also employs drivers and support staff such as receptionists, but all patients are treated by local GPs. The patient population is around 900,000.

Patients contact the service via a variety of means. As the local Clinical Commissioning Group has not signed up to NHs 111 most patients ring seLdOC directly – however around a third are directed via NHs 111.

Once a patient is through to seLdOC their call will be dealt with by a trained call handler who will take the patient's demographic details and, by performing a basic triage, grade the call either as urgent or not urgent. each caller will receive a call back from a fully qualified GP (urgent calls will receive a call back within 20 minutes, non urgent within an hour). Through this system seLdOC manages 65% of its patients via telephone, 25% via face to face consultations at one of their four base centres, and 10% via home visits.

The four base centres are comprised of two walk in centres and two urgent primary care centres co-located within Lewisham hospital and Guy's hospital. seLdOC also provides support to acute trusts by providing GPs to work in emergency departments in King's and st Thomas' hospitals.

during the financial year 2012-2013 seLdOC dealt with 42,000 advice calls from patients, 15,000 face to face consultations at a medical centre and conducted 8,000 home visits during the out of hours period; an increase of 12% on the previous year.

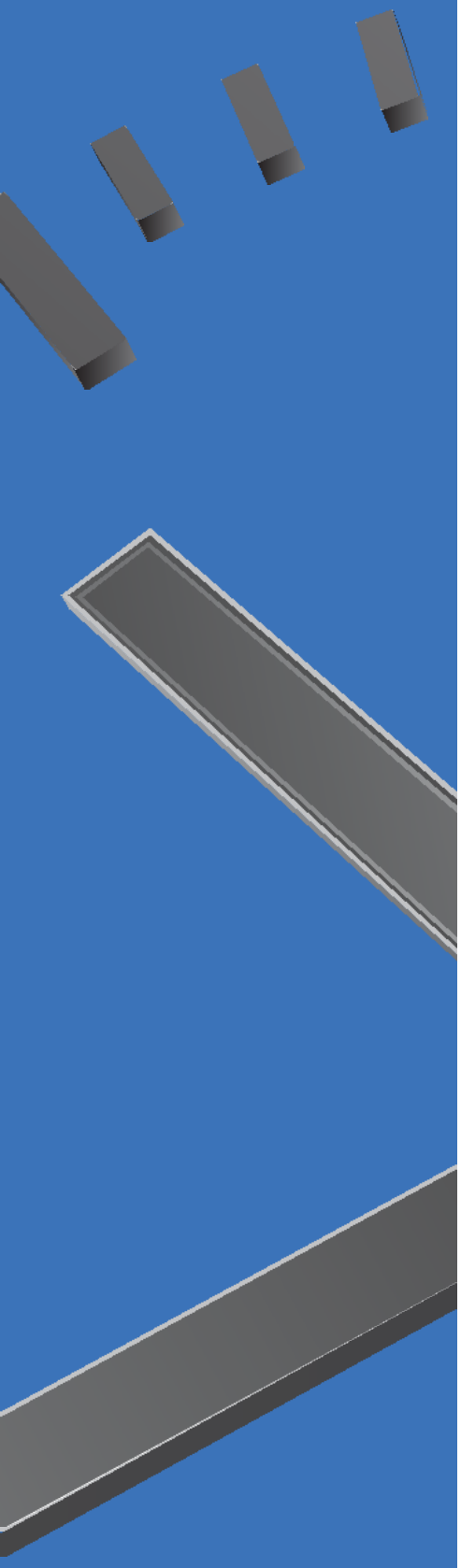
Outcomes and Results:

- A recent inspection by the Care Quality Commission of the seLdOC base at dulwich community hospital found that the "service had systems in place to ensure that the provider could effectively respond to the needs of the patients accessing the out-of-hours service safely. information regarding the care received by patients was shared with the patient's GP in a timely manner to ensure continuity of care between the different service providers". in addition, the inspection found that that the service is well led, patients were happy with the care they received and felt involved in decisions about their care, while the staff felt supported.

"Our motto at SELDOC is that you are treating your colleagues' patients – this means all the patients in Lambeth, Southwark and Lewisham get the kind of care they would expect from their own surgeries, and because it's a close knit professional community it keeps GPs on their toes"

"We are successful and have managed to ride the turbulence of the NHS for the past 17 years as our not-for-profit cooperative ethos focuses on quality and has always created value for patients, our members' surgeries and local commissioners"

dr riaz Jetha
GP director seLdOC



City And Hackney Urgent Healthcare Social Enterprise (CHUHSE)

In many areas of the country out of hours services which had previously been provided by GPs have been outsourced to private sector providers. However, this outsourcing can create problems with recruitment and retention of workforce due to a lack of buy in from the local GP population. This was the case in City and Hackney and the reason behind the emergence of CHUHSE.

CHUHSE is a collaborative model of care staffed and owned by GPs in City and Hackney who provide urgent and emergency general practice services to an urban population in the out of hours period.

Overview

CHuHse is a GP led social enterprise which has recently taken over the provision of out of hours services in the London Boroughs of City and Hackney.

A commercial provider, Harmoni, had taken over the service in 2010 on a temporary basis but was struggling to both recruit and retain GPs for the City and Hackney rota. Therefore, in order to gain a direct influence on the quality of the service, 87% of City and Hackney GPs asked to opt back into responsibility for out of hours care.

Having originally been told that their bid to opt-in to out of hours responsibility would be approved, GPs established CHuHse as a social enterprise to provide the service on their behalf, with a planned commencement date of April 2013. However, with the passing of section 75 of the Health and social Care Act in January 2013, the then PCT received legal advice that there was a risk of a challenge under competition law were the service not to be put out to competitive tender. As a result the City and Hackney CCG decided to put the service out to full competitive tender in spring 2013.

Local GPs then established CHUHSE as a membership based Community Benefit society as the vehicle to bid for the contract. Members were drawn from the local community and local GPs. By the time the tender was submitted the society had 400 members.

CHUHSE won its bid to run the local out of hours service despite the fact that the cost of delivering the service would be higher than under the previous contract. The CCG took this decision as they had faith in the quality of the service model, due to the level of local buy in, engagement and ownership of the service. Moreover, they were convinced that whole system costs would be reduced with the introduction of CHUHSE due to more patients being seen by the out of hours service and fewer by tariff-based services. CHUHSE started running the service on 2 December 2013.

"What makes CHUHSE work is the way that the service has secured the emotional ownership of local GPs and the residents of City and Hackney. Previously the commissioners and wider healthcare community had a purely business relationship with the out of hours provider but there is now a spirit of cooperation and partnership which is helping to improve integrated working"

mark cockerton
Chief executive, CHuHse

Key Features

CHUHSE provides urgent and emergency primary care services in the out of hours period to a population of 280,000 patients. This care is provided by GPs only on a rota system of around 60 GPs. The service also employs drivers, call handlers, receptionists and administrative staff.

NHs 111 does not provide call handling for GP out of hours calls in the area, therefore patients wishing to access the service will do so through their dedicated phone number. All calls are answered by a call handler who will prioritise the call into urgent or less urgent. All patients will receive a call back from a GP who, after definitive clinical assessment, will decide how to progress their case. in this way, CHUHSE deals with 60% of callers with GP advice only, 35% will be seen in person at their primary care centre and 5% receive home visits.

CHUHSE has a co-located primary care centre at Homerton Hospital. There are plans to open an additional two locations in City and Hackney in order to further improve access to out of hours care.

Outcomes and Results:

- As CHUHSE has only been in operation for a short amount of time, the outcomes and results are not as yet quantifiable. However, the switch to a GP led social enterprise away from an outsourced private provider has increased the proportion of local GPs working within the out of hours period, and therefore the ability of the service to provide patient centred continuity of care between the in and out of hours periods.

Devon Doctors

The most common form of GP provided out of hours care is a social enterprise, which can enable general practice services to be delivered in the out of hours period without compromising in hours care by utilising a large number of GPs on a rota system. This model can be used in both a rural location over a large sparsely populated area, and an urban location with a large condensed population.

Overview

devon doctors is a GP owned and led social enterprise which provides urgent out of hours general practice services to a patient population of 1.2 million across devon.

Key Features

devon doctors has 15 treatment centres around the county. They are all co-located with emergency departments and minor injury units in district, general and community hospitals around devon. Patients are responsible for arranging transport to the treatment centres, as they would be to daytime practices.

each of these treatment centres is open in the out of hours period, 6pm - 8am, as well as over the weekends and on bank holidays and will, typically, be staffed by a GP, a driver and an operational assistant. The majority of GPs who work for devon doctors are self employed, however the service as a whole employs the equivalent of 5.5 Whole Time equivalent (WTe) GPs, 2.5 WTe Nurse Practitioners, 2 WTe Treatment Centre nurses, 12 WTe Treatment Centre Operational Assistants and 32 WTe drivers.

> “Devon Doctors is owned on a not-for-profit basis by every GP practice in the county. These same practices also provide the majority of the doctors and nurses who work for us and, what’s more, are ideally placed to assess the standard of care we provide. As a social enterprise, Devon Doctors is not preoccupied with creating a surplus for shareholders; rather its focus is on patient care. Since 2004 it has consistently been rated as one of the best out of hours services in England, as measured by both performance standards and patient feedback. We firmly believe our model of care is the main reason for this”

chris wright
Chief executive, devon doctors

Patients access the service via NHs 111 and are triaged into urgent and not urgent cases. All patients receive a call back from a devon doctors nurse or GP who will decide if they need to be seen via a home visit, at one of the treatment centres or can be dealt with over the phone. Access to the treatment centres is by appointment only, as there is no walk in centre. Over the course of 2013, devon doctors helped 217,588 individuals. Of these 53% were offered advice over the phone, 29% visited a Treatment Centre, 14% were visited at home, and the remaining 4% were classified as ‘other’.

in addition, devon doctors is also responsible for:

- A 24/7 electronic palliative care coordination service & register
- Coordination of out of hours community nursing teams across devon from 5pm - 8am and 24/7 in Plymouth
- Cover for CCG study days
- evening margin cover for GP practices
- Lunchtime cover for GP practices

Outcomes and results:

- in 2012 the Primary Care Foundation rated devon doctors’ out of hours service as one of the best in england – with 75% of service users in both Plymouth and Torbay rating the service as either ‘good’ or ‘very good’.
- 95% of all local GP practices have rated the service as either excellent or very good.

SouthHarrisMedicalPractice

The number of GP practices who directly provide out of hours services to patients on their practice list is relatively low, with the majority of GPs finding the task interferes with their ability to provide care in the in hours period. However, some GP practices, particularly in remote rural locations, choose to continue to provide their own out of hours care. Indeed this method of providing care can have unique advantages, by ensuring continuity of care between the in and out of hours periods and reducing the duplication of general practice services.

Overview

South Harris Medical Practice is a single handed GP practice providing out of hours general practice services to a rural population of 580 patients on the isle of Harris.

Key Features

south Harris Medical Practice has acted as a single handed dispensing practice since 1989. Aside from the single partner, a part time associate GP is employed at the practice. There is only one GP on duty at any time, with the GP partner working up to three weeks on call 24/7 and the part time GP associate working on call every third or fourth week at a time. No other medical practitioners or administrative staff are employed in the out of hours period.

Patients wishing to contact the out of hours service do so by calling the on duty GP's private phone number. The GP then performs a basic triage to decide if advice can be given over the phone or if a home visit or ambulance are required. There is no out of hours patient centre.

> “Patients appreciate the fact that the same doctor who looks after them during the day is also responsible out of hours… we know our own patients reasonably well and can often judge the urgency or otherwise of out of hours calls”

dr Andrew naylor
GP, south Harris Medical Practice

The fact that the out of hours and in hours GP are one and the same aids in the triaging process, with patients and their unique needs often personally known to the doctor on duty.

The practice has a higher than average proportion of over 65s with 30% of all patients falling into this category. The extreme rurality of the area also presents its own challenges. The practice area is around 50 miles from the nearest hospital with only one ambulance servicing the area, with travel times to hospital taking up to an hour, meaning that an ambulance can often be the worst option for even a seriously ill patient.

However, the number of calls that are received is very low, with GPs only seeing around 2-3 night visits (after 10pm) per month. While a serious night visit can be extremely tiring, this system has the advantage of reducing the level to which access is replicated, with patients’ needs being dealt with by their GP in the first instance.

GPs at the south Harris Medical Practice also provide extended opening, with a saturday morning drop in service, and by providing cover for evening opening on Fridays at an adjoining practice. in return the adjoining practice provides cover on Friday for the south Harris Practice during the day.

Outcomes and results:

- Attendances at A&E are relatively low – partly because the distance to the hospital means that the impetus is on the GP not to refer, but mainly because of the effective triage that is carried out by the out of hours GP.
- increased continuity of care, as patients will see the same GP in both the in and out of hours periods.
- Personalisation of the service – the fact that patients are aware that there is only one GP on call at all times means that they are more likely to use the service in a responsible manner.
- increased responsiveness – the fact that the doctor will be on call the following day is an added incentive to try and sort out a problem rather than leaving it for the doctor on duty the next day as perhaps might happen in a larger service.

Shropshire Doctors Cooperative Ltd (Shropdoc)

Shropdoc is a not-for-profit social enterprise. This model exists in order to allow GPs to provide urgent medical care in the out of hours period at scale. In this way GPs are better able to respond flexibly to the needs of patients in their area by joining together to work on a rota system over a large area.

Overview

Shropdoc is not-for-profit social enterprise which provides urgent medical care (which is not life threatening or an emergency) to patients within shropshire, Telford and Wrekin, and Powys in the out of hours period (at weekends, bank holidays and between the hours of 6.30pm and 8.00am Monday to Friday).

Key Features

Shropdoc has 279 local GP members who deliver out of hours care to a population of 600,000 patients. They have approximately 200 support staff including call handlers, drivers and management teams, as well as around 30 Nurse Practitioners (NP). All member GPs must do at least one session a month.

On average, shropdoc provides care for 140,000 patients year. Approximately 35,000 patients are seen at ten primary care centres located at hospital sites, 21,000 patients receive a home visit and around 60% of patients are managed with a telephone consultation. shropdoc also provides medical cover for 12 Community Hospitals and 5 Minor injury units.

Shropdoc does not provide a walk in service. All patients seeking to access the service must go through a central ‘triage’ system, where all patients are subject to expert telephone assessment.

Patients contacting this service will have their demographic details and a brief outline of their presenting condition taken by a call handler. Call handlers complete comprehensive training including the identification of Life Threatening emergencies, and those needing an urgent response from the GP. if it is deemed life threatening the call handler will transfer the patient/carer over directly to the ambulance services to avoid delay and risk to the patient. shropdoc call handlers refer <2% of patients to 999 and <1% to A&e. All other calls are allocated a priority – either 'routine' or 'urgent'. Calls are then placed in the 'Triage pool' to be called back by a GP or NP.

Although the NHs 111 service is available locally the shropdoc out of hours contact service is still funded by the local CCGs. Patients may be redirected from NHs 111 if they need a GP review.

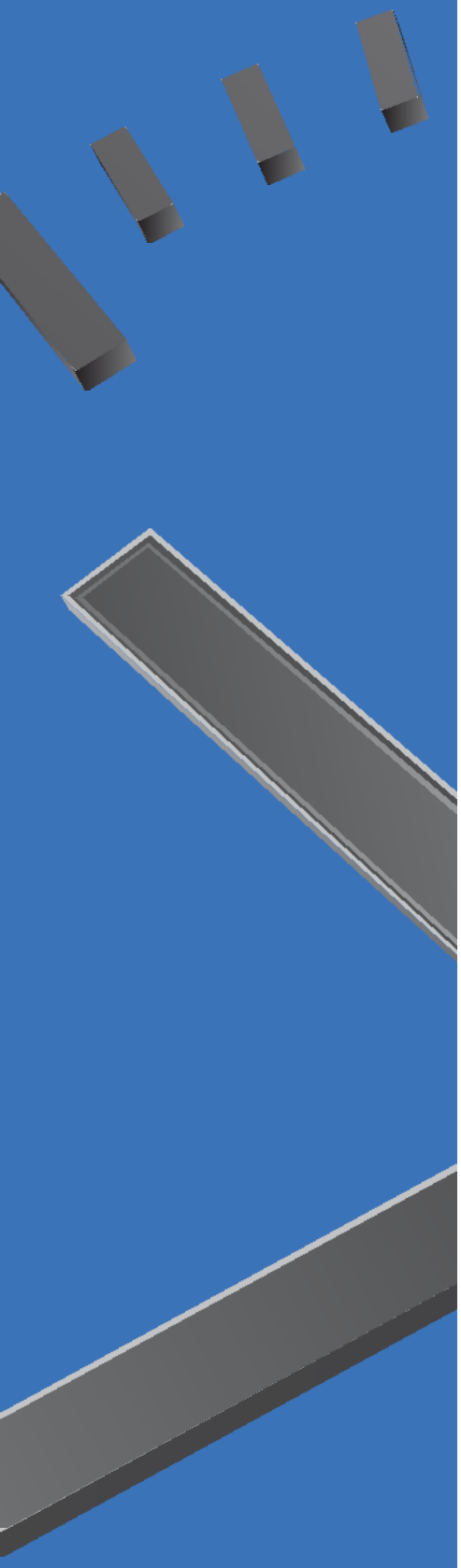
Shropdoc also has a process whereby the local A&e departments can directly book patients into a GP clinic appointment if they judge that their condition could be best dealt with in a primary care setting, by calling a dedicated shropdoc phone line.

OutcOmes And results:

- Shropdoc refers less than 4% of people each year to A&e
- High access rates: 23% of the population contact shropdoc annually
- in a 2011/12 internal audit urgent Health uK (the federation of social enterprise unscheduled Primary Care Providers) rated shropdoc 'commendable' (the highest rating available) and stated that it "continues to maintain good systems in all areas, particularly Patient experience and compliance with CQC standards"

"Shropdoc works so well for patients because the local GP workforce have retained a sense of responsibility for looking after patients out of hours. 72% of our GPs are principals and over 90% are on the local performers list. They know and understand how local services work. We do not use agency staff. Shropdoc provides a safe and supportive working environment for GPs and they are appropriately reimbursed"

dr Gill clements
Medical director, shropdoc



Dalriada Urgent Care

Dalriada Urgent Care is a GP not-for-profit social enterprise operating in Northern Ireland. By far the most common model, the social enterprise allows for GP ownership and oversight of out of hours services to be maintained without requiring all GPs within an area to directly provide out of hours care.

Overview

Dalriada urgent Care is a not-for-profit mutual society formed in 2005 following the introduction of the new GP contract. it developed from dalriada doctor on Call which operated as a GP cooperative. dalriada urgent Care has a steering council comprised of elected members from amongst the society membership, appointed members from stakeholder organisations and lay representatives. The management executive report directly to the steering council.

Key feAtures

Dalriada urgent Care provides out of hours GP services to patients within the Northern sector of the Health and social Care Board (HsCB) in Northern ireland (i.e. at weekends, bank holidays and between the hours of 6pm and 7.30am Monday to Friday). There are four primary care centres based in Ballymena, Whiteabbey, Coleraine and Moneymore to provide cover across the area of almost 1600 square miles.

> "Dalriada Urgent Care provides a high quality, flexible and responsive service for our local population. We have promoted partnerships between primary and secondary care, between in hours and out of hours services and most importantly with the patients we serve. We aim to provide the most efficient, effective and appropriate service we can. We are fortunate in that we retain the support of our local GP population and the cooperation and appreciation of the public"
>
> **david J Johnston**
> Clinical director, dalriada urgent Care

dalriada urgent Care has 190 GPs who deliver out of hours care to a population of 455,000 patients. They have approximately 200 support staff including call handlers, drivers and management, as well as approximately 45 triage nurses. On average, dalriada urgent Care manages 148,000 patients per year.

Other services undertaken include in hours and out of hours dental services for the same area, in hours and out of hours intermediate Care services, a Marie Curie nursing service (10pm to 8am, 7 days per week), nurse triage services for other areas, coordination of out of hours nursing services and medical cover for three Community Hospitals. Coordination and facilitation of first responders schemes providing emergency defibrillation training in the most rural areas has also been provided.

dalriada urgent Care does not provide a walk in service. Patients contacting this service will have their demographic details and a brief outline of their presenting condition taken by a call handler. if it is deemed a life threatening situation the call handler will transfer the call directly to a clinician to avoid delay and risk to the patient. All other calls are allocated a priority – either 'routine' or 'urgent'. All patients go through this 'triage' system, where they are subject to telephone assessment by a clinician (either GP or nurse).

Outcomes and Results:

- 33% of the population contact dalriada urgent Care annually
- 9% of people referred to emergency departments
- 3% of people referred to 999
- 50% of patients provided with advice over the phone, 40% are seen in face to face appointments and 10% receive a home visit

Version date: November 2014

Published by:

RCGP Royal College of General Practitioners	**royal college of General Practitioners** 30 euston square, London NW1 2FB Telephone: 020 3188 7400 Fax: 020 3188 7401 email: policy@rcgp.org.uk Website: www.rcgp.org.uk
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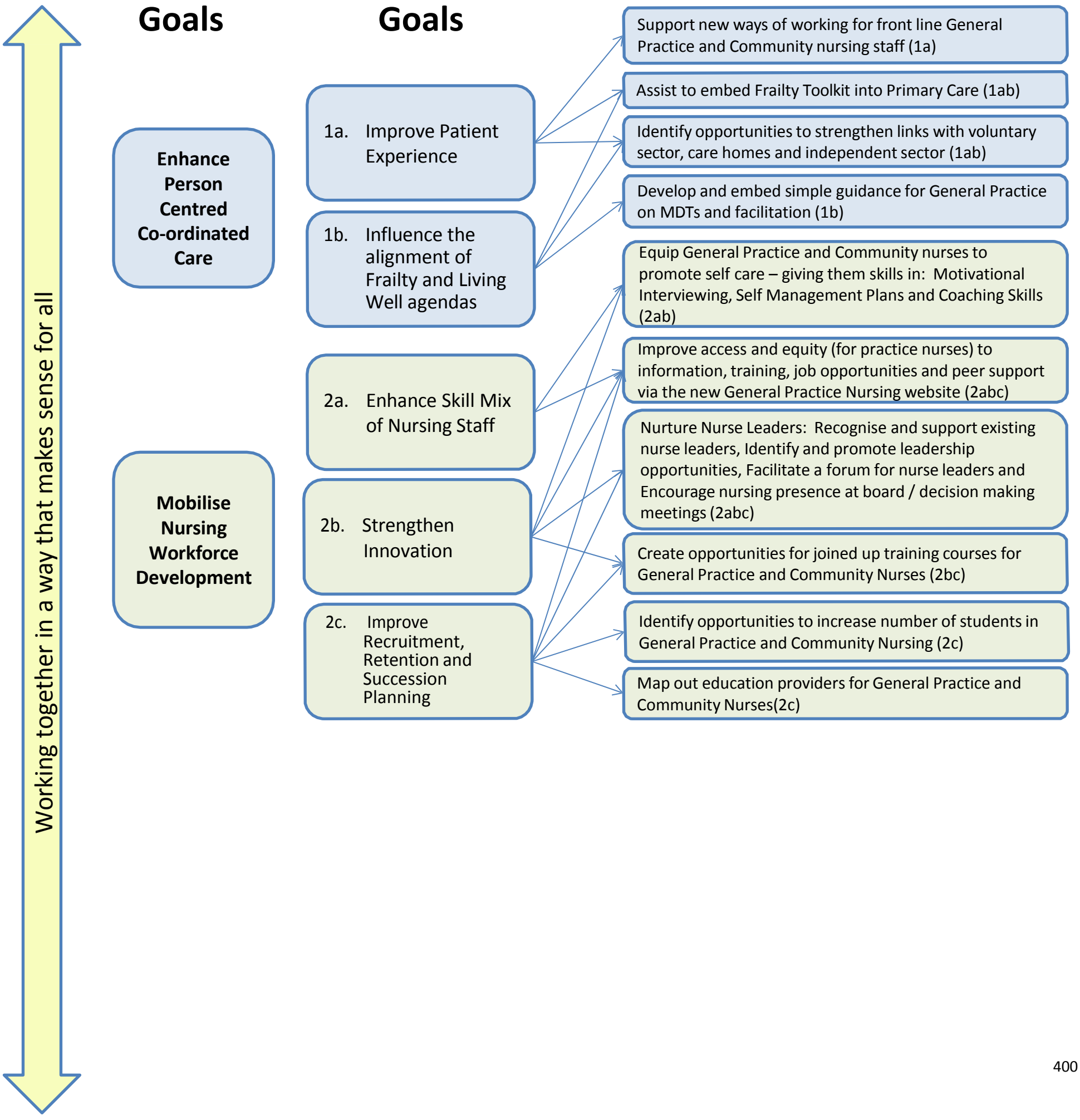
Adopted by the Council of the Royal College of General Practitioners, June 2014

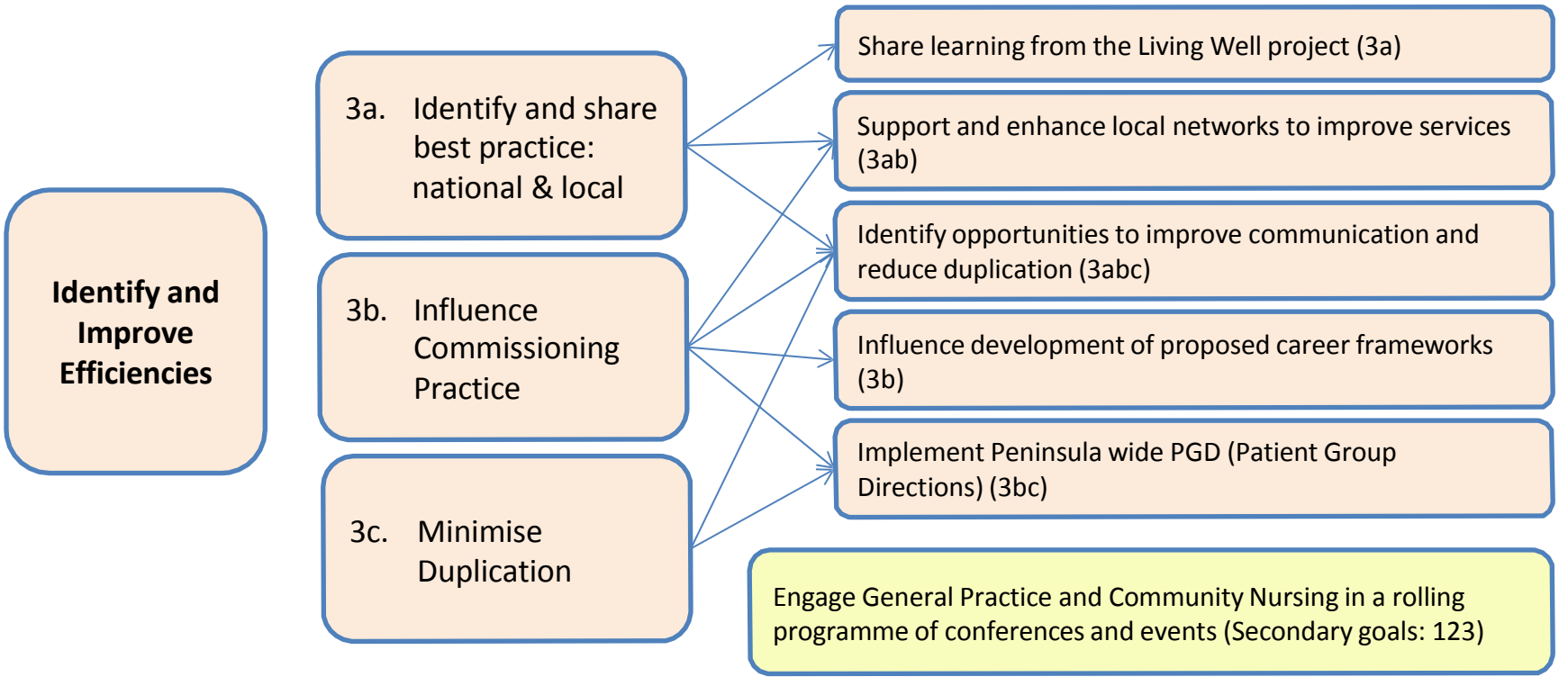
NHS England Devon, Cornwall and Isles of Scilly Area Team

General Practice and Community Nursing Development Programme

To Advance the Implementation of the 5 Year Forward View

Aim: Progressing High Quality, Innovative and Safe General Practice and Community Nursing Across the South West Peninsula - December 2014 - November 2015




Identify and Improve Efficiencies
3a. Identify and share best practice: national & local
3b. Influence Commissioning Practice
3c. Minimise Duplication
Share learning from the Living Well project (3a)
Support and enhance local networks to improve services (3ab)
Identify opportunities to improve communication and reduce duplication (3abc)
Influence development of proposed career frameworks (3b)
Implement Peninsula wide PGD (Patient Group Directions) (3bc)
Engage General Practice and Community Nursing in a rolling programme of conferences and events (Secondary goals: 123)

FF39 Health Education Yorkshire and the Humber

Health Education
Yorkshire and the Humber

A Future Workforce Strategy for General Practice

October 2014

Background

> ***Ten years ago in Yorkshire and the Humber for every GP leaving the workforce there were 1.7 GPs entering the workforce. This allowed for changing working patterns, population growth and allowed our NHS to respond to growing demand. Whilst the number of GPs entering the workforce has grown slightly, the number of GPs leaving the workforce has grown significantly year on year, nearly doubling over the decade. As the headcount of GPs entering the workforce in the last year is only just in balance with the number of leavers, this no longer allows for changes in working patterns, population growth or increased demand for GP services.***
>
> ***This has resulted in the number of full time GPs per 10,000 patients in Yorkshire and the Humber falling from an average of 5.88 in 2009 to 5.73 in 2013. If the impact of this fall was shared equally across our region, it would mean an average sized practice of 10,000 patients losing between one and two GP clinical sessions each week. In fact the GP undersupply is not equally distributed, so the more likely impact scenario is that one in five practices has been unable to replace a leaving GP.***
>
> ***As demand for primary care will not reduce to accommodate this change, our primary care workforce strategies are changing instead.***

Primary care has been highlighted as a key strategic priority by the Local Education and Training Board in Yorkshire and the Humber due to a number of specific challenges. Nationally there is a drive to move services and care out of secondary care, into primary care and the community. There are increased pressures on primary care relating to an ageing population with more co-morbidity. There is also a drive to see extended opening hours within primary care. Demand modelling indicates a doubling of the requirement for General Practice consultations in the next 20 years.

It is clear that a range of strategies are needed to address the overall picture with design solutions that pay particular attention to meeting patient expectations of access to care closer to home, with increased integration of services and greater provision of services out of

hours and at weekends. This will need strategies that build capacity and infrastructure in community and general practice environments, developing roles that have the competences

and skills to carry out more routine patient care, freeing up other clinicians to carry out more specialised and/or targeted care.

We need to build on what we have achieved in the past 5 years. In 2009 we published our five year workforce strategy 'Workforce Ambitions 2009-2014'. We accurately predicted the increase in GP retirements in our region and we have done what we said we would do. In particular we have:

- **Increased primary care training capacity, especially in our underserved areas.** For example there are now almost twice as many GP trainees in Hull as there were in 2008. We have increased the training of nurse mentors in primary care with 90 primary care nurses completing their mentorship training in 2012/13 and 160 in 2013/14.
- **Developed multi-disciplinary training opportunities.** Our network of advanced training practices now covers the whole region, involves 118 practices and is on track to deliver 289 undergraduate nurse placements in 2014/15.
- **Improved Primary Care Workforce Data.** In 2009 we recognised that there was an imperative to underpin our decisions with high quality data on the GP workforce, so we developed the GP Workforce Tool
- **Funded HEYH education and training provision for Primary Care Nurses, Allied Health Practitioners and Health Care Assistants.** More than 2,300 staff from primary care accessed this provision in 2013/14.

Workforce profile

Workforce information obtained through the workforce planning tool, confirms there continues to be a high retirement age profile in traditional general practice roles over the next 5 years; showing that Yorkshire and the Humber has large numbers of GPs, Practice Nurses and practice administrative staff over the age of 55 years. There is an uneven distribution of existing workforce in terms of workforce capacity and capability. There is also a variation in organisational resilience to workforce challenges. The most serious workforce challenges are in practices serving either our rural remote or urban deprived communities.

Recruitment to GP training posts

Despite the national decision to increase the numbers of GP training opportunities available from August 2014 in order to meet the Government target to expand GP training, applications to GP training nationally have dropped by 15% this year. This has meant a reduced fill rate in areas away from the South Coast. HEYH advertised 329 GP Registrar (GPR) training opportunities to achieve the HEE Mandate target set for August 2014. The fill rate at the end of Round 2 was 70%, leaving 90 unfilled GPR posts. The impact of this shortfall has been felt most acutely in our more under-doctored GP workforce communities of North East Lincolnshire, Hull, Scarborough, Calderdale, Kirklees and Doncaster.

Given the combined effect of increased retirement and reduced recruitment, it is necessary for HEYH to work closely with partners to take urgent action. The impact of the low fill rate in Yorkshire and the Humber for GPRs for August 2014 will compound the workforce shortages in many of our hard to fill areas of the region.

The vision for our primary care workforce

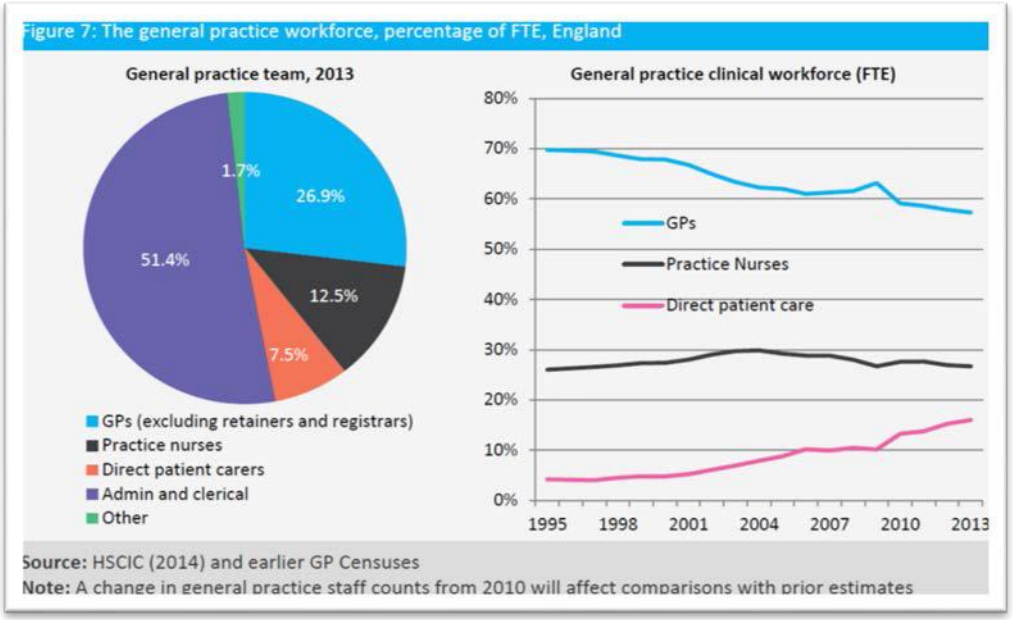
We have identified 3 simplified scenarios for a GP practice clinical staffing ratio that we need to prepare for based on the mix of 3 categories of clinical worker:

- The GP
- The Practice Nurse and/or Advanced Clinical Practitioner
- The Healthcare Assistant (Direct Patient Care band 1-4 support worker)

	GP	Practice Nurse/Advanced Clinical Practitioner	Healthcare Assistant
The conservative model (replacing like for like)	4	2	1
Practices under pressure (evolutionary change)	3	3	2
The extreme scenario (workforce transformation)	1	2	4

There is no single workforce solution. Some practices in areas with lower retirements and healthy local recruitment to training pathways may choose to continue to configure their workforce to historical norms. We believe that most practices will find themselves under increasing workload pressure and will need to see their workforce skill mix evolve through necessity. A few practices will be closer to an extreme scenario that will demand more radical workforce transformation and a complete redesign of primary care clinical pathways.

The changing skill mix of the General Practice Clinical Workforce



Over a period of at least 20 years, General Practice has not simply relied on replacing like for like staff in traditional roles. Increased investment in skills training to create new roles as

well as offering personal development and career progression for existing staff has been important to improve retention and morale, as well as to provide better succession planning.

The benefits of federation (either formally or informally) with other practices is increasingly acknowledged. Federation enables practices to share resources and to focus more on the delivery of a high quality service, extend opening hours and to co-operate in developing a local general practice workforce through shared investment and shared use of existing training capacity.

There needs to be a multi-facetted approach. Looking at just one particular aspect of the workforce in isolation is not a realistic option. An approach that looks at the skill sharing in the workforce and skills development would appear to be the most sensible approach. Clearly defined roles and standards of training for all working within primary care are essential in ensuring high quality and safe care is provided to patients when they are often at their most vulnerable and when it is needed.

The Calderdale framework can help in identifying an appropriate skill mix and improved career structures. Locality based workforce plans of 5-10 years should be developed at practice, CCG and area team level; incorporating short, medium and long term solutions. These plans should enable staff to develop the right skills to meet the needs of our patients that, together, we all serve. Plans will need to involve LMCs, RCGP faculties and our Higher Education Institutions as key partners.

Strategies

HEYH has been working closely with colleagues from across primary care to develop and invest in five core strategies to address some of the key challenges presented across Yorkshire and the Humber.

1. Maximising the supply of GPs and Practice Nurses	**2. Enabling Skill Mix: distributing the practice workload differently**
3. Bringing other professionals/healthcare workers into the practice	**4. Developing new roles as alternatives to the existing GP workforce**
5. Making it happen – the enabling works	

1. Maximising the supply of the existing workforce

a). Exposure to primary care and marketing existing training opportunities
We are investing in mentoring of medical undergraduates with GPs and using widening access schemes that offer 6th form students applying to medical school work experience placements in General Practice. The National Foundation Career Destination Survey in 2012 shows that whilst the average UK medical school produces sees 24.4% of its graduates enter GP training, HYMS see 31.4%, Leeds 29.8% and Sheffield 33.5% of their graduates enter GP training.

We offer taster sessions for FY1 medical students to spend some time in primary care and are engaged in careers events. In 2014 we piloted a pre GP employment initiative to support unsuccessful applicants to GP training with employment opportunities within our region. We believe that supporting unsuccessful applicants to GP training will develop applicants to improve successful applicant numbers in future years, whilst keeping our hospital training capacity in use and delivering service. General Practice is the only specialty that looks after unsuccessful applicants to specialty training in this way. In 2014 we also participated in a third recruitment round, offering GP training opportunities for February 2015 start for applicants who may not have achieved foundation competence by August 2015. Health Education Yorkshire and the Humber has joined with CCGs to improve marketing for our harder to fill areas, including highlighting career development opportunities in General Practice in these areas.

Our Advanced Training Practice network of 10 hubs and 118 practices is growing each year. We will deliver 700 undergraduate nurse placements a year in primary care within five years. We have seen placements in GP practices change the career intentions of undergraduate

nurses and change the attitudes of GP employers towards employing newly qualified nurses in primary care. There are a growing number of practice nurses working in General Practices in Yorkshire and the Humber as a direct result of their undergraduate placement in an Advanced GP Training Practice. Our network of advanced training practices has helped develop competency frameworks for a range of clinical support workers in primary care. In addition to developing undergraduate nurse placements, our ATPs have also developed placements for band 1-4 staff, allied health professions and social care workers. The ATPs have also offered preceptorships, enabling newly qualified nurses to go straight into work in General Practice in our region, something that was hitherto unheard of.

b). Reducing training attrition
We are targeting additional training and support towards those at greatest risk of poor progression through GP training. Targeted interventions include: the placement of lower scoring applicants to their preferred geographical area where they have more support, developing expertise in teaching clinical skills for the examination and exam preparation support for trainees. Whilst this is resource intensive, it gives a good return on investment as we have some of the best exit examination pass rates when compared to our trainees' entry scores through national GP selection tests.

c). Return to practice and retention initiatives
We have developed and funded an Induction, Refresher, Returner scheme to support GPs who have been out of UK General Practice to return to work in our most under-doctored areas. We continue to support a GP retainer scheme. A national campaign was launched Sept 2014 to encourage nurse to return to practice. In Y&H information regarding the launch was sent to Chief Nurses in CCGs for circulation to enable expressions of interest from General Practice to be linked to the programme. A briefing paper about the initiative has also been shared with the ATPs. Whilst practices have yet to express an interest in the nurse return to practice initiative, we are including information about the scheme in our feedback pack for practices supplying workforce data using the GP workforce tool.

2. Enabling Skill Mix: distributing the practice workload differently

a). The Calderdale framework. HEYH have invested in the roll out of the Calderdale framework. This is available to GP practices and CCGs expressing an interest in the model. It enables general practices to work through a framework to help them identify the most appropriate skills required to provide and safe and effective service, taking a whole team approach from beginning to end, to ensure ownership as a practice of the solutions and skill mix identified.

b). Developing new capabilities in existing primary care staff. We have enabled Practice Nurses and Health Care Assistants to access HEYH funded education and training provision available at ten universities across Yorkshire and the Humber as well as the Primary care training centre and Rotherham Respiratory Group. Evidence demonstrates a significant number of primary care staff are accessing this provision.

Access to the e-learning GP Platform (e-TREVOR) will also be available on 2014. This initiative has been developed by the CSU in conjunction with the HEYH e-learning club and

will provide a web-based e-learning for general practice staff.

c). Apprenticeship opportunities. HEYH have supported Apprenticeship Hubs which are now widely established and have better links with practices to support them access programmes for health care assistant and business administration apprenticeship roles. In 2014 there were at least 120 apprenticeships in General Practice providers.

d). Workforce Transformation. Health Education Yorkshire and the Humber has held workshops, conferences and engaged in CCG led locality events on workforce transformation. Many of these events have focused on doing general practice work differently.

3. Bringing healthcare workers into General Practice from other care settings and organisations

This includes Pharmacists, Physiotherapists and Paramedics. There is potential to utilise unfilled GP vocational training capacity to develop placement capacity for Allied Health Professionals wishing to orientate to primary care and enhance contextual skills in the General Practice setting.

We are funding 20 two year placements for advanced clinical practice (AHPs and nurses) working in general practices. We have received over 50 expressions of interest from practices interested in this initiative.

Just as we were one of the lead areas for Broad based Training, Yorkshire and the Humber has contributed to plans for recognising transferable competences for doctors from other specialties who wish to train as GPs having started in a different specialty training programme. It is expected that there will be a shorter training pathway for these GP trainees who will bring competences from other specialty training.

Health Education Yorkshire and the Humber will support integration of care, as proposed in The NHS Five Year Forward View.

4. Developing new roles as alternatives to the existing workforce

Physicians Associates: We have commissioned training for Physicians Associates with an expectation that we will deliver placement capacity in primary care and that on graduation PAs will work in our region. We are working with CCGs to secure employment opportunities in practices for PAs on graduation. We have been working with a beacon practice that has employed several PAs.

Other new roles: At our engagement events and workforce transformation events there was interest in a new role for a band 1-4 support worker who might work alongside GPs and other practitioners to increase efficiency and take share some of the administrative workload from the GP in order to maximise patient throughput.

5. Making it happen – the enabling works

a). Workforce Planning Tool. The tool is currently being used by 52% of Yorkshire and the Humber practices and with increasing interest from Area Team, CCG and General Practice. Practices that are using the GP database tool are able to create better informed workforce plans by analysis of their local practice data and comparisons with other similar practices/CCG areas. This data can be used to model workforce needs for the future, identify risks and opportunities and provide the evidence to demonstrate resource requirements, including additional financial investment. HEYH continue to work with practices to refine this tool and support its use.

b). Advanced Training Practices. The advanced training practices will continue to develop new primary care placement capacity for undergraduate nurse and allied health professional placements, band 1-4 support workers and preceptorships.

c). Local partnerships. In the North Yorkshire and Humber area a Primary care workforce development group was formed early 2013 to tackle local priorities facing the primary care workforce with representation from the LMC, HEYH, CCGs, HEIs, Hull York Medical School, Area Team and practices. This is now being replicated in other localities, feeding into the partnership council network.

CCGs are working locally with practices in order to address some of the issues around recruitment and retention. Some are offering financial incentives to release Practice Nurses to undertake mentor preparation programmes and aid their development, bursaries for GPs to fund Masters and doctorate level education.

CCGs have supported the development of Advanced Training Practices and adoption of the GP Workforce Tool. CCGs with urgent locality GP workforce issues have been proactive in promoting workforce transformation action in these localities.

Ongoing Challenges and Risks

The financial constraints and workload pressures now faced by General Practice are acute. The reorganisation of the primary care commissioning landscape from PCTs to CCGs and Area Teams has meant that practices have spent time/energy becoming familiar with the new organisations and organisational interfaces. Many practices have not been aware in the need to invest or sustain their medical and non-medical training/supervision infrastructure. Release of staff for training is an issue for most practices. Some practices recognise a risk that where they invest in skills development for individuals, neighbouring practices may “poach” experienced trained staff. The opportunity cost of staff development therefore needs to be recognised. Where these obstacles have been overcome we have seen a “virtuous spiral” where practices move from “why would we invest in training our workforce?” to “why wouldn’t we invest in training our workforce?”

Practices across Yorkshire and the Humber are at different stages of development and organisational maturity with respect to workforce insight.

Stages of GP Organisational Maturity with Respect to Workforce Planning

(1) "Passive/Non engaged" - Practices that have not submitted a workforce risk or who see no workforce solutions within their own sphere of influence.

(2) "Reactive" - Practices that address workforce issues as and when they arise within each of their staff groups, but in a "silo" way.

(3) "Anticipative/Responsive" - Practices that look ahead to future retirements/ or workforce changes, and consider shifts of skills/work within the organisation between different staff groups.

(4) "Contributive/Proactive" - Practices that not only look ahead and look at changing work patterns, but who work at a level above their own organisation in partnership to train primary care workers for the wider community.

(5) "Generative/Co-productive/Innovative" - Practices at a level indicated in (4) but who also contribute to innovative or new solutions for the primary care workforce.

What Health Education Yorkshire and the Humber needs from our local partners

Health Education Yorkshire and the Humber will deliver on the strategies outlined in this document. Health Education Yorkshire and the Humber alone cannot address the perceived need for additional investment in general practice, the attractiveness of working in general practice as a career option, nor the attractiveness of working in a particular geographical location. We therefore need our partners to play their part. We need practices/CCGs/Area Teams to create and share their GP workforce plans and to develop greater organisational maturity with respect to workforce planning.

Practices/ Providers of primary care

We need practices to supply workforce data, placement capacity and employment opportunities for the workforce that is trained locally. Where practices federate, we would like to see provision of placement capacity and engagement with training given a high priority, so that primary care invests in and develops its own staff.

Commissioners of Primary Care (Area Teams)

We need commissioners of primary care to align contracts/incentives with patient need, especially with respect to workforce retention. This includes appropriate incentives/levers to ensure supply of accurate workforce information. Where workforce solutions require transformation, commissioning investment decisions (for example regarding estate) need to be aligned so that the transformed workforce can be accommodated.

Commissioners of Secondary Care (CCGs)

We need commissioners of secondary care to signal shifts in commissioning intentions and to share proposals on the development of integrated care solutions where this has an impact

on education and training commissions. In addition CCGs may be the catalyst for federation and are key stakeholders and system leaders.

Other Providers of Primary Care Training placements, including Secondary Care Providers and other partners

We need other providers of primary care training placements to continue to provide placement capacity for training the primary care workforce. This capacity needs to be delivered even as services shift and new models of care delivery are developed.

Developing people for health and healthcare

Yorkshire & the Humber

GP Workforce Q3 Oct-Dec 2014

Elin Sandberg
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Health Education
Yorkshire and the Humber

GP Workforce Report
Q3 : October – December 2014

This report is compiled from the data submitted by General Practices to the Health Education Yorkshire and the Humber online GP Tool.

The GP Tool collects detailed information from practices at an individual staff level. The data is then anonymised and aggregated before being analysed in this report.

The aim of this analysis is to examine General Practices' workforce structure in Yorkshire and the Humber. It includes aggregated workforce profiles, as well as information on age profiles, skill mix, gender splits, time with patients and FTE and patient ratios. It also includes information on GPWsI accreditation, practice nurse qualifications (including mentoring qualifications) and areas of special interest. Finally it includes an analysis of the retirement risks by staff group.

455 practices submitted their workforce data and were included in the analysis.

Breakdown of practices included:

CCG Name	Number of Practices in CCG (1)	Number of Practices using the tool (2)	Number of Practices submitted data (3)	Coverage rate (2/1)	Submission rate (3/1)
NHS Airedale, Wharfedale and Craven CCG	17	15	13	88%	76%
NHS Barnsley CCG	**37**	4	1	11%	3%
NHS Bassetlaw CCG	12	3	1	25%	8%
NHS Bradford City CCG	27	21	15	78%	56%
NHS Bradford Districts CCG	41	18	12	44%	29%
NHS Calderdale CCG	27	25	22	93%	81%
NHS Doncaster CCG	**43**	30	26	70%	60%
NHS East Riding of Yorkshire CCG	37	27	22	73%	59%
NHS Greater Huddersfield CCG	39	36	34	92%	87%
NHS Hambleton, Richmondshire and Whitby CCG	**22**	1	0	5%	0%
NHS Harrogate and Rural District CCG	19	14	12	74%	63%
NHS Hull CCG	57	28	18	49%	32%
NHS Leeds North CCG	**28**	27	21	96%	75%
NHS Leeds South and East CCG	**41**	40	38	98%	93%
NHS Leeds West CCG	38	36	34	95%	89%
NHS North East Lincolnshire CCG	30	28	28	93%	93%
NHS North Kirklees CCG	**29**	29	27	**100%**	93%
NHS North Lincolnshire CCG	21	1	0	5%	0%
NHS Rotherham CCG	**36**	15	13	42%	36%
NHS Scarborough and Ryedale CCG	17	1	0	6%	0%
NHS Sheffield CCG	**87**	79	76	91%	87%

NHS Vale of York CCG	32	5	2	16%	6%
NHS Wakefield CCG	**40**	40	40	**100%**	**100%**
Total	**777**	**523**	**455**	**67%**	**59%**

Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Health Education Yorkshire and the Humber

Aggregated Workforce Profile

Job Role	Under 25		25-34		35-44		45-54		55+		Total
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
GP	26.03	31.92	159.85	221.16	308.56	310.68	331.50	244.25	213.15	80.72	1927.82
GP Partner	14.41	18.46	45.31	37.22	244.25	183.51	302.61	191.77	194.12	67.77	1299.43
GP Salaried	3.90	4.33	57.92	91.83	41.41	92.21	23.83	48.59	16.41	12.02	392.45
GP Registrars - years 3 & 4	3.28	4.12	34.65	66.64	10.92	24.31	0	0	0	0	143.92
GP Foundation Registrar - years 1 & 2	3.22	3.78	18.26	17.61	3.00	1.00	0	1.34	0	0	48.21
GP Retainers	0	0	0	0.77	1.00	3.30	0	0.33	0	0	5.40
Locum - covering vacancy	1.22	0.56	1.50	2.11	4.11	2.66	2.17	0.78	2.01	0.38	17.50
Locum - other	0	0	1.21	3.65	3.65	3.25	1.33	1.44	0.61	0.55	15.69
GP NDF Capacity	0	0	0	0	0.22	0	0	0	0	0	0.22
Locum - covering maternity/paternity	0	0.67	1.00	1.33	0	0.44	1.56	0	0	0	5.00
Practice Nurses	2.11	34.03	2.71	70.66	7.57	200.52	14.01	451.01	4.70	263.38	1050.70
Advanced Nurse Practitioners	0.64	5.60	2.71	9.75	5.77	32.03	6.00	110.03	2.06	59.52	234.11
Extended Role Practice Nurses	0	4.23	0	3.71	1.00	21.09	1.01	41.61	0	23.66	96.31
Specialist Practitioner Nurse	0	2.45	0	1.80	0	11.17	0.72	27.76	0	14.98	58.88
Practice Nurses	1.47	18.26	0	45.22	0.80	127.73	6.28	268.06	2.64	163.75	634.21
New Practice Nurse	0	3.49	0	10.18	0	8.50	0	3.55	0	1.47	27.19
Direct Patient Care	2.84	31.59	4.87	90.86	5.56	109.19	7.95	213.06	3.97	113.50	583.39
Health Care Assistant	0.66	24.21	1.48	70.65	3.78	84.34	0.80	151.10	2.56	71.37	410.95
Physios	0	0	0	0	0	0	0	1.00	0	0.48	1.48
Podiatrists	0	0	0	0.53	0	0	0	0	0	0	0.53
Therapists	0	0	0	0	0	0	0	1.23	0	0.32	1.55
Phlebotomists	0	3.38	0.20	6.01	0.29	4.03	0.21	11.79	0	10.31	36.22
Other	1.43	0.80	0.80	3.44	0.27	2.69	3.22	4.56	0.40	4.83	22.44
Dispenser	0.75	2.44	1.05	8.36	0.69	15.70	0.60	43.02	0.53	25.38	98.52
Pharmacist	0	0.76	0.27	0.80	0.53	2.43	2.05	0.36	0.48	0.81	8.49
Physician's Associate	0	0	1.07	1.07	0	0	1.07	0	0	0	3.21
Practice Management	31.61	257.39	43.56	384.94	42.36	637.84	56.40	1321.39	49.75	1066.06	3891.30
Admin & Clerical	14.17	67.74	14.03	134.94	14.61	237.84	10.13	448.56	8.39	388.71	1339.12
Other Practice Staff	1.99	15.47	4.23	10.46	4.58	16.63	3.58	33.91	7.06	22.52	120.43
Temporary Worker	0	2.00	1.60	0.91	0	2.78	0	2.43	0	1.21	10.93
Reception Staff	13.16	160.44	10.19	209.18	7.56	283.13	4.07	633.29	4.07	489.35	1814.44
Practice Manager	0	6.29	7.53	17.14	12.71	70.97	36.84	144.94	26.19	94.41	417.02
Prescription Clerk	0	1.92	0.96	3.61	0	9.79	0	22.53	0	17.21	56.02
Summariser	1.00	1.00	4.49	3.10	1.00	7.51	0.43	15.91	0.61	22.54	57.59
Cleaner	1.29	2.53	0.53	5.60	1.90	9.19	1.35	19.82	3.43	30.11	75.75
Apprentices	17.71	90.97	1.14	6.15	0	5.45	0	5.13	0	8.39	134.94
Health Care Assistant	0	5.55	0.14	0.42	0	0.99	0	1.04	0	0	8.14
Administrative & Clerical	17.71	84.42	1.00	5.73	0	3.16	0	3.98	0	8.23	124.23
Other	0	1.00	0	0	0	1.30	0	0.11	0	0.16	2.57
Total	80.30	445.90	212.13	773.77	364.05	1263.68	409.86	2234.84	271.57	1532.05	7588.15

* Please note. The staff in the 'Partner' job role have been excluded from the Particpation Rate calculation.

Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Health Education Yorkshire and the Humber

Aggregated Workforce Profile by FTE breakdown

Job Role	FTE			Total FTE	Total Headcount	Absence FTE	Absence Headcount	Participation Rate	People required to fill 1 post
	With patients	Outside traditional role	Non Clinical						
GP	1853.75	24.47	50.71	1927.82	2504	10.37	14	77%	1.3
GP Partner	1249.52	20.59	29.32	1299.43	1589	5.64	7	82%	1.2
GP Salaried	382.05	3.03	7.37	392.45	599	3.79	5	66%	1.5
GP Registrars - years 3 & 4	134.57	0.35	9.00	143.92	167	0.50	1	86%	1.2
GP Foundation Registrar - years 1 & 2	44.96	0.22	3.03	48.21	51	0.00	0	95%	1.1
GP Retainers	4.96	0.00	0.44	5.40	12	0.44	1	45%	2.2
Locum - covering vacancy	17.17	0.11	0.22	17.50	34	0.00	0	51%	1.9
Locum - other	15.30	0.17	0.22	15.69	39	0.00	0	40%	2.5
Partner	0.00	0.00	1.11	0	5	0.00	0	0%	0
GP NDF Capacity	0.22	0.00	0.00	0.22	1	0.00	0	22%	4.5
Locum - covering maternity/paternity	5.00	0.00	0.00	5.00	7	0.00	0	71%	1.4
Practice Nurses	1020.88	0.00	29.82	1050.70	1521	2.03	3	69%	1.4
Advanced Nurse Practitioners	227.39	0.00	6.72	234.11	302	0.00	0	78%	1.3
Extended Role Practice Nurses	92.80	0.00	3.51	96.31	130	0.00	0	74%	1.3
Specialist Practitioner Nurse	56.64	0.00	2.24	58.88	82	0.00	0	72%	1.4
Practice Nurses	617.14	0.00	17.07	634.21	963	2.03	3	66%	1.5
New Practice Nurse	26.91	0.00	0.28	27.19	44	0.00	0	62%	1.6
Direct Patient Care	506.29	0.00	77.10	583.39	1002	2.07	3	58%	1.7
Health Care Assistant	390.64	0.00	20.31	410.95	652	2.07	3	63%	1.6
Physios	1.41	0.00	0.07	1.48	2	0.00	0	74%	1.4
Podiatrists	0.53	0.00	0.00	0.53	1	0.00	0	53%	1.9
Therapists	1.55	0.00	0.00	1.55	5	0.00	0	31%	3.2
Phlebotomists	34.38	0.00	1.84	36.22	119	0.00	0	30%	3.3
Other	20.84	0.00	1.60	22.44	38	0.00	0	59%	1.7
Dispenser	49.21	0.00	49.31	98.52	163	0.00	0	60%	1.7
Pharmacist	4.52	0.00	3.97	8.49	19	0.00	0	45%	2.2
Physician's Associate	3.21	0.00	0.00	3.21	3	0.00	0	107%	0.9
Practice Management	1483.29	0.00	2408.01	3891.30	5791	7.79	12	67%	1.5
Admin & Clerical	483.28	0.00	855.84	1339.12	1891	0.61	1	71%	1.4
Other Practice Staff	43.80	0.00	76.63	120.43	197	1.36	2	61%	1.6
Temporary Worker	3.08	0.00	7.85	10.93	33	0.00	0	33%	3.0
Reception Staff	703.48	0.00	1110.96	1814.44	2773	5.33	8	65%	1.5
Practice Manager	159.31	0.00	257.71	417.02	475	0.49	1	88%	1.1
Prescription Clerk	30.20	0.00	25.82	56.02	88	0.00	0	64%	1.6
Summariser	26.16	0.00	31.43	57.59	126	0.00	0	46%	2.2
Cleaner	33.98	0.00	41.77	75.75	208	0.00	0	36%	2.7
Apprentices	60.26	0.00	74.68	134.94	167	0.00	0	81%	1.2
Health Care Assistant	7.83	0.00	0.31	8.14	14	0.00	0	58%	1.7
Administrative & Clerical	51.15	0.00	73.08	124.23	147	0.00	0	85%	1.2
Other	1.28	0.00	1.29	2.57	6	0.00	0	43%	2.3
Total	4924.47	24.47	2640.32	7588.15	10985	22.26	32	69%	1.4

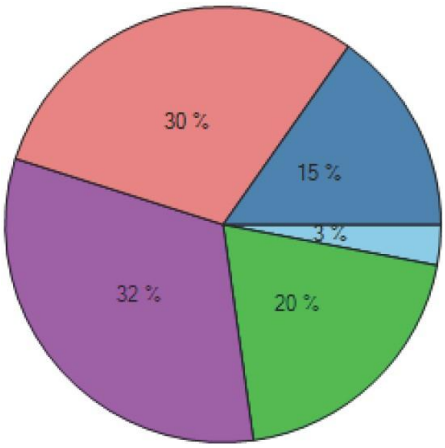
Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Health Education
Yorkshire and the Humber

Age Profile

GP



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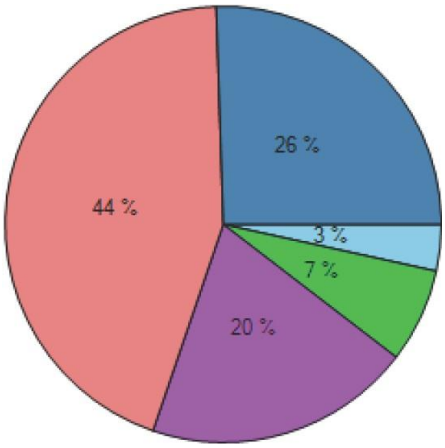
c::::J 25 to 34
-35to44
c::::::::J 45 to 54
–55 +

Practice Nurses



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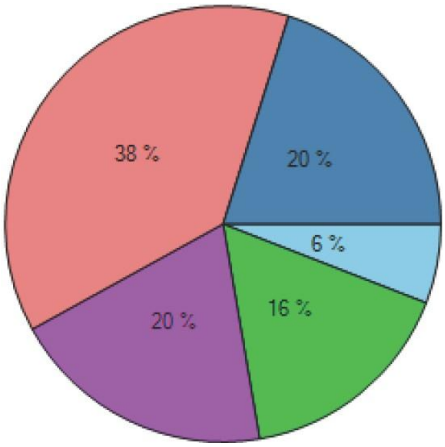
c::::J 25 to 34
-35to 44
c::::::::J 45to54
–55 +

Direct Patient Care



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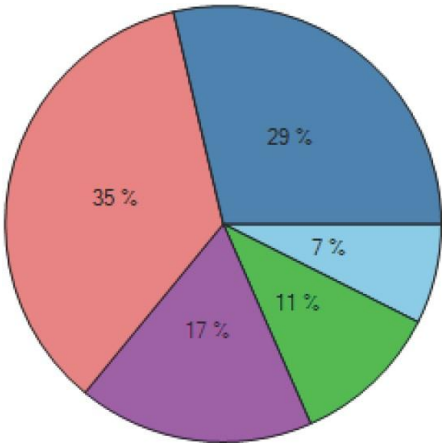
-35to44
c::::::::J 45 to 54
–55 +

Practice Management



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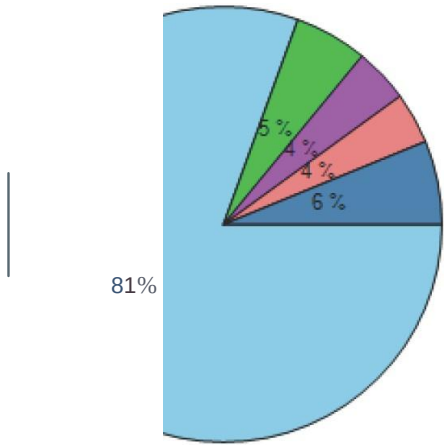
c::::J 25to 34
-35to 44
c::::::::J 45 to 54
–55 +

Apprentices



c:::::::J Under 25
c::::J 25 to 34
-35to44
c::::::::J 45 to 54
–55 +

Workforce Analysis (Oct-Dec 2014)

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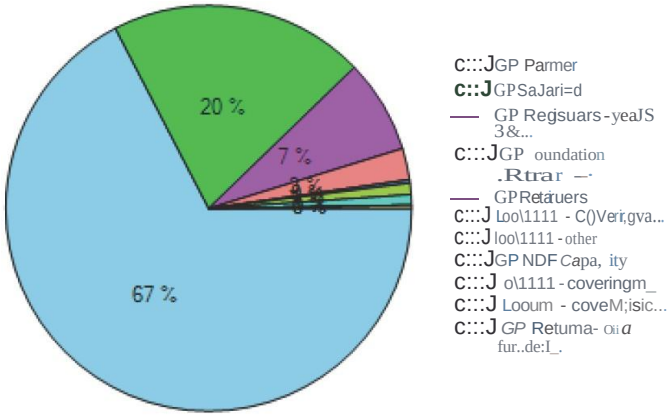
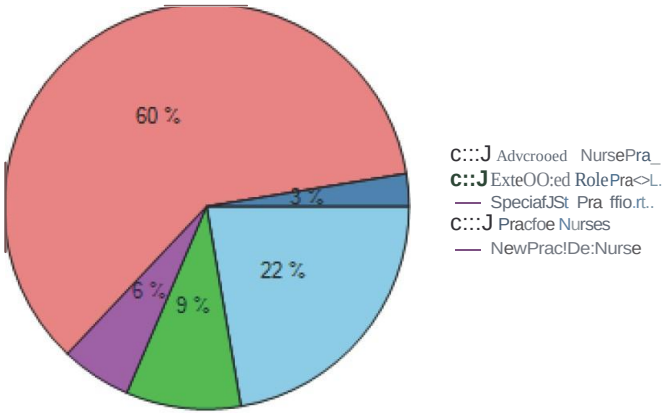
Health Education
Yorkshire and the Humber

Skill Mix

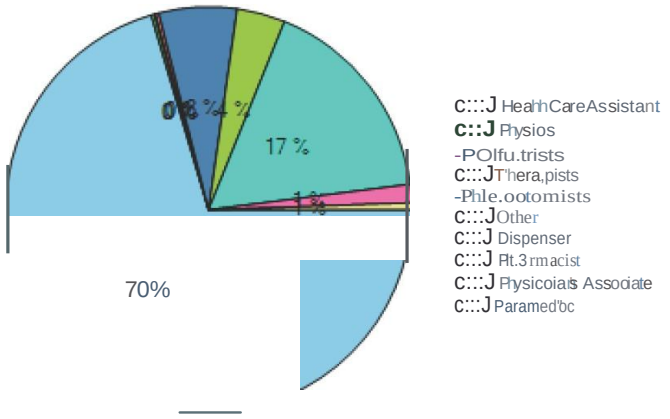
GP



Practice Nurses



Direct Patient Care



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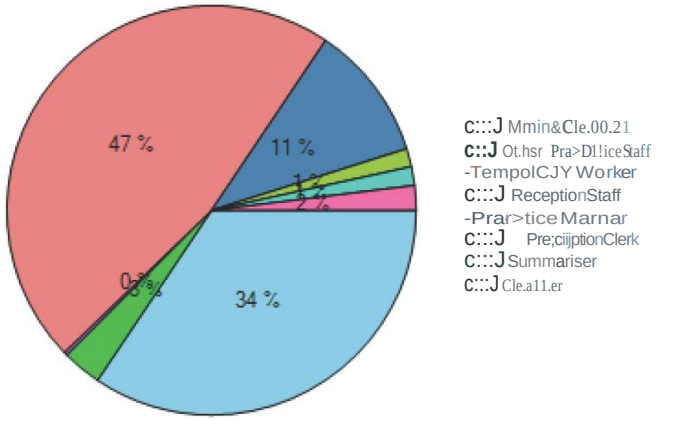

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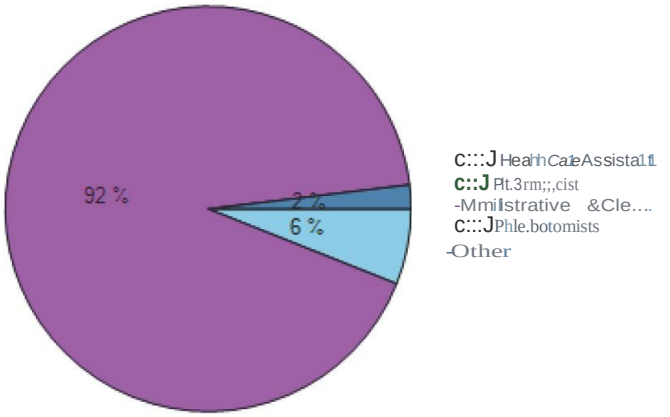
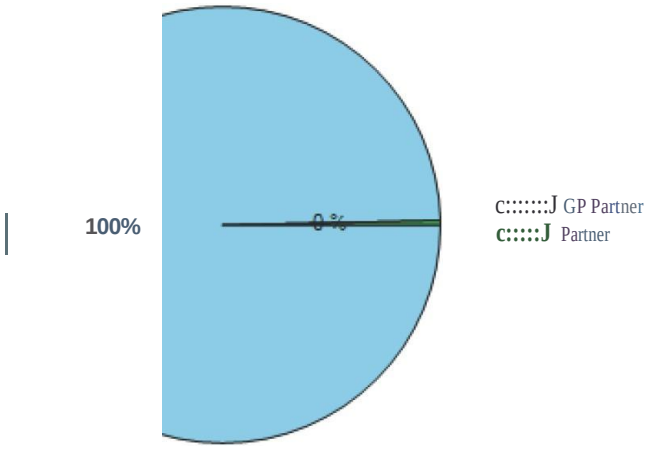


Partner Skill Mix



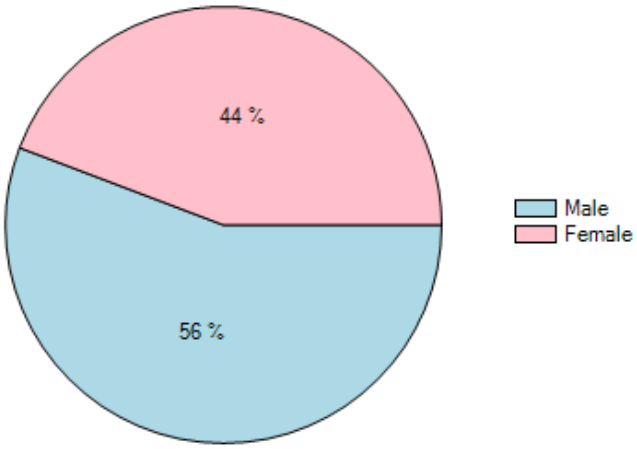
Workforce Analysis (Oct-Dec 2014)

All submitted practice data

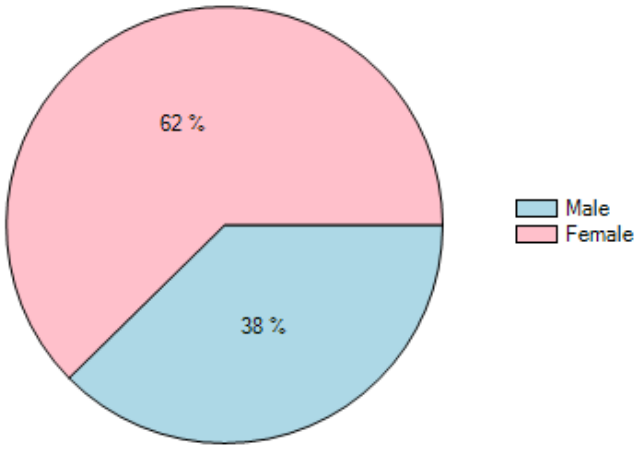
Gender Split

Health Education
Yorkshire and the Humber

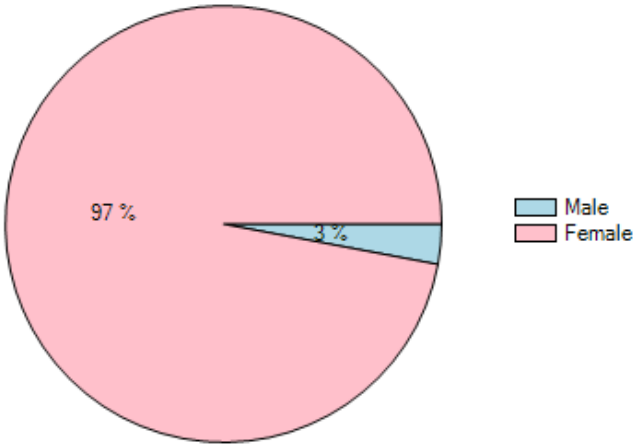
GPs



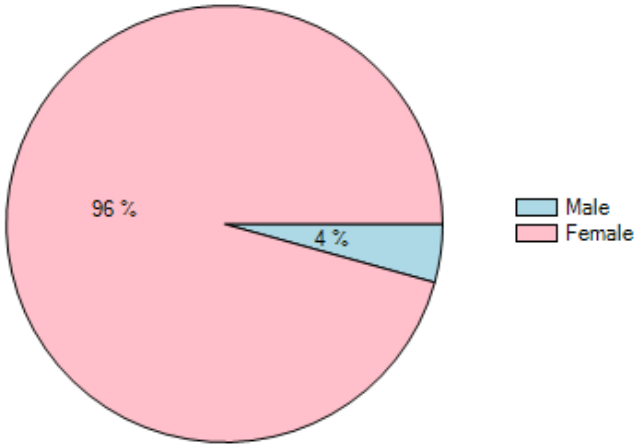
GP Trainee



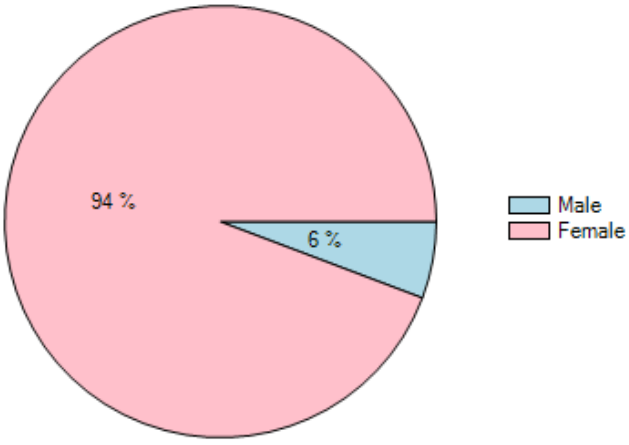
Practice Nurses



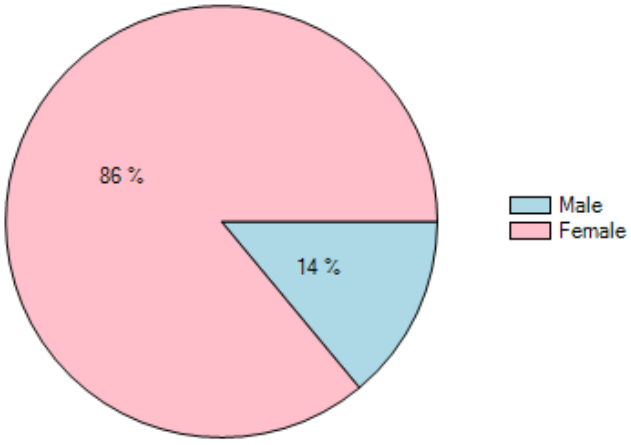
Direct Patient Care



Practice Management



Apprentices



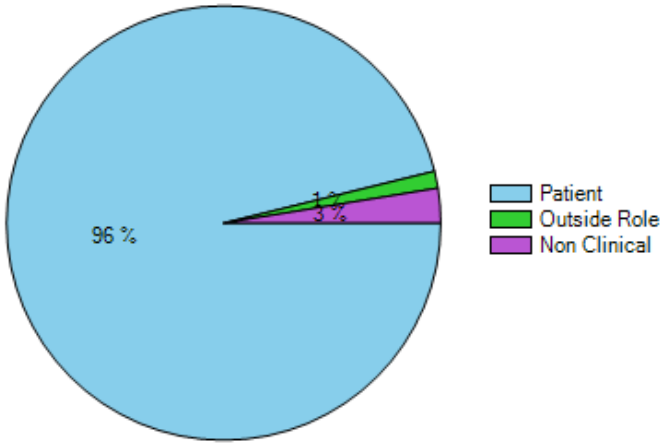
Workforce Analysis (Oct-Dec 2014)

All submitted practice data

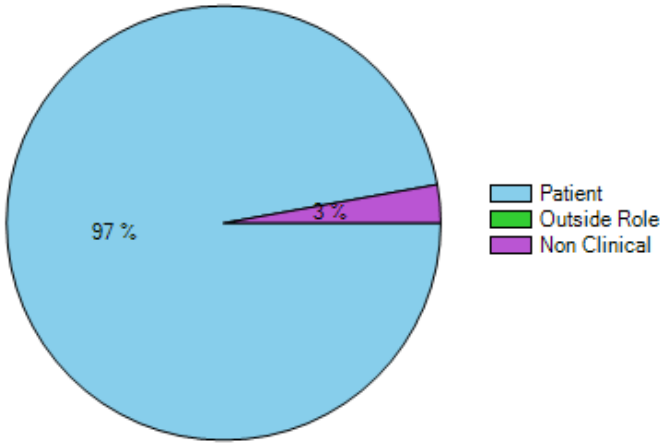
Time with Patients

Health Education
Yorkshire and the Humber

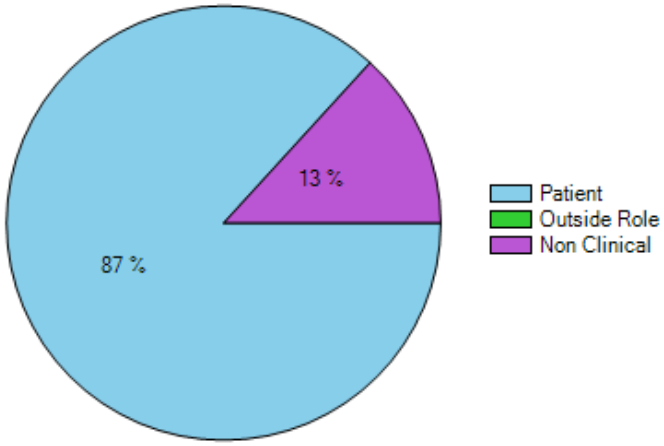
GP



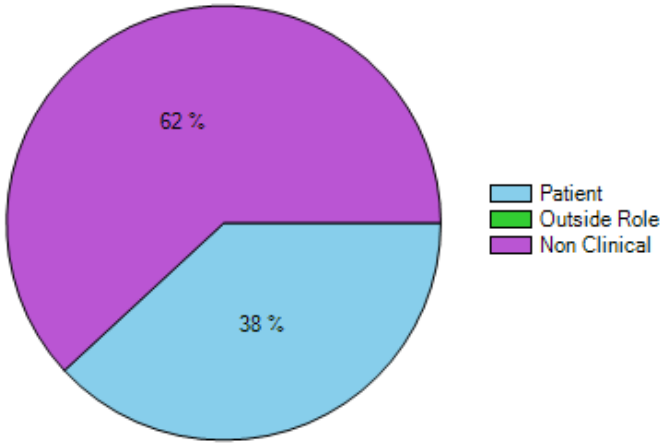
Practice Nurses



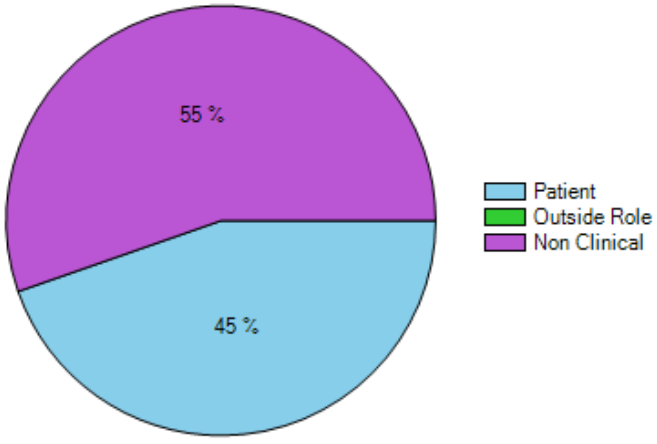
Direct Patient Care



Practice Management



Apprentices

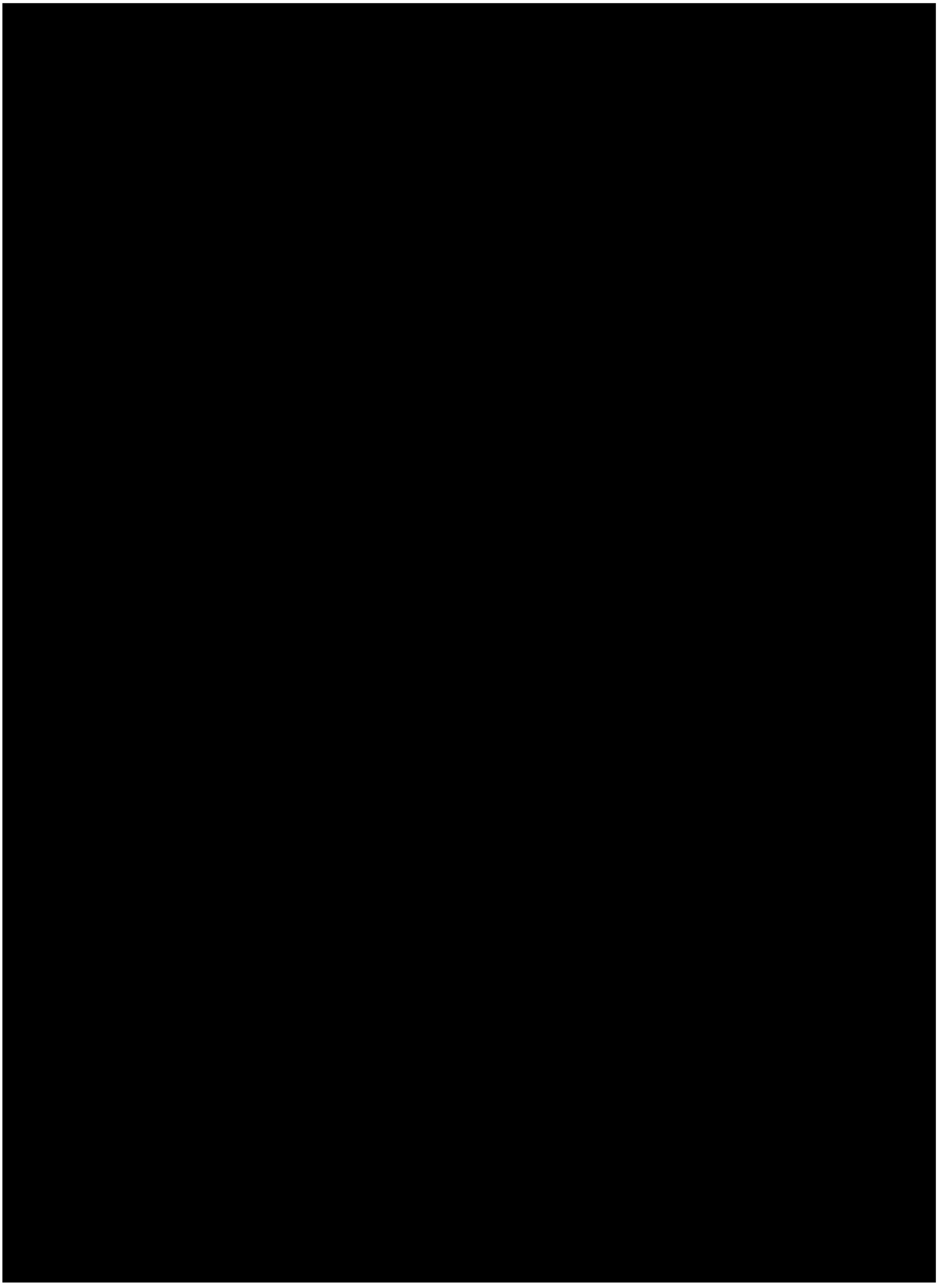


Workforce Analysis (Oct-Dec 2014)

All submitted practice data

FTE Ratios0

Health Education
Yorkshire and the Humber

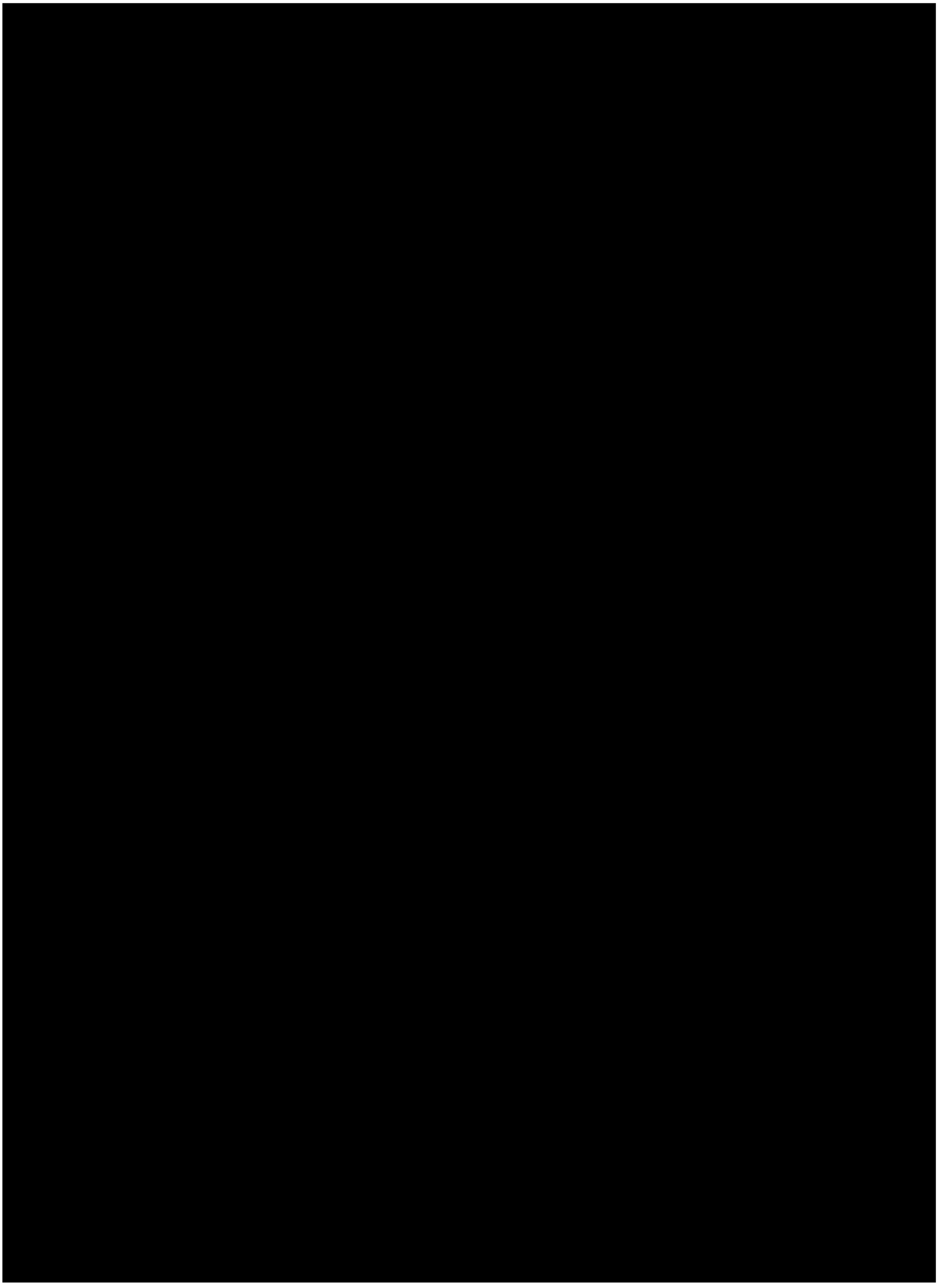


Workforce Analysis (Oct-Dec 2014)

All submitted practice data

FTE Ratios

Health Education
Yorkshire and the Humber

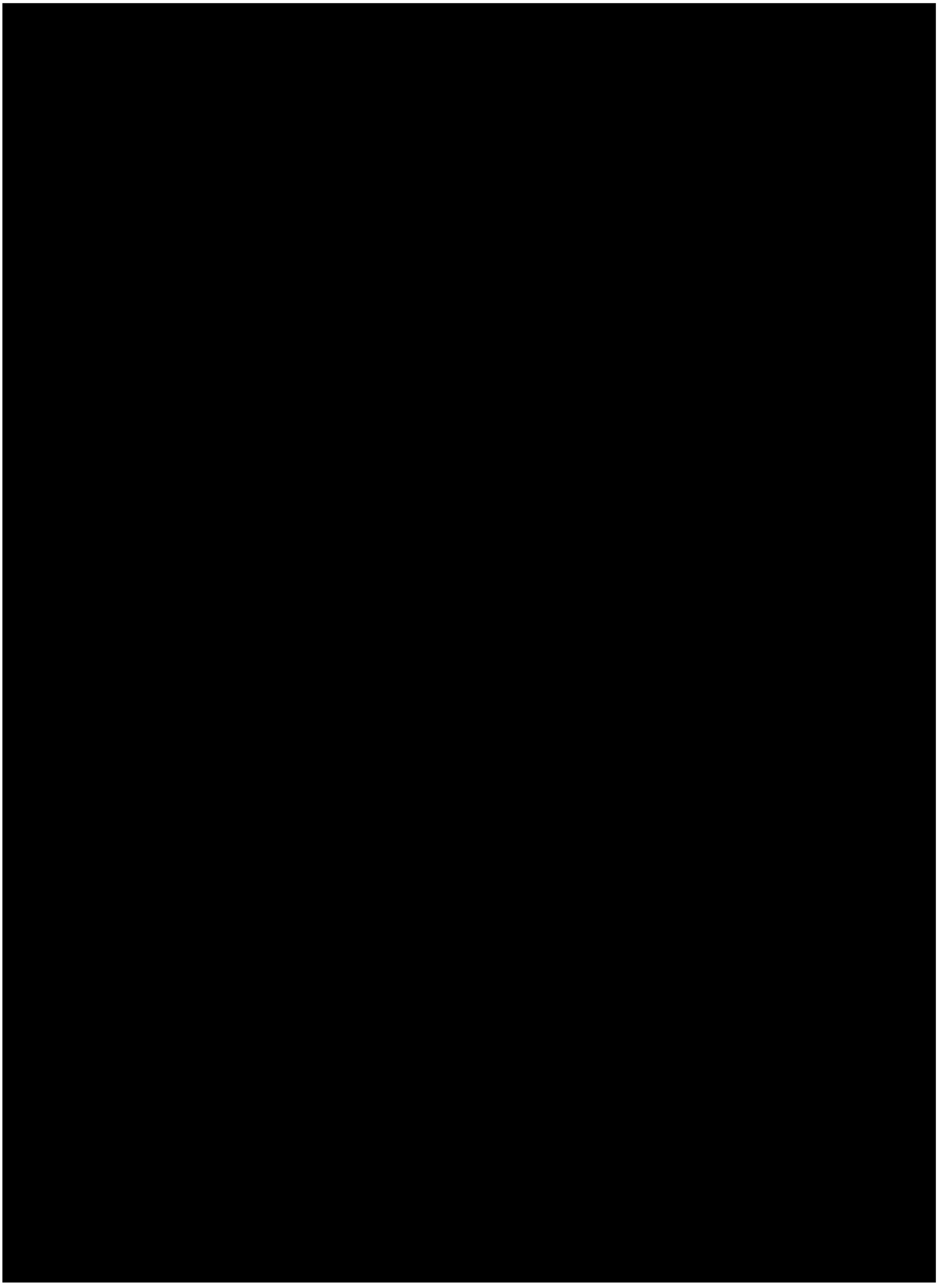


Workforce Analysis (Oct-Dec 2014)

All submitted practice data

FTE Ratios

Health Education
Yorkshire and the Humber

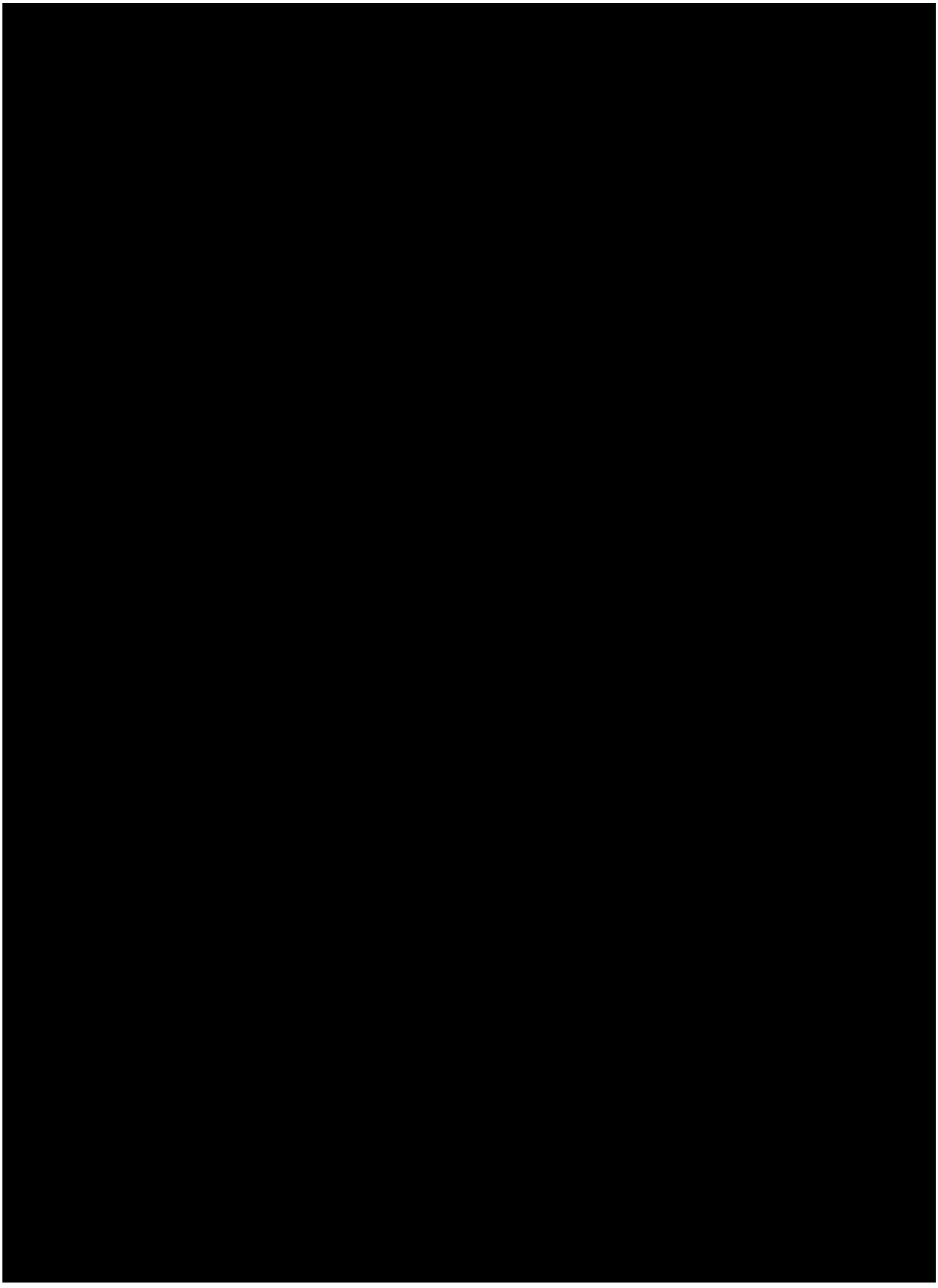


Workforce Analysis (Oct-Dec 2014)

All submitted practice data

FTE Ratios

Health Education
Yorkshire and the Humber

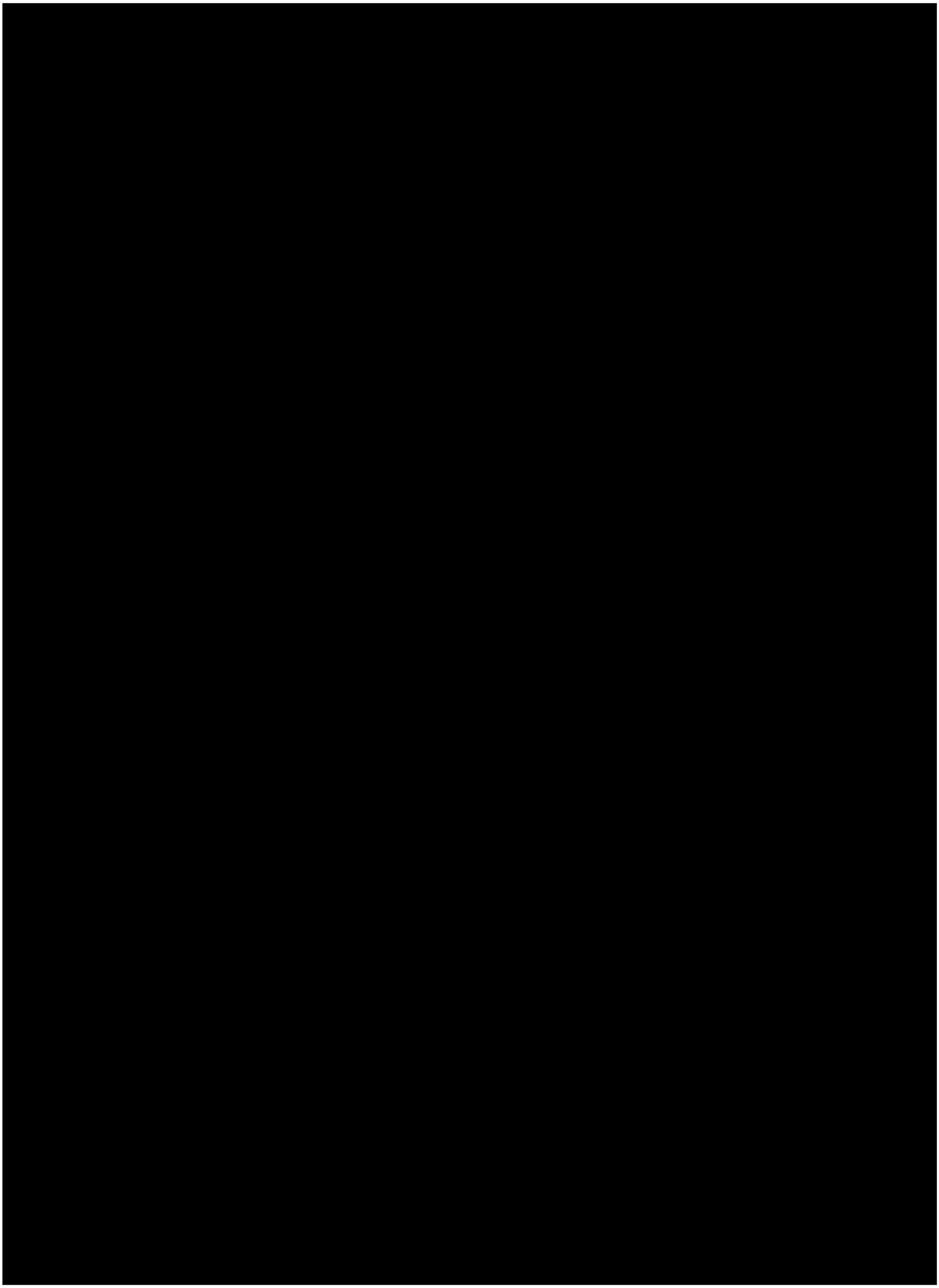


Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Patient Ratios

Health Education
Yorkshire and the Humber

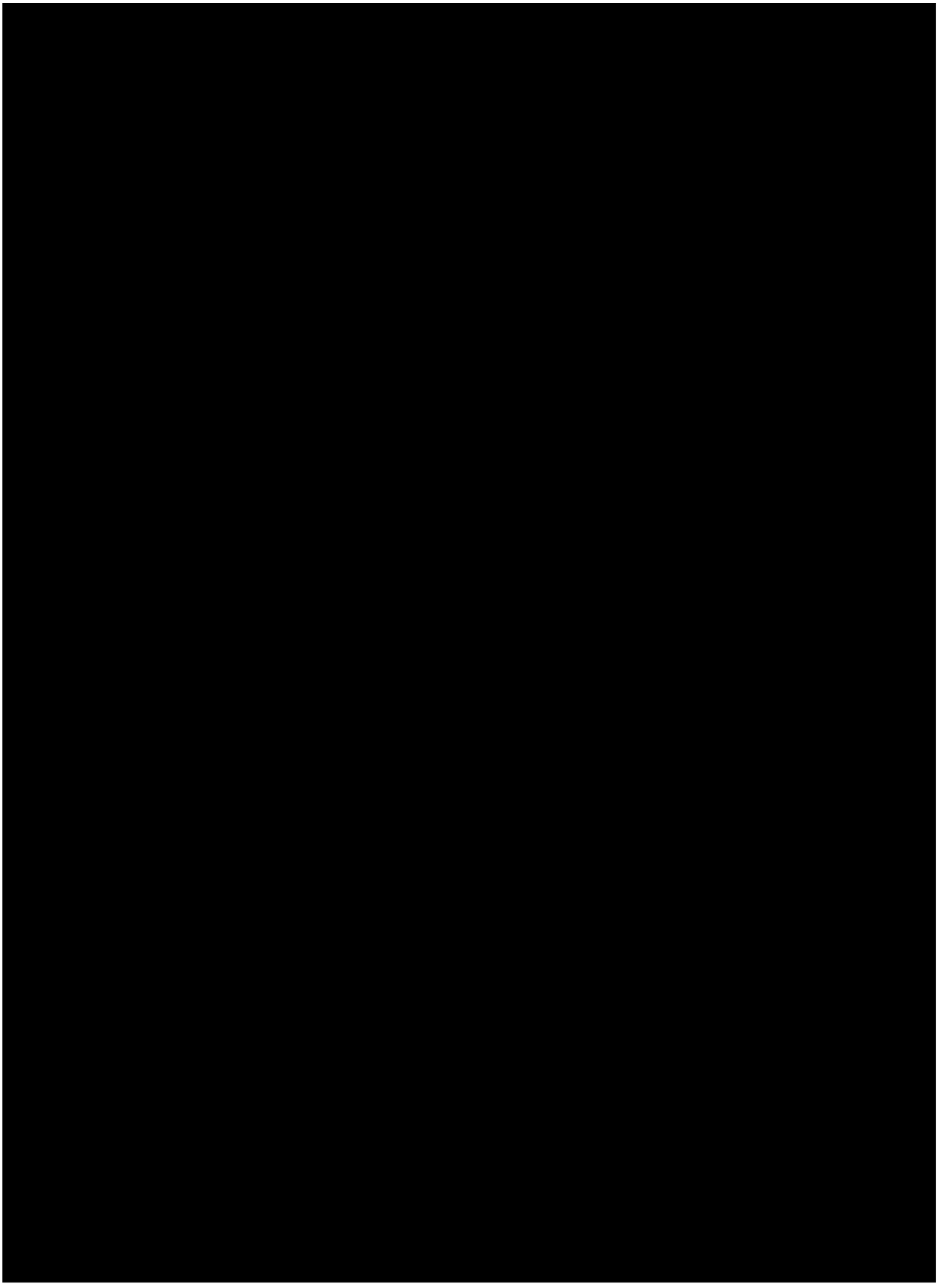


Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Patient Ratios

Health Education
Yorkshire and the Humber

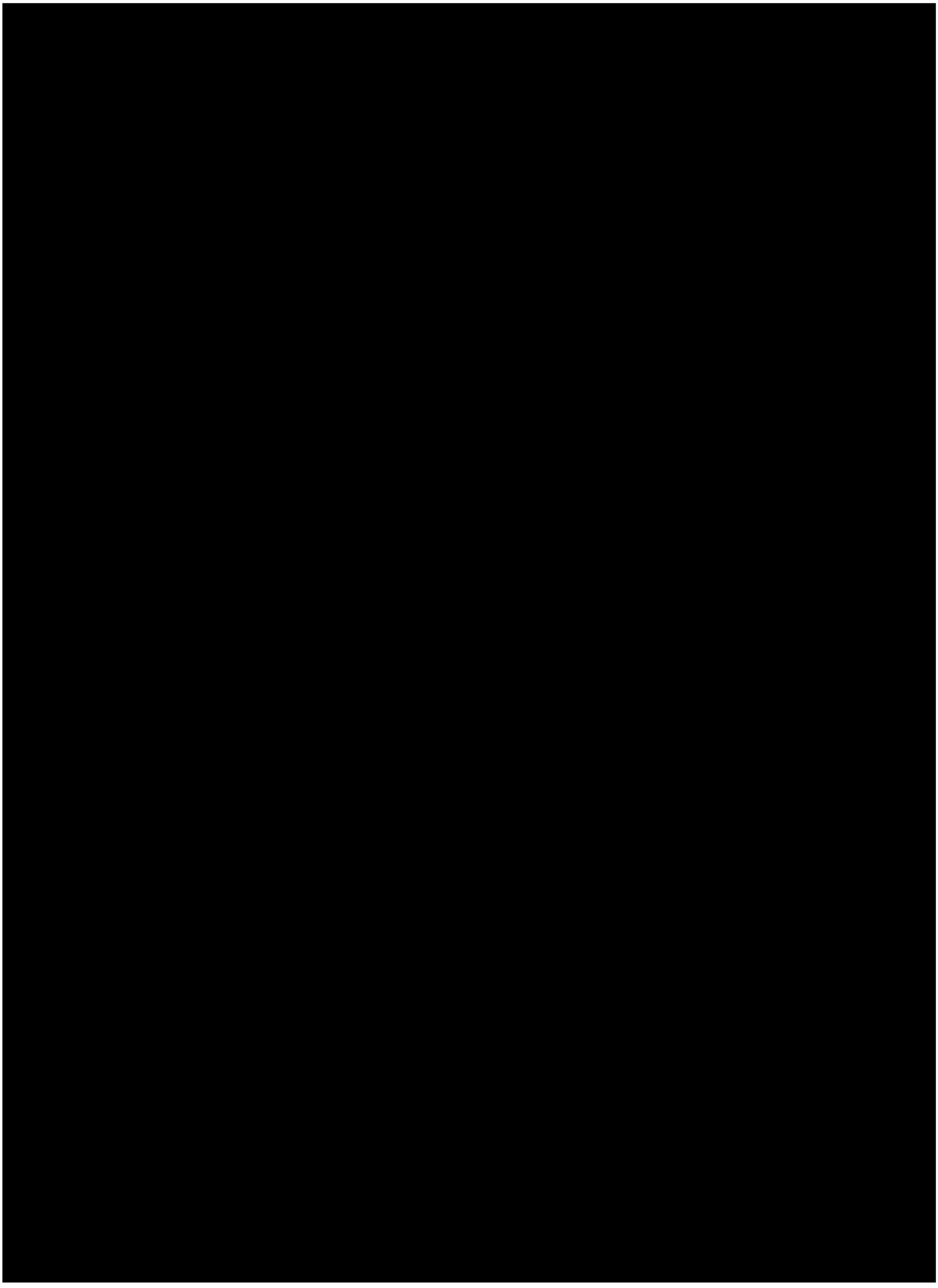


Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Patient Ratios

Health Education
Yorkshire and the Humber



Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Patient Ratios

Health Education
Yorkshire and the Humber

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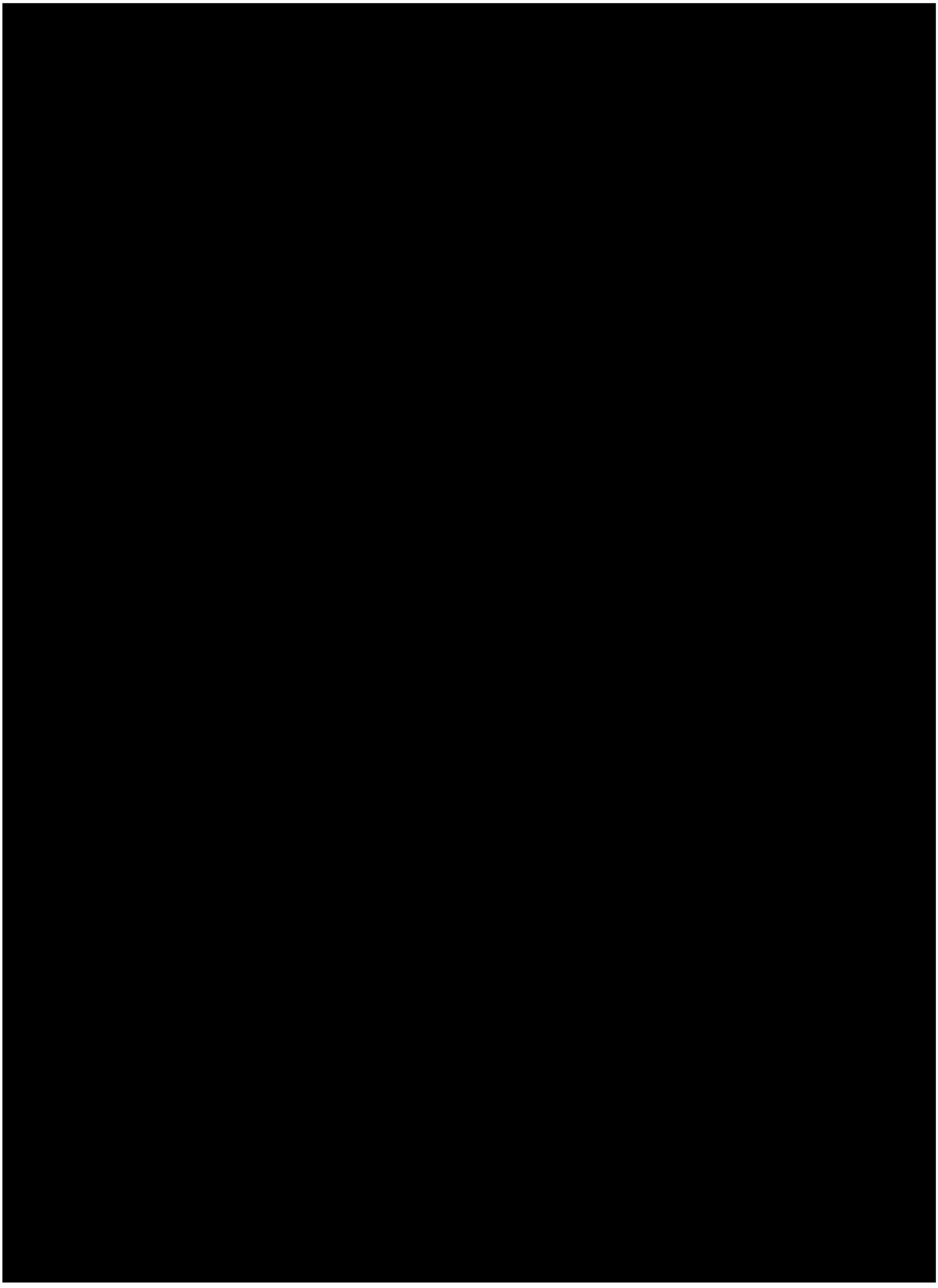
Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Patient Ratios

Health Education
Yorkshire and the Humber



Workforce Analysis (Oct-Dec 2014)

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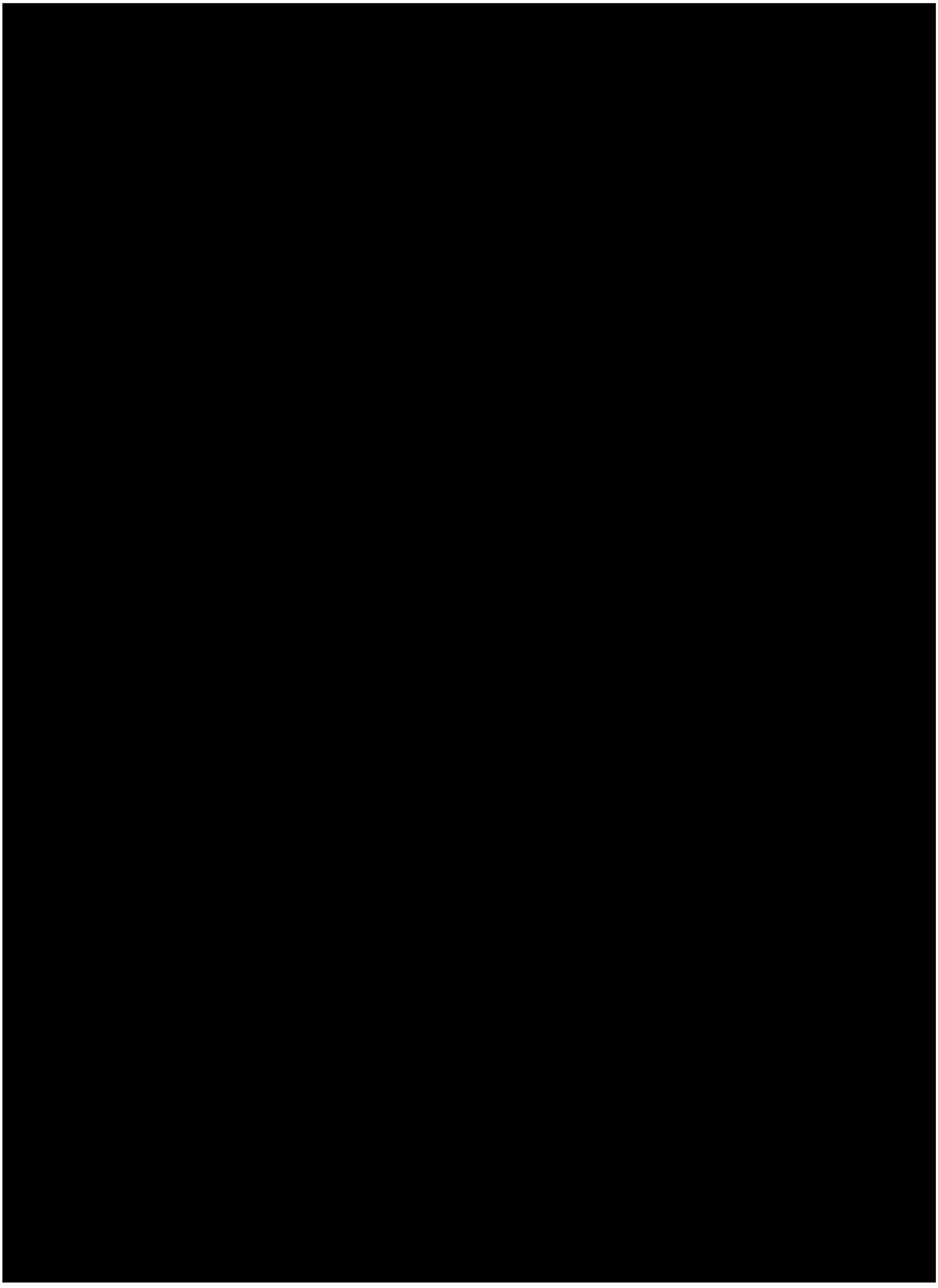
Patient Ratios

Health Education
Yorkshire and the Humber



Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Patient Ratios

Health Education
Yorkshire and the Humber

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Workforce Analysis (Oct-Dec 2014)

All submitted practice data

GPwSI Accreditation Profile

Health Education
Yorkshire and the Humber

GPwSI Accreditation	Under 25	25-34	35-44	45-54	55+	Specialist FTE	Total GP FTE
Cancer	1.56	1.19	2.69	11.60	2.95	19.99	1928.93
Cardiology	0	0.88	8.33	14.33	8.07	31.61	1928.93
Dementia	0.88	0.67	11.97	8.50	4.63	26.65	1928.93
Dermatology	0	3.31	18.38	27.76	15.42	64.87	1928.93
Diabetes	3.56	2.63	28.84	24.76	12.15	71.94	1928.93
Endoscopy	0	0	0.56	3.67	3.56	7.79	1928.93
Epilepsy	0	0	4.23	7.19	3.07	14.49	1928.93
Gastroenterology	0	0	0	0.67	1.29	1.96	1928.93
Genetics	1.00	0	0	0	0.89	1.89	1928.93
Gynaecology	4.46	4.64	18.20	28.11	10.86	66.27	1928.93
Headache	0	0	2.56	3.30	3.29	9.15	1928.93
Learning disability	0	0	9.16	7.13	4.96	21.25	1928.93
Mental health	0	0.89	6.19	12.67	10.47	30.22	1928.93
Musculoskeletal medicine	1.77	2.31	8.21	13.79	7.47	33.55	1928.93
Occupational health	0	0	0.78	4.60	4.34	9.72	1928.93
Older people	0	1.67	15.03	10.83	7.23	34.76	1928.93
Paediatrics	0	1.64	7.36	15.33	5.97	30.30	1928.93
Pain management	0	1.62	5.65	6.81	6.52	20.60	1928.93
Palliative care	1.56	3.31	18.57	21.11	8.73	53.28	1928.93
Respiratory	0	0.89	10.13	7.91	5.30	24.23	1928.93
Safeguarding children and young people	1.34	2.39	28.65	22.00	8.31	62.69	1928.93
Sexual health	4.46	10.57	34.60	30.41	8.32	88.36	1928.93
Substance misuse	0	1.12	14.99	7.16	10.51	33.78	1928.93
Urgent and emergency care	0	1.45	3.78	2.89	5.39	13.51	1928.93
Veteran's Health	0	0	0	0	0	0.00	1928.93

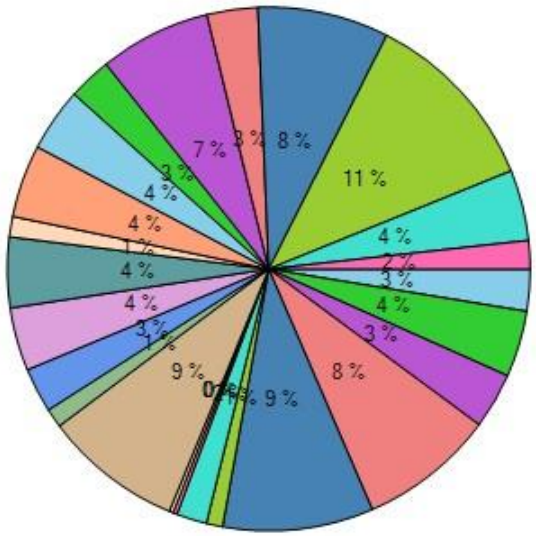
Workforce Analysis (Oct-Dec 2014)

All submitted practice data

GPwSI Accreditation

Health Education
Yorkshire and the Humber

GPwSI Accreditation Ratios



- Cancer
- Cardiology
- Dementia
- Dermatology
- Diabetes
- Endoscopy
- Epilepsy
- Gastroenterology
- Genetics
- Gynaecology
- Headache
- Learning disability
- Mental health
- Musculoskeletal medicine
- Occupational health
- Older people
- Paediatrics
- Pain management
- Palliative care
- Respiratory
- Safeguarding children and young people
- Sexual health
- Substance misuse
- Urgent and emergency care
- Veteran's Health

Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Health Education Yorkshire and the Humber

Practice Nurse Qualifications

Nursing Qualifications

Qualification	Qualification FTE	Total Nurses FTE
Specialist Practitioner Qualification (SPQ) SPQ General	18.77	1050.70
Practice Nursing	188.30	1050.70
Community Nursing degree	24.44	1050.70
Foundation programme (60 credits level3 or more)	13.02	1050.70
Accredited Advanced Nurse Practitioner degree/masters	87.50	1050.70
Nursing Degree or Masters	136.53	1050.70
Other	76.61	1050.70

Mentor Qualification

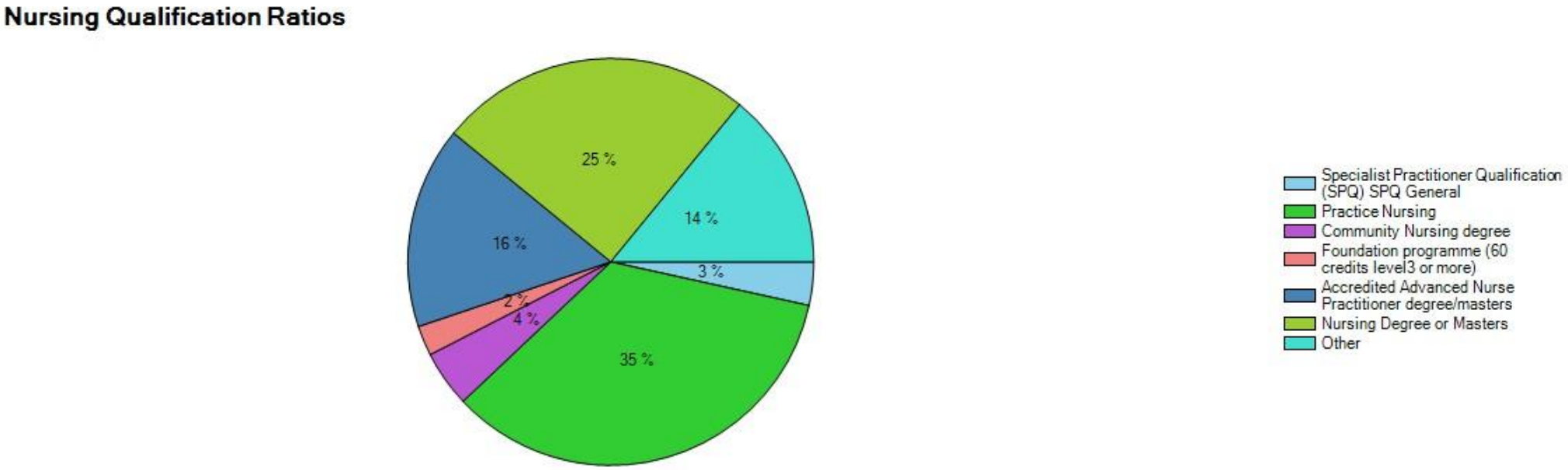
Qualification Type	FTE
ENB 997/998	60.38
Mentor Preparation Level 6	12.83
Mentor Preparation Level 7	3.88
Mentor -Sign-off Mentor	15.12
Mentorship	49.54
Midwifery Sign-off Mentor Prepartion Level 6/ Level 7	1.21
NMC Lecturer/ Practice Educator (PE)	3.70
Postgraduate Cert (Health and Social Care Education)	8.15

Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Nursing Qualification Ratios

Health Education
Yorkshire and the Humber



Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Nurses Specialist Areas & Age Profile

Health Education
Yorkshire and the Humber

Specialist Area	Under 25	25-34	35-44	45-54	55+	Specialist FTE	Total Nurses FTE
Basic Observations (BP,Pulse,Sats)	5.54	14.74	49.50	116.53	59.14	245.45	1050.70
Childhood vaccinations	4.79	15.37	46.51	110.53	53.94	231.14	1050.70
Chronic Kidney Disease	1.05	6.85	17.90	55.96	33.53	115.29	1050.70
Coil Fitting	0.40	0.96	6.85	17.65	9.14	35.00	1050.70
COPD Management	6.14	11.41	38.44	108.03	51.78	215.80	1050.70
COPD screening (Vitalograph)	3.26	6.32	22.95	58.51	22.37	113.41	1050.70
Cytology	4.90	12.40	47.76	135.00	71.24	271.30	1050.70
Dementia	0	2.82	11.64	38.31	18.91	71.68	1050.70
Depo Injections	2.69	10.97	38.07	104.51	51.37	207.61	1050.70
Diabetes Management	6.09	9.31	43.79	122.33	59.11	240.63	1050.70
Doppler assessments	0.65	8.11	22.33	49.05	26.64	106.78	1050.70
ECGs	2.51	9.83	42.07	91.27	48.10	193.78	1050.70
Family Planning	3.79	5.76	37.03	94.38	46.66	187.62	1050.70
Flu and Pneumococcal Injections	3.66	17.02	45.13	126.47	60.09	252.37	1050.70
Heart Disease Management	3.88	8.64	32.78	99.40	48.40	193.10	1050.70
Home visits	1.91	7.88	15.40	46.85	24.61	96.65	1050.70
Hypertension	4.26	11.58	41.32	102.37	53.37	212.90	1050.70
Implanon fitting	0.40	0.43	5.34	24.54	13.61	44.32	1050.70
Leg ulcer management	1.05	10.45	26.05	65.73	37.91	141.19	1050.70
Mental Health	0.86	1.29	11.75	30.77	12.85	57.52	1050.70
Minor illness	2.26	2.67	18.59	66.25	38.12	127.89	1050.70
Minor Injuries	1.86	2.67	15.54	57.79	29.80	107.66	1050.70
Neuromedicine	0	0	2.91	5.70	1.03	9.64	1050.70
NHS Healthchecks	3.44	12.66	45.79	102.34	46.29	210.52	1050.70
Non Medical Prescribing	1.00	3.61	15.61	58.12	25.25	103.59	1050.70
Palliative care	0	1.60	8.87	12.19	7.96	30.62	1050.70
Processing samples (Urine,sputum,stool)	3.66	13.13	40.67	105.04	50.69	213.19	1050.70
Sexual Health	4.08	7.06	34.68	93.23	48.88	187.93	1050.70
Smoking cessation	3.04	6.06	31.44	78.41	35.85	154.80	1050.70
Spirometry	5.86	9.58	38.87	96.93	53.70	204.94	1050.70
Sutures and Clip Removal	3.44	11.26	43.39	104.39	48.40	210.88	1050.70

Travel Health	5.54	13.84	46.69	113.46	53.34	232.87	1050.70
Venepuncture	4.94	13.75	44.84	105.43	53.01	221.97	1050.70
Weight Management	5.54	10.09	36.63	98.87	43.08	194.21	1050.70
Woundcare	3.44	13.09	43.19	114.91	55.39	230.02	1050.70

Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Nurses skill-mix Qualification Matrix

Health Education Yorkshire and the Humber

Specialist Areas	Advanced Nurse Practitioners					Extended Role Practice Nurses				Specialist Practitioner Nurse					Practice Nurses					New Practice Nurse				Health Care Assistant				Phlebotomists		Other		Pharmacist		Total Specialist FTE	Total Nurses & NCA FTE
	Certificate	Diploma (level 5)	First degree (level 6)	Master degree (level 5)	Other	Certificate	Diploma (level 5)	First degree (level 6)	Other	Certificate	Diploma (level 5)	First degree (level 6)	Master degree (level 5)	Other	Certificate	Diploma (level 5)	First degree (level 6)	Master degree (level 5)	Other	Certificate	Diploma (level 5)	First degree (level 6)	Other	Certificate	Diploma (level 5)	First degree (level 6)	Other	Certificate	Other	Certificate	First degree (level 6)	Certificate	Other		
Basic Observations (BP,Pulse,Sats)	22.12	2.73	0.64	8.39	9.30	16.09	3.70	1.00	5.95	12.89	0	1.64	0	4.04	93.02	13.37	6.04	0.84	33.41	6.25	1.60	0.40	2.03	73.21	0.80	0.80	16.92	1.38	0.73	0	0	0	0	339.29	1634.09
Childhood vaccinations	17.09	1.00	0.64	3.33	4.17	22.13	2.14	1.00	3.69	12.40	1.00	0	0	3.15	119.43	12.00	0.97	0.84	18.14	7.42	0.60	0	0	2.63	0	0	0	0	0	0	0	0	0	233.77	1634.09
Chronic Kidney Disease	14.15	0.77	0	6.54	2.88	6.29	0	1.00	1.53	8.71	1.79	0	0	3.15	45.41	6.72	0.37	0	15.98	0	0	0	0	1.62	0	0	4.66	0	0	0	0	0	0	121.57	1634.09
Coil Fitting	3.47	1.11	0	1.00	0.64	5.15	3.23	0	0.72	2.86	0.73	0	0	0	10.14	3.34	0	0	2.61	0	0	0	0	0	0	0	0	0	0	0	0	0	0	35.00	1634.09
COPD Management	18.27	18.09	2.25	7.18	2.58	14.33	10.69	1.00	0	5.65	7.17	0.79	0	0	66.38	46.71	4.12	0.84	7.15	2.00	0.60	0	0	3.34	0	0	2.00	0	0	0	0	0	0	221.14	1634.09
COPD screening (Vitalograph)	9.27	6.37	0	3.33	2.58	6.16	4.90	0	1.96	5.82	2.84	0	0	0	47.47	14.58	0.97	0.84	3.65	2.67	0	0	0	10.82	0	0	0	0	0	0	0	0	0	124.23	1634.09
Cytology	28.02	4.39	0.85	5.33	1.52	23.94	4.65	1.57	2.42	15.92	6.21	0	0	0	123.79	34.38	3.75	2.34	8.89	0.44	1.27	0	1.62	0	0	0	0	0	0	0	0	0	0	271.30	1634.09
Dementia	7.82	0	0	5.33	2.08	6.57	0.91	1.00	1.68	3.18	0	0	0	0.91	25.34	4.28	0.37	0	12.01	0	0	0	0.20	2.49	0	0	1.11	0	0	0	0	0	0	75.28	1634.09
Depo Injections	20.63	2.80	1.85	5.33	6.74	13.95	3.58	1.00	7.01	8.47	2.55	0.64	0	4.95	79.96	12.07	1.50	0.84	29.15	3.97	0	0	0.62	4.43	0	1.00	1.34	0	0	0	0	0	0	214.38	1634.09
Diabetes Management	18.74	12.60	1.01	7.11	5.89	18.73	13.54	1.00	0.54	10.66	11.17	0	0	0	67.27	60.27	4.05	0	7.05	1.00	0	0	0	9.95	0.88	0	6.05	0	0	0	0	0	0	257.51	1634.09
Doppler assessments	9.55	0.80	0	4.26	0.64	11.36	2.23	1.00	0.44	6.27	1.00	0.64	0	1.35	48.91	3.63	1.43	0	11.27	2.00	0	0	0	4.59	0	0	1.27	0	0	0	0	0	0	112.64	1634.09
ECGs	10.01	2.52	1.01	5.33	2.23	17.93	1.23	1.00	5.02	8.88	2.00	0.64	0	4.06	88.72	9.83	0.97	0	25.22	7.18	0	0	0	63.18	0.80	0	17.31	0.13	1.27	0	0	0	0	276.47	1634.09
Family Planning	22.66	9.14	1.21	5.33	3.08	12.17	5.59	1.57	5.91	11.29	5.05	0	0	2.73	59.94	19.49	2.79	0.84	17.01	1.62	0	0	0.20	2.83	0	0	2.00	0	0	0	0	0	0	192.45	1634.09
Flu and Pneumococcal Injections	22.15	1.73	0.64	5.33	8.57	19.57	2.14	1.00	7.35	14.75	1.00	0.64	0	3.04	121.41	8.86	1.66	0.84	23.89	6.50	0	0	1.30	64.41	0	0	9.31	0.11	0	0	0	0.20	0	326.40	1634.09
Heart Disease Management	19.61	8.23	0.64	6.18	4.99	14.16	5.47	1.00	3.22	13.34	7.00	0	0	2.15	60.69	32.26	1.12	0	11.31	1.53	0	0	0.20	7.90	0	0	0.53	0	0	0	0	0	0	201.53	1634.09
Home visits	10.04	0	0	1.53	6.87	9.00	0	1.00	5.05	4.02	0	0	0	1.03	35.93	4.04	1.01	0	14.65	1.00	0	0	1.48	21.44	0	0	10.92	0.27	0.73	0	0	0	0	130.01	1634.09
Hypertension	21.34	1.73	0.64	6.39	6.24	13.69	2.94	1.00	6.23	14.76	3.75	0	0	0	86.37	14.11	1.98	0	25.58	4.87	0.60	0	0.68	35.83	0	0	6.77	0.27	0	0	0	0	0	255.77	1634.09
Implanon fitting	7.60	2.11	1.01	2.33	0.64	6.87	3.23	0	1.26	2.53	0.69	0	0	0	11.28	2.56	0.60	0	0.99	0.62	0	0	0	0	1.00	0	0	0	0	0	0	0	0	45.32	1634.09

Leg ulcer management	9.24	0.80	0	3.33	3.08	16.92	2.67	1.00	1.44	8.30	1.00	0.64	0	0.60	68.17	5.64	1.66	0	13.30	3.20	0	0	0.20	10.02	0	0	3.49	0	0	0	1.00	0	0	155.70	1634.09
Mental Health	4.46	0.93	0	6.54	6.92	4.61	0.91	1.00	2.20	3.61	0	0	0	0	15.95	0.85	0.37	0	8.97	0	0	0	0.20	1.90	0	0	0	0	0	0	0	0	0	59.42	1634.09
Minor illness	24.95	5.01	4.25	8.35	7.29	15.00	0.91	1.44	2.79	8.46	1.56	1.00	0	2.00	28.50	8.02	0.60	1.00	5.23	0.80	0	0	0.73	1.81	0	0	2.00	0	0	0	0	0	0	131.70	1634.09
Minor Injuries	19.73	2.72	3.44	7.18	6.96	12.97	0	1.44	2.79	5.21	0.91	0	0	0	31.65	1.59	0.60	0	8.94	1.33	0	0	0.20	7.80	0	0	2.21	0	0	0	0	0	0	117.67	1634.09
Neuromedicine	0.60	0	0	2.80	0	0	0	0	0	1.34	0	0	0	0	1.00	2.42	0	0	1.48	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9.64	1634.09
NHS Healthchecks	19.19	0.93	0.64	5.33	7.69	18.11	0	1.00	5.27	9.63	1.91	0	0	4.04	94.28	7.13	0.97	0.84	28.02	5.34	0	0	0.20	61.52	0	0	19.29	0.27	1.27	0	0	0	0	292.87	1634.09
Non Medical Prescribing	13.79	1.92	13.76	9.08	4.09	5.84	2.91	4.91	4.24	3.92	0.81	4.31	1.64	0	14.70	4.61	2.53	3.31	6.54	0.68	0	0	0	1.20	0	0	0	0	0	0	0	0.40	0.20	105.39	1634.09
Palliative care	4.06	0.77	0	1.00	3.08	2.87	0	0	1.00	1.82	0	0	0	1.00	8.08	3.58	0	0	3.36	0	0	0	0	0	0	0	0.43	0	0	0	0	0	0	31.05	1634.09
Processing samples (Urine,sputum,stool)	23.09	0.93	0.80	5.33	5.87	16.02	0.91	1.00	7.06	8.78	1.00	0.64	0	4.49	86.51	7.54	1.06	0.84	36.02	5.10	0	0	0.20	60.80	0	0	17.07	1.26	0	0	0	0	0	292.32	1634.09
Sexual Health	24.64	4.67	3.93	5.44	3.96	16.01	5.74	1.57	2.42	9.37	5.05	0	0	1.82	67.83	18.96	4.19	0.84	9.87	1.62	0	0	0	2.45	0	0	0	0	0	0	0	0	0	190.38	1634.09
Smoking cessation	14.50	1.36	0	5.33	3.01	11.88	1.55	1.00	3.31	9.50	1.91	0	0	1.75	82.25	4.72	0.97	0.84	8.32	1.80	0.60	0	0.20	46.32	0.81	0	8.27	0.54	0.73	0.08	0	0	0	211.55	1634.09
Spirometry	21.69	7.09	0.64	3.33	5.30	17.89	4.54	1.37	0	8.56	4.84	0	0	0	97.78	18.27	1.97	0.84	8.03	2.20	0.60	0	0	44.69	0	0	4.62	0	0	0	0	0	0	254.25	1634.09
Sutures and Clip Removal	21.33	1.73	1.00	5.33	5.61	14.52	2.14	1.00	7.47	9.28	1.00	0.64	0	3.95	88.84	7.37	1.91	0.84	30.47	5.77	0	0	0.68	37.04	0	0	11.96	0	0	0	0	0	0	259.88	1634.09
Travel Health	18.50	0	0	5.33	6.77	24.19	3.14	1.00	1.88	13.71	1.00	0	0	0.89	122.59	12.04	0.97	0.84	14.62	4.80	0.60	0	0	1.00	0	0	0	0	0	0	0	0	0	233.87	1634.09
Venepuncture	25.39	1.73	0	5.33	5.68	19.43	2.14	1.00	4.95	14.19	1.00	0	0	1.00	106.18	6.94	1.06	0	17.92	7.41	0	0	0.62	71.77	0	0	8.16	5.59	0	0	0	0	0	307.49	1634.09
Weight Management	20.08	1.73	0	5.33	7.42	15.95	2.14	1.00	7.10	8.66	1.43	0.64	0	3.80	77.95	6.17	1.66	0.84	26.27	5.24	0.60	0	0.20	48.14	0	0	7.47	0.13	0.73	0	0	0	0	250.68	1634.09
Woundcare	21.27	1.80	0	6.34	6.46	19.43	2.58	1.00	4.27	13.55	1.00	0.64	0	3.69	104.32	8.32	2.88	0.84	24.64	6.31	0	0	0.68	44.29	0.80	0	10.23	0	0	0	0	0	0	285.34	1634.09

Workforce Analysis (Oct-Dec 2014)

All submitted practice data

Health Education Yorkshire and the Humber

Risk of Retirement

Job Role	55+ FTE	Total FTE	% in staff group
GP	293.87	1927.82	15%
GP Partner	261.89	1299.43	20%
GP Salaried	28.43	392.45	7%
Locum - covering vacancy	2.39	17.50	14%
Locum - other	1.16	15.69	7%
Practice Nurses	268.08	1050.70	26%
Advanced Nurse Practitioners	61.58	234.11	26%
Extended Role Practice Nurses	23.66	96.31	25%
Specialist Practitioner Nurse	14.98	58.88	25%
Practice Nurses	166.39	634.21	26%
New Practice Nurse	1.47	27.19	5%
Direct Patient Care	117.47	583.39	20%
Health Care Assistant	73.93	410.95	18%
Physios	0.48	1.48	32%
Therapists	0.32	1.55	21%
Phlebotomists	10.31	36.22	28%
Other	5.23	22.44	23%
Dispenser	25.91	98.52	26%
Pharmacist	1.29	8.49	15%
Practice Management	1115.81	3891.30	29%
Admin & Clerical	397.10	1339.12	30%
Other Practice Staff	29.58	120.43	25%
Temporary Worker	1.21	10.93	11%
Reception Staff	493.42	1814.44	27%
Practice Manager	120.60	417.02	29%
Prescription Clerk	17.21	56.02	31%
Summariser	23.15	57.59	40%
Cleaner	33.54	75.75	44%
Apprentices	8.39	134.94	6%
Administrative & Clerical	8.23	124.23	7%
Other	0.16	2.57	6%

Risks & Actions

CCG	Risks	Actions
NHS Airedale, Wharfedale and Craven CCG	Pressure on GPs which has seen significant turnover in the last 12 months; current sickness asbence has incrased with 2 full time clinicians absent on sick leave at the time of writing; ageing profile amongst staff - however as much an opportunity as a threat; ageing profile amongst nursing team however assuming we can recruit well as people choose to retire we can better balance this team	Administratively we have changed our recruitment profile and typically employ younger, more resillient and cheaper staff - this is acheiveable a long as we retain a balnace with our more mature experienced staff. Clinically little we can do other than try to ride the storm; we are currently progressing recruitemnet for a new partner and physician associate/s to replace leavers proposed at end of year.
NHS Airedale, Wharfedale and Craven CCG	District Nursing (contracted by local care trust) high turnover of staff Meeting access demands of patient population Shortage of GP's looking for full time posts (most wanting locum or instant partnership)	We are looking at career planning for new GP's (tiered management structure from salaried through to partner) Closer collaboration with other practices in our locality and CCG Recruitment of apprentices for non-clinical succession planning
NHS Bradford City CCG	Skill shortages,practice staff and non medical staff	Recruit extra staff with GP practice knowledge ans skills and continued professional development for current staff.
NHS Bradford City CCG	We have a high percentage of staff turnover.	Demand in continuity and consistancy of patient care. Another Office Administrator and Health Care Assistant are in the processs of recruitment in January 2015.
NHS Bradford City CCG	Frontline Staff training required in assessing minor medical conditions over the telephone, to be able to give basic advice over the telephone about how to treat minor conditions.Basic telephone triage. Staff shortage not enough hours to be allocated to complete the workload but practice can not increase the staff or the staff 's working hours.Sometimes staff finds it difficult to manage the workload in a particular time. Increasing workload day by day, increasing patient demands, patients education needed, patients need to learn they do not always have to rely on their GP to look after their health.	practice management role has expanded eg engaging with the patients, listening to the patients what they are saying and analysing. Need more skills devloping training and training programmes on howto engage with difficult patients and chsanging patient behaviour . Teach patients Self care and how to look after and manage their own health.
NHS Bradford City CCG		Everything mentioned in the main risks prevents us from developing the Practice further.
NHS Bradford City CCG	Practice Nursing problems trying to cover additional hours -vacancy	Temp nurse for 8 weeks
NHS Bradford City CCG		Trainee Nurse Practitioners - Already recruited one

NHS Bradford City CCG	Recruitment is a key issue, especially nursing staff.	We are looking at options to expand roles to admin staff and also provide existing staff with incentives to continue working for us. We are also looking at a prorgramme of training development for key staff.
NHS Bradford City CCG	Recruitment is a key issue, especially nursing staff.	We are looking at options to expand roles to admin staff and also provide exsiting staff with incentives to continue working for us. We are also looking at training development.
NHS Bradford City CCG	Recruitment is a key issue, especially nursing staff.	We are looking at options to expand roles to admin staff and also provide exsiting staff with incentives to continue working for us. We are also looking at training development.
NHS Bradford Districts CCG	Massive defunding of our practice (32% loss from baseline) via PMS equalisation Unable to effectively recruit due to the level of finance insecurity caused by this and until resolved If potential loses are not covered by alternative funding then current very high clinical performance will not be possible for our very deprived population resulting in total practice instability and probable closure. Current paralysis with premises development - current limitation on rent reimbursment for premises developments prevents us from developing our practice to meet recognised existing patient need, from expanding our training provision, from developing new services to improve patient care whilst reducing NHS costs	Negotiation via all possible routes to mitigate any defunding. If this fails then escalate to a high profile media campaign in a similar way to the MPIG review process in central London.
NHS Bradford Districts CCG	lack of retention, cannot recruit salaried GP's	Training Nurse Practitioners
NHS Bradford Districts CCG	ever increasing primary care workload without proper funding to resource. This practice will not be investing any further money into staffing whilst facing a £110 000 reduction in PMS funding over the next 5 years.	be innovative and smart with the resources we have and educate patients about self care and appropriateness. considering joining a federation.
NHS Greater Huddersfield CCG	Same as last quarter	Same as last quarter
NHS Greater Huddersfield CCG	Clinical workload increasing but PMS Contract under review. Services may have to be withdrawn and staff budget cut.	Currently recruiting a Practice Nurse and then plan to replace practice nurse hours with healthcare assistant hours ongoing.
NHS Leeds North CCG	None	Current staffing is adequate and no plans for any change
NHS Leeds North CCG	parter resignation - doifficulty of replacement ANP retirement - difficulty of replacing & need to chnage clinical team skillmix	currently writing options report

NHS Leeds South and East CCG	Retention of staff is a big problem. We work in a highly-pressured environment and not everyone enjoys that sort of atmosphere. Our biggest issue is ensuring adequate access for our patients. This is exacerbated by the difficulty of large numbers of our patients speaking different languages.	In the future we should like our nurses to be multi-skilled in the care of long-term conditions, so that they can look after patients with both diabetes and COPD. Our current nurses, however, do not have the desire to expand their knowledge to that extent. We are recruiting a Treatment Room Nurse to allow our Practice Nurses more time to spend on LTCs. We shall also train her in compression bandaging.
NHS Leeds South and East CCG	staff shortage	away day
NHS Leeds South and East CCG	experienced nurse on maternity leave until jan 2015 gp vacancy having had 2 gps leave within a short space of time - one planned, one unplanned	
NHS Leeds South and East CCG	Retirement of FT partner 31.12.14. Retirement age of partners in next 5/10 years. Retirement age of practice nurse in next 5 years. Retirement age of numerous reception team in next 3-5 years. Senior administrator retired 31.5.14. New current staff member now undertaking training in receptionist role which has demands on other receptionists. Imminent retirement of GP partner, being replaced by a new partner May 2015 (recrutment comlpeted) Possibilty of new Treatment room nurse wanting to leave practice nursing. Updated contract of apprentice for another 12/12, increased to 34hrs per week. Practice nurse completed nurse mentor training. Winter pressures with increased patient deman now impacting on primary care services. Increased prevalance of diabetes in the practice and increased targets for 2014 / 2015 flu campagine have been a capacity issue. Backlog of admin work at present.	Chronic Disease Prevelance is growing in the practice population, especially diabetes. We have employed 2 new practice nurses in the past 6 months who have no experience/qualifications in chronic disease management. The demand for chronic disease management appointments with the nursing team is growing and we need to plan for shortfall of nursing time with chronic disease management until the 2 new nurses are fully trained in this area. New HCA recruited in last 12 months is currently undergoing training for core skills. Retirement of GPs is an issue at present. Next partner is due to retire in 31.12.2014. LT has now qualified as a student nurse mentor and the practice will be taking on student nurses from April 2015. Backlog of admin work being undertaken in the practice by short term increase of admin hours. The practice has an excellent skill mix at this present time amongst clinical and non-clinical staff, apart from the above mentioned. The practice continues to develop the workforce in the practice. Nurses/GPs attend update courses, clinical meetings and any personal development needs are highlighted at their appraisals. As above, 1 practice nurse has completed training in asthma diploma. Other practice nurse is undertaking training in core skills for practice nursing (cytology/travel vaccines/dressings) New HCA currently undertaking

		qualification. The practice is having issues around study leave for the nursing team as previously with the PCT the practice could get nursing backfill for these sessions and NHS Leeds currently do not have a bank of nurses who can provide cover. Non-clinical staff continues to have development sessions during target afternoons. The practice has a well-developed training programme with core skills and mandatory requirements. This is continually reviewed and updated. The practice has employed an apprentice to help with the increased demand and workload of non-clinical staff. She continues to undertake training in all non-clinical roles in the practice to alleviate staff workload in these areas. Completed NVQ in customer services and currently undertaking an NVQ in business admin. Assistant practice manger has now completed NVQ 3 Team leadership. YOC training completed by relevant practice staff, templates etc to be put in place to start YOC in 2015 (delayed due to work load pressures)
NHS Leeds South and East CCG	1. Our Admin Team are all aged 50+. 2. Our Practice Secretary is retiring at the end of the year.	In the future, as our Admin Team retires, we need to recruit and retain people who can support our young dynamic team of doctors throughout their careers. A new Practice Secretary is starting in November to help ensure a smooth changeover when the current Secretary retires in December.
NHS Leeds South and East CCG	Main risks this quarter as ever are lack of enough staff to manage the ever increasing workload and patient expectation and demands. We have staff retiring in the next year and are currently redoing a skill mix audit when considering their replacements	Changing workload and staff who do certain jobs to ensure all using their relevant skills accordingly

NHS Leeds South and East CCG	Retirement of 2 GP partners in the next 12 months.	We are considering how best to replace the vacancies left by the retiring partners. It may be that we replace with one full time salaried GP and use the funding for the second GP vacancy to increase the capacity of our nursing department with the increase in the chronic disease management and the implementation of the year of care.
NHS Leeds South and East CCG		Recruitment of further Practice Nurse for 25hr/week from 02.02.15
NHS Leeds South and East CCG	We are currently running with 1 main Gp and 2 locums. Idealy we would like to solve this by employing either 1 saleried GP for 4 session per week or 2 Gps for 2 sessions each.	We are currently employing locums to the surgeryfor trial periods to see if they work welkl with staff and patients. If this does not work then we will advertise the position/s.
NHS Leeds South and East CCG	Staff turnround, difficulty in recruiting nursing staff.	Have signed up to recruitment agencies and also looking to train staff in house to tackle the issues.
NHS Leeds South and East CCG	Well stabilised practice.All staff are skilled and coping well.	No extra staff required at present as cover is adequate for illnesses or annual leave
NHS Leeds South and East CCG	At the moment reduced staff so extra stress and strain on the rest of the staff. Recruiting Nursing staff has been a problem.	Going forward we have a new receptionist starting in January.
NHS Leeds South and East CCG	Increased work load/demands on admin staff	Increase admin staff hours
NHS Leeds West CCG	Concerns about recruitment as it is becoming incerasingly difficult to find GP locums. We also have grave concerns about the loss of funding following our PMS review. We are currently facing a budget cut of £163,129 over a four year period. It is difficult to see how we can continue to retain current staffing levels with a funding loss of this magnitude. We aim to work with other local practices, MPs and our CCG to establish how we can manage this to protect the services offered to patients and limit the damage that this may cause an already demoralised workforce.	

NHS Leeds West CCG	Both of our Practice nurses are due to retire in the next 2 years. 2 GP Partners retire in the next 4 years.	We have just this week started to host a CCG employed 'Preceptee Practice Nurse' - an experienced secondary care nurse wishing to move into primary care who will shadow and learn from our nurses for the next 6 months. If we like her and she likes us, we plan to offer a permanent contract to replace one of our retiring nurses, and request a new preceptee as a potential replacement for the next nurse to retire. One of our GPs has just qualified as a GP Trainer. We plan to take our first trainee GP in August 2015 and by being a training practice hope to be more attractive to potential future GP Partners, and to also find a potential Partner via a trainee coming through our surgery.
NHS Leeds West CCG	Majority of staff work part – time Increase work load, further external training pressure. Online training staff do find this use friend and would prefer one to one or group session in house. Staff work part time and would prefer internal training when possible. Further shortage within community staffing this is putting further pressure on existing service with the Practice environment	Mixed skill have been developed and further training support has been made available, this has been positive however further support is still required. In the passed it has taken the practice 3 yrs to recruit a practice nurse the entire practice relayed the Doctor to undertake the work load with little support of PCT. The practice has already mentioned to CCG the practice nurse will retire and would like assistant etc
NHS North Kirklees CCG	no current issues	no issues
NHS Wakefield CCG	Difficulties in recruiting trained staff Uncertainties re PMS funding	Expanded IT roles Qualified staff Continuing development for receptionists and admin staff
NHS Wakefield CCG		PMS Contract - Financial Loss £136K. To assess all PMS services and staffing to evaluate how this financial loss will impact upon the team.
NHS Wakefield CCG	Unable to recruit new salaried GPs, currently 1wte vacancy. We have no registrars for the first time in many years even though we have 2 GP trainers. We are taking on nurse students from Feb15 in hope that we can talent spot to replace ageing nurse workforce. We have also taken on 4 rotations of GP med students this year	Reorganise Nursing team and possibly bring in more HCAs if possible

NHS Wakefield CCG	Staff sickness one GP on long term sick and only able to do administration work and one GP in the early stages of pregnancy and feeling unwell.Use of Locums and re-arranging of rotas so that more GPs are available on the busy days. Also cancelled days off on bank holiday weeks. Have recruited a second Nurse Practitioner to triage and also see diabetic patients to free up slots for the GPs.	We will need to recruit a further Partner and a maternity locum next year and the concern is that there won't be the availability of staff. Maternity locums are hard to find and these are essential for continuity of care for patients but also for the Practice. There is a distinct lack of GPs wanting to become Partners
NHS Wakefield CCG	There is a risk that we will not be able to recruit a further practice nurse leaving us understaffed in that area. No other new risks /issues identified since last return.	Further advertisement for the role to reach as many potential applicants as possible.
NHS Wakefield CCG	A number of reception and administration staff are nearing or are already at the age of retirement.	Re-employ retired staff who have taken pension but on reduced hours and the recruit/train new staff to fill the shortfall.

HEYH Primary Care projects

HEYH produced a comprehensive Primary Care strategy in November 2014. Copies of this strategy are available from workforce.information@yh.hee.nhs.uk This strategy outlines a number of project and initiatives to support primary care, including:

- HEYH continues to work with Advanced Training Practices, CCGs and Area Teams to standardise staff roles including Health Care Assistants, Practice Nurses and Advanced Nurse Practitioners – improving consistency and benchmarking for learning beyond registration as well as induction, preceptorship and refresher/update training. HEYH will use the eWIN site as an electronic resource area for any templates created.

- Advanced Training Practices Network - Work continues to expand the model and number of hubs and spokes. The plan over the next three years to increase placement capacity for undergraduate nursing placements http://yh.hee.nhs.uk/what-we-do/education-training/advanced-training-practices/

- Apprenticeships at business admin and health care assistant levels – (alison.ackew@yh.hee.nhs.uk or Ian.Wragg@yh.hee.nhs.uk)

- Calderdale Framework into organisations. The Calderdale Framework is a transformational workforce development tool that provides a systematic and objective method of reviewing skill, role and service design. It empowers & engages front line staff in developing the workforce. (Lyndsay.hamilton2@yh.hee.nhs.uk) or visit http://effectiveworkforcesolutions.com/

- Advanced Practice Framework for use within the region's NHS trusts and primary care organisations. HEYH have committed over £5m to the development of AP roles this year, with over 200 planned across the region, and are working closely with organisations to monitor their progress. For more information, please visit http://yh.hee.nhs.uk/what-we-do/education-training/advanced-practice/

- eLearning for General Practices. A GP Platform has now been developed and will be launched later in the year. Initial materials for GP staff will include statutory and mandatory training for clinical and non clinical areas. (kate.holliday@yh.hee.nhs.uk)

- Primary Care Network on eWIN . The portal will allow us to share information with General Practices and enables Practice Managers to communicate with each other and work on projects together. (Debbie.Bottomley@yh.hee.nhs.uk)

- A national campaign was launched Sept 2014 to encourage nurse to return to practice. In Y&H information regarding the launch was sent to Chief nurses in CCGs for circulation to enable expressions of interest from General practice to be linked to the programme . A briefing paper about the initiative has also been shared with the ATPs. No general practices have come forward to date.

FF41 Health Education Yorkshire and the Humber

Building the Workforce- the New Deal for General Practice. Delivering in Yorkshire and the Humber

1. Promoting General Practice

Long Term:

Working with local medical schools, practices, RCGP faculties, CCGs and Area Teams to promote high quality general practice work experience to 6th form students. Need positive role models who make a difference and can inspire the next generation. This requires pleasant primary care working environments that are safe and enjoyable to work in.

Benefit: GP orientation prior to entry to medical school (SOAMS, WAMS, HYMS).

What more is needed: we understand that there are diverse solutions, but we would support a co-ordinated approach to resourcing, sharing best practice and joined up evaluation of impact of such initiative.

Medium Term:

Careers fairs

Links with undergraduate departments of primary care to promote General Practice in the undergraduate curriculum and to support medical students with a special interest in primary care.

Promoting vertical integration of teaching and learning with GP specialty trainees developing education expertise post CSA/AKT through honorary visiting teaching fellow posts.

To explore the variation in curriculum delivery in primary care between UK medical schools and variation in GP career destination between UK medical schools.

Promotion events: RCGP and other partners

F2 experience in GP – delivering high quality training capacity in general practice for foundation placements (improved use of F2 feedback in selection higher quality placements for F2 doctors, including placement in vacant training practices.)

F1/F2 taster days to promote general practice.

Pre-specialty training programme for GP

Shorter term:

Marketing campaigns including

https://www.youtube.com/watch?x-yt-ts=1422327029&x-yt-cl=84838260&v=miSPY03k0_g&feature=player_embedded

https://www.youtube.com/watch?x-yt-ts=1422327029&v=IMt2ZNE0iII&x-yt-cl=84838260&feature=player_embedded

https://www.youtube.com/watch?v=m1OZ3CKJ4Pk&x-yt-ts=1422327029&x-yt-cl=84838260&feature=player_embedded

https://www.youtube.com/watch?x-yt-cl=84838260&v=YTs46cUrhHQ&feature=player_embedded&x-yt-ts=1422327029

https://www.youtube.com/watch?v=Pxx42sm7V6o

http://jobs.bmj.com/job/15349/gp-specialty-training-in-2015-18/?gclid=CJ3_-L-wqsICFQ6WtAodYzkARQ

https://www.youtube.com/watch?v=lEZh-2cmIeo

Can our trainees do better – challenge the faculties to create a prize for the best scheme video?

We are working with CCGs to explore recruitment of trained GPs from other European countries.

Promoting international teaching exchanges to showcase our region to the rest of the world.

2. Improving the Breadth of Training

ST4 and leadership posts

Mainstreaming this with post CSA stretch work on service improvement projects

Post CCT development opportunities sponsored by CCGs, for example:

https://yh.hee.nhs.uk/2014/11/14/interested-in-a-gp-salaried-post-with-an-opportunity-to-develop-clinical-commissioning-skills-and-more-as-part-of-a-ccg-team/

Academic teaching fellowships

Developing GP educators and investment in postgraduate certificate of primary care education

https://yh.hee.nhs.uk/2014/10/17/calling-gps-in-east-riding-are-you-interested-in-an-mba/

http://yh.hee.nhs.uk/files/2014/10/56160-GP-Bursary-Leaflet-East-Riding.pdf

Developing a clinical expertise, e.g. GPwSI courses run by CCGs

GPwSI Older People Flyer - Jan 2015 eve

OOP(E) abroad in NZ or Africa

3. Training Hubs

Inter-professional training and increased training capacity in General practice through the award winning Advanced Training Practice network

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

4. Targeted Support

HEYH already targets fill in specific hard to recruit areas: protecting training infrastructure, geographical choices policy, targeted promotion, targeted leadership development

5. Retainer Schemes

http://yorksandhumberdeanery.co.uk/general_practice/retainer__returner/retainer_scheme/

6. Improving the training capacity in general practice

HEYH uses non recurrent funds to invest in training infrastructure (equipment) in primary care with a minimum support in 2014/15 of £750 per practice. In 2009 The GP School worked with NHS Estates and PCTs to invest £10million in Yorkshire and the Humber GP Practices to create additional training estate.

7. Incentives to Remain in Practice

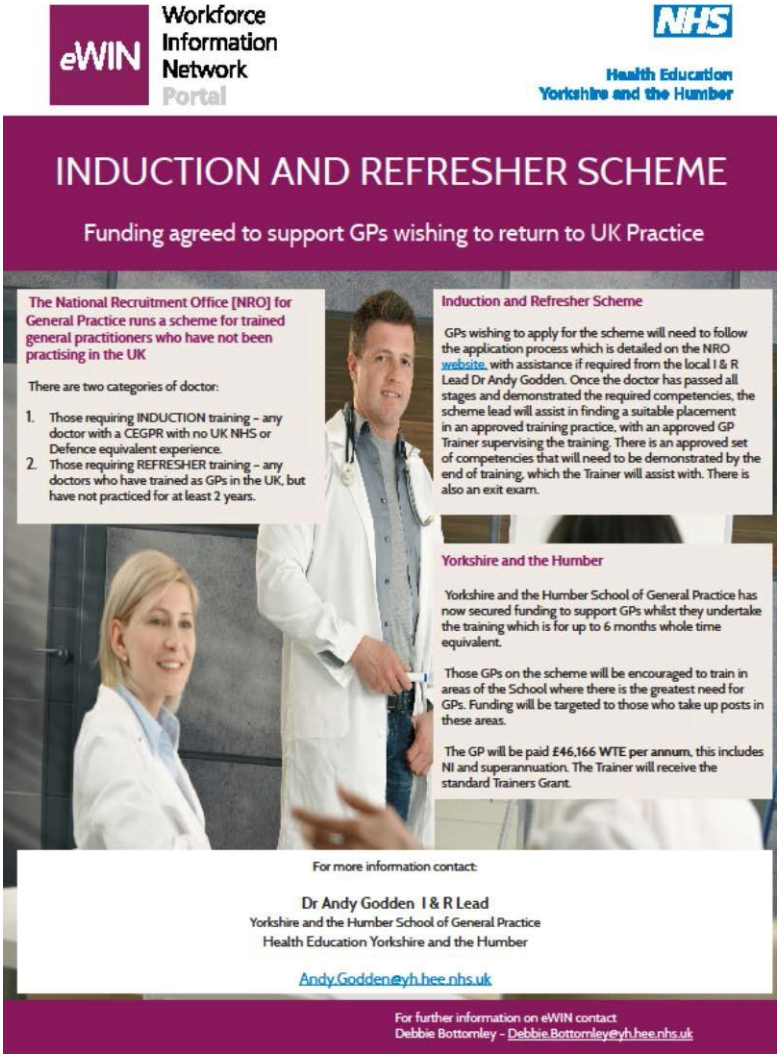
HEYH supports GP educators who have taken retirement to retain educational roles. Many of our GP educators tell us that a portfolio career that contains education roles can extend their career contribution beyond their anticipated retirement date. We support GP Educators who wish to take sabbaticals.

8. New Ways of Working

HEYH in engaged with providers who are transforming their ways of working. We are using existing training capacity to train a broader range of primary care staff, including physicians associates, advanced clinical practice for nursing and allied health professions. Engagement with providers and commissioners in workforce transformation. Use of tools such as Calderdale Framework tool.

9. Easy Return to Practice

http://yorksandhumberdeanery.co.uk/general_practice/retainer__returner/induction__refresher/



10 Targeted Investment in returners

HEYH supports the targeted placement of returners in areas of greatest workforce need. Our workforce profiling tool is useful in identifying areas of greatest workforce risk/challenge.

FF42 Health Education Yorkshire and the Humber

Widening Participation Strategy

To make General Practice future proof we need to develop the workforce of tomorrow. This has been outlined in the Royal College of General Practitioners document: The 2022 GP A vision for General Practice in the Future NHS (1) which states the importance of developing "an expanded, skilled, resilient and adaptable general practice workforce".

The medical profession has been criticised for its selection and recruitment processes that reinforce the current socio-economic make-up of the professions. Alan Milburn in his report has suggested measures to combat this including targeted work experience (2). The Medical Schools Council(3) states that "candidates should demonstrate some understanding of what a career in medicine involves" but pupils defined as likely to benefit from widening participation (WP) find it difficult to gain this.

In response to these concerns, a pilot project was initiated by Leeds medical school and West Yorkshire locality of the GP medical school last year. It successful placed 24 6th formers for 3 day placements in training practices in West Yorkshire. These students were selected through the 'Reach for Excellence' scheme which supports pre medical students in deprived areas. They received administration and pastoral support through the Admissions department and practice placements were funded £150 per student placement through a grant received by and distributed through the medical school. The success of the scheme is being monitored and is linked to a nationally funded research project which includes tracking of these students, questionnaires and focus groups. Initial results are positive with many students commenting on the gains especially around professionalism. Training practice feedback has also been positive with many commenting on the essential need to promote general practice as a choice for pre medical students. Practices were positive about the workbook and workshops dealing with ethics, medial indemnity, professionalism and confidentiality produced by amalgamating information from similar national initiatives. Some comments have occurred regarding the funding not being sufficient for continued support for this scheme in the current crisis on general practice. The scheme is being presented at the RCGP annual conference in the form of a workshop (Oct 2014).

It is hoped to continue and expand the scheme this year from this year's 24 placement's to 50 3 day placements separated into 2 cohorts with more formalised entrance assessment and continued links into national research projects. The first cohort would ideally be placed in practices at the end of this year, 2014. The proposal is that training practices should continue to be used to provide the best quality placements for students. If 50 placements in Leeds were achieved at a payment of £200/ 3 day placement this would equate to a budget of £10,000.

Other medical schools in Yorkshire and Humber are also involved in this type of venture. HYMS and Sheffield have currently smaller non funded schemes with different assessment and entrance requirements. The Director for Admissions, Gail Nicholls, at Leeds University is establishing a working group with all three Y and H medical schools, with clear links to the GP faculty recruitment tutors as well as national initiatives.

This was discussed at GP School Senior Management Team meeting SMT on the 24th September,

2014 and the following was agreed:

1. The support and co-working with our medical schools to influence prospective medial students' choice of future speciality is important.
2. Support in principal for this project and its proposed move to a School wide initiative.
3. That further financial advice needs to be sought regarding the utilisation of PG budgets through PGMDE.

Kirsty Baldwin
Locality Lead GP PG E (West Yorkshire)
September 2014

1. The 2022 GP: A Vision for General Practice in the Future NHS. Royal College of General Practitioners. May 2013.

http://www.rcgp.org.uk/campaign-home/~/media/Files/Policy/A-Z-policy/The-2022-GP-A-Vision-for-General-Practice-in-the-Future-NHS.ashx

2. Fair Access to Professional Careers: A progress report by the Independent Reviewer on Social Mobility and Child Poverty, May 2012.

3. Guiding Principles for the Admission of Medical Students, Medical Schools Council, Revised Nov 2006.

http://www.medschools.ac.uk/Publications/Pages/GuidingPrinciplesfortheAdmissionofMedicalStudents.aspx

FF43 Health Education Yorkshire and the Humber

An evaluation of a pilot 'taster' programme in GP training practices for Foundation Doctors.

Iolanthe Fowler and Ben Jackson September 2014

Introduction

In 2012 a programme of taster weeks in General Practice was started for Foundation Trainees in South Yorkshire who did not have General Practice as part of their Foundation programme. Such taster weeks are intended to allow trainees to experience a specialty not included in their rotation to help them reflect on their career choice (1). These were commonly available in hospital specialties but prior to this programme were not widely available for general practice in Yorkshire and the Humber. With the premise that positive experiences in the specialty would aid recruitment, the tasters were offered at the end of FY1 or start of FY2 to coincide as closely as possible to submission of applications to specialty training and only practices approved for postgraduate training were invited to take part. In accordance with national guidance (1), a specified menu of desired activity was described that included discussion about future career choice on a one-to-one basis with a GP. Trainees were offered up to 5 days in Practices, but reported difficulty with rotas and leave and the average duration was 3 days. An on-line questionnaire was used to evaluate any immediate impact of the experience on the trainees' career choices and the practicality for practices that took part and the foundation school destination survey analysed to examine subsequent career choices (7)

Background

It is well known within medical education that General Practice is struggling to recruit enough applicants to fill vacancies on specialty training programmes at a time when there is already a shortage of GPs to meet current demand (2, 3). This is coinciding with a re-configuration of health services that is

increasing the strain on primary care services to patients whilst requiring

additional management input from GPs to be involved in commissioning activities.

With only around 20% of current graduates reportedly expressing a clear preference for general practice one year after qualification (4), medical educators need to consider every possible measure that could encourage young doctors to choose General Practice as a career. As Lambert et al also report that around 50% have general practice as one of their top 3 career choices and some evidence that short periods of exposure to primary care can increase the likelihood of medical students choosing a career in general practice (5), it was considered that any possible additional positive experience in General Practice should be explored. The evaluation therefore looked to assess the usefulness of the placements in helping trainees decide on their future career choice and any immediate positive effect in promoting General Practice as a career. Qualitative data was obtained through space for free text comments and an additional e-mail shot to GP trainers from the nine practices involved to assess the impact on practices. Lastly, the foundation school destination survey was also examined to assess future career choice of the relevant trainees. .

Results

28 taster placements were reportedly undertaken in 2012 and 2013, with 20 trainees completed the on-line survey (71% response rate). The results for the questions about careers discussions and immediate impact on choice of general practice as a career are shown below.

	Yes	No
Time spent discussing career in general practice with senior GP (e.g. work/life balance)	13	7
Time spent discussing GP training with current trainee (work/life balance, career	14	6

choice, entry into training)		
Placement allowed exploration of what a career in GP entails (Skills, Behaviours, Aptitudes)	20	0
More or less likely to choose GP as a career after placement	**18**	**2**

A summary of the qualitative responses to the two additional showed a generally positive experience from all the trainees taking part.

1. What were the most useful features of this placement?

Themes emerged regarding;

- Flexibility and friendliness/ approachability of the doctors and wider team,
- An exposure to a variety of GP work, including visits, palliative care meetings, debriefs sessions and minor surgery as well as standard surgeries and clinics.
- Seeing different GPs consult and thus experiencing different consulting styles
- Opportunities to speak openly with GPs about what a career in GP was like.
- Gaining an insight into the everyday professional life of a GP
- Talking to current trainees at different stages of training about their working life, GPSTP and how to apply
- General discussions about careers and work-life balance

2. Was there anything about your placement that could have been improved?

Themes emerged regarding requests for;

- More than 2-3 days for the GP taster session, but rota's prohibited this (even 2-3 days though was felt to be valuable and worthwhile)

- More time with trainees to watch them at work/discuss the post and training and work- life balance
- Being able to see patients independently
- A more structured approach to the placement- i.e. timetabled

The free text comments from the two trainees LESS likely to choose GP were not particularly different from the group as a whole, providing no further insight into what affected this response.

Comments from Trainers

Six of the nine Trainers from the 2012 cohort responded to an on line questionnaire regarding the usefulness and practicality of the 'taster' programme. Responses were mixed, particularly practicalities.

- one trainer valued being able to give Trainees an insight into GP, being able to counsel trainees regarding career choices, and the chance to encourage trainees to consider GP as a career.
- Another explained having trainees with new ideas and a fresh, potentially challenging perspective, was welcomed.
- One trainer commented that though having taster trainees in the practice was not useful, they would be willing to take part in the scheme to promote GP as a career.
- Overall trainers viewed the main challenges of the taster sessions as logistical with short notice, space and time the main issues.

What career choices did the trainees make to date?

15 (54%) of the trainees are now in General Practice training programmes

3 are training in psychiatry (one of these applied for GP as first choice)

1 trainee started for core medical training.

1 trainee is in paediatrics

2 are in service posts

6 are currently not working in the UK

Data from the 2013 and 2014 foundation school destination surveys (7) show that of the 5 trainees now in specialty training who reported a change in first career choice during foundation and had a taster in general practice, three switched to general practice (from core surgery, core medicine and acute common care stem (ACCS)).

Discussion

The 'taster' sessions in foundation are designed to allow trainees to experience a specialty not available in their foundation training in order to reflect on their career choices. Despite certain difficulties with rotas and obtaining leave all the trainees managing to overcome this were able to be matched with Practices. As all trainees felt that they were able to explore what a future career in General Practice would entail, the pilot programme served its primary function and it has now been rolled out across the other foundation schools across Yorkshire and the Humber.

Immediately after the placement, eighteen of the twenty trainees reported they were more likely to choose a career in GP (in the follow up e-mail, one who subsequently chose GPST commented that "the taster days definitely helped me make my career decision"). The two trainees that reported they became less likely to opt for GP as a career also reported having had a positive experience in the taster sessions. An attempt was made to explore the underlying reasons these trainees felt less likely to choose GP via e-mail contact but no replies were received.

It would seem logical that trainees already having some interest in GP as a career would choose the taster as a way of exploring their interest further, and it is more than encouraging that such a significant majority reported they were more likely to choose GP afterwards with 15 of the 28 (54%) successfully applying for general practice. Over the last two years 175 of the

372 (47%) foundation trainees completing the destination survey in South Yorkshire had general practice in their FY2 rotations but only 112 (30%) had completed this placement before applications were required. Therefore the offer of some experience in general practice prior to application may be important to these trainees in order to consider their choices fully.

Conclusions

Overall the results suggest the pilot fulfilled its intention of helping foundation doctors decide whether general practice was a career for them. The results give an impression that it may have helped cement an idea of GP as a future career for some with 54% now in GP training though with such small numbers a clear conclusion is not possible. The administrative team reported a significant number of trainees having difficulty obtaining time away from their trust rotas resulting in cancellation for some trainees or short notice to the practices hosting them.

In this time of workforce crisis for general practice and Health Education England's clear objective that 50% of qualifying doctors become GPs (6), the message from above is that all avenues must be explored. Here we have reported a positive response to the taster sessions we piloted and this year to date, 40 trainees have expressed an interest in undertaking a GP taster. Bearing in mind the previously reported difficulties in obtaining leave, we would hope that any barriers can be overcome and recommend that the promotion or expansion of such opportunities in general practice might form part of the overall strategy of Local Education and Training boards

REFERENCES

1. Specialty Tasters in the Foundation Programme: Guidance for Foundation Schools. *UK foundation programme office*. March 2011
2. In-depth review of the general practitioner workforce. *Centre for workforce intelligence.* July 2014

3. GP taskforce report. Health Education England. July 2014
4. Lambert T and Goldacre M. 2011 Trends in doctors' early career choices for general practice in the UK. *British Journal of General Practice*, 2011 Jul;61(588):e397-403.
5. Deutsch R, Hönigschmid P, Frese T and Sandholzer H. Early community-based family practice elective positively influences medical students' career considerations – a Pre-post-comparison *BMC Family Practice* 2013, 14
6. Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. *Department of Health* May 2013
7. South Yorkshire foundation school destinations surveys. Health Education Yorkshire and the Humber. 2013/2014

Health Education
Yorkshire and the Humber

Health Education Yorkshire and the Humber
Advanced Clinical Practitioners and Physician Associate Initiative:
Programme Infrastructure and Resourcing

February 2015

Background

A key priority for Health Education Yorkshire and the Humber (HEYH) is the development of new roles to minimise workforce gaps and recruitment shortages and alleviate the challenges of an ageing population. The development of Physician Associates (PAs) and Advanced Clinical Practitioners (ACPs) is a primary element of this work.

Physician Associate

The current definition for a PA on the University of Birmingham's website is: *Physician Associate (formerly known as Physician Assistant) is a rapidly growing healthcare role in the UK, working alongside doctors in hospitals and in GP surgeries. Physician Associates will support doctors in the diagnosis and management of patients. They are trained to perform a number of roles including: taking medical histories, performing examinations, analysing test results, and diagnosing illnesses* ***under the direct supervision of a doctor****.*

Physician Associates support doctors in the diagnosis and management of patients. They are trained to perform a number of roles including:

- taking medical histories
- performing examinations
- diagnosing illnesses
- analysing test results
- developing management plans

They cannot however currently prescribe medication or order ionising radiation. They are under the Royal College of Physicians and are likely to receive GMC accreditation in the near future. They work under the direct supervision of a doctor and we have evidence of success in a number of hospital acute-based specialties and in general practice. This video from HEE in West Midlands describes the day in a life of a PA: http://wm.hee.nhs.uk/our-work/physician-associate/

Students from the January cohort of the University of Birmingham long established PA, are due to start primary care placements in this region in January 2016. Several local universities are currently developing plans for PA courses in this region. Placements for these courses will also take place from 15/16.

Advanced Clinical Practitioner

Our local task and finish group has agreed the following multi-disciplinary definition for an Advanced Clinical Practitioner. This definition is equivalent to the definition of an Advanced Nurse Practitioner working in General Practice:- 'An Advanced Practitioner is a professional who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which she/he is credentialed to practice. A master's degree is essential for entry level'

Following a successful programme supporting the creation of Advanced Clinical Practitioner roles in secondary care, HEYH are now facilitating posts in GP practices, with a particular focus on areas with low GP fill rates. The intention is for an additional 20 places to commence the Leeds Beckett University course in spring 2015, primarily from a pharmacy, paramedic or physiotherapy background. Trainees will attend university on a part-time basis and will receive work-based learning in the practice that they have been employed in. HEYH will fully fund both their training and employment whilst training.

Primary Care Placements of PAs/ ACPs

HEYH wish to establish a consistent approach for the creation of training placements for ACPs and PAs.

The initial intention is to use our under filled primary care training practices as placements for these new roles to help create and influence the curriculum, development and establishment of these roles in primary care.

Workforce planning

HEE YH will devise criteria around allocation of primary care training placements with essential and desirable criteria including being a GMC registered trainer and training environment, fallow training resources due to current under recruitment of GP trainees and in a geographical area of workforce needs.

Programme support

HEYH will help and support practices to work together with Higher Education Institutes to share resources, risks and development.

Supervision/mentorship

It is important that PAs and ACPs receive adequate levels of supervision whilst in training placements. HEYH will provide financial support on a pro rata basis, based on the current GPR Trainers Grant level of funding.

Training placement treatment room/area

A suitable treatment room/area and equipment must be made available to enable trainees to undertake their clinical training. HEYH anticipates that these facilities will already be available, using existing unfilled GPR (General Practice Specialty trainee) training capacity.

FF45 Health Education Yorkshire and the Humber

Practice Managers: Discussion Paper

Background

The North Yorkshire and Humber Workforce Development Group is a network of primary care service providers, education providers, CCGs, Area Team representatives, LMC representatives and Health Education Yorkshire and the Humber representatives. In addition to a number of specific task and finish groups the network supports action to deliver a primary care workforce for the area that is fit for purpose.

The meeting on 11th February 2015 focused on current and future needs for the practice management and administrative workforce for primary care.

The group notes that Health Education Yorkshire and the Humber's GP Primary Care Workforce Strategy focuses on the clinical workforce.

Main Themes Identified

- There are good data from the HEYH GP Workforce Database tool that shows: 29% of the administration/management workforce is over the age of 55 and 36% are between the ages of 45 and 54. Total of 65% of the administrative staff in primary care are over the age of 45. 98% of apprenticeships in the locality are in administrative roles. There is approximately one FTE practice manager for every 5 FTE GPs (salaried and partner). Practice managers make up 10.7% of the administrative and clerical workforce.
- Apprenticeships are the main route into clerical roles in primary care.
- There is a perceived need to refresh, augment or replace the AMSPAR route for developing practice management capability.
- There is no core job description or agreed competency framework for practice management.
- The fact that primary care has not embraced Agenda for Change is an issue (and possibly a risk).
- Access to statutory and mandatory training through e-learning is variable.
- There is a trend towards outsourcing some practice management roles: e.g. payroll.
- There is a trend towards federation/merging to have larger primary care provider organisations with economies of scale to concentrate and enhance practice management expertise.
- There is concern that small practices may get "left behind" and develop a capability deficit for some of the higher functions of practice management. This in turn may create an "inverse care law" where those practices with a practice management capability deficit are serving populations of greater need.
- There is concern at a possible training need to support the changing role of the practice manager in the move from many small units delivering primary care to fewer larger units delivering primary care at a greater scale.
- There is recognition that leadership development has been focused on CCG capability and clinical leadership. It was suggested that schemes such as the NHS graduate management

scheme do not include primary care providers.

Action

- MP to write to Professor Martin Rowland to see if the administrative and management workforce is in the scope of the Independent Primary Care Workforce Commission.
- MP to ask the Regional Leadership Council if they have scoped the need for leadership training for primary care providers, including practice managers
- MP to share the themes identified with Michael Holgate to establish what other initiatives are in place for Practice Manger training in Yorkshire and the Humber.

CENTRE FOR WORKFORCE INTELLIGENCE

FF46 CFWI

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20 February 2015

PRIMARY CARE WORKFORCE COMMISSION CALL FOR EVIDENCE

Dear Professor Roland,

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

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

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

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

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

Second, we may be able to help with analysis, primary care workforce mapping and modelling relating to future models of primary care you wish to explore. For example we could model the workforce impacts of various 'what if scenarios' and different skill mix permutations (involving

new primary care workers - such as the 'medical assistant' proposal as discussed in the NHS 5 Year Forward Plan).

CENTRE FOR WORKFORCE INTELLIGENCE

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

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

Yours sincerely,

Hannah Darvill
Head of Health (Medical), Centre for Workforce Intelligence

ROYAL PHARMACEUTICAL SOCIETY England

Shaping pharmacy for the future

FF47 Royal Pharmaceutical Society

Improving Urgent and Emergency care through better use of pharmacists

The Royal Pharmaceutical Society (RPS) believes that pharmacists are an underutilised resource in the delivery of better urgent and emergency care for patients.

Introduction

A key issue with the current growth in waiting times for accident and emergency (A&E) services is the number of people with conditions that could be treated elsewhere but who use A&E services as an alternative source of healthcare. Some people view the A&E services as a valid first point of contact with the NHS. Incorporating pharmacists more fully into the delivery of urgent and emergency (U&E) care would have a substantial impact on A&E waiting times and improve the care for patients.

Recommendations

- NHS England should nationally contract all community pharmacies to provide a common ailment service
- All A&E departments should incorporate a pharmacist to manage medicines related issues
- NHS 111 should ensure, as part of the national standards, that pharmacists are considered as an option to support urgent and emergency care at a local level, particularly around treatment of common ailments and emergency supplies of medicines.

Background

A&E is a critical concern for policy makers and the public. NHS England has stated that tinkering around the edges isn't the answer to secure its long-term future. Wholesale reform is, and that's been a priority for NHS England throughout its Urgent and Emergency Care Review[1]. This review states that '*We must provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E. This will mean providing faster and consistent same-day, every-day access to general practitioners, primary care and community services such as local mental health teams and community nurses for patients with urgent care needs. It will also mean harnessing the skills, experience and accessibility of a range of healthcare professionals including community pharmacists and ambulance paramedics.*'

And that *'Community pharmacies are an under-used resource: many are now open 100 hours a week with a qualified pharmacist on hand to advise on minor illness, medication queries and other problems. We can capitalise on the untapped potential, and convenience, that greater utilisation of the skills and expertise of the pharmacy workforce can offer*'.

The review also highlighted that community pharmacies are often the first point of contact for patients as every year the NHS deals with:

- 438 million visits to a pharmacy in England for health related reasons;
- 340 million GP consultations
- 24 million calls to NHS urgent and emergency care telephone services;
- 7 million emergency ambulance journeys;
- 21.7 million attendances at A&E departments, minor injury units and urgent care centres;
- 5.2 million emergency admissions to England's hospitals.

The Review, and the extensive professional and public engagement that was a part of it, has since generated recommendations that are likely to have a profound effect on the way in which urgent and emergency care is delivered in the next three to five years.

[1] http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

Where can pharmacy help?

The RPS believes that there are two main areas where pharmacists can play a greater role.

1. Providing capability and capacity of urgent care systems inside and outside of hospital

Emergency Departments (EDs) and General Practitioners (GPs) are attended by significant numbers of people experiencing common ailments that could be managed without recourse to an intervention by a medical practitioner. Common self-limiting illness places a substantial burden on health services by increasing waiting times in GP surgeries and EDs, reducing availability of care for more serious conditions and inflating the cost of service provision in both settings. This is particularly true of many painful musculoskeletal conditions, which constitute the highest proportion of common illness attendances in EDs.

Solutions are needed to optimise the use of scarce NHS resources by directing people to more cost-effective services when they require help to manage their common self-limiting illness, and to improve the patient experience by minimising waiting times.

Pharmacists in the community could play a greater role in urgent care requests from people with common self-limiting ailments, both as a triage and referral service but also as an end point for self limiting common ailments.

Common self-limiting illness can be managed in community pharmacies: the majority of the UK population has access to community pharmacies. Community pharmacists are easily accessible with around 11,400 community pharmacies in England located where people live, shop and work. The latest information shows that 99% of the population – even those living in the most deprived areas – can get to a pharmacy within 20 minutes by car and 96% by walking or using public transport[2]. No appointments are necessary which keeps waiting times relatively short; staff have the skills to advise and support people wishing to self-care; and they can supply a wide range of products for treating them. Approximately 70% of the UK population visits a community pharmacy at least monthly[3].

"Minor Ailment Schemes (MAS)" have been introduced into community pharmacies to varying degrees across the UK, providing a suitable alternative to medical consultations for common ailments. Currently in England NHS minor ailment services are locally commissioned meaning there is no consistency or standardisation across the country. A nationally funded pharmacy based common ailment service will ensure that services are delivered to the same standards and quality across the country and that patients know that they can access this service from all community pharmacies.

[2] http://psnc.org.uk/psncs-work/about-community-pharmacy/
[3] http://jpubhealth.oxfordjournals.org/content/27/3/254.full

The MINA Study, conducted in North East Scotland and East Anglia, showed that "Minor Ailment Schemes (MAS)" achieved high rates of symptom resolution, low rates of re-consultation and high patient satisfaction[4]. In ED, more than three-quarters of attendances for minor ailments (76%) concerned musculoskeletal pain, and almost half of GP attendances (45%) concerned upper respiratory tract conditions (cough, cold, sore throat). The MINA Cohort Study showed that symptom resolution with pharmacy consultations was as good as that found in ED and general practice.

Limited evidence from economic evaluations suggests that MAS are less expensive than GP consultations[5].

Pharmacies can supply a wide range of treatments: The range of products obtainable from community pharmacies for the management of common ailments is wider than ever before. Many medicines for treating the symptoms of common ailments, previously available by prescription only (POM), have been reclassified; in the past 30 years, more than 90 POMs have been made available for supply from pharmacies either for sale or via schemes such as patient group directives and MAS or for purchase[6].

People value the convenience of community pharmacies: A survey conducted as part of the MINA study found that the most common reasons for choosing to visit a pharmacy when managing a minor ailment were convenience and short travelling times[7].

Data from one large ED and two general practices in North East Scotland showed that at least 5% and 13% of ED and GP attendances, respectively, were for common ailments that could have been managed in a community pharmacy. Cost estimates based on these and national data suggest that £1.1 billion could be saved if these types of consultations were redirected to community pharmacy[8].

The "MINA" Cohort Study showed that symptom resolution with pharmacy consultations was as good as that found in ED and general practice.

NHS 111 is a service that is commissioned and delivered locally but in line with a national service specification and standards. If there was a nationally commissioned common ailment service it would be easier for this to be included in the local Directory of Services (DoS) for NHS 111 as it would be standardised and available from all community pharmacies.

[4] Prevalence of self-limiting common illness in higher cost settings: The MINA Study (Watson et al. 2014)
[5] Paudyal V, et al. Are pharmacy based minor ailment schemes a substitute for other service providers? Br J Gen Pract 2013; 63 (612), July 2013: 472-481
[6] http://www.pagb.co.uk/publications/pdfs/annualreview2013.pdf
[7] http://www.pharmacyresearchuk.org/waterway/wp-content/uploads/2014/01/MINA-Study-Final-Report.pdf
[8] http://www.pharmacyresearchuk.org/waterway/wp-content/uploads/2014/01/MINA-Study-Final-Report.pdf

2. Helping with lack of capacity within Accident and Emergency (A&E) departments to deal with current and projected workloads

A recent Health Select Committee report looking into urgent and emergency services[9] stated the following:

"Staffing levels in emergency departments are an area of considerable concern to the Committee. They are not sufficient to meet demand, with only 17% of emergency departments managing to provide 16 hour consultant coverage during the working week.

The situation is even worse at weekends and consultant staffing levels are nowhere near meeting recommended best practice.

Emergency staffing at all levels is under strain and a 50% fill rate of trainees is now resulting in a shortfall of senior trainees and future consultants. Emergency medicine is not seen as an attractive specialty by young doctors considering their long-term futures".

Research conducted by Health Education West Midlands and led by the West Midlands Post-Graduate Dean has identified a possible role for the Pharmacist in areas such as pre-discharge medicines optimisation in the ED and Acute Medicine Units, as well as within Clinical Decision Teams in the undertaking of medicines-related and common ailments. Such duties are currently undertaken by junior medical staff; staff who face significant demands on their time with emergency admissions.

The aims of developing these enhanced roles for pharmacists include:

- Appropriate use of the workforce - freeing up middle grades, junior doctors and consultants to conduct clinical work
- Developing the multi-skilled ED and Medical Assessment Unit teams.

The ED pharmacy pilot was developed to investigate the potential for an enhanced clinical role for Pharmacists within the ED, as part of a multi-disciplinary team (alongside other roles such as Advanced Practice Nurses and Physician Associates).

[9] http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2010/emergency-services-and-emergen-

The pilot aimed to test and justify development of clinical pharmacist roles within the ED, with guiding questions:

- "To what extent can pharmacists manage patients in the ED?"
- "What extra training is needed to create an enhanced clinical ED pharmacist?"

This pilot has been undertaken in A & E Departments in various hospitals in Birmingham. In each hospital a pharmacist, who is an independent prescriber, is included as part of the multidisciplinary team.

Amongst its portfolio of innovative medical and non-medical workforce strategies, Health Education West Midlands continues to support the development of enhanced skills training for pharmacists, as part of the integrated future workforce.

Key outcomes from this work to date include a positive impact on patient safety, improved patient experience and throughput, expediting safe discharge of patients from hospital and, consequently, an increased capacity in the acute care pathway.

Summary

Utilising the skills, expertise and accessibility of pharmacists can help to alleviate some of the pressures currently being experienced in the delivery of urgent and emergency care.

FF48 Royal Pharmaceutical Society

ROYAL PHARMACEUTICAL SOCIETY

NOW OR NEVER:
shaping pharmacy for the future

Judith Smith
Catherine Picton
Mark Dayan

acknowleDgements

the chair of the commission would like to acknowledge the contributions of the many individuals who generously gave their time and experience to help inform our work. the report would have been much the poorer without their input which is gratefully acknowledged here – they are named individually in appendix 1.

the expert advisory group (appendix 2) has played a central role in the work of the commission and have been unstinting in their support and encouragement.

Sally Williams and Mita Shah provided a sound basis of evidence for the early work of the commission with their excellent literature review. the full review is available on the royal pharmaceutical society website at www.rpharms.com/futuremodels

the team at the royal pharmaceutical society that supported the effective running of the commission are also gratefully acknowledged. They are: Beth Allen, Y vonne Dennington, Howard Duff, Sera Onofrei and N eal Patel alongside Claire Groom at the Nuffield Trust.

Title now or never: shaping pharmacy for the future

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key points

Recent nhs reforms, along with an unprecedented era of economic, demographic and technological change, present both challenges and opportunities for the pharmacy profession. there are many visions for pharmacy in circulation, and many new models of practice have been developed by pharmacists across England. However, as yet there has been little to knit these together in a coherent narrative for the profession's future role in the English NHS.

With this in mind, the royal pharmaceutical society set up a commission on future models of care, chaired by Dr Judith smith, Director of policy at the Nuffield trust. The commission has brought together expertise from across pharmacy, the wider health care sector, and patients and the public to develop practical ideas about how future models of care can be delivered through pharmacy. the commission has now completed its work, and this paper provides a summary of the key findings and recommendations from its work.

- the traditional model of community pharmacy will be challenged as economic austerity in the NHS, a crowded market of local pharmacies, increasing use of technicians and automated technology to undertake dispensing, and the use of online and e-prescribing bear down on community pharmacies' income and drive change. a broader role for pharmacists as caregivers will be central to securing the future of community pharmacy.
- the NHS is engaged in an urgent search for ways to provide better standards of care in the face of unprecedented pressure on budgets, and justifiably intense scrutiny of quality. only by adapting to the needs of patients with long-term conditions and preventable illnesses can this be achieved. pharmacists have a vital role in helping the NHS make the shift from acute to integrated care, and fulfilling the pressing need to do more for less.
- some patients, carers and members of the public have access to a broader range of services and care from pharmacy than the traditional dispensing and supply of medicines. pharmacists increasingly provide services that help people stay well and use their medicines to best effect. however, the pace of change remains slow, and financial and structural incentives are not sufficiently aligned to support it.
- pharmacists are working more closely with patients and healthcare colleagues in hospitals, outreach teams, patients' homes, residential care, hospices, and general practice, as well as in community pharmacies. they are helping patients to manage their own conditions, providing health checks, supporting best use of medicines, and detecting early deterioration in patients' conditions.
- high street presence and long opening hours mean that community pharmacy has the potential to play a crucial role in new models of out-of-hours primary and urgent care. access by pharmacists to integrated patient records will be a key enabler of this, as will the active engagement of pharmacists in local primary care federations, networks and super-partnerships.
- Despite its potential, pharmacy – and particularly community pharmacy – is marginalised in the health and social care system at both local and national level. it is seen by others as a rather insular profession, busy with its own concerns and missing out on debates and decisions in other health and social care organisations and the wider world of health policy.
- alongside this, there is insufficient public awareness of the range of services pharmacists can offer. there is a pressing need to de-mystify pharmacy so that patients, the public and the rest of the health service understand the extent of the role that pharmacists can and do have in providing direct care.
- focused, outward-looking local and national leadership of pharmacy will be needed to change this. leaders within pharmacy need to work with national and local commissioners and providers of other care services to ensure a shift in the balance of funding, contracts and service provision away from dispensing and supply, towards using the professional expertise of pharmacists to enable people to get the most from their medicines and stay healthy.
- to enable such a shift, there will be a need for a significant rethink of the models of care through which pharmacy is delivered, as a prerequisite to developing new approaches to contracting and funding that include the possibility of specific contracts with groups of pharmacists to deliver patient services; and population-based contracts for new larger primary care organisations that include pharmacists in their membership along with GPs, nurses and others.

contents

5. why aren't these new models of care widely available?

6. what needs to be done

7. recommendations

appendix 1. contributors to the report

appendix 2. members of the expert advisory group

1. introDuction

the commission

In April 2013, the English pharmacy Board of the Royal Pharmaceutical Society launched a commission on future models of care delivered through pharmacy. the independent chair of the commission was Dr Judith Smith, Director of Policy at the Nuffield Trust, an independent charitable health research foundation.

The commission was supported by a project secretariat led by Catherine Picton, and established an expert advisory group whose membership is set out in appendix 2.

the commission was asked by the royal pharmaceutical society to do the following:

- make the case for change in relation to the role that pharmacy can play in the delivery of care
- articulate the benefits to patients of involving pharmacists in the delivery of a wider range of services
- identify the range of models of care involving pharmacy that are starting to emerge in the UK and overseas
- examine what has helped or hindered the development of such models of care
- identify what needs to be done to enable and support the spread of such models of care
- consider the implications of the commission's findings for policy and practice in the English NHS and more widely.

The intention on the part of the royal pharmaceutical society was to undertake work that could help the society in setting direction for the role and position of pharmacy within the wider development of the NHS and its services.

how we worked

The commission approached its task by focusing primarily on the current and projected needs of patients and the population in the NHS in England. To this end, we ensured that we had effective patient and professional involvement in the work of the commission, and we undertook extensive engagement work including:

- a launch event in London attended by over 100 people from across pharmacy, primary care, national health policy organisations, and patient groups
- an online consultation, via a survey questionnaire that was open for eight weeks and yielded over 130 responses. a list of those who made submissions is set out in appendix 1
- two stakeholder workshops with a wider range of pharmacy, other health professional and patient groups, one in Manchester and one in Birmingham
- three meetings of the commission's expert advisory group, and an additional two meetings of a sub-group that focused on detailed analysis of submissions received
- interviews carried out by the chair of the commission with key stakeholders involved in the development of services involving pharmacy, in the UK and overseas. a list of those interviewed is set out in appendix 1
- interviews and meetings carried out by Judith smith and Catherine Picton to follow up emerging models, ideas and themes
- presentation to and discussion with delegates at the royal pharmaceutical society annual conference in Birmingham.

A review was commissioned of literature on models of care delivered through pharmacy, and this was undertaken by Sally Williams and Mita Shah. This covered the five years since 'pharmacy inEengland: Building on strengths – delivering the future' (2008) and examined the health policy context to pharmacy services in England, the range of models of care involving pharmacy that are in place or being developed in the UK and overseas, and evidence about the effectiveness of such models of care. The full literature review is available on the RPS website (www.rpharms.com/futuremodels).

this report

This report sets out the conclusions of the commission, based on analysis of submissions made through the on-line consultation, ideas presented and discussed at stakeholder workshops and in individual interviews, debate within the expert advisory group, and reflections on feedback given generously by those who reviewed a draft of this report.

The report starts with an examination of the challenges facing the NHS, with a particular focus on the financial context and the need to assure and improve the quality of care. This context is critical to any consideration of future models of care involving pharmacy, and is used as a way of highlighting how pharmacy can position itself to be part of the answer to difficult policy and organisational questions facing the NHS.

An examination is then made of how the role of pharmacy is changing, with a particular focus on the shift from dispensing and supply towards services that help people to get the most from their medicines and stay well. this is followed by a consideration of the range of models of care involving pharmacy that are emerging in the NHS, and an analysis of why it is that such models remain relatively thinly spread.

the final sections of the report focus on what needs to be done if pharmacists are to increasingly assume the role of supporting patients with effective medicines use and by serving as care-givers in the health system, working in close partnership with other health and social care professionals as well as with patients. The report concludes with a set of recommendations for NHS England, Public Health England, the Department of health, local commissioners, leaders of pharmacy, and pharmacists themselves.

The decision to appoint an independent chair of the commission was taken by the royal pharmaceutical society on the basis that they wanted a fresh and external critique of the current and potential role of pharmacy in delivering models of care. The conclusions are set out in that spirit and are ultimately those drawn by Judith smith as independent chair of the commission, and any errors or misunderstandings remain their responsibility.

2. the challenges facing the NHS

pharmacy within the wider Nhs

Future models of care delivered through pharmacy depend fundamentally on what is happening, and likely to happen, in the wider NHS. The NHS, like all public services, faces profound challenges, most notably in respect of the economic contextandsignificantly constrained funding, and the requirement to assure and improve the quality of care for patients, and in particular for those living with long-term conditions experiencing frailty.

economic austerity

Since its foundation in 1948, the NHS has enjoyed more or less continuous growth in its budget, both as a proportion of public spending and Britain's GDP. Since 2009/10 however, this trend has come to a halt. it is highly unlikely that the budget will increase at all up to 2015-16, and even if increases in spending return after this it is likely to be at a considerably lower rate.[1] Demand for health care continues to grow at the same pace or even faster, meaning that the NHS has to find ways of becoming increasingly productive. Studies suggest that by 2021–22, the NHS budget will be between £34 billion and £48 billion per year too small to meet the projected needs of the population, assuming no change in population trends, productivity, or efficiency. This gap is created by long-term trends such as technological change and an ageing population living with more long- term conditions (see figure 1).

To date, the NHS has met its targets associated with this productivity challenge largely by making cuts in real terms to pay, administrative efficiencies, and reductions in the 'tariff' price paid to hospitals for their services. Many bodies, including the national audit office[2] and the

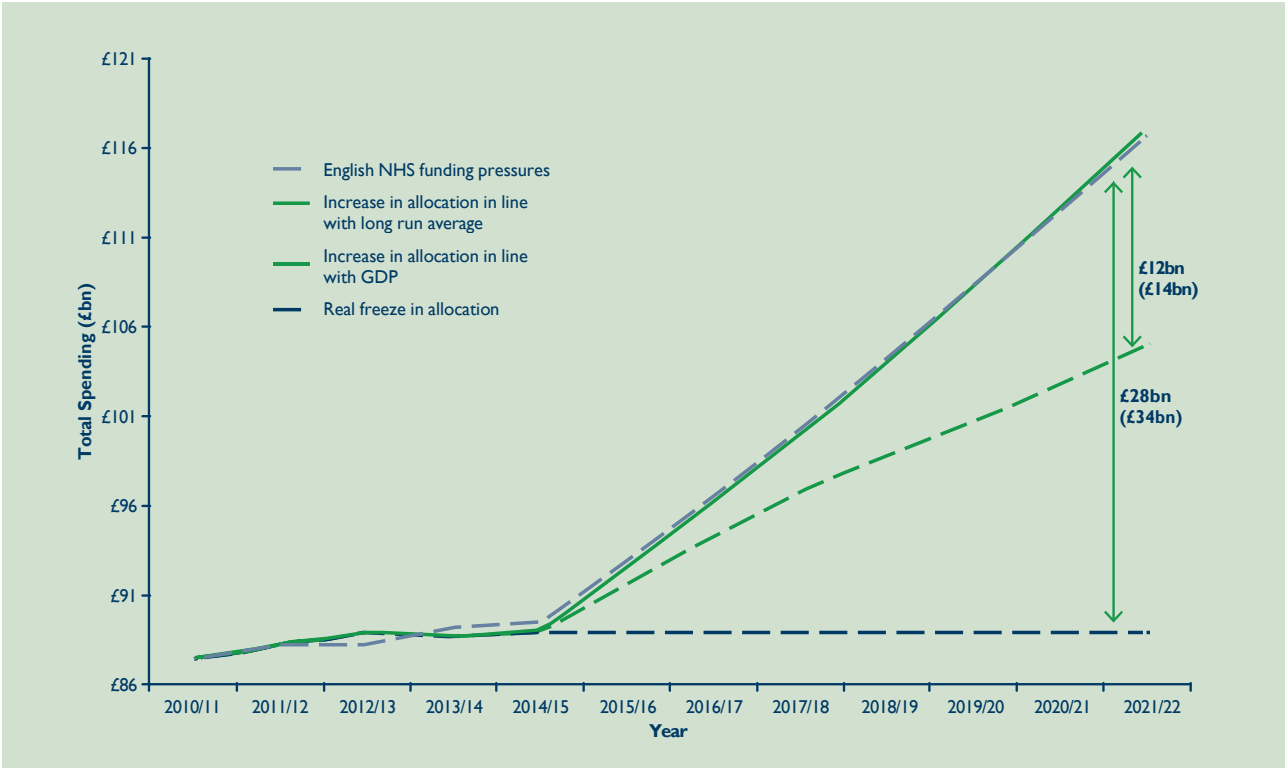

FiguRE 1: fuNdiNg pressure iN relatioN to three possible fuNdiNg sceNarios for the Nhs iN eNglaNd

1. roberts a, marshall l and charlesworth a (2012) *The funding pressures facing the NHS from 2010/11 to 2021/22 A Decade of Austerity?* london: nuffield trust www.nuffieldtrust.org.uk/sites/files/nuffield/121203_a_decade_of_austerity_full_report_1.pdf
2. national audit office (2012) *Progress in making NHS efficiency savings* london: stationery office www.nao.org.uk/wp-content/uploads/2012/12/1213686.pdf

Health Select Committee,[3] have raised concerns that these relatively straightforward, if painful, changes will not provide sufficient savings over the remainder of this decade.

a crucial part of achieving sustainable changes will be to ensure that resources and professionals are being used to optimum capacity, and in ways that have the greatest positive impact for patients, and pharmacy will be examined in this light. government, independent researchers, and NHS England have all suggested that progress could be made by improving the treatment, across the system as a whole, of vulnerable older people and those with long-term conditions in particular.[4]

Importantly, even a return to economic growth would leave limited room for the NHS budget to expand at past rates. the Nuffield trust has estimated that even if growth recovered fully, returning to NHS budget growth of 4% from 2015–16 to 2021–22 would require either freezing all other government departmental budgets for this seven-year period, or £10 billion of extra taxation or borrowing.[5]

Quality in the spotlight

alongside financial austerity, the quality of health care has become a prominent issue, particularly in the wake of the appalling lapses in safety, treatment and patient experience uncovered at mid Staffordshire NHS foundation trust.[6] while meeting the economic challenges outlined above, the NHS must find new ways to guarantee that patients are treated with compassion and dignity, that they do not come to harm, and that the care they receive meaningfully improves their health and wellbeing. This includes the pharmaceutical elements of patients' care, a fact that has been fully acknowledged by the royal pharmaceutical society in its response to the Francis inquiry into the events at mid Staffordshire.[7]

The response from central government to the Francis inquiry has been a series of programmes designed to increase transparency and accountability of nhs services. this includes an emerging system of published ratings, which will aggregate quality indicators and the results of inspections, in order to class providers as 'unsatisfactory', 'requires improvement', 'good' or 'excellent'. This system will be delivered by chief inspectors of hospitals, general practice and social care, working within the care Quality commission (CQC). The CQC has also announced that it will be changing some registration criteria to improve the strength of accountability across all providers, most notably by introducing a 'duty of candour' and simpler,

more robust fundamental standards of care.
the general pharmaceutical council is the independent regulator for pharmacists, pharmacy technicians and pharmacy premises in great Britain. the general pharmaceutical council is responsible for establishing and promoting standards for the safe and effective practice of pharmacy at registered pharmacies. in 2012 new standards for these registered pharmacies were introduced that set out the outcomes that the general pharmaceutical council expects pharmacy owners and superintendent pharmacists[9] to achieve for patients and the public. The general pharmaceutical council will begin inspecting against the new standards later in 2013 using a prototype model. once the inspection model is finalised, inspection reports will be made public and pharmacies will be rated as poor", "satisfactory", "good" or "excellent". after consultation, the general pharmaceutical council's powers of enforcement for poorly performing pharmacies are due to be confirmed
in law after a parliamentary review.

the Department of health, nhs england and regulators will continue to use all the levers available to them to attempt to generate pressure on health providers to guarantee and improve standards of quality. pharmacy has a central role to play in assuring safe and consistent care, in primary, community, social and acute care.

3. health select committee (2013) *Eleventh Report – Public Expenditure on Health and Care Services* london: stationery office www.publications.parliament.uk/pa/cm201213/cmselect/cmhealth/651/65102.htm
4. select committee on public service and Demographic change (2013) *Report of Session 2012–13: Ready for Ageing?* london: stationery office www.publications.parliament.uk/pa/ld201213/ldselect/ldpublic/140/140.pdf
5. roberts a, marshall l and charlesworth a (2012) *The funding pressures facing the NHS from 2010/11 to 2021/22 A Decade of Austerity?* london: nuffield trust www.nuffieldtrust.org.uk/sites/files/nuffield/121203_a_decade_of_austerity_full_report_1.pdf
6. francis r (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* london: stationery office www.midstaffspublicinquiry.com/report
7. royal pharmaceutical society (2013) *Responding to the Francis Inquiry* online document available at

www.rpharms.com/promoting-pharmacy/responding-to-the-francis-inquiry.asp

8. care Quality commission (2013) *A new start: Consultation on changes to the way CQC regulates, inspects and monitors care* london www.cqc.org.uk/sites/default/files/media/documents/cqc_consultation_2013_tagged_0.pdf
9. if a registered pharmacy is owned by a 'body corporate' (for example a company or nhs organisation) the superintendent pharmacist also carries responsibility fortheregulatory standards

meeting the needs of people with long-term conditions

the core business of today's NHS is meeting the needs of people with long-term conditions and very often more than one of them, such as asthma (and chronic obstructive pulmonary disease, copD), diabetes, hypertension, heart failure and dementia. long-term conditions generally cannot be cured by successful treatment, but by managing them, it is possible for health professionals and patients themselves to alleviate symptoms and reduce the need for invasive, costly and disruptive medical treatment. There is evidence that the likelihood of people with long-term conditions requiring inpatient or emergency care can be reduced by lifestyle change;[10] using medicines and treatments correctly;[11] support to live independently;[12] the ability to understand, monitor and manage their condition;[13] and contact with professionals able to assess the degree of illness progression and recommend the most appropriate treatment.[14 15]

These services are largely provided outside hospital, through general practice, social care, pharmacy, community care and the third sector. The NHS has, since the 1990s, made it a key priority to substitute these interventions for hospital care earlier in the progression of chronic illness, and to encourage improved coordination of care across services and organisations. Recent summaries of evidence by the Nuffield trust[16] and the king's fund,[17] however, have suggested that this has not yet happened to as great an extent as should be possible.

to take advantage of the opportunities for better care, improved coordination and greater efficiency generated, joint working needs to be built around a shared commitment towards improving ultimate outcomes for patients. Different health providers must innovate to show that they have a distinctive role to play in an integrated system, and the future will be dominated by those able to demonstrate that they could do more to help those with long-term conditions to stay healthy for longer.

assuring access

access to care, the dominant issue of the previous decade under New Labour, remains a vital issue for the NHS. the focus has shifted from reducing waiting times for elective care to finding ways to provide more accessible care in emergencies, including out-of-hours outside hospital,[18] and making sure that people have easy access to a full range of primary care services wherever they live and regardless of their condition.

A recent house of commons select committee report[19] confirmed that pressure on emergency services appears to be growing. it expressed concern that the current system of urgent care was not monitored closely enough for the underlying causes to be established. the report echoed NHS England's urgent and emergency care review[20] in questioning whether poor co-ordination with primary and social care might be leading to patients ending up unnecessarily in accident and emergency departments. it has also been suggested that the new NHS 111 helpline has, in some areas, failed to earn enough public trust to become a recognised alternative to local GP out-of-hours

10. Billings J, Dixon J et al (2006) *Case finding for patients at risk of readmission to hospital: development of algorithm to identify high risk patients* published in *British Medical Journal* london: Vol 333 (7563) pp.327–330 www.bmj.com/content/333/7563/327
11. howardrl, avery aJ etal(2007) in *British Journalof Clinical Pharmacology* london: Vol 63, issue 2, pp.136–147
12. nationalpatientsafety agency (2007) *Safetyindoses: medicationsafetyincidents in the NHS* london: npsa www.nrls.npsa.nhs.uk/easysiteweb/getresource.axd?assetid=61392
13. Begum n, Donald m et al (2011) *Hospital admissions, emergency department utilisation and patient activation for self-management among people with diabetes* published in *Diabetes Research and Clinical Practice* Vol 93 (2) pp.260–7 www.ncbi.nlm.nih.gov/pubmed/21684030
14. goodwin n, curry n et al (2010) *Managing people with long-termconditions* london: the king's fund www.kingsfund.org.uk/sites/files/kf/field/field_document/managing-people-long-term-conditions-gp-inquiry-research-paper-mar11.pdf
15. purdy s (2010) *Avoiding hospital admissions: What does the research evidence say?* london: the king's fund www.kingsfund.org.uk/sites/files/kf/avoiding-hospital-admissions-sarah-purdy-december2010.pdf
16. Bardsley m, Blunt i et al (2013) *Is secondary preventive care improving? Observational study of 10-year trends in emergency admissions for conditions amenable to ambulatory care* published in *BMJ Open* Vol 3 (1) bmjopen.bmj.com/content/3/1/e002007?cpetoc
17. tian y,Dixon aandgao h(2012) emergency hospitaladmissions for ambulatory care-sensitive conditions: identifying thepotential for reductions london: the king's fund www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/data-briefing-emergency-hospital-admissions-for-ambulatory-care-sensitive-conditions-apr-2012.pdf
18. goodwin n, smith J et al (2012) *Integrated care for patients and populations: Improving outcomes by working together* london: the king's fund www.kingsfund.org.uk/sites/files/kf/integrated-care-patients-populations-paper-nuffield-trust-kings-fund-january-2012.pdf
19. health select committee (2013) *Second report: Urgent and Emergency Care Services* london: stationery office www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/17102.htm
20. nhs england (2013) *Urgent and Emergency Care Review – Evidence Base Engagement Document* leeds: nhs england www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf

services or accident and emergency departments. While statistics suggest that rising pressure on accident and emergency services predates these developments, the desire to give primary care (including pharmacy) an increased role in out-of-hours services is likely to become a growing priority.

Finally, access often lies at the heart of the controversial question of hospital reconfiguration. Attempts to move towards a smaller number of hospitals, or wards for certain conditions are typically driven by evidence that hospitals with full-time consultant cover have better outcomes for patients,[21] as well as in some cases by a desire to find solutions to financial problems. Local resistance to reconfiguration plans is often rooted in fear that access to care will suffer if local hospital provision is scaled back. If future reconfigurations reduce local hospital capacity, public concern will need to be met by guaranteeing high-quality, accessible care from other primary or community providers.

working with the NHS reforms

Taken together, these challenges of money, quality, long-term conditions and access suggest an NHS which:

- is much more proactive in its approach to addressing risk of ill-health through prevention and public health;
- prevents costly and intrusive hospital admissions by managing chronic illness more effectively;
- provides rapid 24/7 access to high quality advice, diagnosis and support, particularly for people living with long-term conditions;
- improves collaborative working across community, primary and social care; and
- makes this shift in the place of care based on a strong case about improving care outcomes for patients, and putting in place accessible alternative services.

Commissioners will need to drive improvements and reform that can meet the challenges of finance, quality and long-term conditions. The responsibility for commissioning services in the NHS in England is now subject to considerable fragmentation – and in the case of community pharmacy services, a lack of clarity on the ground. NHS England is responsible for commissioning primary care (including community pharmacy) and specialized health services; clinical commissioning groups commission other acute, mental and community care; and local authorities purchase social care and public health services. Additional and enhanced services may be commissioned by any of these bodies. This is set in the context of a general move toward local commissioning for local populations. this creates a system in which the creation of new models of care which work across provider boundaries is most easily achieved by providers and commissioners taking initiative at local level, helped by supportive central bodies.

Particularly in primary care, there is a need to consider new structures which can ensure that professionals have the flexibility and capacity to innovate, and to do this in ways

That bring together general practice, community pharmacy and other professionals. networks or federations of general practices are forming across the NHS, and community pharmacies and/or pharmacists are well-placed to become part of these, as we explore later in this report.

Given the wider financial context, it is likely that those providers most ready to prove and improve their case to deliver new models of care will find larger roles in the future. Those who are unwilling, unable or too slow to change may find that their services will not be commissioned in the longer term.

21.academy of medical royal colleges (2012) *The benefits of consultant-delivered care* london www.aomrc.org.uk/about-us/news/item/benefits-of-consultant-delivered-care.html

key points

- future models of care delivered through pharmacy depend fundamentally on what is happening, and likely to happen, in the wider NHS
- the NHS faces a decade of flat funding whilst demand for health services, especially for people with long-term conditions, continues to rise. pressure to deliver care in different ways will increase, and service developments will have to be made through productivity gains
- with a £12billion annual investment in medicines the NHS has to make sure that it gets the best possible value out of medicines use, something which it is not doing at present
- following the Francis inquiry report, there is a stronger focus on assuring and improving the quality of care – all health care providers must get better at finding out what patients want and need, and delivering this with safety, consistency and compassion
- pharmacy, as the third largest health profession, with universally available and accessible community service, has a central role to play in assuring the safe and consistent use of medicines and as a provider of wider care, in primary, social and acute care
- pharmacy will have to make its case for delivering new models of care, based on evidence of cost and clinical effectiveness, and the ways in which it can help address the core problems facing the NHS.

3. the challenges facing pharmacy

from supply of medicines to the provision of care

Medicines are the backbone of modern health care. undoubtedly, medicines enhance quality of life and improve patient outcomes, but the complexities of ensuring optimal use of medicines cannot be underestimated, and are arguably increasing. There is a significant body of evidence emerging that demonstrates that medicines use in practice is currently less than optimal to the detriment of patient outcomes.[22]

The English policy response to the opportunities for improved use of medicines has been to pursue a strategy of 'medicines optimisation'. NHS England is currently developing a strategy for medicines use that focuses on achieving improved outcomes from medicines by engaging patients effectively in understanding how to take their medicines, as opposed to just focusing on the cost of medicine itself. this work is exploring the development of services that support patients in taking their medicines as intended, reduce medicines waste, and reduce admissions to hospital caused by issues with medicines. the strategy will build on the clinical guideline on medicines optimisation being developed by the national institute for health and care excellence (nice)[23] and the royal pharmaceutical society medicines optimisation principles.[24]

Internationally, health systems are increasingly recognising the role of pharmacists in providing *pharmaceutical care*;[25 26] a philosophy that emphasises that the pharmacist's responsibility is for the outcome of treatment not just its supply.[27] pharmaceutical care aims to help patients get the most benefit from their medicines and to minimise the associated risks. This is done by identifying, resolving and preventing medicine-related problems so the patient understands and gets the desired therapeutic goal for each medical condition being treated.

explaining this to the wider world

This commission has been struck by the difficulty experienced by pharmacy in expressing clearly to the wider world (health and social care professionals, policy makers, patients, the population) what is meant by terms such as 'pharmaceutical care' and 'medicines optimisation'. Whilst hotly debated within pharmacy circles, the terms mean very little to even informed health policy and management experts, let alone the wider public. Given the conclusion of this commission that pharmacy faces a significant challenge in making a case (and hence being commissioned and funded) for the provision of a greater degree of patient services aimed at improving the use of medicines and helping address wider NHS service problems, it is vital that pharmacy as a profession finds clear and accessible ways of expressing what it can and should be giving by way of additional patient services.

services delivered by pharmacy

Pharmacists delivering care to patients can be broadly separated into community pharmacists, hospital pharmacists and primary care pharmacists. the majority of pharmacists work in the community pharmacy sector. Community pharmacy is generally thought of as the shops we see on the high street, and increasingly we find community pharmacies situated in supermarkets, and health centres. Community pharmacies operate with a range of different skill mixes and in addition to the pharmacist, the pharmacy team may comprise some or none of the following: a healthcare assistant, a registered pharmacy technician, a dispensing assistant, and a delivery driver.

The major component of the pharmacist's role has traditionally been to oversee the safe and effective dispensing of prescription medicines. However community pharmacists

22. royal pharmaceutical society (2013) *Medicines Optimisation: Helping patients to make the most of medicines* london www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf
23. nice (2013) *Medicines optimisation: scope consultation* published online at guidance.nice.org.uk/cg/wave0/676/scopeconsultation
24. royal pharmaceutical society (2013) *Medicines Optimisation: Helping patients to make the most of medicines* london www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf
25. pharmaceutical care (2012) *Policies and Practices for a Safer, More Responsible and Cost-effective Health System.* european Directorate for the Quality of medicines & healthcare, eDQm www.edqm.eu/en/pharmaceutical-care-1517.html
26. scottish government (2013) *Prescription for Excellence: A Vision and Action Plan for the Right Pharmaceutical Care through Integrated Partnerships and Innovation* edinburgh: scottish government www.scotland.gov.uk/publications/2013/09/3025
27. hepler DD and strand lm (1990) *Opportunities and responsibilities in pharmaceutical care* published in *American Journal of Hospital Pharmacy* Vol 47 pp.533–543

have always been available to offer advice to patients on wellbeing, the treatment of illnesses, and if appropriate to sell 'over the counter' remedies, as well as counselling patients on the use of their prescription medicines.

Medicines should only be given to patients if a pharmacist has first checked that the medicine is safe and effective for that particular patient – this is a critical part of a pharmacist's role. However, the technical dispensing of the medicine can be done by other trained members of the pharmacy team, and where skill mix is used effectively alongside technical innovation, this has the potential to release pharmacists' time to provide other services that are more in tune with the philosophy of providing better care to patients. In recent years, community pharmacy has been commissioned to provide more structured services aimed at supporting patients in the use of their medicines (see Box 1).

This is with the aim of moving to a system (highlighted in figure 2) where the 1.6 million people visiting a community pharmacy each day should expect to:

- see their pharmacist more often and have more opportunities to discuss their health and wellbeing and early detection of serious illness
- Be signposted to community services and facilities aimed at helping to address some of the underlying determinants of health
- have diabetes checks, blood pressure tests, flu vaccinations and a range of other patient services offered at convenient times in their local community pharmacy
- access services like smoking cessation, weight management and sexual health
- use community pharmacy as a first point of contact for advice on minor illnesses.

People with a long-term condition should expect:

- pharmacists and GPs working in partnership to ensure the best possible care, with linked it systems
- pharmacists to help them to manage their medicines needs on an ongoing basis
- support from pharmacists and their teams to self-manage their conditions so that they can stay well and out of hospital
- early detection of problems or deterioration in their condition through routine monitoring
- pharmacists to consult with them in a range of settings appropriate and convenient to them. for example, pharmacy consulting rooms, GP practices, home visits, skype or telephone calls.

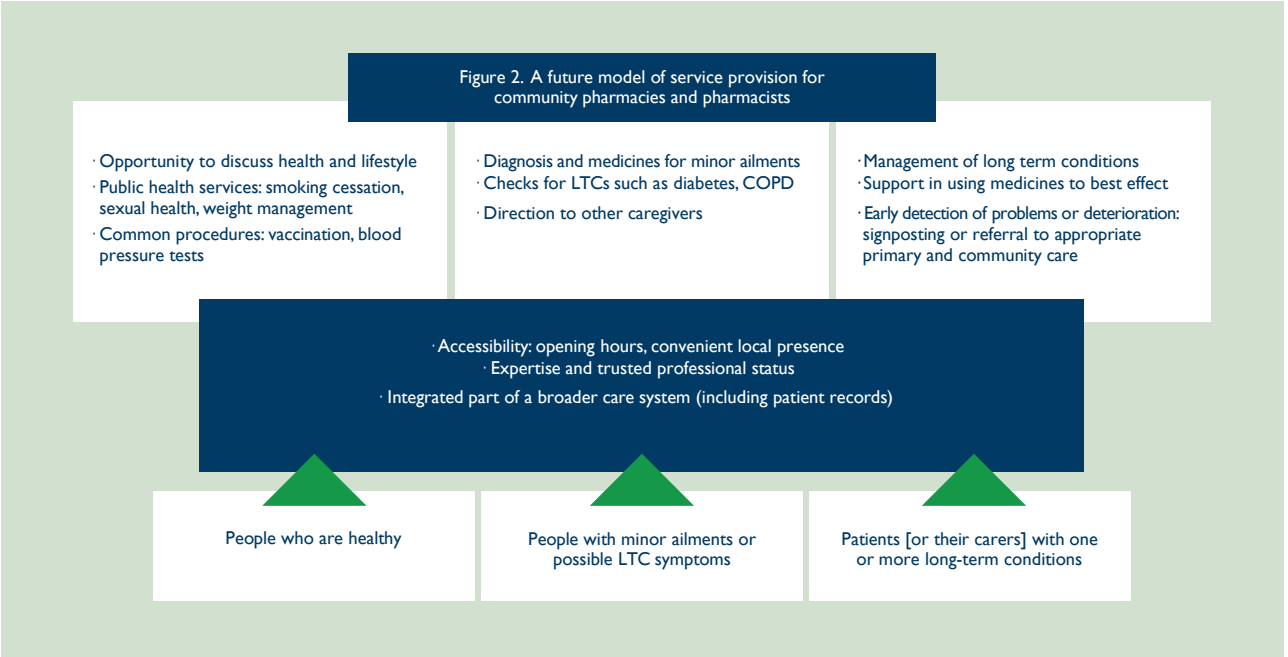

FIGURE 2: a future model of service provision for community pharmacies and pharmacists

box 1: services commissioned nationally from community pharmacists to support patients in their medicines use in England

to encourage community pharmacists to support patients with effective medicines use, two services are commissioned in England as part of the *national* pharmacy contract. the medicines use review service and the new medicines service both provide a mechanism by which community pharmacies* can be reimbursed for supporting patients in their medicines use.

medicines use review

Since 2005 community pharmacists have been paid a set fee for 'medicines use reviews'. The medicines use reviews are consultations with patients aimed at helping patients to get the best out of their medicines. Community pharmacies are paid a set fee for up to 400 medicines use reviews per year of which since 2011, 50% must be targeted at patient groups thought most likely to gain from additional support. The targeted groups are: patients taking specific high risk medicines; patients recently discharged from hospital who have had a change in medicines during their hospital stay; and patients with respiratory disease (asthma and copD) taking specific medicines. Whilst medicines use reviews undoubtedly provide benefits to patients when used in an integrated way, there have been criticisms levelled at the way in which the national commissioning of the service focuses on bald numbers of reviews, and not on any assessment of patient outcomes, nor integration with other local primary care services (Bradley et al (2008) *Determinants of the uptake of medicines use reviews (MURs) by community pharmacies in England: A multi-method study*. Health policy Vol 88 pp.258-268).

The new medicines service

The new medicine service was introduced in 2011 and is for patients with long-term conditions (primarily asthma; copD, type 2 diabetes, antiplatelet/anticoagulant therapy, and hypertension) who have been prescribed new medicines. Patients can be offered the service when they present with a prescription for a new medicine in a community pharmacy, or may be referred to the service by GPs or hospital pharmacy teams. The new medicines service is an 'after care service' to support patients in using their new medicines most effectively.
The aim is to help people adhere to their treatment, engage with their condition and their medicines, and reduce the likelihood of unnecessary hospital admissions due to adverse events associated with their medicines. The new medicines service is
An advanced service so pharmacies can choose whether or not to provide it. The service has been commissioned until the end of 2013 and an evaluation of the service is due to be published in 2014. How or if this service will be commissioned in the longer-term is not clear.

**for both the new medicines service and the medicines use review service the national contract is with the community pharmacy as opposed to the individual pharmacist.*

By contrast to community pharmacy, hospital teams are much bigger and typically comprise large numbers of pharmacists, as well as a significant number of pharmacy technicians and other support staff (see Box 2). Hospitals have long used automation and skill mix to release pharmacists from dispensaries, driven by the need to demonstrate efficient resource use and to target scarce pharmacist input where it can be most effective. Hospital clinical pharmacists are Generally well integrated into ward teams to provide generalist or highly specialist pharmaceutical input into individual patient care. hospital pharmacists also have a much wider remit in ensuring the safe and effective use of medicines including: provision of expertise to medical and nursing staff through training and information services; leadership of electronic prescribing initiatives; implementation of guidance from the national institute for health and

care excellence and safety alerts; ensuring responsible useofantimicrobials(through antibioticstewardship);[28] overseeing the safe and secure handling of medicines across the hospital; and the manufacture of specialist pharmaceutical products.[29]

however hospitals and the pharmacy teams within them also face challenges to make sure that they can deliver safe and high quality services in the future.[30] Delivering pharmacy services seven days a week, ensuring that e-prescribing and decision support is implemented effectively, and improving the transfer of information about medicines and the support that patients receive when they leave hospital and return back to their home setting are all significant challenges, as is ensuring that skill mix is fully utilised across hospitals with pharmacist prescribers and pharmacy teams fully integrated into accident and emergency departments and admissions wards. A small but influential group of pharmacists are collectively known as 'primary care' pharmacists. These are pharmacists usually based within clinical commissioning groups or commissioning opportunities, Typically having been transferred across from the former primary care trusts. Pharmacists working in the community services organisations that emerged from the splitting off of primary care trust's provider units also form part of this group. Along with hospital pharmacy, this sector has led the way in helping t o develop new roles for pharmacists and pharmacy technicians. These range from practice-based pharmacists working in GP surgeries (employed either by the surgery or clinical commissioning groups – see Box 9 chapter 4) to

box 2: pharmacy in Northumbria healthcare foundation trust

The pharmacy team at Northumbria healthcare foundation trust has 148 members, including 49 pharmacists, 47 pharmacy technicians and 52 other technical and support staff. the pharmacy team has embraced technology and skill mix to enable pharmacists and ward based technical staff to maximise the time they have available to provide direct care and support for patients.

medicines stock supply is centralised and automated using a robot in the pharmacy department at North Tyneside general hospital; supply services are managed and delivered by pharmacy technicians and assistants. Automated medicines storage cabinets (omnicell) are located in the accident and emergency departments and in emergency care units at the trust's acute sites. as well as improving medicines safety and security, this has freed up of pharmacy and nursing staff time which has been redirected towards more patient facing roles.

all pharmacists are required to undertake post graduate development with an expectation to progress beyond clinical diploma training to achieve a prescribing qualification. pharmacists are currently prescribing for 44% of all patients admitted to the hospital. all managers and middle grade pharmacists, and technical managers are required to undergo management and leadership development. ward-based pharmacy technicians support pharmacists and the wider health care team with medicines reconciliation, patient counselling, medicines supply and clinical audit. pharmacy provides a clinical service to all its wards, as well as a seven-day service to the trust's emergency medical admissions unit. in the emergency care setting, pharmacy staff routinely use patients' GP summary care records. Support from pharmacy extends into primary care, with pharmacists identifying and managing elderly patients at risk of readmission before and after discharge. the trust also employs the region's only consultant pharmacist foroncology.

28. Department of health (2013) *Annual Report of the Chief Medical Officer Volume Two, Infections and the rise of antimicrobial resistance.* london www.gov.uk/government/uploads/system/uploads/attachment_data/file/138331/cmo_annual_report_volume_2_2011.pdf
29. royal pharmaceutical society (2013) *Professional standards for hospital pharmacy services; optimising patient outcomes from medicines* http://www.rpharms.com/unsecure-support-resources/professional-standards-for-hospital-pharmacy.asp
30. future hospital commission to the royal college of physicians (2013). *Future Hospital. Caring for medical patients* london www.rcplondon.ac.uk/sites/default/files/future-hospital-commission-report.pdf

provide targeted care to specific patient groups (including prescribing), through to the teams working in clinical commissioning groups and commissioning support units to develop strategies and initiatives locally to ensure optimal use of medicines. By being based in general practice or commissioning organisations, these primary care pharmacists have been able to push at the boundaries of local models of care. The recent reforms have however been a time of significant upheaval for primary care pharmacists and the loss of expertise and networks has impacted on their ability to act as enablers of service development.

There is a broad consensus both in the UK and internationally that pharmacists, as the experts in medicines and their use, are an under utilised resource and that their skills could be used to better effect to help people stay healthy for longer and at home longer (see figure 2). In England, government policy is promoting a shift in emphasis from pharmacists dispensing prescriptions to providing pharmaceutical, health and social care services. But how might this look in practice?
In parts of England some people are experiencing all of these visions of pharmacist involvement in their care however this is by no means the norm, and we examine the reasons for this patchy development in chapter 5.

the impact of technology

To enable pharmacists to take on these new roles in patient services, especially in community pharmacy, traditional models of NHS pharmacy provision will have to change, as has been the case in much of hospital pharmacy. The current business model of community pharmacy is already being challenged by technological developments that enable new forms of dispensing, such as the use of robotics, something which has become widespread within hospital pharmacy, and in community pharmacy in some countries such as the Netherlands. Use of the internet to supply pharmaceuticals on an amazon-type basis is also in its infancy in the UK, compared to other countries and retail sectors.

The likely growth of robotic and online dispensing threatens an NHS community pharmacy business model which is funded mainly through dispensing activity and purchase profits (see Box 3). While these technological developments will not remove the need for pharmacists to check that the medicine is safe and effective for that particular patient, they will likely lead to pharmacy technicians running much of the day-to-day business of dispensing (as they already do in hospitals). the challenge to pharmacists is how they shape a new role in giving pharmaceutical care and optimising the use of medicines, and persuade commissioners to purchase this care. Without this, there is a risk that technology will reduce the perceived need for pharmacists, and that employers will seek to cut costs by reducing the number of pharmacists.

At the same time, there are signs that innovation in the creation of medicines is moving towards products which require clinically complex delivery in both hospitals and the home. It should be noted that the emergence of fewer major new pharmaceutical product lines has been linked to an overall flat-lining of primary care medicine sales by value.[31 32]

constrained funding

Meanwhile, the funding settlement in the NHS overall is being keenly felt in community pharmacy, which on average relies on the health service for funding the supply of medicines (a per item dispensing fee) to the tune of 85% of turnover. Extended NHS patient services such as support for patients starting on some new medicines, or reviews of medication where patients are on a number of different drugs, represent a small percentage of community pharmacy income (see Box 4). it should be noted that while the introduction of extended services to the new pharmacy contract from 2005 resulted in expenditure for these pharmaceutical services rising quickly through to 2010, the latest figures show that spending has now become flat.[33] this has occurred partly through a drive to make savings from the increasing prevalence of generics, which has seen the Department of health claw back from pharmacists around 20% of profits under the 'category m' component of drug pricing which guarantees income for generic dispensing. at the same time, pharmacy faces similar demand growth as other NHS-funded services for activity related to long-term conditions, and prescription volume continues to rise at around 4% per year.[36]

31. thomas m and plimley J (2012) *The future of community pharmacy in England* london: at kearney www.atkearney.com/documents/10192/649132/the+future+of+community+pharmacy.pdf/1838dede-b95a-4989-8600-6b435bd00171
32. psnc (2013) *NHS Statistics* available online at psnc.org.uk/funding-and-statistics/nhs-statistics/
33. Jones nm and charlesworth a (2013) *The Anatomy of Health Spending 2011/12* london: nuffield trust www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130305_anatomy-health-spending_0.pdf
34. the audit commission. *A spoonful of sugar. Medicines management in NHS hospitals*. 2001. www.archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/auditcommissionreports/Nationalstudies/nrspoonfulsugar.pdf

box 3: automation in pharmacies

in 2001, the audit commission published a review of how medicines were managed in NHS hospitals in England and Wales (a spoonful of sugar).[34]

It recommended that dispensing be automated to improve the safety and efficiency of the process, and to release pharmacists' time for clinical care. Since the 2001 report, robots have been widely adopted in hospitals across the UK with demonstrable benefits to patient care. The adoption of robots in community pharmacy has been much slower, Although a small number of community pharmacies are now investing in robots to gain much needed efficiencies in their dispensing processes.

one example is thackers pharmacy in Manchester where the installation of a dispensing robot speeded up their dispensing times, improved their stock control and saved on space to enable the construction of three patient consultation rooms. the robot also released pharmacists' time enabling them to focus on more clinical services including weight loss clinics, the new medicines

box 4: the community pharmacy contract in England – how the funding flows [35]

- A global sum is negotiated for community
- the pharmacy contract also allows for an additional £500 million for 'retained buying margin' which is the profit community pharmacies are allowed to retain through the cost effective purchasing of prescribed medicines for the NHS.
- the global sum is allocated through a system of fees and allowances.
- the largest proportion of the fees and allowances are directly linked to the volume of prescriptions dispensed – approximately £1.5 billion in 2011/12.
- the fees and allowances available for advanced services provided through pharmacy, including medicines use reviews and the new medicines service, amounted to around £74 million in 2011/12.

35. psnc.org.uk/funding-and-statistics/structure-of-pharmacy-funding/
36. health and social care information centre (2012) *General Pharmaceutical Services in England: 2002–03 to 2011–12* available online at www.hscic.gov.uk/searchcatalogue?productid=9731&q=title%3a%22general+pharmaceutical+services%22&sort=relevance&size=10&page=1#top

an overcrowded market

A further challenge facing community pharmacy is the increase in the number of registered providers which occurred following the introduction of new regulations in 2005 which exempted four categories of pharmacy, including 100-hour suppliers, from the test of necessity and expediency, resulting in a 15% rise in the number of community pharmacies in England. while the new regulations on entry to the NHS pharmaceutical market introduced by the Department of health in 2012 are considerably tighter,[37] and growth may slow in future figures, pharmacy numbers grew as quickly as ever between 2010-11 and 2011-12.[38] this means that effectively more pharmacies are competing for the same pot of money (the global sum – see Box 4). as a result, at a time when income is being squeezed and technology is changing, pharmacies also face intense competition in an arguably overcrowded market.

Taken together, the management consultancy group at Kearney estimates that these factors will result in the profits of an average pharmacy falling by 33% by 2016.[39] large pharmacy groups (often referred to as 'multiples') are expected to be able to respond more quickly to the need to take advantage of technology to streamline dispensing and supply, and, if they are incentivised to do so, to move into the pharmaceutical care market. the at Kearney study estimates that, as a result, 900 community pharmacies, or 7.5% of the total in England, will be forced to close. as it becomes increasingly clear that the squeeze on community pharmacy from technological, financial and workforce factors will continue well beyond 2016, we can expect to see even higher estimates of pharmacy closures in future, unless pharmacy is able to create a new extended role in patient care and persuade commissioners to purchase this as part of wider programmes of public health, common ailments, care for people with long-term conditions and so forth.

the pharmacy workforce also faces particular challenges. the number of qualified pharmacists is rising, exceeding the rate at which new employment opportunities arise. a recent study by the centre for workforce intelligence[40] projected a considerable oversupply of pharmacists under almost any future conditions, representing a threat to employment and salary. However, the centre for workforce intelligence research estimates that a substantial reduction in the gap between supply and demand could be achieved in scenarios where pharmacists assume a broader role in providing care. this projected increase in pharmacist numbers is in stark contrast to the projections for general practice and primary care nursing where a projected shortfall in the current decade is imminent due to the retirement of both GPs and practice nurses. Despite this shortfall the number of GP trainees is well below the government target.[41]

The ready availability of a highly trained pharmacy workforce could be seen as an opportunity to take some of the pressure off general practice by integrating pharmacists more effectively into primary care teams, and redirecting some patient demand.

the potential to do more

For almost thirty years, studies of pharmacy have suggested that pharmacists have the capacity to take on this broader role, and in particular in relation to the care of people with long-term conditions, the management of medicines for people taking multiple drugs, the provision of advice for minor ailments, and the delivery of public health services such as weight management, sexual health, and smoking cessation.[42 43 44] this is reflected in the current proposed changes to the undergraduate curriculum for pharmacists that will see pharmacy become a five-year integrated programme that focuses more on pharmacists as providers of clinical care that improve the use of medicines and help people to stay well.[45]

37. Department of health (2012) *New regulations on entry to the NHS pharmaceutical market* www.gov.uk/government/publications/new-regulations-on-entry-to-the-nhs-pharmaceutical-market
38. Davies J (2010) *Telepharmacy — opportunity or threat?* published in *The British Journal of Clinical Pharmacy* available online at www.clinicalpharmacy.org.uk/volume1_2/2010/july/july10_commentary.pdf
39. thomas m and anscombe J (2012) *The future of community pharmacy in England* london: at kearney www.atkearney.com/documents/10192/649132/the+future+of+community+pharmacy.pdf/1838dede-b95a-4989-8600-6b435bd00171
40. centre for workforce intelligence (2013) *A strategic review of the future pharmacist workforce* london: published online at www.cfwi.org.uk/publications/a-strategic-review-of-the-future-pharmacist-workforce/@@publication-detail
41. the kings fund and the nuffield trust 2013 *Securing the future of General Practice: new models of primary care* london www.nuffieldtrust.org.uk/publications/securing-future-general-practice
42. clucas k (1986) *Pharmacy. The Report of a Committee of Inquiry Appointed by the Nuffield Foundation* london: nuffield foundation
43. the royal pharmaceutical society of great Britain (1996) *Pharmacy in a New Age: The New Horizon* london: the royal pharmaceutical society of great Britain.
44. Department of health (2008) *Pharmacy in England: Building on Strengths – Delivering the Future* london: stationery office www.official-documents.gov.uk/document/cm73/7341/7341.pdf
45. smith aand Darracottr(2011)*Review of pharmacistundergraduateeducationandpre-registrationtrainingandproposals forreform* london: medicaleducation england

hee.nhs.uk/healtheducationengland/files/2012/10/pharmacist-pre-registration-training-proposals-for-reform.pdf

as highlighted earlier with the introduction in England of NHS funding for two national services that support patients to use medicines (medicines use reviews in 2005 and the new medicines service in 2011 – see Box 1 for details), as well as locally commissioned services such as smoking cessation and flu vaccinations, there are signs of some progress in this shift towards community pharmacists also assuming a broader role in care.

However, community pharmacy in England remains far from reaching its potential: the scope of work already being done at the most innovative edge of the profession (and highlighted in chapter 4) demonstrates how much more is possible. it is of note that in contrast the Scottish government has committed to a policy of developing comprehensive pharmaceutical care, and has more fundamentally altered the balance of the global sum available to community pharmacy to reflect its decision

FiguRE 3: the developmeNt of scottish policy oN pharmaceutical care for patieNts

to spend more on patient-facing services from pharmacies and a lesser proportion on dispensing and supply – see figure 3 and Box 5.

Improved monitoring of patients' use of medicines – something which is within pharmacy's core competency – could also make a direct contribution to reducing the time that patients have to spend consulting their GP, or staying in hospital following an unplanned admission: 8-10% of all hospital admissions are medicines related.[46]

There is much more that pharmacy could do to support people in making optimal use of their medicines, as shown by some of the innovative services in chapter 4. to reach an integrated system of care where effective use and review of medicines forms a core part of people's care, the collection, transfer and use of patient information must improve. Within traditional community pharmacy services, access to patient medication records or the summary care record could be used to support a medicines optimisation service for over-the-counter drugs, improving safety and effectiveness. more ambitious uses of data could include pharmacy teams undertaking predictive risk analysis of a local population of patients in order to identify and target patients considered at risk of developing complications in conditions like asthma, or when taking high risk medicines.

Providing a proactive public health service to people coming into pharmacies is the other area where pharmacists have the potential to help reduce demands on the NHS. Only by preventing ill-health and helping people to stay healthy can the NHS hope to manage demand on overstretched services. Exercise, diet, infectious disease, drug use and sexual health are key determinants of the occurrence and severity of most of the ill health facing the NHS. The advice and support needed to secure improvement in these areas should be easily available and widely advertised and offered (it is not enough to have a notice in the window – pharmacists have to actively offer services to people coming into the pharmacy) wherever it is most convenient and visible to the public. as accessible professionals with a high street presence, and increasingly found in supermarkets, community pharmacists can play an important role in providing these public health services. In Scotland, a nationally commissioned public health service has seen the delivery of smoking cessation services through community pharmacies become the norm.[47]

workforce and skill mix

Crucial to making this broader, care-giving role possible are the size and expertise of the profession itself. With over 40,000 registered pharmacists in England alone, pharmacy is the third largest health profession after medicine and nursing. all pharmacists study a range of health sciences as part of their qualifying degrees, focusing on advanced study of pharmacology and medicines management.

in recognition of this status as broadly educated experts in medicines, almost 3000 pharmacists have now been accredited as pharmacist independent prescribers following extra training. This confers full powers to prescribe any drugs for all conditions within the pharmacist's competence except for certain addiction treatments, enhancing their capacity to take responsibility for treating minor illnesses, and the on-going care of people with long-term conditions.

There are indications however that the core skills of pharmacists are not being fully utilised in the English NHS. Studies of different diseases show that 30-50% of medication is still not used according to prescriber instructions.[48] this is an international problem, particularly prevalent for many long-term conditions associated with higher risk of hospitalisation including diabetes, depression and asthma. At the same time, error rates are high in general practice with a recent study for the general medical council finding that one in eight patients have prescribing or monitoring errors.[49]

these factors present an opportunity for pharmacists to assume a much more active role alongside other health professionals within integrated care pathways designed to manage long-term illness.

46. sharpes (2013) *From Making Medicines to Optimising Health*. lecture–available online at psnc.org.uk/wp-content/uploads/2013/08/ucl_lecture.pdf
47. scottish government (2013) *Creating a tobacco-free generation: A Tobacco Control Strategy for Scotland* edinburgh: scottish government www.scotland.gov.uk/resource/0041/00417331.pdf pp.30
48. carroll r, hewittson m and carroll s (2010) *Delivering Enhanced Pharmacy Services in a Modern NHS: Improving Outcomes in Public Health and Long-Term Conditions* london: Bow group www.bowgroup.org/sites/bowgroup.uat.pleasetest.co.uk/files/delivering%2520enhanced%2520pharmacy%2520services%2520%252016%252009%252010%2520fiNal_0.pdf
49. avery a, Barber n, ghaleb m et al (2012) *Investigating the prevalence and causes of prescribing errors in general practice: ThePRACtICe Study, A report for the GMC*, www.gmc-uk.org/investigating_the_prevalence_and_causes_of_prescribing_errors_in_general_practice___the_practice_study_reoprt_

the opportunity presented by access

The nature and frequency of contact between patients and community pharmacists provides significant opportunities for the provision of a wider range of health and care services. pharmacies often open well beyond standard working hours and are located close to where people live and shop, making them easy to access. in 2008, the Department of health estimated that 96% of people in England could reach a pharmacy within 20 minutes on foot or using public transport.[50] unlike general practice and most other community health services, community pharmacies do not require appointments or extended waiting times, although as the range and number of patient services grows, pharmacies typically seek to have booked appointments for certain categories of patients.

each year, 84% of adults in England visit a pharmacy at least once, 78% of these attendances being for health related reasons. While medicines use reviews, appliance use reviews, and the new medicines service for certain chronic illnesses are now widely available in pharmacies, some pharmacies are still not taking full advantage of the opportunities for advice, diagnosis, medicine support and public health services presented by the local and accessible nature of community pharmacy.[51]

The accessible expertise of NHS community pharmacists makes them ideally situated to play an expanded role in direct patient care. yet while a 2008 consumer survey found that 43% of people would consider consulting a pharmacist for tests related to their long-term condition, only 6% had actually done so.[52] this raises very important questions about the actual availability and profile of

box 5: scottish 'pharmaceutical care' services

the chronic medication service

The chronic medication service (cms) introduced in 2010 is a service for patients in Scotland with long-term conditions that enables a community pharmacy of their choice to manage their pharmaceutical care. The patient must choose to opt into the service. Once a patient registered for the service the community pharmacy it system alerts the patient's GP. A pharmaceutical care plan is developed by the pharmacist and the patient that includes details of review and monitoring arrangements. GPs can also choose to enter into a shared care arrangement with the pharmacist that allows the patient's GP to produce a serial prescription for up to 48 weeks and which is dispensed at appropriate time intervals to be determined by the patient's GP. Patients can choose to opt out of the service at any point or change to a different pharmacy.

minor ailment service

The minor ailment service, introduced in Scotland in 2006, aims to support the provision of direct pharmaceutical care on the NHS by community pharmacists to members of the public presenting with a common illness. Utilising it to support registration with a specific pharmacy the minor ailments service requires people to register with and use their community pharmacy as the first port of call for the consultation and treatment of common illnesses. The pharmacist advises, treats or refers the patient according to their needs.

Community pharmacy prescribing clinics

Community pharmacists, working in partnership with GPs have since 2007 had access to Scottish government funding for community pharmacy supplementary and independent prescribing clinics.

50. Department of health (2008) *Pharmacy in England: Building on strengths – delivering the future*. london: the stationery office. Johnson a (2008)
51. health and social care information centre (2012) *General Pharmaceutical Services in England: 2002–03 to 2011–12* available online at www.hscic.gov.uk/searchcatalogue?productid=9731&q=title%3a%22general+pharmaceutical+services%22&sort=relevance&size=10&page=1#top
52. which? (2008) *A test of your own medicine* october pp.12–15

Services that pharmacists can provide for patients, in comparison with the assertions often made about the potential of pharmacy to deliver such care.

Alongside long-term conditions, minor ailments are another significant pressure on out-of-hours medical care. this is another area where pharmacy could be commissioned to deliver a proportion of first-line diagnosis, advice and care, forming a core part of local out-of-hours care networks. at a time when general practice faces enormous pressure and increasingly recognises the need to focus on treating people with complex and multiple conditions, alternative approaches to dealing with minor ailments have to be found. it has been estimated that around 18% of gp consultations involve minor ailments which could be dealt with by a pharmacist.[53]

a minor ailments service has been commissioned from pharmacies across Scotland for over seven years. pharmacists register patients to be part of the service and then receive funding to deliver this care – some 2 million people are now registered (see Box 5). The welsh NHS now also has such a service that like the national Scottish service, requires patient registration with their local community pharmacy.[54]

commissioning in transition

It is a source of concern that the most recent figures from the health and social care information centre show that the number of local enhanced services provided by community pharmacies has been falling since the start of the financial squeeze in 2010, sharply reversing an earlier upward trend.[55] this likely reflects the abolition of primary care trusts, (and the resulting upheaval to primary care pharmacists), which were the local commissioners of pharmacy and other services, and the organisational hiatus caused by major reforms to the NHS which are only now, in 2013, starting to bed down. There still appears however to be confusion in the system about who has responsibility for commissioning some community pharmacy services.

The commissioning landscape for community pharmacies has changed significantly since April 2013. Community pharmacy services (essential, advanced and some local enhanced services – see Box 6) are now commissioned nationally by NHS England through its local area teams. Some local services are commissioned directly through local authorities and it is expected that clinical commissioning groups will wish to do the same in due course. Local health economies now face a challenge as to how they will design and commission pharmaceutical care services to support wider programmes of care for the local population. it is likely that local pharmacy services will increasingly be commissioned directly through clinical commissioning groups (using the standard nhs contract) and local authorities. Whilst this represents an opportunity for pharmacy, community pharmacies will likely need support in working with commissioners, designing service offers, preparing tenders, and hence taking advantage of the opportunities.

Indeed, as we explore in chapter 6, commissioners will largely rely on offers of services and care designed by groups of local pharmacists – waiting for commissions will be a fruitless task on the part of community pharmacy, for other health services will be approached first and will inevitably take priority with policymakers and commissioners.

It is important to note that in the English health system, pharmacy-provided services are not generally incentivized or evaluated against the outcomes they achieve for populations as a whole. The main metrics applied to community pharmacy services continue to focus on numbers of items dispensed, and numbers of medicines use reviews (or other such services) undertaken. this also reflects the relatively under-developed approach to the commissioning of pharmacy services in the English NHS, a factor to which we return in chapter 6.

It is of note that the longest section of this chapter is the one focusing on the potential of pharmacy to do more, and that this has been a central theme to the work of this commission. in the next chapter, we explore some of the many examples of innovative models of care delivered through pharmacy that were submitted to the commission, before moving on to ask the tough questions of: what has prevented these models of care becoming widespread in the NHS in England and what needs to be done now, if pharmacy is to reach its potential and make the contribution to health and social care that is so desperately needed?

53. tisman a (2008) *Driving the self care agenda* london: pagB www.pagb.co.uk/information/pdfs/andytismanarticle.pdf

54. griffiths I (2012) *Establishment of a National Minor Ailments Scheme in Wales* the welsh government wales.gov.uk/about/cabinet/cabinetstatements/2012/minorailments/?lang=en
55. health and social care information centre (2012) *General Pharmaceutical Services in England: 2002–03 to 2011–12* available online at www.hscic.gov.uk/searchcatalogue?productid=9731&q=title%3a%22general+pharmaceutical+services%22&sort=relevance&size=10&page=1#top

box 6: who commissions the services in the current community pharmacy contract in England?

The community pharmacy contract currently has three tiers of services – essential, advanced and local enhanced. Essential and advanced services are commissioned by NHS England. the local enhanced services are currently commissioned by local authorities (for public health services) and by NHS England area teams.*

Essential services: under the community pharmacy supervised contractual framework, each community pharmacy must provide essential services – dispensing healthy lifestyle advice, signposting to other and repeat dispensing services, health promotion services, support for self care and disposal of medicines.

advanced services: there are four nationally commissioned advanced services that community pharmacies can supply: medicines use review service; the new medicines service (see Box 1); appliance use reviews; and stoma appliance *customisation*.

Local enhanced services: these are locally commissioned services. Examples of common services include stop smoking schemes, administration of methadone, emergency contraception, nicotine replacement therapy, and minor ailment schemes.

*It is unlikely that in the longer term that area teams will want to develop and commission local pharmaceutical services and that the commissioning of the majority of local services will move to local authorities and clinical

key points

- Pharmacy has long talked about its potential to assume a broader role in patient care, moving from a service largely based on the dispensing and supply of medicines to one focused on helping people to make the most of their medicines, supporting their clinical care and helping them to stay well.
- Technology is driving change in pharmacy, as robotics and electronic prescribing are used to reshape the dispensing function, and this has the potential, with judicious use of skill mix, to release pharmacists to undertake more patient-oriented care.
- community pharmacy is under pressure as NHS funding for dispensing and other services is constrained, reimbursement of drug costs is less remunerative than in the past, non-pharmaceutical sales are falling, and the over-supply of pharmacies and pharmacists starts to bite.
- pharmacy has a once-in-a-generation opportunity to capitalise on its highly trained professional workforce, local and accessible premises, and understanding of local communities to offer commissioners a range of pharmaceutical services that form part of the solution to wider NHS concerns such as delivering clinically and cost-effective urgent and out-of-hours care, long term condition management, and the promotion of healthy lifestyle choices.

4. models of care delivered through pharmacy

the future is already here

This chapter highlights the range of models of care received by the commission, and the ways in which pharmacists and pharmacy are extending the scope and reach of their services. We give a snapshot rather than a comprehensive summary of the submissions received by the commission, for the volume of submissions meant that we could only ever use them in a selective manner to support our wider conclusions and recommendations. The examples given reflect the general themes deduced through the literature review that framed the early part of the commission's work.[56] it should however be noted that most of the models of care cited are local 'one-off' developments and/or remain at proof of concept stage. We found few examples of innovative care delivery that had been rolled out consistently and at scale across a district or region.

this apparent inability on the part of pharmacy to persuade local and national commissioners of the value of extended pharmaceutical care services, and to embed new service developments within funded networks of care with other providers, raises important questions about the ways in which pharmacy is able to operate and influence within the wider NHS, a topic we address in chapter 6.

the models of care set out in this chapter (and illustrated in figure 4) offer potential solutions to some of the more pressing problems facing the NHS, such as: access to out-of-hours diagnosis, advice and care; long-term condition management; care of older and vulnerable people; preventing unnecessary admissions to hospital; and providing local public health services.

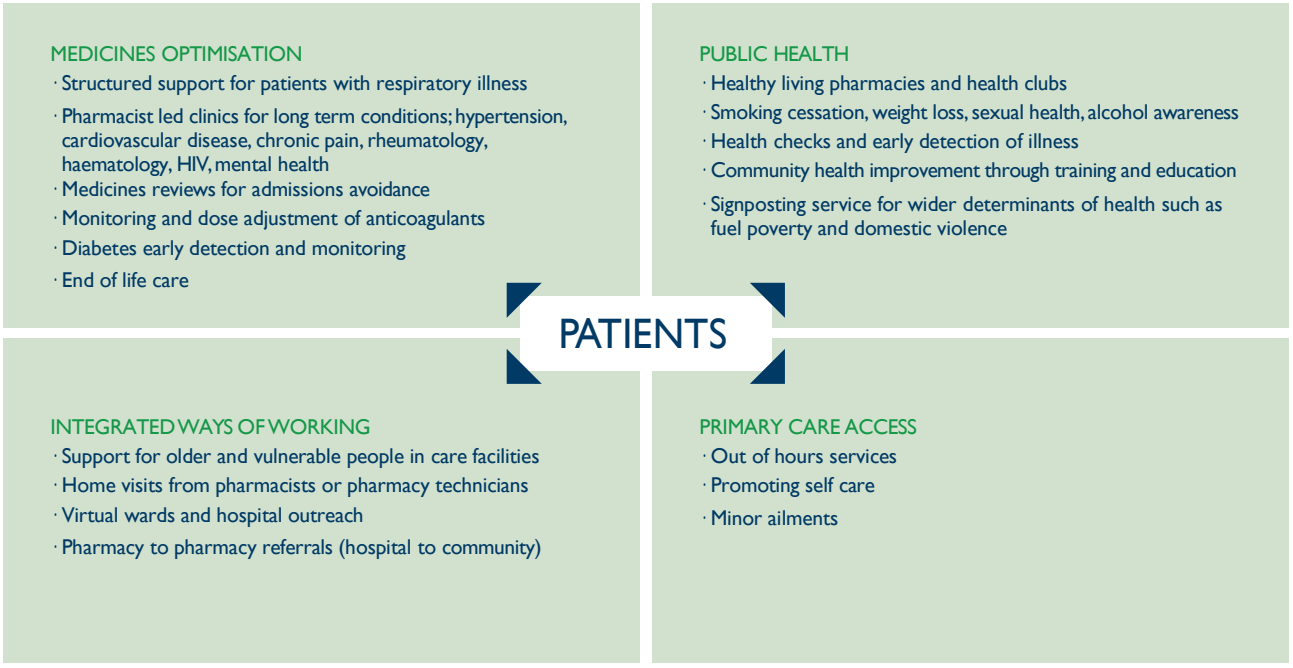

Figure 4: overview of the highlighted models of care

56. the royal pharmaceutical society england *(2013) New models of pharmacy: what is emerging and what is possible. A review of the literature* london www.rpharms.com/futuremodels

access for advice and minor ailments

Using community pharmacies as a first port of call for minor self-limiting conditions, and having pharmacists help people to manage these condition themselves, has long been seen as a way of reducing the demand on general practice.[57] The 'minor ailments service' was commissioned locally by primary care trusts in some areas of England and is designed to encourage people to use community pharmacies as the first point of contact for a range of self-limiting conditions. minor ailments services provide an effective alternative to general practice consultations and are less expensive. The number of consultations and prescribing for minor ailments at general practices often declines following the introduction of minor ailment schemes.[58]

In some parts of England, primary care trusts (prior to April 2013) coordinated activity to ensure that common ailments services with similar specifications could be commissioned across a wider geographical area (for example, the Lancashire PCTs). This allowed for consistency of access for a local population, and enabled local health professionals to give a clear and consistent message to people about the merit of attending community pharmacies for a range of common ailments such as head lice, coughs, colds, flu and hay fever. in other areas of the country however, availability of common ailments services in pharmacies is patchy, because the former primary care trusts chose not to commission such care from pharmacies, capped services to manage budgets or commissioned these services only on a pilot or occasional basis.

Other than this, there has been little attempt in England to utilise community pharmacy as a first point of contact for out-of-hours patient services. Indeed even when it would be appropriate for a patient to be directed to a community pharmacy (for example, for emergency hormonal contraception over the weekend) NHS 111 services do not consistently signpost the service, nor do they signpost patients to their pharmacy when they have run out of their regular medicines. Given the current strain on health service urgent care, this is surprising.

there are however local examples of more effective and co-ordinated approaches to involving pharmacy in out-of-hours care. for example, in Bromley-by-Bow in London, an NHS walk-in centre is co-located with a green light pharmacy, and the walk-in centre triages people who do not need to see a doctor or nurse to the pharmacy for advice and self-care (see Box 7).

integrated long-term conditions management

Finding clinically and cost-effective ways of managing long-term conditions (and often multi-morbidity) is possibly the biggest challenge faced by the NHS. health and care systems need to get better at supporting people with long-term conditions to manage their own care, and as part of this to use their medicines more effectively on an on-going basis.[59] pharmacists are beginning to play a much bigger part in helping patients get the best from their use of medicines, and there is ample evidence to suggest that this is a fruitful direction for pharmacists and the wider NHS to pursue.[60 61 62] this commission has heard of several examples where community pharmacists are supporting people with asthma and/or chronic obstructive airways disease (copD) to use their medicines more effectively
– see Box 8 for an example.

The nationally commissioned medicines use review service (see Box 1) is being used in a number of localities in england as a mechanism to provide support to patients with asthma and copD in a more consistent way. a range of initiatives set up by former primary care trusts or strategic health authorities entailed standardised training for community pharmacists to deliver structured interventions for patients with asthma and/or copD, sometimes linked to public health interventions such as stop smoking initiatives, with the intention of improving care and reducing hospital admissions.[63]

57. health select committee (2013) *Written evidence from Pharmacy Voice (ES11)* london: stationery office www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/171vw07.htm
58. paudyal V, watson mc et al (2013) *Are pharmacy-based minor ailment schemes a substitute for other service providers? A systematic review The* British Journal of general practice Vol 63 (612) pp.472–481 www.ncbi.nlm.nih.gov/pubmed/23834884
59. royal pharmaceutical society (2013) *Medicines Optimisation: Helping patients to make the most of medicines* london www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf
60. Barber n, parsons J et al (2004) *Patients' problems with new medication for chronic conditions*. Quality and safety in health care Vol 13 pp.172–175 qualitysafety.bmj.com/search?author1=r+horne&sortspec=date&submit=submit
61. york health economics consortium and the school of pharmacy, university of london (2012) *Evaluation of the Scale, Causes and Costs of Waste Medicines*. eprints.pharmacy.ac.uk/2605/1/evaluation_of_Nhs_medicines_waste__web_publication_version.pdf
62. pirmohamed m, James s et al (2004) *Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients* BmJ Vol 329 pp.15–19
63. the cambridge consortium (2012) *Evaluation of Inhaler Technique Improvement Project* www.networks.nhs.uk/nhs-networks/innovation-south-central/documents/120904%20cirem_itip_hiec_evaluation.pdf

box 7: greeN light pharmacy aNd st aNdrews walk-iN ceNtre

green light pharmacy and the walk in centre are co-located with a gp practice. co-location has enabled the pharmacy team to work closely with all members of the general practice team (both clinical and administration). the good working relationships and excellent communication benefit the pharmacy, the gps, the walk-in centre and ultimately the walk-in centre patients.

people who don't need to see a doctor or nurse are signposted to the pharmacy for self-care, either for advice, to buy medicines or to obtain them through the local minor ailments scheme (pharmacy first). patients through pharmacy first do not need to pay for medicines that they would otherwise have needed a prescription from the gp/nurse to obtain free of charge. the triage to pharmacy for self care and the pharmacy first scheme frees up walk-in centre appointments for people with greater need, which in turn prevents them from having to go to the local accident and emergency department.

green light's relationship with the local surgery is all about the organic development of local networks which they have proactively formed over the first year of operation. they were specifically commissioned as a local pharmaceutical services pharmacy with the expectation that they would integrate within the primary care network. to support this objective further they have been commissioned to deliver a programme of clinical leadership to develop local community pharmacy leaders. under this programme these clinical leaders will provide leadership on medicines optimisation and also ensure pharmacist input in clinical pathways design with the clinical commissioning group and health and wellbeing Board.

box 8: commuNity pharmacists helpiNg improve outcomes for people with copd

on the wirral, four of the large pharmacy multiple groups, Boots, co-operative pharmacy, lloyds and rowlands have come together with independent and supermarket pharmacies in a pilot to provide a programme of structured practical support for patients to help them get the best outcomes from their medicines and thus support their condition.

patients undergo an initial assessment once they have joined the service. this involves a copD test (copD assessment test) and dyspnoea score. public health advice and information on lung health, diet, exercise and lifestyle are provided and interventions such as smoking cessation signposted

adherence with medication are monitored regularly to improve medicine optimisation and inhaler technique is checked to ensure they are receiving maximum benefit. this typically happens when patients come into the pharmacy for their prescriptions. a patient held personal record card is provided and this is checked and updated.

targeted medicines use reviews are provided as part of the service and the provision of a rescue pack for rapid intervention is provided if necessary. patients undertake an annual health assessment with measurement of outcomes and patient satisfaction, alongside appropriate seasonal

several of the larger pharmacy chains have developed their own services for patients with asthma or copD. for example, after a pilot that demonstrated a structured medicines use review led to better symptom control for people with copD, rowlands now offer a standardised inhaler service in all of their pharmacies. any patient using an inhaler can have a medicines use review appointment in a rowlands pharmacy, along with counselling about how best to use their inhalers. a symptom control check is undertaken at the initial review and repeated by the community pharmacist as necessary.

across a range of other long-term conditions, a model of care which is becoming more common is the use of pharmacist-led clinics in both primary and hospital care. this model has developed primarily for patients where medicines are fundamental to how they manage their conditions on a day-to-day basis. in primary care, examples include gps referring patients to their own practice-based pharmacist for on-going management of hypertension and cardiovasculardisease; and referringpatientswithchronic pain to a community pharmacy-based chronic pain management clinic (see Box 9).

box 9: pharmacist-led cliNics

loNg-termcoNditioNs cliNic iN a gp practice

at hartland way surgery in croydon a pharmacist prescriber (who is also a partner in the practice) runs clinics twice a week for patients with long-term conditions (cardiovascular disease, respiratory disease and hypertension). the clinics aim to optimise the patient's medicines use by providing structured support that gives them a better understanding of their condition, improves the way they take their medicines, reduces their chances of hospital admission, allows fortimely intervention if their condition deteriorates or relapses, and provides appropriate referral to other agencies when needed. the pharmacist also manages medicines issues related to any hospital admissions, ensuring that on discharge from hospital, any changes to the patient's medicines, or queries about medications, are picked up early.

chroNicpaiNmaNagemeNtcliNic iN a commuNity pharmacy

a pharmacist prescriber with a specialism in pain management ran an nhs pain management clinic from a community pharmacy in essex (one year pilot). patients were referred to the clinic by gps from a local health centre. patients referred had unresolved chronic pain and would normally have been referred to a secondary care pain team. the community pharmacist had full access to the patient record (via a laptop pre-load with system-one software) and could issue printed nhs prescriptions for repeat medication or initiate new medication as appropriate. patients prescribed a new medicine during the clinic had the option to see the pharmacist during the day without an appointment to discuss any follow-up issues.

the clinic gave patients quicker and more convenient local access to care than the alternative of travelling to, and waiting for, a hospital out-patient appointment. it reduced the number of gp appointments for patients with chronic pain and patients who previously would have used a&e accessed the pharmacy as the first port of call.

the pharmacy pain clinic has not been commissioned as the ccg is re-commissioning its musculoskeletal pathway using a lead accountable provider model. it will be critical for services such as the pharmacy pain clinic to demonstrate how their service can support the lead accountable provider to deliver the (pain) pathway and achieve the outcomes required oftheir contract.

in a hospital setting, we have seen examples that include: rheumatologists referring patients to pharmacist-led clinics for support in the choice and use of specialist medicines to help control rheumatoid arthritis; haematologists and nurses referring patients on chemotherapy to a pharmacist-led symptom control clinic; pharmacist-led clinics for patients with hiV where the pharmacist provides assessment, prescribing and support for medicines taken; and pharmacists running clinics for adults with attention deficit disorder.

Similarly, in some areas community mental health teams are able to refer patients based in the community directly to specialist mental health pharmacists for advice, review and prescribing.[64]

the commission has also heard of examples of pharmacists working with hospices and with patients to support them with medicines use as they near the end of life; for example, in hull, Macmillan pharmacists are working in a specialist community palliative care clinic, and with the local hospice and hospital to ensure best use of medicines and seamless transfer of care for patients between these settings.[65]

Another emerging model of care by pharmacists for people with long-term conditions is to offer blood monitoring services that were more traditionally delivered by hospital outpatient departments. for example in Brighton, patients taking an anticoagulant medication that requires regular blood test monitoring are able to choose a local community pharmacy at which to have their blood tests, review of results, and modification of dosage – see Box 10. similarly, some community pharmacies now offer blood tests to help identify people at risk of diabetes as well as regular blood sugar monitoring services (for hba1c levels) and support for people with diagnosed diabetes.

support for older and vulnerable people at home or in care

Care for older and vulnerable people will increasingly involve helping them to take their medicines effectively, in order to maintain their health and avoid hospital admissions. This is whether they are living independently in their own homes, in care homes or sheltered housing. There is ample evidence that for older people living in care homes their medicines are frequently given incorrectly[66] and infrequently monitored or reviewed. The commission heard of several models of care where pharmacists and pharmacy technicians have been integrated into multidisciplinary teams to help ensure that older people are supported to take the medicines appropriate for them (see Box 11).

The commission heard of other examples where pharmacy teams working in social enterprises or private companies have been commissioned by a former primary care trust or a new clinical commissioning group to provide medicines support to patients in local care homes, either

box 10: on-going monitoring: quick and convenient access for patients

Patients taking an anticoagulation medication can choose one of seventeen pharmacies in Brighton for their regular blood test with appointments available at flexible times that include one early morning and on alternate weeks either a late evening or a Saturday clinic. The pharmacist tests the patient's blood levels of medication and can adjust the dosage of medication there and then if necessary. Appointments usually last around ten patients to make an appointment at a hospital with limited opening times, blood was taken in one part of the hospital and then the patient had to go to another department to have their levels interpreted. The service is commissioned using a community service contract with Boots as the lead provider and the other community pharmacies as sub-contractors. It is supported by a team of general practitioners with a special interest in anticoagulation.

64. parker c, Duggan c. Developing a pharmacist-led medicines management service for mental health patients. British Journal of clinical pharmacy. 2011: 3; 182–4.
65. royal pharmaceutical society (2013) submission cited in the final report of the rps future models of care commission. london http: www.rpharms.com/futuremodels
66. Barber nD, alldred Dp et al (2009) *Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people* Quality and safety in health care Vol 18 pp.341–346 www.ncbi.nlm.nih.gov/pubmed/19812095

box 11: Enfield council and Enfield clinical commissioning group support for care homes

Enfield has one of the highest populations of older people in London, with 30,000 people aged 65 or older, and the borough has 110 different residential care facilities. Enfield council and Enfield clinical commissioning group jointly employ a pharmacist who sits in the CCG's medicines management team and who both provide pharmaceutical care to residents and respond to safeguarding alerts relating to medicines in any of the care facilities.

The pharmacists' clinical priorities are to ensure that all residents have medication reviews and to make sure that the medicines they are taking are all still needed, can be taken together, and are optimal for the individual patient. at the same time the pharmacist offers education and training for care home staff to help improve the use and handling of medicines.

When a safeguarding alert related to medicines is raised, the pharmacist carries out a risk assessment on the care facility. An implementation plan to correct problems with medicines governance is developed and the home is followed up against the plan.

on a time-limited basis to review the homes' systems and processes for storing and administering medicines, or on a regular footing to review patients' medication, train and support care staff, and provide on-going advice and supervision about the safe use of medicines. this points to the potential for pharmacists of forming networks, chambers or companies, as a basis for bidding for and delivering specific pharmaceutical services that are sought by clinical commissioning groups, local authorities, or indeed GP federations or networks – the latter may sub-contract for medicines optimisation and other services as part of plans to extend urgent and long-term conditions care. we return to this topic in chapter 6.

For older or vulnerable people who are housebound, the model of domiciliary pharmacist or pharmacy technician visits is beginning to emerge as a means of offering medicines management support. in north west London, domiciliary medicines reviews for older patients taking four or more medicines are commissioned from central London community healthcare to support patients' medicines use. Commissioned through the integrated care pathway, using innovation monies, it is hoped that this service will ultimately be funded by the CCG once the results of the evaluation are available. The commission heard of several examples where community pharmacists visit patients in their home to support them in their medicines use (see Box 12 for an example).

In an approach that links health and social care, northern Devon healthcare NHS trust has pharmacists and pharmacy technicians as core members of multidisciplinary complex care teams comprising health and social care staff. The pharmacy team provides a domiciliary medicines optimisation service to adult patients to try to reduce medicine-related hospital admissions and improve patients' use of their medicines and their understanding of why they are taking them. interventions made by the pharmacy team are fed back to the patient's GP and a follow up visit or telephone call is arranged where necessary.

The commission has revealed that in the area of long-term conditions care, and the provision of support for older and vulnerable people, there is a wealth of examples of innovative services involving pharmacists, pharmacy technicians, and pharmacies. There is a strong focus on helping people and their carers get the most out of the medicines they are prescribed, and in providing advice, expertise and safety monitoring to wider pathways of care.

The patchy provision of these new services is again striking, as is the prevalence of pilots and short-term projects, and an overall sense of innovation happening in a rather haphazard and opportunistic manner. There is less of a sense of a strategic plan for the role of pharmacy teams in long-term conditions and medicines management. One other striking feature however is the way in which groups of pharmacists are often responsible for the development

box 12: home visits for people who need medicines support

In Croydon the local authority has commissioned
local community pharmacists to visit people at home to undertake medicines use reviews. housebound patients who need additional support with medicines use are identified by the community pharmacist or by the GP, who refers directly to the community pharmacist. Patients are also identified by teams in the local hospital (accident and emergency nurses and the pharmacy team) who are referred initially to the pharmaceutical team at the clinical commissioning group, who then refer patients to the community pharmacist if adherence to medicines has been highlighted as a possible issue.

The contract for the domiciliary medicines use review service is funded by the local authority and managed by the CCG. The service is open to any community pharmacist who has attended the training and is accredited to deliver the reviews. The impact of the service has been demonstrated by recording the interventions made as part of the medicines use review, and assessing whether the intervention could have avoided an emergency hospital admission. The interventions are peer reviewed and then quantified in terms of cost avoidance using current cost of an emergency admission in Croydon.

and 'selling' to commissioners of new services. whether through the emergence of social enterprises or companies comprised of groups of pharmacists, or the pharmacy teams in hospitals or community service providers, there is clearly a desire on the part of pharmacists to contract locally for services, and to do this as a group of professionals, rather than necessarily as pharmacies.

helping people to get or stay out of hospital

The commission heard of outreach pharmacists employed by hospitals or community services, these professionals forming part of the care team for frail older people in particular, working with patients to ensure that medicines are not the reason that they remain in hospital unnecessarily or find themselves readmitted. For example, the reablement service for patients leaving the Whittington hospital in north LONDON has a pharmacist as a core member of the team, attending twice weekly multidisciplinary team meetings at which the care of frail hospital patients is discussed. From this, the pharmacists pick up referrals and visit these patients post-discharge in their own homes, to pick up any problems or difficulties with medicines use. similarly, guy's and st thomas' community services team have pharmacists as core members, working with nurses and others to manage complex patients in the community to avoid unnecessary admissions or readmissions.

Community pharmacists are often described as the missing link in the transfer of hospital discharge information and some models of care submitted to the commission are trying to integrate pharmacists more routinely into the care pathway of patients discharged from hospital. Lack of it and lack of electronic communication has been a significant barrier to ensuring that patients are safely discharged into the community. one example of this being tackled is at east Lancashire hospitals – see Box 13.

providing local public health services

The potential role that community pharmacy can play in improving and maintaining the public's health is consistently identified as being underutilised.[67] community pharmacies are accessible, open long hours and present in communities across the country including areas of deprivation. Primary care trusts typically commissioned public health services from pharmacies as local enhanced services. However, because services were commissioned locally the scope and availability was variable across England, and contracts were often short-term. this has limited the ability of community pharmacies to deliver services on a larger scale, and to make investments in facilities and staff to support extended service provision.[68 t] The commissioning of all public health enhanced pharmacy services is now the responsibility of local authorities and this presents an opportunity to scale up the commissioning of pharmacy-based public health services, if groups of pharmacists and/or pharmacies can persuade cash-strapped local authorities that pharmacies are cost-effective organisations for the delivery of services aimed at improving people's health.

although the availability of public health and preventative services varies across England, the commission heard about a wide range of initiatives delivered through community pharmacies. examples included:

- smoking cessation services
- substance misuseservices (e.g. supervised administration of medication, syringe exchange)
- flu immunisations (and potentially other immunisation programmes) – see Box 14
- weight management services and nutritional advice (for example for infants and children)
- NHS health checks (in some cases with specific focus on hard to reach groups e.g. cardiovascular checks for younger men)
- alcohol awareness and brief interventions with onward referral if necessary
- sexual health services (including emergency contraception, chlamydia screening and treatment, ongoing supply of contraception)
- screening services (for example for hepatitis B, HIV)
- referral for early detection of bowel and skin cancer

box 13: providing medicines support to patients discharged from hospital

in east Lancashire hospitals patients who need additional support with their medicines are given the opportunity to have a direct referral of their medicines information and care from the hospital pharmacy team to a community pharmacist of their choice. a newly developed system for the trust called refer-to-pharmacy allows patients to identify their local community pharmacy, and a referral, together with a copy of their hospital discharge summary, is sent directly to the community pharmacy. Patients are asked to give consent and shown a short film to inform them of why the system has been developed, and what benefits they can expect to gain (this can be viewed at www.elht.nhs.uk/refer). The referral will then be followed up by the community pharmacist. an audit function allows the hospital team and community pharmacists to monitor performance and analyse the effect of referral on re-admissions to hospital. refer to pharmacy e-referral links the care patients receive in hospital to that in the community to help them get the best from their medicines and stay healthy at home.

67. the royal pharmaceutical society england *(2013) New models of pharmacy: what is emerging and what is possible. A review of the literature* london www.rpharmc.com/futuremodels
68. nhs confederation (2013) health on the high street. rethinking the role of community pharmacy london www.nhsconfed.org/publications/reports/pages/health-on-high-street-rethinking-community-pharmacy.aspx

box 14: flu vaccinations in community pharmacy

In 2012-13, following accredited training, 24 community pharmacies in Sheffield were commissioned by the local primary care trust to provide flu vaccination services for difficult-to-reach groups identified as being at risk. an evaluation provided clear evidence that the programme succeeded in reaching individuals beyond the reach of general practice. Twenty per cent, in a survey with a high response rate, said that they would not otherwise have received vaccination. fifty-eight per cent expressed convenience as the main reason that they had chosen to visit a pharmacy for the service.[69]

The ability of pharmacists to vaccinate hard to reach groups is being increasingly recognised, for example, in London there is now a pan – London community pharmacy flu Vaccination service. This means that people who live, work or access services in any of the London Boroughs will be

As a framework for the delivery of public health services, disease prevention and the promotion of healthy living there is considerable interest in encouraging community pharmacies to act as a 'health hub'. This approach is demonstrated by the growth of the healthy living pharmacy programme (see Box 15). a local initiative that started in Portsmouth and is now spreading across England, encouraging community pharmacies to support healthy living in a proactive way that makes the most of the pharmacy team and location of the pharmacy in the centre of a community.

In some areas, there is interest in pharmacies helping to tackle the social determinants of health as in Wigan, where community pharmacies have been used innovatively to help address two key public health challenges in the area: fuel poverty and supporting people at risk of domestic abuse.[71] Similarly, there is an increasing imperative to improve the extent to which people have the capacity to obtain, process, and understand basic health information (health literacy) pharmacists clearly have a role to play here in their interactions with patients.[72]

Building on their position as providers of health and wellbeing services on the high street some community pharmacies are beginning to partner with local organisations to help improve the health of their local communities
– see Box 16.

There is also some evidence to suggest that pharmacists can become trusted figures for patients and those receiving help to remain healthy. the wells family challenge, a small pilot programme carried out in Sainsbury's pharmacies through 2011-12, saw pharmacists help those with risk factors for cardiovascular disease to improve their health through lifestyle change. evaluation of their interactions saw pharmacists quickly become trusted 'mentor' figures. In many cases, people who were already aware of ways to improve their lifestyle reported that hearing the same thing from a pharmacist made them more likely to follow recommendations.[73]

69. nhs sheffield (2013) nhs sheffield community pharmacy seasonal flu Vaccination programme for hard to reach at risk groups 2012–13 (and catch up campaign for over 65s). service evaluation psnc.org.uk/sheffield-lpc/wp-content/uploads/sites/79/2013/06/i-evaluation-of-pharmacy-flu-service-2012-13-1.pdf
70. pharmacy london (2013) london community pharmacy seasonal flu Vaccination enhanced service 2013–14 service guidance. psnc.org.uk/city-and-hackney-lpc/wp-content/uploads/sites/69/2013/08/pharmacy-london-community-pharmacy-seasonal-flu-vaccination-enhanced-service-v31.pdf
71. royal pharmaceutical society (2013) submission cited in the final report of the rps future models of care commission. london www.rpharms.com/futuremodels
72. research in social and administrative pharmacy Volume 9, issue 5, september 2013
73. royal pharmaceutical society (2013) submission cited in the final report of the rps future models of care commission. london www.rpharms.com/futuremodels

box 15: healthy living pharmacies[74]

The healthy living pharmacy programme was originally developed by Portsmouth primary care trust and the Hampshire and isle of Wight local pharmaceutical committee. It aimed to create pharmacies committed to provide public health and lifestyle improvement services, commissioned on the basis of local need. The services provided included smoking cessation, sexual health advice, and guidance on lifestyle changes to combat obesity. a key theme was building on the essential and advanced services already being provided. leadership training was provided for pharmacists, each pharmacy was required to have a team member trained as a health champion to royal society of public health standard, and consultation rooms were equipped to deal with new services. The regularity of contact with the public in community pharmacy was used to give health advice at every opportunity. The programme showed significant results, particularly in smoking cessation and related illnesses. Seventy per cent of patients with a respiratory condition showed improvement in their ability to manage their illness, with the total number of people stopping smoking exceeding agreed targets by 42%. the health living pharmacy concept has now been rolled out to 721 pathfinders nationwide. A recent evaluation found evidence that similar gains were made for populations served by the wider group of healthy living pharmacies. these data also show that it is not only pharmacists who can provide effective stop smoking services, with similar quit rates achieved by other trained pharmacy team members, allowing more effective use of skill mix for this service.

box 16: healthy living pharmacies

Green light pharmacy in Easton is a partner in the west Easton healthy communities project which is supported by the new opportunities fund (now the Big lottery). it operates a training programme for volunteers, who then encourage local people to complete a series of questions about their health. Based on the results of the questionnaire, individuals may then be invited to the pharmacy for health checks and health education, for example, about diet and smoking cessation.

Jhoot's pharmacy chain is a key partner in a social enterprise (community interest company) called innovation health and wellbeing. the partnership includes Walsall council Walsall housing group Jobcentre plus and Walsall college and brings together the expertise of all partners in the development of interventions that aim to improve the health and wellbeing of local communities. as part of this aim a life style and weight management Qualification has been jointly developed and piloted jointly by Walsall college, Jhoots pharmacy and Walsall housing group within local communities and will soon be accredited for wider national use. it aims to improve residents own health, but also for those interested in a health-centred career, to provide them with a qualification that will help them with their ambition to secure employment.

74. ucl institute of health equity (2013) *Evaluation of the Healthy Living Pharmacy Pathfinder Work Programme 2011–2012*

learning from these models of care

The commission was extremely impressed by the number and nature of submissions received from across the NHS, describing different models of care involving pharmacy. this chapter has set out a summary of these models of care, examined within the thematic framework that was developed via the literature review undertaken for the commission. what is clear is that pharmacists in the community, primary care, social care and the acute sector are keen to develop innovative ways of delivering services to patients, in particular those that come under the banner of 'medicines optimisation', integrated care and public health. it is also evident that in these many examples, people have been able to overcome the barriers to innovation and service development that are often cited, and which we examine in more detail in the following chapter.

the most striking aspect of our analysis of these many models of care is that they remain exceptional and hence 'innovative' when arguably the majority could and should be mainstream, given presenting health needs, years of discussion and writing about broadening the role of pharmacists (especially in the community), and the apparent hunger within pharmacy to ensure that skills and experience are used to maximum patient and population benefit.

In the next chapter, we explore what it is that seems to hinder the implementation at scale of new models of care delivered through pharmacy.

key points

- over 100 examples of models of care delivered through pharmacy were submitted to this commission during the call for evidence.
- these models of care reflect the categories of patient-oriented services and care deduced from the review of literature undertaken to inform this commission: access to medicines, advice and care; optimising the use of medicines; improving public health; and new integrated ways of working.
- the models of care are striking in that they have been put in place despite the barriers so often reported as being the reason for the relative lack of development of the pharmacist as a care giver.
- pharmacists are forming new networks and organisations, often in collaboration with other health professionals, to design, bid for and deliver new models of care. in this they reflect trends elsewhere in primary and wider care.
- perhaps the most disheartening aspect of the work of this commission has been the fact that there is widespread consensus that pharmacists should engage much more widely in the delivery of direct patient and population health services, yet examples of such care remain relatively rare and considered 'innovative'.
- after many years of describing visions of future pharmaceutical care provision and more recently medicines optimisation, and the desire of pharmacists to use their skills more fully, there is clearly much that remains to be done to move from visions and strategies to plans and implementation.

5. why aren't these new models of care widely available?

In this chapter we set out our analysis of the reasons why new models of care delivered through pharmacy have been slow to spread beyond a relatively small number of projects, schemes and pilots. This is based on what we heard during our work as a commission, for in our call for evidence, we asked people to comment on barriers to implementing new models of care involving pharmacy, and this issue was also explored in commission workshops, interviews and meetings of the expert advisory group.

pharmacy is marginalised within the NHS

Despite calls from many pharmacy organisations and in numerous policy documents for pharmacists to make better use of their clinical skills and take on a broader care-giving role, there is still a sense that community pharmacies in particular, and the pharmacists who work within them, sit outside the NHS and are primarily suppliers of medicines to patients, rather than core members of local integrated health and social care teams. Whilst there have unquestionably been some developments in the services that patients access through community pharmacies (as evidenced by the models of care submitted to the commission and summarised in chapter 4), the proper integration of community pharmacists into the primary and community care team still remains for the most part an aspiration.

In hospitals, and for pharmacists working in primary care either in GP practices or for clinical commissioning groups, there has been more progress in integrating pharmacists into core teams. Indeed there have recently been calls from the NHS alliance to embed medicines optimisation within general practice through the employment or attachment of medicines optimisation pharmacists to practices.[75] this, along with evidence that demonstrates the impact pharmacists can have on improving medicines use[76] is testament to the increasing acceptance of the role of primary care pharmacists.

there is poor public understanding of the role of pharmacists

Whilst the public in general has a high regard for pharmacists, there is a low awareness of the range and benefits of services that pharmacists can offer.[77] During the work of the commission, we heard from patient groups of the need to 'demystify' pharmacy in the eyes of the public, and of the importance of putting in place services that demonstrate to people the potential of medicines optimisation and direct patient care – and these need to be explained in much clearer lay terms. the need to build a strong and straight forward narrative about the role pharmacists can play in people's care and the services that they can offer was asserted to be critical; in particular in the management of long-term conditions, self care and public health. Furthermore, we heard of the need for such services to be offered proactively to people – a list of services in a pharmacy window will not suffice – pharmacists need to be out at the front of pharmacies actively engaging in conversation with people and offering services to those coming in.

pharmacy lacks leadership and consistent vision

We have been told repeatedly that pharmacy as a profession has suffered from a lack of strong and consistent leadership. The many bodies that claim to represent pharmacy are fractured and frequently pulling in different directions. The major employers of pharmacists are private enterprises who understandably have their own agendas. This means

75. nhs alliance (2013) *Breaking boundaries. A manifesto for primary care by the MHS Alliance* www.nhsalliance.org/wp-content/uploads/2013/03/Nhs-alliance-manifesto-fiNal.pdf
76. avery aJ, rodgers s et al (2012) *A pharmacist-led information technology intervention for medication errors (PINCER): a multicentre, cluster randomised, controlled trial and cost-effectiveness analysis* the lancet vol 379 (9823) pp.1310-1319
77. Department of health (2008) speech by the rt hon alan Johnson mp, secretary of state for health *NHS Confederation Primary Care Network* webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/mediacentre/speeches/speecheslist/dh_083369

that it appears to have been difficult to unite the pharmacy profession around a single coherent narrative and direction for the future. In our work for the commission, we heard of people's encouragement in relation to the developing role of the royal pharmaceutical society as a professional leadership body, which was considered to have made sound progress in setting out direction for the profession. there was however a strong message that this now needed to be taken to the next level, with a focus on influencing the wider world of health policy and management, and other health professions.

in addition, at a national policy level pharmacy appears to be punching below its weight, often missing from significant discussions about the future of commissioning primary care, integrated care, the 24/7 hospital and urgent care. There may be structural reasons for some of this, within NHS England and the Department of Health, related to the other roles that pharmacy leaders have to play. However, in the realm of mainstream service development, pharmacy clearly needs to find more effective presence, direction and representation.

This commission has heard of many local pharmacy leaders who are developing pockets of excellent practice, but we have been struck by the apparently few mechanisms by which these local leaders can be mentored and developed alongside the wider community of clinical and managerial leaders, and given the skills to help propel the profession forward to develop, take on, and relish new roles.

pharmacy needs a more structured development pathway

The lack of a structured programme and national resource to support pharmacists in the development of new roles has been reported to this commission as a significant inhibitor to the development of new models of care. Hospital pharmacy has moved toward providing more structured career progression, although this still needs further development. in community pharmacy however, there has to date been no structured pathway to support the development of new roles in giving patient care. This lack of professional development for pharmacists currently in practice will be important to address as this is the workforce that will largely be providing new roles and models of care.

The commission heard of the positive reception being given to the new royal pharmaceutical society faculty, and this clearly has potential to be used to underpin the next phase of developing both the clinical and leadership capacity required for future models of care. the lack of pharmacist prescribers being used actively in primary care to support extended roles is testament to the fact that providing skills development is not enough.

Enabling pharmacists to have the skills and leadership to negotiate and secure funding for new roles and services is equally important, and yet more difficult to deliver, given the history of pharmacists being relatively isolated from wider management and leadership development in the NHS. the examples of where pharmacists are actively prescribing in hospital, primary care and more rarely community pharmacy provide a strong basis on which the roles of pharmacists as prescribers can be further explored with GP colleagues and clinical commissioning groups.

In hospitals and primary care, where arguably pharmacists have made most progress toward fulfilling their potential, the role of the pharmacy technician has developed in parallel. In many hospitals, technicians have taken on more of the dispensing and supply function, and in some areas other functions that pharmacists traditionally performed. This has freed up pharmacists to develop their clinical role, including as consultant pharmacists in areas of specialist care, and as core members of hospital clinical teams. There has however been little or no comparable change to the use of skill mix in community pharmacy, which is in any case harder to do in smaller organisations. Although there are no national data on community pharmacy workforce and skill mix, we heard that in many pharmacies, pharmacists still spend a considerable amount of time dispensing and checking medicines,[78] rather than providing patient services such as those set out in chapter 4 of this report. Only with effective use of skill mix in community pharmacies will pharmacists and the businesses that they work for be able to free up the time to deliver a wider range of clinical services.

78. Davies Je, taylor Dg, and Barber n. (2012). what do community pharmacists do? results from a work sampling study in london. international Journal of pharmacy practice 20: p40. [abstract at hsrpp conference, university college cork, ireland]

community pharmacists are often professionally isolated

Historically community pharmacists have been poorly integrated into local clinical teams and there is often a corresponding lack of awareness amongst other professionals about the potential impact that pharmacists can have on patients' medicines management, care and health improvement. This is exacerbated by the lack of integrated it systems. This means that when local managers, clinicians and patient groups embark on a programme of service redesign (for example for the care of people with dementia or diabetes) pharmacists are frequently overlooked or only considered in relation to supply.

in recent years there has been work to try and improve relationships and stimulate joint working between community pharmacists and general practitioners.[79] this is in recognition of the fact that this key professional relationship is often under-developed locally. This may in part be a consequence of the turnover in community pharmacy employees that has detracted from the establishment of longer term working relationships across the professions in primary care. There have also been suggestions made to this commission that pharmacists can be reluctant to engage in clinical discussions with their medical peers on an equal footing, remaining somewhat unknown and isolated. On the other hand, we have heard of community pharmacists who regularly reach out to local practices, commissioning forums and groups, and thus have been able to establish themselves as important local players in the development of services.

Primary care pharmacists (those based formerly in primary care trusts and now in clinical commissioning groups or commissioning support units) have done a lot already to break down barriers between GPs and pharmacists by working in an integrated way with GPs, nurses and the wider primary care team. Examples reported to this commission included pharmacists working with multidisciplinary teams to review GPs' patients identified as at high risk of admission to hospital because of their medicines, or working with practices to ensure that people with heart disease are on the optimum combination of medicines (and at the same time helping GP's achieve their quality and outcomes framework points). There were also examples of pharmacists more strategically helping practices to ensure that their medicines processes are robust so that changes made to patients' medicines in hospitals are safely reconciled onto the GP's prescribing system.

Community pharmacists are less likely to have experienced working in these collective or networked ways, being focused on the delivery of services in their pharmacies (which we have noted earlier are under significant economic pressure) and struggling to find the time and space to get out and develop relationships that in time could lead to the commissioning and funding of other services. This pressure seems to apply equally to pharmacists who own their business, and those working as employees of large companies or pharmacy groups.

It is of note that this 'treadmill' effect reported by community pharmacy is something that is also reported in general medical practice when exhorted to move into federated or networked models of care. This underlines the importance of pharmacy making sure that it is part of wider discussions about care futures, rather than seeking to solve its care and funding problems in isolation. Creating the time and capacity for pharmacists and GPs to get together and work on local solutions will be critical to achieving this and the royal pharmaceutical society and royal college of general practitioners joint working offers one way of starting to address this.[80]

The last two decades have seen community pharmacy slowly become more dominated by the largest provider groups.[81] at the same time, the number of locums in the workforce has grown as has the turnover rate of staff. This means that the majority of community pharmacists are now employees or locums.

The pharmacy profession should be keenly aware of factors that risk undermining local relationships, continuity of care and accessibility which are among pharmacy's key assets, and which are critical to new forms of long-term conditions care.

79. royal pharmaceutical society and royal college of general practitioners (2011) *Breaking down the barriers- how community pharmacists and GPs can work together to improve patient care* www.rpharms.com/public-affairs-pdfs/rpsrcgpjointstatement.pdf
80. royal pharmaceutical society and royal college of general practitioners (2011) *Breaking down the barriers- how community pharmacists and GPs can work together to improve patient care* www.rpharms.com/public-affairs-pdfs/rpsrcgpjointstatement.pdf
81. health and social care information centre (2012) *General Pharmaceutical Services in England: 2002-03 to 2011-12* available online at www.hscic.gov.uk/searchcatalogue?productid=9731&q=title%3a%22general+pharmaceutical+services%22&sort=relevance&size=10&page=1#top

Given these factors, it is crucial to have professional leadership which understands the importance of local relationships and can facilitate the development of local networks, Alongside support system that recognises employed pharmacists are often professionally isolated in what can be a highly competitive retail environment.

pharmacy services are not well commissioned

The absence of a coherent, strategic approach to commissioning pharmacy services, and in particular community pharmacy services, appears to have hampered the development of pharmacists in taking on a broader care-giving role. This is in contrast to the approach taken in Scotland where a systematic national policy of developing pharmaceutical care has been pursued for over a decade, with a clear intention to integrate pharmacists into the NHS as providers of patient care in areas such as minor ailments and chronic disease.

In England, whilst progress has been made in developing local services delivered through pharmacy (twenty nine thousand local enhanced services were commissioned in England in 2012-2013)[82], and some additional services have been included in the national pharmacy contract, local pilots or proof of concept initiatives have typically been subject to short-term funding that makes it difficult to move even the best initiatives forward. this has clearly been exacerbated by the periodicre organization of commissioning arrangements in the English NHS – something that is strikingly different from the organisational stability enjoyed in the Scottish NHS inrecent years.

For a profession that struggles to make its voice heard at health policy tables, the recent restructuring of the English NHS has the potential to hamper development further. However, the opportunities offered by such far reaching change should not be ignored. if pharmacists locally can be supported with guidance and strong leadership there may be opportunities for pharmacy that can be levered through new contracting mechanisms and the presence of multiple commissioners of pharmacy services (NHS England, CCGs and local authorities).

incentives and funding are not aligned to best effect

The nationally negotiated community pharmacy contract is often cited as a barrier to the development of community pharmacy. As box 4 highlights, pharmacy owners are paid a fee for every item they dispense, plus the cost of the medicines, as set by a national tariff. the bulk of the contract is activity-based, so the more medicines a pharmacy supplies

The more money it makes. Whilst attempts have been made to introduce patient-focused services through the funding of medicines use reviews and the new medicines service, these have not to date been outcome-based and the medicines use reviews in particular have attracted criticisms of being quantity, rather than quality driven, and having little focus on patient outcomes.

There have been calls for the national pharmacy contract to be better aligned with the general medical services contract used for GPs, and for the quality and outcomes framework of the general medical services contract to be extended to community pharmacy. The lack of aligned incentives can lead to perceived competition and protectionism between GPs and community pharmacists. in primary care, there can also be perceptions that pharmacists are there to save GPs money on medicines expenditure rather than improve patient care, and this perception may have held pharmacists back from working with primary care teams to design and deliver new models of care. we return to the issue of commissioning pharmacy care in chapter 6 of this report.

82. health and social care information centre (2012) *General Pharmaceutical Services in England: 2002-03 to 2011-12* available online at www.hscic.gov.uk/searchcatalogue?productid=9731&q=title%3a%22general+pharmaceutical+services%22&sort=relevance&size=10&page=1#top

key points

- pharmacists, and community pharmacists in particular, are marginalised within the NHS, and not sufficiently integrated into care teams
- there is a poor level of understanding among the public, and within the NHS, of the potential role of pharmacists, and the range of services they can provide
- pharmacy appears to have suffered from a lack of national and local leadership, which is not helped by its tendency as a profession to have multiple groups and factions, and to talk to itself more than to the wider NHS world
- much has been done to strengthen and extend the training and education of pharmacists and their teams, but this commission has heard lots about the lack of fulfilling career opportunities for new graduates and of their subsequent frustration
- at a local level, pharmacists often find themselves professionally isolated from the wider primary care team, and lacking time (or permission if employed) to engage in local health service design and development work
- community pharmacy suffers from poor commissioning of its services, with a lack of courage to fund and incentivize a strategic direction (away from reliance on dispensing and supply towards the delivery of pharmaceutical care) that appears to this commission to be broadly supported across the profession and NHS
- pharmacy is similarly marginalised in respect of its funding and contract, with little alignment of its objectives, services and future with that of general practice and other community health providers.

6. what needs to Be Done

pharmacy must advocate for its own future

The public has a high regard for pharmacy, but considers it first and foremost a service for supplying and dispensing medications, this being what most people see and experience. there is low awareness of the range of services that pharmacies increasingly provide, such as advice on minor ailments, prescribing, support for managing long-term conditions such as asthma and hypertension, and public health interventions such as smoking cessation, sexual health advice, and weight management.

This limited awareness of the existing and potential role of pharmacy is not confined to the public. There is evidence that many other health professions lack understanding of the shift that is taking place within pharmacy from a focus on the supply of medicines to a role as giver of care. where health professionals workclosely with pharmacists, As in hospital services or when pharmacists are employed by general practice or clinical commissioning groups, the potential of pharmacy to enhance patient care and wider professional practice is appreciated and understood. Without such direct experience, however, pharmacy remains something of an unknown and misunderstood profession.

The work of this commission has revealed the relative lack of knowledge about pharmacy within mainstream health policy and management circles. One has to conclude that pharmacy in England has to date struggled to have an impact on the broader health service and policy stage. in interviews with non-pharmacy stakeholders, we heard repeatedly of the marginal nature of pharmacy as a profession, and the fact that pharmacy seems to spend too much time 'talking to itself'. This is easy for pharmacy to do, given the many organisations claiming to represent its interests. the large number of groups arguably gives the profession the ability to distract itself with complex

Internal politics and debates, thus avoiding the challenge of taking up leadership of the profession and its core purpose at a local and national level. It was however striking that in the work of this commission, there was a strong sense of consensus from across the pharmacy profession about the importance of focusing on the provision of a wider range of pharmaceutical care services. This makes the lack of impact by pharmacy in the wider health policy and organisational world even more puzzling – the vision seems to be shared, yet implementation seems to have been just too difficult to make happen.

It is pharmacy itself that has to address this lack of public, professional and policy understanding of its role, purpose and potential by providing a strong, clear and consistent narrative. local and national leaders of pharmacy have to spell out relentlessly, in practical terms (and using language that non-pharmacists readily understand), the nature of 'pharmaceutical care' or 'medicines optimisation', explaining the services people should expect to receive from pharmacists in the community and in hospital. people need to know that they can have their blood pressure tested and monitored by a pharmacist, medication reviewed and re-prescribed, smoking cessation advice and treatment given, flu jab administered, asthma inhaler technique reviewed and support given, and use the community pharmacy as the first port of call for minor ailments and c ommon health issues.

This narrative of pharmacists as care-givers has to become the 'golden thread' running through all policy and organisational announcements made about pharmacy's future. it is not sufficient for this to be in one or two Department of health or royal pharmaceutical society policy documents, it has to be at the core of the story that pharmacists tell the public, patients, carers, and health and social care professionals, at every available opportunity. Only if pharmacy believes and owns this view of its future will others understand and sign up to it.

pharmacy must continue to develop the provision of direct patient services

however powerful and clear the narrative, what will enable people to understand the wider and future role of pharmacy will be experience of a broader range of services. Pharmacy has to find ways to deliver its future, with a much stronger focus on care-giving (health, social care and public health), a modern approach to dispensing and supply that takes full advantage of new technology and skill-mix, and working

constantly to find ways of becoming better integrated into primary, secondary and social care teams.

There are plenty of documents stretching back to the 1970s that set out a vision for pharmacy. What it needs now is to focus on putting this into practice (and not waiting for permission to do this), using the many tools, contracts, and policies available. the fact that so many hospitals, primary care organisations and community pharmacies have developed the models of care described in chapter 4 shows that as William Gibson said 'the future is here, it's just not very evenly distributed'.[83]

The current NHS policy context of constrained funding, concerns about quality and safety, rising incidence of long-term conditions, and debate about access to effective out-of-hours and urgent care provides pharmacy with an excellent opportunity to propose and enact local and national service solutions.

to take full advantage of this wider policy context, local leaders of pharmacy (such as those on the new local professional networks established by NHS England)[84] need to make sure that they work closely with urgent care boards, clinical commissioning groups, and local area teams of NHS England in designing and procuring new forms of urgent and out-of-hours care. pharmacists in primary, community and secondary care need to be ready, alongside GP, nursing, consultant, ambulance and social care colleagues to bid for contracts to provide new local services. this entails pharmacists forming local provider networks (as groups of pharmacists, or in collectives with other health professionals such as GP or primary care federations) as the entity that can bid and deliver new services. Pharmacy needs to be proactive in setting out what it can do, how and for what resource – waiting to be asked will not work.

Community pharmacy is open long hours (some for 100 hours a week), and is considered accessible to the public, being present in most communities, including those very deprived areas where general practice may be absent. pharmacies must currently have a pharmacist present in order to supply medicines, and although this means that a highly trained professional is on site for 100 hours a week, the pharmacist will only have time and capacity to deliver care services if more judicious use is made of skill-mix, for example by combining robotic dispensing with the use of accredited technicians. with thoughtful use of technology and skill-mix, pharmacists can be freed up to become a more extensive care giver, and pharmacies could assume the role of 'local health hub', ideally within a wider primary and urgent care network.

stronger local and national leadership of pharmacy is needed

Pharmacy is crying out for strong, assertive and consistent leadership at a national and local level. The President of the Royal Pharmaceutical Society, and the Chair of the English Pharmacy Board, need to have the presence and reputations of presidents and chairs of a major medical royal college, representing as they do the third largest group of health professionals in the NHS. The lack of presence and standing of the profession within health policy and management circles reveals an absence of effective direction for and influence by the profession in what is a crowded and complicated policy arena. What is not however needed is a blame game by the many different organisations claiming to lead or represent pharmacy.

Instead, the royal pharmaceutical society should seize the opportunity presented by its establishment of this commission to draw together a 'leaders' forum' of those willing innovative individuals from different parts of the profession who share the vision of pharmacists as care-givers, and are enthused about getting on and making this happen across health and social care. this forum should lead the development of a narrative for the future of pharmacy, support the roll-out of new models of care, take every opportunity to engage actively in health policy and management circles, and accept that such leadership will not always be popular, but is critical to assure a vibrant future for pharmacy as a caring profession much less reliant on the supply and dispensing of medicines.

local leadership is equally as important as national leadership, and the new local professional networks established by NHS England offer a real opportunity here, especially given the loss of former pharmacy networks that occurred during the 2013 NHS reforms. Local professional networks must be formed of innovative, risk-taking pharmacists who share the vision of pharmacists as advocates of better medicines use and direct service providers in the NHS and social care. these local leaders

83. the economist, December 4, 2003
84. geddes D and pritchard s (2012) local professional networks (lpns) nhs england available online at www.england.nhs.uk/ourwork/d-com/primary-care-comm/lpn/

are the ones who can share that vision with GPs, consultants, nurses and allied health professionals, spotting opportunities to design, bid for and provide new forms of health and social care involving pharmacy.

this commission has been very struck by the relative lack of investment in and development of leaders within pharmacy, and the under-representation of pharmacists on (and ineligibility of community pharmacists to apply for) national leadership development programmes such as the extensive new suite of programmes recently established by the NHS leadership academy.[85] there is an urgent need for investment in leadership development for a new cohort of pharmacy leaders emerging through local professional networks and new models of care, and for professional facilitation and coaching support to be offered to them, including the provision of advice and skills development
in how to work with and in wider health care teams, and support in how to design, bid for and deliver new forms of service. these local leaders should be encouraged and supported to explore ways in which they might develop pharmacy consortia or networks, or join GP federations and networks, for this offers significant promise for pharmacists (like GPs) to gain the economies and benefits of providing new forms of care at scale.[86]

bold commissioning of pharmacy services is vital

there is a need for bold commissioning of pharmacy services that focuses on the delivery of care within a wider strategy for the future of primary and community health and social care. in pragmatic terms, this could start to be put in place initially through locally commissioned (enhanced) and nationally commissioned advanced services (e.g. for common ailments) as part of the current community pharmacy contract.

Subsequent to this, there will likely be a need for bold decisions on the part of nhs england and the Department of health (the Department of health retains responsibility for reimbursement of community pharmacies) about how national contracting for community pharmacy will go forward, and how the balance of dispensing and supply, compared with medicines optimisation services will be struck within a newly commissioned modern pharmacy service that can meet the health needs of the population in a changing and financially constrained NHS. in the medium to long term there will likely be a need for a new outcomes- based alternative contract for general practice and primary care – and pharmacy needs to consider being a core part of this, rather than remaining to one side and potentially becoming further marginalised - that can be assumed by a group or network of primary care professionals (including pharmacists) to deliver a set of local health services for a population, or services for a specific condition (e.g. asthma) or client group (frail elderly housebound). this could perhaps draw on recent king's fund and nuffield trust work on design principles for primary care, focusing on the needs of patients and the population in determining the shape of services to be commissioned.[87]

any new contract for community pharmacy should be developed in tandem with changes to, or an alternative, general medical services contract that gives local doctors, pharmacists and other professionals the scope to assume population-based funding with which to deliver a wider range of primary and other care. commissioners at NHS England and in clinical commissioning groups will need detailed advice from local professional networks on how to commission care delivered through pharmacy as part of wider plans for primary, long-term conditions and urgent care.

There is currently significant interest in a new or revised contract for general practice, and in the strategic development of primary and integrated care. this presents a particular opportunity for pharmacy to either align its own contract and funding to the strategic direction of other primary care, or to even plan how to form part of a wider primary care contract. pharmacy will however find itself side-lined in the development of new services and contracts for primary care, unless pharmacists at both local and national level engage actively in advocacy and influencing, offering specifications for services that can be offered and solutions to local health and funding problems. large multiple pharmacy providers have an important role to play here, given their organisational capacity to plan and put in place significantly different models of care at scale and pace. But if pharmacy waits to be asked to the negotiating and policy development table, it will be waiting for a long time.

85. nhs leadership academy www.leadershipacademy.nhs.uk/grow/leadership-development-programmes/
86. smith J, holder h et al (2013) *Securing the future of general practice: new models of primary care* london: nuffield trust www.nuffieldtrust.org.uk/publications/securing-future-general-practice
87. smith J, holder h et al (2013) *Securing the future of general practice: new models of primary care* london: nuffield trust www.nuffieldtrust.org.uk/publications/securing-future-general-practice

there is a range of contractual opportunities for pharmacists

the policy of 'any Qualified provider' offers the potential for consortia of pharmacists (either from community pharmacy, or from a mix of hospital, community and primary care) to make offers to local health and social care commissioners, or bid for contracts to deliver services such as minor ailments, obesity management, alcohol advice, sexual health, and smoking cessation. pharmacists should make such offers to local authorities, NHS England area teams and clinical commissioning groups, and use the health and wellbeing board as a forum to advocate for what pharmacy can do with and for health and social care. it is worth noting that other contractual arrangements, such as local pharmaceutical services,[88] remain on the statute book and could be used to commission new extended local services.

Pharmacies are registered with the general Pharmaceutical Council as providers of NHS care, so are legitimate bidders for any Qualified provider, and also local pharmaceutical services contracts. They are located at the heart of local shopping areas, close to general practices, open typically long hours, and have to have a pharmacist present on the premises, thus offering a professionally-led and accessible primary care service. this can be extended using any Qualified provider contracts alongside locally commissioned enhanced services. the challenge for pharmacists is to work in local professional networks and consortia to determine how best to secure funding for services not usually associated with pharmacy. Local professional networks need to focus on how they can design, fund and deliver extended local services, and avoid the temptation of being drawn into endless commentary on the plans of others in the commissioning system. Local professional networks, and national bodies such as the royal pharmaceutical society, with the support of trade bodies and pharmacy owners, should assume a role in advising local groups of pharmacists in how to design, bid for and manage new forms of care.

Commissioning through any Qualified provider, and any new alternative contract for primary care or pharmacy should have the possibility of being undertaken with individual primary, community and/or hospital pharmacists (acting as consortia, community interest companies, partnerships etc.) as well as with pharmacy employers or provider groups (known as 'multiples'). Pharmacists need to be able to regain status as individual professionals, and to do this, may wish to form professional chambers, companies or networks in the way that barristers and other professionals operate, and some GPs are starting to do for the purpose of securing contracts for service provision. This may entail different pharmacy contracts for supply and care. indeed, the future may see two 'tiers' of pharmacists, those who focus on the supply and dispensing of medicines, and those who take on additional care-giving roles, including prescribing, public health work, and management of long-term conditions and common ailments.

local authorities are important new commissioners of services

Pharmacy has the potential to be commissioned by local government social services and/or clinical commissioning groups to provide bespoke pharmaceutical care to vulnerable older people in nursing and residential homes, and to those served by home care agencies. this could include support when prescribed new drugs, on-going review and supervision of medicines, repeat prescribing, training for social and nursing care staff, and advice to care providers on medicines use, side effects, and storage.

there is a powerful case to be made by pharmacists for such a role, based on the error rate for medicines in residential and nursing home care,[89] and the potential of offering tailored pharmaceutical care services to social care and its staff. whilst many pharmacies already deliver medicines to older people's homes, there is not often any follow-up supervision in respect of whether the drugs are taken properly, monitoring of side effects, advice to carers about medicines use as part of wider primary care for an individual.

Pharmacy can increasingly become a local public health provider, being located in many communities, open long hours, and trusted by the public. Between them, local authorities and clinical commissioning groups could commission pharmacies (individually or in consortia)

88. national health service (primary care) act 1997 www.legislation.gov.uk/ukpga/1997/46/part/ii/crossheading/pharmaceutical-services
89. Barber nD, alldred Dp et al (2009) *Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people* Quality and safety in health care Vol 18 pp.341-346

to deliver a range of preventive, lifestyle and long-term conditions services. pharmacy thus can become a 'local health hub' as part of a wider primary and community health network, and a form core part of neighbourhood renewal if it works more closely with communities to engage disadvantaged and marginalised people.

New roles and consortia must be developed by pharmacists

Primary care pharmacists in general practice, the former primary care trusts, and now clinical commissioning groups and commissioning support units, have shown how new roles can be developed which offer professional autonomy, significant team working with other health professionals, and the ability to influence care at a patient and population level. local professional networks need to explore how to extend primary care pharmacist roles within GP federations and networks, namely within the provision, as well as commissioning domain of general practice.

Some 'scaled up' general practice organisations such as super-partnerships (e.g. the Vitality partnership in Birmingham and the own health partnership in Sandwell), multi-practice organisations (e.g. the Hurley group in London) and community health organisations (e.g. Bromley-by-Bow in Tower Hamlets) have elected to employ or contract with pharmacists to deliver medicines management and other advice and support to both professionals and patients within the population covered by these organisations.

Community pharmacy may in some cases become the 'health hub' for the local population, employing or contracting for sessions of other health professionals' time, including nurses, doctors, podiatrists and health educators. In other cases, pharmacists will need to move into general practice and become co-located with, or employed by or contracted to, local primary care teams .outpatient) hospital pharmacy services.

Secondary care pharmacy has to some extent led the way in terms of developing pharmacy services, modernising supply and dispensing, demonstrating clinical and business effectiveness, and gaining clinical and managerial stature within NHS trusts and foundation trusts. as primary care 'scales up' to meet the challenges of the decade of austerity, improved care quality, and rising demand for out-of-hospital care, so primary care pharmacists need to be at the heart of planning new general practice, pharmacy and other primary care services for local populations.

federations or consortia offer pharmacists the same benefits offered to GPs by these provider networks. the autonomy of individual practitioners or organisations can be preserved, whilst gaining benefits of scale such as support for clinical governance, management infrastructure to bid for and run new service contracts, and a population base to deliver a wider range of services across the network.

NHS and foundation trusts can become providers of community and primary care pharmacy

There is potential for NHS trusts and foundation trusts to develop local primary care pharmacy services (especially if community pharmacy proves unable or unwilling to do so), extending trust pharmacy services into the community, especially for frail older people, as has been the case in Northumbria and at the Whittington hospital in London. Commissioners and local professional networks, as well as hospital providers themselves should explore the option of trusts and foundation trusts as providers of primary care pharmacy services, using any alternative contract that is developed for pharmacy and general medical services.

The boundaries between community and hospital health services are blurring as a result of the transforming community services policy[90] which has seen many hospital or mental health providers take on the management of community health care. in a similar vein, some pharmacy groups (the 'multiples') are running aspects of (usually Just as there will likely be variation in how community pharmacy and general practice develop more integrated services (perhaps with more pharmacists becoming employed by or partners in general practice – see Box 9), so we may see different approaches to the development of pharmaceutical and other care across the hospital and community sectors.

90. Department of health (2006) *Our health, out care, our say: a new direction for community services* london: the stationery office www.official-documents.gov.uk/document/cm67/6737/6737.pdf

91. royal pharmaceutical society (2013) submission cited in the final report of the rps future models of care commission. london www.rpharms.com/futuremodels

pharmacists must seize the opportunities of technology and skill-mix

Technology is already changing the structure of the supply and dispensing role of pharmacy, as electronic prescribing, robotic dispensing, and new forms of supply chain become widespread. Change of this nature is likely to lead to major structural and skill-mix changes to community pharmacy services, with strong similarities to what has happened with local bookshops and travel agents as a result of on-line sale, supply and distribution. Technology is the potential saviour of community pharmacy, if the profession is able to design and embrace new forms of supply and dispensing and roles for staff, whilst advocating for, and persuading commissioners to purchase, its role in advice and support on medicines use, prescribing, management of long-term conditions, treatment of minor ailments, and support for public health work.

Many of the services and models of care submitted to the commission call for integration of patient records as the basis for enabling pharmacy to assume a fuller role within integrated pathways of care for patients. the commission has heard that the technology is already available that allows pharmacists working from a laptop access to the patient's GP record (see Box 9), and it is of note that in Scotland, community pharmacies and GP practices are all electronically linked and that this is being used for the management of medicines in patients with long-term conditions, and for the minor ailments service (see Box 5).

it will be important for pharmacists to embrace opportunities offered by the many routes of communication now available.
Skype, text messaging and the telephone are all tools that pharmacists could use to provide support services. in 2008, one in three Finnish community pharmacies were offering their patients the opportunity for medication counselling by email.[92] similarly some pharmacy chains in the united states are offering people the opportunity to 'live chat' with a pharmacist on their internet sites. the opportunity to 'live chat' with pharmacists (about contraception or colds and flu) will also form part of a new online service to be launched by NHS England.[93]

There are lessons to be drawn from the us in this regard, where pharmacists in Walgreens outlets are being brought out to the front of pharmacy stores to offer patient-facing care and advice alongside care navigators, whilst technicians dispense drugs with the support of new robotic technology. Walgreens are also partners in some accountable care organisation pilots, these being pilots where groups of health providers take on a risk-based capitated budget with which to give health care to a defined population. this points again the way to how pharmacies in England could form consortia or federations with GPs and others to assume responsibility for managing care for a population or client group, especially if freed from some of the current workload associated with dispensing and supply of medicines.

If NHS England is prepared to commission a different balance of dispensing, supply and pharmaceutical care, pharmacy employers will need to ensure that they craft roles and careers that are professionally satisfying and assure autonomy for pharmacists in becoming care givers, consultants, prescribers, and public health professionals. this applies equally to hospitals, community pharmacy employers, clinical commissioning groups, general practice organisations and independent pharmacies, for care is increasingly delivered across organisational boundaries, and the dominant health policy direction at present is that of enabling more integrated care for people with complex needs, whether elderly, in a vulnerable family, or living with mental health problems.

there has been more than enough analysis of pharmacy – now action is needed

pharmacy is in some ways its own worst enemy, having spent over 20 years pointing out that it is under-utilised, writing plans and visions for the future, yet seeming unable to influence in a significant manner the commissioning and implementation of this alternative world.

The work of this commission has revealed many examples of innovative new services delivered through pharmacy, these having been put in place using existing funding and contractual mechanisms. They bear witness to the

92. pohjanoksa-mäntylä mk et al (2008) email medication counseling services provided by finnish community pharmacies ann pharmacother Vol 42(12) pp 1782-90. www.ncbi.nlm.nih.gov/pubmed/19033478
93. e health insider (2013) *Supply options outlined for renamed ICSP*. www.ehi.co.uk/news/primary-care/8888/supply-options-outlined-for-renamed-icsp

initiative of individual pharmacists and their teams, bold local commissioners, and a local culture of 'let's just do it'. this 'can-do' approach needs to be adopted by pharmacy at a local and national level, with strong advocacy about how pharmacy is changing (and is ready to change further) to meet technological, service and professional needs, and how new services will be experienced by patients and the wider population.

Advocacy has however to be supported by action, and pharmacy must get on with this, influencing NHS England, clinical commissioning groups and local authorities to fund new services, using existing contractual mechanisms where possible, and pushing at the boundaries of innovation in organisation and management to call for new funding and contractual approaches alongside GPs and others.

There are important changes required at a national policy level to support pharmacy to rebalance its work to focus more strongly on medicines management and other direct patient care. These include a new alternative contract for population-based care (either for pharmacy, or along with GPs and others), the ability for pharmacists (as individuals or in groups) rather than owners/employers to hold contracts for pharmaceutical care, a national primary care strategy that embraces the potential of pharmacy alongside that of general practice and nursing, and bold and imaginative commissioning that supports new models of integrated patient care.

The main challenge from this commission is however for pharmacy itself. The profession has to strengthen its leadership at a local and national level, and advocate for its actual and potential role in giving care to a much wider range of people. Pharmacy and its leaders need to achieve the visibility of national medical and nursing organisations in the media and across the NHS, and at a local level, use all available funding and contractual mechanisms to set up new services focused on pharmaceutical care. Only then will the public and other health professionals understand the full potential offered by pharmacy.

7. recommendations

The commission found widespread support for the idea of pharmacy extending its role and focusing more on the provision of services to patients and the public. analysis by pharmacy of what this might look like has not been in short supply over the years, the direction of travel is clear, and yet progress in making change remains far too slow.

Drawing on submissions to the commission, published research, and conversations with pharmacists and others in the broader health and care system, we set out here what needs to be done to enable the shift towards a greater role for pharmacy in delivering patient care. the commission has developed recommendations about the changes needed if pharmacy is to flourish in the future and offer the population the range of services it should rightly expect.

recommendations to pharmacists

Pharmacists and their employers must recognise the imperative to shift their focus away from dispensing and supply of medicines towards providing a broader range of services. They must see their ultimate goal as helping people get the most from their medicines and keeping them healthy.

pharmacists and employers should not wait for national solutions but should drive change at a local level, proving their case for service provision to clinical commissioning groups, local area teams and local government commissioners by making and winning tenders.

Pharmacists must appreciate the financial constraint and intense scrutiny of quality facing the NHS. They must show how they can meet patient needs better and more efficiently than many existing providers. This will have to be done by developing new services through reallocation of existing funding: there will be no new money.

Pharmacists must collaborate with each other across community social, secondary and tertiary care and with other healthcare professions, to develop models of care which enable commissioners to deliver integrated patient pathways, and ensure patients have consistent access to support with medicines use as they move between care settings.

Pharmacists should develop networks or professional 'chambers' to pool the expertise, influence and managerial capacity they will need to develop proposals, deliver larger scale services, and work with the increasingly influential federations, networks and super-partnerships in general practice.

recommendations to NHS England, Public Health England, and the department of health

NHS England and Public Health England should work with the Royal Pharmaceutical Society and other leaders of the profession to drive a consistent vision of the future of pharmacy.

NHS England and Public Health England must include pharmacy in plans for the future of out-of-hours and urgent care, public health, and the management of long-term conditions. they will likely need the help of pharmacy leaders here, and should consider seconding innovative local pharmacy leaders into central organisations to provide support.

The Department of Health must take account of the role that pharmacy can play when planning initiatives such as the integration transformation fund and the 2014-15 accident and emergency fund.

Nationally and locally, NHS England and its local area teams should convene relevant bodies to support and share pilots of new models of care that involve pharmacy. Their goal should be to demonstrate how existing mechanisms such as local pharmaceutical services, enhanced services, any qualified provider, and clinical commissioning group and local government contracts can be used to deliver alternative forms of care.

NHS England should use its national commissioning role for pharmacy to continue changing the balance of funding from dispensing and supply towards medicines optimisation and the provision of new forms of patient care. This may include the possibility of community pharmacy having separate core contracts for dispensing and supply on the one hand, and for service provision in a broader primary care context on the other.

there should be openness by NHS England to pharmacists holding these contracts as professionals, perhaps through networks or chambers, rather than through their employers.

NHS England must be bold in thinking about how pharmacy can form part of any new local population-based contract for primary medical and other care and how the incentives in pharmacy and medical contracts can be aligned. This should include giving full backing to primary care federations, networks and super-partnerships which include pharmacists.

NHS England's pharmacy team needs to ensure that pharmacy forms a core part of discussions and plans about integrated patient records, so that pharmacists can be a central part of new models of urgent, out-of-hours and long-term conditions care in particular.

The Department of health should work with the NHS leadership academy and NHS England to ensure that pharmacists (and those in the community in particular) have full access to the leadership programmes and resources available to other clinical professions.

recommendations to local commissioners

Clinical commissioning groups should draw on the potential of pharmacy to improve local services, particularly in response to challenges such as urgent care, out-of-hours primary care, and the need to coordinate care for frail elderly (and other) people living with multiple conditions.

Local authorities and health and wellbeing boards should study the best examples of provision by pharmacy as they commission public health and social care services. Pharmacy has a central role to play in the delivery of safe and high quality care to people in nursing and residential homes, and to those receiving domiciliary social care.

recommendations to the royal pharmaceutical society and leaders of the profession

The royal pharmaceutical society and other leaders of the profession (and there are many of these) should unite around a clear narrative of the role, purpose and potential of pharmacy.

The royal pharmaceutical society must raise public and wider NHS and social care awareness of what people should expect from pharmacy, at the same time making the case for a shift in the focus of funding from dispensing and supply to services that support the effective use of medicines and help people stay healthy.

Pharmacists need stronger, more focused professional leadership, nationally and locally. The royal pharmaceutical society should work with other innovative pharmacy leaders to support networks of emerging pharmacy leaders. It should consider drawing together a leaders' forum made up of those committed to reshaping pharmacy as a care-giving profession of equal status and profile to medicine and nursing.

The royal pharmaceutical society should accept accountability for moving the profession forward towards a future focused on care delivery, and influencing commissioners and policy makers to enable this. as part of this, it should ask this commission to reconvene in six months, and again in twelve months, to review progress against these recommendations and to report publicly on this.

appendix 1. contributors to the report

individuals interviewed (by the chair of the commission or the project lead)

Dr Kate Ardern, Director of Public Health Wigan Council Sue Ambler, Head of Education And Training, Health Education England
Emma Baggaley, Senior Pharmacist, City Health Care Partnership Cic
Dr Philip Brown, Chair of the Courts Pharmacy Group and Former Chair of the Council of The Ucl School Of Pharmacy Sibby Buckle, English Pharmacy Board Member, Community Pharmacist
Alistair Buxton , Head Of NHS Services, Pharmaceutical Services and Negotiating Committee
Nigel Clarke, Senior Partner, Learned Lion Partners and Chair, Inquiry into the Future Professional Body For Pharmacy
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Dr James Kingsland, General Practitioner, President of National Association of Primary Care.
Mike Farrar, Chief Executive, NHS Confederation [When Interviewed].
John Foreman, Green Light Pharmacy
Stephen Gough, Local Professional Networks Lead, Lancashire, NHS England
Ken Jarrold, Chair, Medicines Legislation and Pharmacy Regulation Programme Board
Manjit Jhooty, Managing Director, Jhoots Pharmacy
Mark Koziol , Chair, Pharmacists Defence Association
Geraint Lewis, Chief Data Officer, NHS England
Fin Mccaul, Chair, Independent Pharmacy Federation
Alistair Murray, Green Light Pharmacy
Niall Murray, Community Pharmacist
Bob Nicholls, Chair, General Pharmaceutical Council Dr Keith Ridge, Chief Pharmaceutical Officer, Supporting NHS England, Department of Health And Health Education England
Mark Robinson, Medicines Management Partnership, Special Advisor (Pharmacy, Medicines And Medicines Optimisation) NHS Alliance
Gul Root, Principal Pharmaceutical Officer, Department Of Health
Drkarenerosenbloom, Clinical effectiveness lead, Hertfordshire LPC
Bill Scott, Chief Pharmaceutical Officer, Scotland
Sue Sharpe, Chief Executive, Pharmaceutical Services And Negotiating Committee
Liz Stafford, External Relations and Policy Development Manager, Rowlands Pharmacy
Anita Sheth, Senior Pharmacist, Central London Community Healthcare
Ash Soni , Vice Chair English Pharmacy Board
Richard Taunt , Deputy Director, NHS Policy & Strategy Unit Department Of Health [When Interviewed]
David Taylor , Professor Of Pharmaceutical And Public Health Policy, University College London
Richard Wells, Superintendent Pharmacist, Weldricks Pharmacy
Liesel Wett, Chief Executive, Pharmaceutical Society of Australia
Paula Wilkinson, Chief Pharmacist, Mid Essex Clinical Commissioning Group

individuals attending the manchester event on 1 may 2013

Sadaf Adnan, Patient, Healthcare Projects Coordinator Epilepsy Action
Elizabeth Allen, Patient, British Association of Skin Camouflage
Jan Bassey, Greater Manchester Local Practice Forum Dawn Bell, University Hospital of South Manchester NHS Foundation Trust
Dianne Bell, Senior Medicines Management Pharmacist, Community Services Medicines Management Team, Central Manchester University Hospitals Nhs Foundation Trust
Petra Brown, Chief Pharmacist, Manchester Mental Health and Social Care Trust
Dr Helen Burgess, General Practitioner, Ladybarn Group Practice and clinical lead For Medicines management, South Manchester CCG.
Lynne Calvert, Manager For Health Improvement & Neighbourhoods, Wigan Council
Alan Campbell, Patient, Diabetes Voices
Phil Conley, Public Health England
Chris Cutts, Director, Centre For Pharmacy Postgraduate Education
Jane Devenish, Clinical Service Development Lead, The Co-Operative Pharmacy Representing Community Pharmacy Future
Rob Duncombe, Chief Pharmacist, The Christie NHS Foundation Trust
Dr Peter Elton, Director Of Public Health, Bury Council
Dr Rebecca Elvey, Research Associate, School of Pharmacy And Pharmaceutical Sciences, The University Of Manchester Alistair Gray, Clinical Services Lead Pharmacist,
East Lancashire Hospitals NHS Trust
Dr Nicola Gray, Pharmacist and Director, Green Line Consulting Limited
Nick Guerin, Patient, Diabetes Voices
Kath Gulson, Healthcare Development Manager, Boots Uk, Representing Community Pharmacy Future
Dr Devina Halsall, Research Fellow, Manchester School Of Pharmacy, University Of Manchester
David Hamilton, Staff Governor, the Christie NHS Foundation Trust
Dr Amir Hamman, General Practitioner, Haughton Thornley Medical Centres And CCG Board Member With Lead Responsibility For Long Term Conditions, Information Management And Technology And Patient Engagement/ Empowerment, Tameside And Glossop

Nigel Hughes, Community Pharmacy West Yorkshire David Hume, Patient, Diabetes Voices
Dr Carianne Hunt, Research Fellow, Nihr Clahrc For Greater Manchester
Dr Raj Kumar, Clinical Leaders Network and Department of Health
David Lee, Patient, Epilepsy Society
Amy Lepiorz, Quality And Qipp Manager – Optometry And Pharmacy, Greater Manchester Area Team
Helen Liddell, Head of Medicines Management, Leeds South and East CCG
Kay Marshall, University Of Manchester, School Of Pharmacy Fin Mccaul, Chairman, Independent Pharmacy Federation Ann Mccrystal, Carer
Dr Ivor Nathan , Lay Rep, Nice
Susan Newsham, Arthritis Care
Nicky Patel, Pennine Care Foundation Trust Bruce Prentice, Ashton Leigh and Wigan Local Pharmaceutical Committee
Liz Stafford, Rowlands Pharmacy
Emma Street, Lead Nurse – Medicines Management And Non-Medical Prescribing, Manchester Mental Health And Social Care Trust
Rosemary Wheeler, Team Manager, Intermediate Care, Stockport Foundation Trust

individuals attending the birmingham round table on 10 september 13

Dr Arun Ahluwalia, Birmingham City Council
Alison Blenkinsopp, Professor of The Practice Of Pharmacy, University Of Bradford
Corinne Boulnois, third year pharmacy student, Aston University
Dr Jamie Coleman, Consultant in Clinical Pharmacology, University of Birmingham
James Davies, University College London, School Of Pharmacy Nadia Hussain, Third Year Pharmacy Student, Aston University
Manjit Jhooty, Managing Director, Jhoots Pharmacy
Rajinder Kaur, Community Pharmacist (Superdrug)
Mark Koziol, Chair, Pharmacists Defence Association
Cheryl Mcgreevy, Community Pharmacist (Rowlands) Richard Seal, Chair Of Birmingham And Solihull Local Practice Forum
Priya Warner, Head Of Standards and Fitness to Practise Policy, General Pharmaceutical Council

submissions to the 'tell us what you think' submissions process

All the submissions to the commission that can be made public (as determined by the individual submitting) are available on the rps website. the submissions cited in the report are also available in a separate document. We thank all the individuals and organisations who submitted.

The individual names and organisations submitting are listed here.

individuals: Alisdair Jones; Alyson Elliman; Andrew Low; Andrew Peers; Anees Al-Mushadani; Barbara Jesson; Barbara Lynn Haygarth; Barry Ireland; Bassam Bekdash; Brian Cremin; Bridget Coleman; Carina Livingstone; Caroline Parker; Catherine Leon; Chetan Shah; Chris Hetherington; Christopher Rose; David Branford; David Campbell; David Green; David Ogden; Dianne Bell; Dianne Sanderson; David Campbell; Dr Andrew Mcdowell; Dr Caroline Jessel; Dr H Burgess; Dr Nuttan Tanna; Elaine Weston; Eileen Nielson; Elizabeth Beech; Evelyn Frank; Fay Hartley; Fiona Smith; Gabriela Peterlin; Gemma Dowell; Girish Mehta; Graham Phillips; Graham Walker; Hannah Wilton; Helen Taylor; Helen Williams; Helen Wilson; If Chan; Inderjit Sanghera; Jackie Lewis; Jaime Whiteside; Janet Rittman; Jayesh Shah; Jennifer Southern; Joanne Bartlett; Karen Acott; Karen Barker; Kath Mitchell; Kieran Hand; Chris Howland Harris; Laura O'loan; Lelly Oboh; Leon O'hagan; Lesley Tasker; Linda Dodds; Marianne Price; Martin Astbury; Dr Martin Johnson; Mark Tomlin; Martin Phillips; Martin Roland; Michael Twigg; Mike Hedley; Neil Shepherd; Neil Watson; Niall Murray; Nicola Gray; Nina Barnett; Parag Oza; Paula Wilkinson; Peter Marshall; Peter Rivers; Petra Brown; Philippa Hill; Prof Dk Theo Raynor; Rebecca Chennels; Rena Amin; Richard Seal; Richard Shircore; Richard Sykes; Rob Wise; Ruth Bosch; Sara Dilks; Sarah Leaver; Shaun Hockey; Stephen Riley; Steve Acres; Sue Schechter; Sundip Gill; Susan Keeling; Toby James; Ulrike Dewhurst; Una Laverty; Unoma Okoli.

Organisations: 2020health; association of pharmacy technicians (uk); asthma uk; Barnsley hospital nhs foundation trust; Boots the chemist; British pharmaceutical students association; calderdale and huddersfield nhs foundation trust; celesio uk; central and north west london nhs foundation trust; central manchester university hospitals nhs foundation trust; college of mental health pharmacy; coastal west sussex clinicalcommissioning group; community pharmacy future project; croydon clinical commissioning group; Diabetes uk; ealing hospital nhs trust; east and south east england specialist pharmacy services; faculty of sexual and reproductive healthcare; general pharmaceutical council; guys and st thomas nhs foundation trust; injectable medicines guide website (medusa); John taylor hospice social enterprise cic; leeds teaching hospital nhs trust; manchester mental health and social care trust; medicines use and safety team, east and south east england specialist pharmacy services; national institute for health and care excellence; nhs alliance; nhs confederation; nhs england surrey and sussex team; norfolk medicines support service; north west london hospitals nhs trust – pharmacy Dept; north west london hospitals trust; northern Devon healthcare nhs trust; northumbria healthcare foundation trust; northwest london hospitals nhs trust pharmacy; pharmacists' Defence association; pharmaceutical services negotiating committee; pharmacy Voices; royal college of nursing; royal society for public health; rowlands pharmacies; school of pharmacy, university of nottingham; south east england specialist pharmacy services; south warwickshire nhs foundation trust; southern health foundation nhs trust; st george's healthcare nhs trust; the company chemists association; the performance coach; the pharmacy schools council; the english pharmacy Board, royal pharmaceutical society; the scottish pharmacy Board, royal pharmaceutical society; united kingdom clinical pharmacy association.

appendix 2.
members of the expert advisory group

Professor Tony Avery, professor of primary health care, faculty of medicine & health sciences, university of Nottingham
Professor Nick Barber , Director of Research & Evaluation, Health Foundation
Professor Alison Blenkinsopp , Professor Of The Practice Of Pharmacy, University pf Bradford
David Chandler, patient representative
Professor David Colin-Thomé, G P, chair, primary care commissioning and former Director of primary care
Chris Howland-Harris , community pharmacist
Clare Howard, Deputy Chief Pharmaceutical Officer, NHS England
Professor Sue Latter, Professor of Nursing, University of Southampton
Dr Johnny Marshall, GP and interim partnership Development Director for NHS clinical commissioners David Martin, patient representative
Cllr Jonathan Mcshane, local government authority – public health lead
Martin Stephens, Associate Medical Director for clinical effectiveness, University Hospital Southampton Tracey Thornley, Senior Research And Development Manager, Boots uk
Dr Nicola Walsh, assistant Director, leadership Development, the king's fund
Helen Williams, consultant pharmacist for cardiovascular Disease, Southwark health and social care/south London cardiac and stroke networks

Notes

Notes

ROYAL PHARMACEUTICAL SOCIETY England

Shaping pharmacy for the future

Pharmacist access to the Patient Health Record

The Royal Pharmaceutical Society (RPS) believes that all pharmacists should have full read and write access to the patient health record in the interest of high quality, safe and effective patient care.

Introduction

Access to the patient's health record, their laboratory results and previous treatment with medicines is routine for pharmacists working in hospitals. These pharmacists would consider their practice unsafe to have no such access.

In August 2014, according to new research from YouGov[1], an overwhelming majority of the British public, 85%, said they want any healthcare professional treating them to have secure electronic access to key data from the GP record.

We believe that there should be full read and write access to the patient health record by all pharmacists, but are aware that this could be a stepwise process, with the first step being access to the Summary Care Record (SCR).

Recommendations

A position of "access to health records in the patient's interest" must be adopted for all professionals providing care to patients.

Pharmacists have a legitimate need to access patient health records as the more information available to them when providing care to patients, the better the outcome for patients.

The RPS is calling for NHS England, over time, to enable full read and write access to the patient health record for all pharmacists.

[1] Managing medicines in care homes (2014) https://www.nice.org.uk/guidance/SC1/chapter/what-is-this-guideline-about-and-who-is-it-for

Background

The Caldicott 2 Information Governance review[2] recommended that '*for the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professional who have a legitimate relationship with the patient' (recommendation 2).* Pharmacists, as registered and regulated healthcare professionals, should therefore have access to the patients' record when providing direct care to them.

The government response to the Review[3] states:' *Sharing information to support care is essential. It is not acceptable that the care a patient or service user receives might be undermined because the different organisations providing health and care to an individual do not share information effectively.'*

The RPS believes that such sharing of information will become even more important when care providers start to provide services under the 'Any Qualified Provider' route, when records of patient care from organisation not previously associated with care provision, will need to be captured on the patient record. For example, private companies may start to deliver health services to patients. Basically, any professional who provides direct care to the patient should have read and write access to the patient record, with patient consent.

The government recognises the need to include pharmacists in information-sharing, set out clearly by Jeremy Hunt on 6 Nov 2013: *'I am aware of the important role that pharmacists play in supporting the rest of the healthcare system, and am keen to explore how this role could be developed through electronic record sharing. I think it is important that the Department, in partnership with NHS England, look strategically at how pharmacy can support the rest of the healthcare system, in the context of working towards more integrated care and a paperless NHS by 2018. In particular, I would like to see if, when a patient gives permission, it would be possible for a pharmacist to access a GP record in order to give the best possible advice. There are many other areas to consider as well, and I look forward to discussion'.*

[2] https://www.gov.uk/government/publications/the-information-governance-review
[3] https://www.gov.uk/government/publications/caldicott-information-governance-review-department-of-health-response

Access to the Summary Care Record

The SCR contains details of a patient's key health information such as patient demographics, current and most recently prescribed medicines, adverse reactions and known allergies. Access to this information can support pharmacists to ensure there is no interaction between a patients currently prescribed therapy and any new treatments. It is the first step towards ensuring continuity of medicines when transitioning from primary to secondary care and vice versa.

Currently 57% of hospital pharmacies have access to the patient's SCR. This has shown in audits and service evaluations, conducted by a number of hospital trusts, to have a huge positive impact on the ability to undertake effective medicines reconciliation when a patient comes into the hospital (medicines reconciliation is a process which ensures clinicians know what medicines a patient is currently taking). Hospital pharmacy teams have found that access to the SCR has assisted in improving patient safety and identifying adherence issues.

'*This service evaluation has shown that one out of every five patients assessed on a Medical Assessment Unit had an intervention that improved prescribing when the SCR was made available to Pharmacy staff*'. (Northumbria Healthcare NHS Foundation Trust)

The results of this audit demonstrate the following benefits of SCR

- *SCR is used for more complex cases*
- *Time taken to complete a medication history is quicker when SCR is used.*
- *There is a reduction in communication time, resources and effort between health care providers*
- *SCR increases the number of discrepancies identified, thereby improving accuracy.*

(Basildon and Thurrock University Hospital NHS Foundation Trust).

In July 2014 NHS England announced that it would undertake a proof of concept exercise to consider how access to the SCR would be undertaken in community pharmacies and what benefits this would have for patients. The areas where this is being piloted are Somerset, Derbyshire, Northampton, Sheffield and West Yorkshire.

A community pharmacy in Sheffield currently has access to a patient's SCR with patient consent. Over the Easter period 2014, they had consultations with 91 people regarding emergency supplies of medicines, which resulted in the dispensing of 165 items that had either run out, not been ordered, forgotten to pick up prescriptions before surgeries closed etc. 39% of these patients said they would have gone to A&E / urgent care centre if the service via the community pharmacy had not been available. The SCR was used in these cases to support safe provision of emergency supplies of the patient's medicines.

Access to the full record

There are already several areas in England where community pharmacists have some access to patient information but this is not standardised and allows access of varying degrees. Whilst we recognise that access to a patient's SCR is the first step we believe that to fully realise the benefit of access to information the full record should be made available to all pharmacists. This will support pharmacists in optimising a patient's medicines, ensuring that patients get the most from their medicines. As many medicines have more than one use, for example, carbamazepine for both epilepsy and pain, and doses can vary according to diagnosis, it is vital that pharmacists know the patient's history to be able to make a fully informed clinical judgement when checking the prescription. To ensure safety and optimum use of medicines it would be useful for the pharmacists to have an accurate picture of the patient's diagnostic history as well as recent investigational data to show the success of, or potential adverse reactions to medicines. In addition a GP is currently limited in their ability to know if a patient is taking a medicine that they have been prescribed, or even if that medicine has been dispensed. With the roll out of a variety of services such as medicines use reviews (MURs) and the new medicine service (NMS) more information on pharmaceutical care issues is being recorded and stored in community pharmacy patient medication record systems. This could be transferred back to the GP as required, but currently there is no link between the pharmacy record and the GP record. Also, medicines that a patient may purchase from the pharmacy are also currently unknown to the prescriber.

Summary

- Information is key to reducing medicine errors, improving medicines adherence and delivering safe and more effective care to patients. Pharmacists should have full read and write access to the patient health record to improve patient care and patient safety
- Access to the patient health record will allow pharmacists to make more informed clinical decisions, in partnership with patients, about the pharmaceutical care that patients receive. This will improve medicines adherence, supporting improvement in the treatment of individual patients and helping the NHS to maximise the value of the significant investment it makes in medicines.
- The ability to access the patient health record will allow pharmacists to play an even greater role in the provision of unscheduled care by improving their ability to respond to emergency requests for medicines safely.

ROYAL PHARMACEUTICAL SOCIETY England

Shaping pharmacy for the future

Pharmacist-led care of people with long term conditions

The Royal Pharmaceutical Society believes that utilising pharmacist led care of people with long term conditions will deliver cost-effective services that will bring significant results to patients and the NHS.

Introduction

Primary care has come under greater pressure in recent years, with higher demands on General Practitioners (GPs) and patient waiting times increasing[1]. The number of people with three or more long term conditions (LTCs) was 1.9 million in 2008 and expected to rise to 2.9 million in 2018[2]. People waiting one week or more to see their GP will rise from 26.2 million in 2013 to 27 million in 2014[3]. Alongside this, demands on urgent and emergency care are rising, with 10am on Mondays being the peak hour for attendances in a typical week[4]. The Royal College of General Practitioners (RCGP) is calling for increased numbers of GPs and additional funding for GP services to manage the increased demand and expectations of patients[5]. The Royal Pharmaceutical Society (RPS) is proposing that in addition, pharmacist led care of people with long term conditions will enable resources to be utilised more efficiently to deliver the standard and level of care expected by patients. Pharmacists are an unused resource that can make an immediate difference by freeing up GPs to manage more complex or demanding cases.

Recommendations

The RPS believes that utilising pharmacist led care of people with long term conditions will deliver cost-effective services that will bring significant results to patients and the NHS:

- Waiting lists in urgent and emergency care, and GP surgeries will be reduced by utilising the skills of pharmacists to provide care to people with long term conditions
- People are kept healthier for longer, reducing hospital admissions
- Medicine waste and over prescribing is reduced and savings realised.

[1] Royal College of General Practitioners:http://www.rcgp.org.uk/news/2013/december/27m-patients-to- wait-week-or-more-to-see-gp-in-2014.aspx
[2] Department of Health (2012). Report. Long-term conditions compendium of Information: 3rd edition

[3] Royal College of General Practitioners:
http://www.rcgp.org.uk/news/2013/december/27m-patients-to-wait-week-or-more-to-see-gp-in-2014.aspx
[4] Hospital Episode Statistics Accident and Emergency Attendances in England – 2012-13, Health and Social Care Information Centre published 28th January 2014
[5] http://www.rcgp.org.uk/news/2014/may/rcgp-response-to-times-ar ticle-on-gp-pay-and-workload.aspx

Background

There is a body of evidence demonstrating that pharmacist-led care for people with LTCs delivers significant results. Pharmacist-led services are used in areas spread across England but there is no consistency. Innovative commissioning is required locally to enable pharmacists to demonstrate their full potential. In some Clinical Commissioning Groups (CCGs) pharmacists run clinics for people with LTCs either in a pharmacy or working alongside GPs in a practice; taking on patient caseloads and providing care for people with stable LTCs. It has been demonstrated that people using pharmacist-led services are more likely to take their medicine and achieve the associated health benefits. It is also known that patient satisfaction is high amongst those who receive care from pharmacists. The recent evaluation of the New Medicine Service[6], which focuses on supporting patients with asthma, COPD, hypertension, type II diabetes and those on antiplatelet / anticoagulation medicines who are prescribed a new medicine, demonstrates that this service carried out by community pharmacists significantly increased medicines adherence by around 10%.

Asthma

According to Asthma UK[7] there are 5.4 million people in the UK that are receiving treatment for asthma. The NHS spends around £1 billion a year treating and caring for people with this long-term condition. In the UK every day 200 people are hospitalised with asthma and 3 of these will die. In 2010 there were 1,143 deaths from asthma in the UK. It is estimated that 75 per cent of hospital admissions and 90 per cent of the deaths that may follow are preventable.

According to NICE guidelines[8] people with asthma should receive an annual review and have a written action plan from their doctor or asthma nurse. Those without an action plan are four times more likely to need emergency care in hospital. Despite this, according to Asthma UK only 12 per cent of people with asthma have an action plan[9]. In addition, it is reported that only two-thirds of patients with asthma have a routine asthma review each year.

The recent National Review of Asthma Deaths (NRAD)[10] identified prescribing errors in nearly half (47%) of asthma deaths and room for improvement in the care received by 83% of those who died. The NRAD also highlighted that only 57% of those who died had an annual review in the last 12 months of their life and, of those who did have one, many people's reviews didn't even include the key components.

[6] http://www.nottingham.ac.uk/~pazmjb/nms/
[7] http://www.asthma.org.uk/
[8] http://www.nice.org.uk/guidance/qs25/chapter/Introduction-and-overview
[9] http://www.asthma.org.uk/compareyourcare-reports
[10] https://www.rcplondon.ac.uk/sites/default/files/why-asthma-still-kills-full-report.pdf

Asthma patients are a particularly hard to reach group often not engaging with their GP services but they are seen regularly by their community pharmacist for repeat prescriptions. An average pharmacy has around 450 asthma patients and 400 of them are probably not getting the best from their treatment. It is thought that approximately 50% of asthma patients have poor inhaler technique resulting in poor control of their disease.

The case study below clearly illustrates the benefits of fully integrating the pharmacists into the healthcare team, utilising the pharmacist clinical skills to improve patient outcomes, reduce hospital admissions and GP appointments.

Case Study 1

In collaboration with other health professionals, community pharmacists were given extra training to deliver structured asthma reviews including reviewing inhaler technique.

13 pharmacists carried out reviews in Leicester city centre on 165 patients with follow-up appointments at 3 and 6 months:

- 42% of patients had not had an asthma review at their GP practice in the last 12 months
- 56% had not had their inhaler technique checked in the last year.

Using the validated Asthma Control Test (ACT) the results showed most improvement in those patients who had not had an asthma review from their GP in the last 12 months; showing patients receiving significant clinical and quality of life improvement.

It is known that people only take their medicines as prescribed 50% of the time which leads to poor outcomes and wasted resources. The study found considerable improvement in patients' compliance with their medicines, resulting in better overall asthma control.

The study demonstrated a 32% decrease in GP appointments and a 40% reduction in hospital admissions. The authors concluded that to improve patient outcomes and thus decrease hospital admissions, pharmacist asthma reviews should be targeted at patients who have not had a review from the GP recently, capitalising on the accessibility and approachability of the community pharmacist.

Hypertension

Hypertension is one of the most prevalent cardiovascular (CV) risk factors in England and one of the most important preventable causes of premature morbidity and mortality. The risk associated with increasing blood pressure (BP) is continuous - each 2mmHg rise in systolic BP is associated with a 7% increased risk of mortality from ischaemic heart disease and a 10% increased risk of mortality from stroke[11]. Lowering BP reduces the risk of CV events in people with established hypertension.

Case Study 2

Analysis of the effectiveness of utilising prescribing pharmacists to deliver BP management services across South London demonstrated significant positive outcomes for patients, when measured against the Quality and Outcomes Framework BP audit standard (150/90mmHg) and the clinical BP target (≤140/90mmHg). In addition, data were collected relating to assessment of CV risk, prescribing interventions made, adherence counselling offered and lifestyle advice given. The costs of this service were significantly more cost-effective than the traditional use of medical staff.

Of those referred with uncontrolled BP at the commencement of the study, 79% (181/229) achieved the QOF BP target (≤150/90mmHg) at 6 months; while 58% (128/229) had achieved the clinical BP target (≤140/90mmHg) at 6 months. This outcome alone represents a substantial potential benefit in terms of health gains and excellent value for money. The estimated cost of the pharmacist service was approximately £70 per BP controlled, which compares favourably with a first referral to specialist care at £200 or more and with follow visits costing at least £90.

[11] http://www.nice.org.uk/guidance/cg127/chapter/introduction

Polypharmacy

At least 25% of people over 60 years old have two or more LTCs which means that there a number of patients on a multitude of medicines. Such multiple medicines use (polypharmacy) is widespread and increasingly common, occurring in both primary and secondary care. It is driven by an ageing, increasingly frail and multimorbid population, coupled to a single-disease health service framework supported by numerous poorly-connected clinical guidelines. Polypharmacy may be clinically appropriate, but can increase clinical workload and clinical complexity. Polypharmacy can also be problematic, where multiple medicines are prescribed inappropriately or where the intended benefit of the medicine is not realised. Harms associated with polypharmacy include risk of errors associated with medicines (including prescription, monitoring, dispensing and administration errors), adverse drug reactions, impaired medicines adherence and compromised quality of life for patients. There are costs not only in terms of morbidity and mortality, but also of pharmaceutical products (including waste) and health service utilisation.

Growing concerns around polypharmacy led to the publication of 'Polypharmacy and medicines optimisation: Making it safe and sound' by the Kings Fund in 2013[12]. This report highlights the implications of multi-morbidity and polypharmacy for clinical practice, services and policy, and calls for actions to facilitate the management of complex multimorbidity and systems to optimise medicines use. This report states that 'Multi-morbidity and polypharmacy increase clinical workload. Doctors, nurses and pharmacists need to work coherently as a team, with a carefully balanced clinical skill-mix'. Pharmacists, as experts in medicines use, can play a significant role in the reduction of problematic polypharmacy.

Summary

There is a body of evidence demonstrating that pharmacist-led care for people with LTCs delivers results. Such services are available in pockets across England but there is no consistency. We are in a period where funding levels cannot increase and health care professionals must become more efficient. GPs are also clear: they cannot maintain existing levels of service let alone increase levels of service to meet patient demand and expectations. The effective use of pharmacists would increase efficiency, improve quality, reduce cost per patient and potentially provide services nearer to the patient.

The examples demonstrate some of the types of pharmacist-led care available to the public, where integrating the pharmacist into the healthcare team and collaborative work across primary and secondary care can improve patient outcomes significantly and make better use of NHS resources. All of these services could be provided at a national level, across every CCG.

[12] http://www.kingsfund.org.uk/publications/polypharmacy-and-medicines-optimisation