Supporting evidence

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Old School Pharmacy

Managing Patients with Long Term Conditions

A Model for Primary Care

Jonathan Campbell – Pharmacy Contractor, BNSSSG LPN Chair (Pharmacy)

Old School Pharmacy

Delivering an Integrated Pharmacy Service

Patients have access to an integrated medical / pharmacy service

- **Utilises the entire professional workforce within the practice and the pharmacy.**
- **Pharmacy has on-site access to patient records (EMIS)**
- **Creates capacity within the practice.**
- **Improves patient experiences and outcomes.**

Old School Pharmacy

Delivering an Integrated Pharmacy Service

- **Practice refers all patients to the pharmacy for:**
  - **All Minor Ailments - Treatment / Advice Service**
  - **Triage urgent appointment requests**
  - **Smoking Cessation Support / Advice (70% 4 wk quit rate)**
  - **EHC Supply and Advice**
  - **Urgent Repeat Medication Requests**

Old School Pharmacy

Managing LTC Patients within Primary Care

monitor more carefully individualise care review medicines more frequently

reduce wastage of medicines improve medicines safety

focus on patients and their experiences

improve outcomes

Medicines Optimisation Service

Old School Pharmacy

Medicines Optimisation Service – Step 1

- **Practice / Pharmacy work together to identify high risk LTC patients.**
    - **Patients are flagged on Practice and Pharmacy Systems**
- **Selected LTC Patients visits the pharmacy for an initial MuR**
    - **All the medication is aligned**
    - **Patient is issued with a maximum supply of 28 days**

Old School Pharmacy

Medicines Optimisation Service – Step 2

- **Practice issues Repeat Dispensing (RD) Scripts for each medication**
    - **RD scripts are held in patients file in pharmacy**
- **Pharmacist rings the patient / carer every month**
    - **Medicines are reconciled**
    - **Compliance is checked**
    - **Each medication is reset up to 28 days, if required.**

Old School Pharmacy

Medicines Optimisation Service – Step 3

- **Pharmacy refers the patient back to the prescriber, if:**
    - **3 or more medicines have to be re-set, on one occasion.**
    - **1 medication has to be re-set, on 3 consecutive occasions.**
- **Pharmacist will notify the practice, of any outstanding;**
    - **medication reviews.**
    - **therapeutic clinic reviews.**
    - **blood monitoring tests.**
- **Pharmacist responsible for re-ordering follow on RD scripts**

Old School Pharmacy

Medicines Optimisation Service – Step 4

- **Prescriber completes a “Medication Change Form”:**
  - **informs the pharmacy about any change in medication.**
  - **any new or changed medication is prescribed as an acute medication until patient is stable**
  - **pharmacist still includes the new / changed medication within the monthly review.**
  - **any RD scripts for stopped medication are destroyed.**

Old School Pharmacy

Pharmacy Medicines Optimisation Service

- **Pharmacy currently has c.600 LTC patients signed onto service.**
- **Surgery has the highest % of RD items in Bristol CCG (51%)**
- **Pharmacist spends approx. 4 hours per week on phone**
- **Pro-active approach to medicines optimisation**
- **Pharmacy helps LTC patients manage their condition more effectively through medicines optimisation.**

FF02 RCGP

September Clinical News RCGP

Newsletter Summary

Integrated pharmacy – a model for the future

How can integrated pharmacy provision benefit your practice?
Dr Carole Buckley explains and examines the widespread benefits gained at her practice. She focuses on the how the local health economy has benefited from better medicine management and the reduced costs, and at how patients get a better and safer service.

Click here to read about the positive impact on general practice

Website Article

Dr Carole Buckley

The head of medicines management for Bristol PCT had a vision to put a prescribing support pharmacist in every practice in Bristol. Alaster Rutherford succeeded in achieving this, and his influence has continued with independent prescribing pharmacists in many practices in the area.

Alaster Rutherford's vision started the journey for The Old School Surgery in recognising and then realising the potential for integrated pharmacists and pharmacy into the primary health care team.

In 2002 Rachel Hall joined the practice for half a day a week as our prescribing support pharmacist and soon became an integral part of the practice team. We mentored her to become an independent prescriber, and in 2006, we changed her hours to full time at the practice as a clinical pharmacist. She remains in the post to this day, and last year became a partner in the practice having widened her role beyond treating patients to clinical management. Rachel divides her time between clinical practice when she sees patients with long-term conditions, conducts medication reviews, all aspects of the practice prescribing, and working with the practice manager to deliver the QOF and enhanced services. She continues to offer training to the primary health care team, including visiting medical students and doctors in training on medicines, and regularly writes articles for the pharmacy journals on her expanded role in the practice. Rachel has been accepted as a clinician in her own right by the wider health care community and makes her own referral to secondary care as appropriate. Her area of specialist interest is diabetes and she contributes to the local specialist network, Her opinions have also been sought nationally on the role of the pharmacist in the future.

Alongside Rachel, we have an onsite pharmacy that is partly owned by the practice, and we are in partnership with another visionary pharmacist, Jonathan Campbell.

Jonathan and his pharmacy team, share the practice facilities, and we combine social events so that the staff consider us to be one unit. This is clearly a business

arrangement and we are mindful of the need to remain open and honest with the patients, and avoid any accusations of directing patients. However, the service offered by the pharmacy stands on its merits and patients are full of praise for the standard of care they receive. It offers every additional pharmacy service, and it delivers medicines to the homes of housebound patients.

The pharmacy is integrated in many other ways:

- It has access to the practice EMIS computer system and, with the patient's permission, can look at their records.
- It offers an enhanced service to over 600 vulnerable patients identified by the practice which includes regular review of compliance and a monthly phone call from the pharmacist to ensure all is well.
- It provides a regular visit to the local nursing home from a member of the pharmacy staff to ensure appropriate use of medicines and to avoid waste.
- It has over 50% of patients with regular medication on repeat dispensing cutting the practice workload and improving medicines adherence.
- It runs a minor ailment scheme that cuts the practice workload.
- It is the first point of call for smoking cessation to the practice population – with one of the highest quit rates in Bristol.
- It is active in promoting chlamydia screening with provision of prescriptions if the result is positive, which is very useful with our high student population.
- It has instant messaging access to the prescribers so when a drug is out of stock or there is a problem an alternative can be offered without inconveniencing the patient.
- It offers training for the doctors and medical students attached to the practice.

The combination of working with such dedicated and active pharmacists has resulted in the practice being well below its prescribing budget for many years, we also have a lower cost per item than both the PCT and national average. The patient pathways for safe use of medicines and prescribing review and reauthorisation are firmly embedded with well-trained staff in both the practice and pharmacy.

In 2015 it is hoped that we will run a pilot to offer pre-registration pharmacists the opportunity to spend time in the practice and pharmacy to get enhanced community training.

Pharmacists should be viewed as the well trained and dedicated professionals that they are, and that primary care can gain a great deal by working closely with them. It is forecast that there will be too many trained pharmacist over the next few years – unlike GPs and nurses, so consider the opportunity that can be gained by welcoming them to the practice team.

Pharmacy Business Awards 2014

Medicines Optimisation Award

WINNER : Jonathan Campbell, Old School Pharmacy, Bristol

Jonathan Campbell is doing his best to ensure the government knows about pharmacy's medicines optimisation role. The Medicines Optimisation Award winner talks to **Neil Trainis**...

"That's a good question," Jonathan Campbell says as he weighs up whether community pharmacists across the UK get the credit they deserve for the role they play in medicines optimisation.

Rather unsurprising then that the winner of the Pharmacy Business Medicines Optimisation Award is not lost for words.

"There are two edges to that. I don't think they do but then again I don't think we've been very good at promoting ourselves," he says.

"Pharmacy has been too focused on dispensing. We can do much more. There is a group of pharmacists still living in a world where they think they can get by dispensing. We need to combine the two. It's an opportunity to engage with the public."

Old School Pharmacy in Bristol has certainly engaged with its public. And with their local GPs. Jonathan has implemented quite a system of engagement and collaboration.

The pharmacy, in tandem with the local GP surgery, initially focused on 400 Long Term Condition patients deemed vulnerable on the pharmacy and GP list and ensured that each and every one received a Medicines Use Review.

Jonathan and his team were able to closely monitor each patient by shifting their medication from 56 to 28-day prescribing, with patients phoned after 21 days to make sure they were taking their medication properly.

This was fed into the next dispensing cycle where items were reviewed and quantities adjusted to ensure patients started the cycle with 28 days' supply of each medicine.

Any patient identified as at-risk through poor compliance who could not be helped by the pharmacy was referred back to the GP, avoiding the scenario where they continued ordering the medication and not taking it.

Jonathan chuckles when it is suggested he makes it all sound so easy. "It's

not easy but it's easily thought. I didn't qualify to stand around at the end of a conveyor belt."

If an effective medicines optimisation process in the pharmacy can reduce the workload and pressure on general practice, one imagines that GPs would value it.

"It's about sharing the benefit that brings," Jonathan muses. "I sat down with my GPs when I bought the pharmacy and said 'we need to work together for the benefit of the patient.' They bought into that idea. We use our skill mix. We have to triage the patients."

Pertinently, given there are pharmacists who have still not managed to establish a collaboration with their local general practice, he adds: "There's responsibility on pharmacists to engage with GPs more rather than be apprehensive or afraid. Go to the GP and say 'how can we help you with the challenges you have?'"

He is proud of his and his team's work on medicines optimisation. "I put the medicines optimisation system in place. We haven't had the details on reduced A&E admissions. But the GPs said they are not seeing patients as much as they used to."

Passion is the secret of Jonathan's success. The passion he has for his patients' health and wellbeing.

Pharmacists have to endure a lack of funds for helping people optimise their use of medicines, despite it being critical to the success of a patient-centric NHS. Yet not even a lack of funds douses his enthusiasm.

"There's an argument to say we're not being paid for it but we need to demonstrate we can do it consistently," he says.

"I'm a believer that change starts with yourself. There has to be some income stream attached to it but its about shifting existing funding , not new funding"

"It's about building up small pilots, engaging the commissioners to do things differently. It would be nice to have pharmacists working as prescribers helping in the surgery but we need to do more."

His medicines optimisation programme has been such a success that it has grown to accommodate 600 patients, a figure that might be too much for some pharmacies but not Jonathan and his 14 staff, some of whom are full-time, some part-time.

"It's about using the skill mix, it's about using the consulting room to say 'this is how you use your medicine' when you start engaging the patients," he insists.

"It can take a while to explain things to them at first but the loyalty you get from them is amazing.

"When they get used to the phone calls and the process, I hand them over to the technician. That's why we increased it from 400 to 600 patients."

The patient compliance system has reaped its rewards, reducing prescribing costs and waste.

In the pharmacy community, there was some chagrin that the 400-cap on MURs was not lifted in the last community pharmacy financial settlement but that setback didn't stop Jonathan in his tracks.

"I wouldn't say I'm disappointed. It's another challenge we have to face. The NHS is going through immense challenges. We need to demonstrate our worth."

George Osborne, barring the kind of broken promises levelled at him by Ed Balls over the nation's deficit, appeared to hand pharmacy hope that money may, after all, be available for the provision of health services. An extra £2 billion a year, the Chancellor said last month, would be put into the NHS.

"It's about collecting the evidence, lobbying the government to say 'this is what we can do,'" Jonathan says with an air of composure. He adroitly conceals concern, however.

"I don't think the government understands pharmacy," he suggests. "It sees it as a retail environment. They don't understand how it manages patients with long-term conditions."

Hence the Manifesto for Community Pharmacy, the sector's latest attempt to shine a light on itself.
"I like it," Jonathan says. "It's simple, five simple steps. One is around long-term conditions. What we've got to do is give them evidence."

Evidence has become the watchword of the NHS. Community pharmacists' futures rest on evidence. Evidence of their ability to keep patients from going to A&E for minor ailments, evidence of their ability to reduce the pressure on general practice, evidence of their ability to ameliorate the public's health, evidence of the value they bring to an NHS buckling under the weight of demand.

Some community pharmacists think it is unrealistic for them to collect such evidence. Many would say they barely have time to blow their nose much less audit the health improvements they have achieved for their patients.

Jonathan is not one of those pharmacists. He thinks individual pharmacists should be collecting evidence of what they do.

"Michael Jackson had a great saying...'It starts with the man in the mirror.' We need to show what we can do."

Pharmacists and GPs complement each other – Keith Ridge

10 June 2014 - 14:25

Dr Keith Ridge CBE, the Chief Pharmaceutical Officer for NHS England, gives his views on best practice in action:

One of the privileges of my job is being able to get out and about to see great clinical practice up close.

Last week was one of those opportunities arose when, together with the Chief Executive of the Royal Pharmaceutical Society, Helen Gordon, I spent an enthralling few hours at the Old School Surgery in Fishponds, Bristol.

It's a modern GP practice with a growing list of 15,000 situated in the heart of the local community.

Two things make the practice a bit different from the norm. Firstly, an independent pharmacist prescriber, Rachel Hall, is a partner in the practice. The second is that there is a community pharmacy on site.

Rachel is a clinical pharmacist. She wasn't brought in as a partner but earned the position through working in the practice for a number of years.

The ex-PCT prescribing lead, Carole Buckley, a GP principal and partner in the practice, helped Rachel become an independent prescriber.

Rachel runs her own clinics, undertakes research, carries out audit and does all the other things that a committed partner in a GP practice does. She also supports her fellow clinicians on all things medicines.

This seems, for example, to give the GPs the confidence to use innovative medicines, such as the Novel Oral Anticoagulants, not just safely and appropriately, but also more frequently than other practices in the area.

This not only reduces attendances at warfarin clinics but, looking

at The Lancet from a year or two ago, also shows the presence of a clinical pharmacist like Rachel keeps patients safer too. The “PINCER” trial has clearly demonstrated this [1].

Clinical pharmacy is well established in hospitals and my impression is that GPs remember back to their training in hospital, and recall how valuable the support from the ward clinical pharmacist was. Pharmacist prescribing takes that clinical relationship to another level.

The relationship with the community pharmacy is interesting. Now there is a business relationship and nobody hides that. It’s all above board. Patients are effectively triaged to the pharmacy for minor ailments, taking workload off the GPs. Anybody needing emergency hormonal contraception goes to the pharmacy.

But the particularly inspiring activity was how the community pharmacist, Jonathan Campbell, supported patients with long term conditions, with some 60 per cent of prescriptions run through a repeat dispensing scheme. He spends a lot of his time talking to patients whether face to face or on the phone.

This means the community pharmacist is able to optimise prescriptions and medicines accordingly, discussing with patients how they are getting on with their medicines, and linking with the practice clinical staff.

This is not only good for outcomes, but also reduces waste. And it’s also good for drug expenditure, with the practice having prescribing/dispensing costs considerably less than the national average.

So, in summary, not only great care, but also great clinical relationships within and across professions, that also creates headroom for innovation.

FF07 Family Doctor Association Federation

See next page

Federation & GP Practices

The Basics of Federation

Factsheet No. 1

Andrew Lockhart-Mirams, Lockharts Solicitors
Series Editor: Moira Auchterlonie, Family Doctor Association

Factsheets on GP Federations
www.family-doctor.org.uk

The Basics of Federation

This is the first in a series of three factsheets outlining what to consider before forming a GP Federation. The factsheets are written by Andrew Lockhart-Mirams at Lockharts Solicitors. The Family Doctor Association commissioned these factsheets in response to requests from members. Full of tips for the unwary based on the collective experiences of other GP practices who have gone down the federation route. In this edition, Andrew shares his experiences of federating.

Introduction

'The traditional small business model of general practice is unsustainable.' So said the BMA in March 2009. Four years later, the accuracy of this statement seems even more evident, with GP practices, whether small, medium or large, coming under increased administrative and financial pressures.

Simple federated working: three stages

Whilst the third article in this series examines the mechanics of merging practices, we start here with the simple proposition that practices have to work together in order to obtain the benefits of the economies of scale that are available. This is achieved through federated working.

1. Sharing "back room" administration

Possibly the simplest example of federated working arises where two or three practices share a 'back room' administrative resource, such as bookkeeping. This does not involve one practice being the employer and then seconding the bookkeeper to another practice. Instead, practices simply agree that they will use the same bookkeeper at different times of the week, with each practice making a separate arrangement with the bookkeeper. This arrangement offers the advantage of advertising the position jointly. It also permits the practices to offer what is in effect a full-time working week, rather than part-time working arrangement, and is likely to attract a higher calibre of candidate as a result.

2. Staff sharing — slightly more complex

Staff sharing, in contrast, constitutes a slightly more complex example of federated working. Here, one practice employs, for example, a nurse, who is used by the practice but also 'hired' out to another practice. This allows a great deal more flexibility than having two separate contracts, as set out in our bookkeeper example above. However, it also requires a certain amount of management, particularly if things go wrong.

The main problem that can arise when sharing staff occurs where, for example, a nurse employed by 'practice A' is seconded to 'practice B' and is subject to a discriminatory act. This discriminatory act will be attributed to something said or done by a staff member at 'practice B'; the employment claim, however, will be made against the partners in the employer 'practice A'. In order to tackle this potential issue, 'practice B' will need to indemnify the partners in 'practice A' against employment related liabilities. The provision of such indemnities and the terms upon which staff are seconded must be properly recorded in written documentation. Where clinical staff members are seconded, care must also be taken with regard to clinical negligence cover.

3. Sharing premises and facilities—a lot more complex

The most complicated form of sharing is probably the sharing of premises and facilities. Often, two or more practices will occupy the same health centre, taking their own consulting suites, but sharing a nurse treatment room or, for example, a minor surgery facility. The terms on which this sharing takes place require very careful consideration, as do the proportions in which the costs of sharing are spread between the two practices. In very simple terms, a practice with 6000 patients might be expected to pay two thirds of the cost, as against a practice with only 3000 patients. There are, however, a number of variables, as the demographics within each practice might be very different. It may also be that, for other reasons, the smaller practice, for example, does not use 33.3% of the facility but say 43.3%. The costs of running a shared facility can be quite substantial and cost sharing mechanisms, however complicated, should therefore be properly recorded.

Issues may also arise where one of the two practices that are sharing premises and facilities wishes to withdraw from the arrangement. In this instance, the other practice(s) will not wish to be left carrying all of the costs. A cost sharing arrangement should therefore govern the procedure should this occur. Such an arrangement constitutes federating in simple terms and many groups of practices up and down the country are already involved in similar arrangements.

Larger federated units and conflicts of interest?

In addition to arrangements between two or three practices, there is an increasing trend towards the creation of larger federated units. This can give rise to difficulties where, say, seven or eight practices want to work together, but two or three of these practice are already joined together in another federation. Although the separate federation will in some cases be providing a different service, there is often a strong possibility of this extending into overlapping work. Where this is the case, a conflict of interest will arise.

Conflicts of interest have always existed, particularly in the regulation of companies, where directors may be on the boards of various companies and/or have interests in other businesses. In the NHS, however, conflicts have only really been identified since 2004, when the door to outside providers was opened. Proposals for clinical commissioning have brought matters to the fore. Many GPs have been quite gravely troubled, wanting, on the one hand, to participate in commissioning, whilst on the other, being aware that they might benefit if services were commissioned from their own practice.

Federation conflicts; commissioning conflicts

The first type of conflict, where a GP is involved in two federations, can simply be resolved by the GP in question electing which federation to be involved in. The commissioning conflict, however, is different. Although it is clear that GPs who stand to benefit can properly take part in assisting their CCG to identify the services that are needed in the locality, such a GP cannot then assist the CCG further in identifying and agreeing on the eventual provider of services. It might seem that this could totally negate the commissioning powers of the CCG, as the board might be comprised very largely of GPs who are members of practices who would participate in provision. However, this difficulty can be overcome by CCGs taking outside advice from other CCGs. Having reflected upon possible conflicts of interest and simple forms of federating, the second factsheet in this series will consider more formal federating arrangements.

The Basics of Federation

Simple Federations: Check List

Federating can offer practices:

- efficiency savings/economies of scale by sharing back office functions or procurement of practice services
- strengthening the capacity of practices
- survival to strengthen clinical governance
- development for training and education capacity
- critical size to enable tendering for new services
- opportunity to improve the quality and safety of services

Questions to ask yourself at the start

1. Who can you work with?
2. What are the reasons for working together?
3. Who do you know that has had a go at federating to ask how it went?
4. What back office functions could you share easily?
5. What about your practice identity?
6. What is your CCG attitude to federations?

Must do's

Seek appropriate advice Get on with it!

Further resources

Useful reading: RCGP GP Federation Toolkit
Ideas: www.family-doctor.org.uk
Federation Agreements: www.lockharts.co.uk

About the Author

Andrew Lockhart-Mirams

Andrew co-founded Lockharts in 1995 and has had 30 years of experience in primary care regulatory and contract work. For more than 20 years he acted for the General Practitioners Committee of the BMA on a wide range of regulatory and contractual issues affecting GPs, including the New GMS Contract in 2004. Andrew has a national reputation for his work in the development of PMS and APMS agreements. He has produced agreements for federations of practices, and shareholder agreements for provider companies wishing to provide to NHS bodies.

The Family Doctor Association

We are the national voice of frontline GPs and their practices. An educational charity founded in 1985, our members are GPs and practices that offer their patients the benefits of continuity of care; the cor- nerstone of UK general practice. Charity registration 299871.

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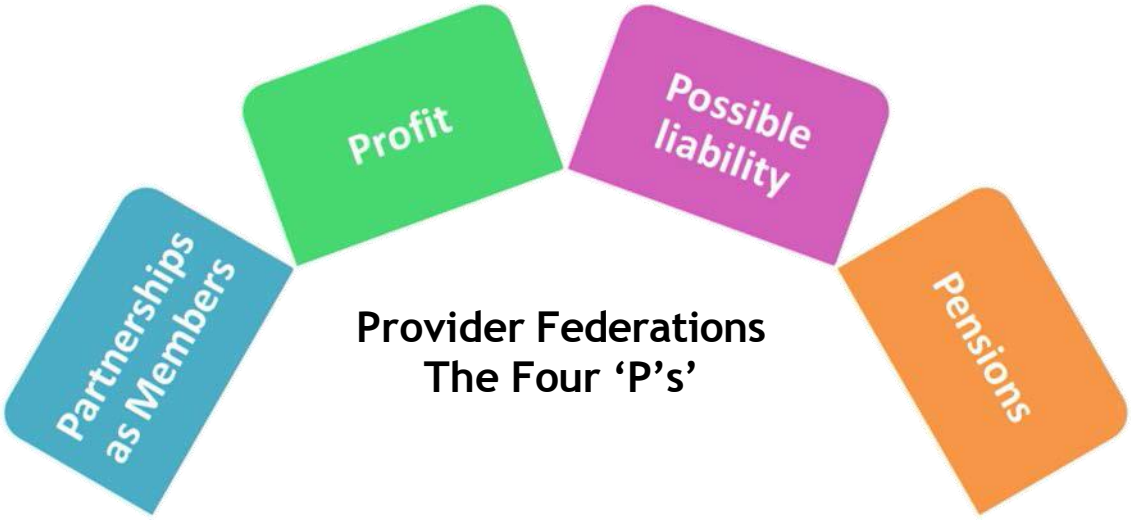
FF08 Family Doctor Association Federation

See next page

Federation & GP Practices

More Formal Federation Arrangements
Factsheet *No. 2*



Andrew Lockhart-Mirams, Lockharts Solicitors
Series Editor: Moira Auchterlonie, Family Doctor Association

Factsheets on GP Federations
www.family-doctor.org.uk

More Formal Federation Arrangements

This is the second in a series of three factsheets on GP Federations written by Andrew Lockhart-Mirams at Lockharts Solicitors. The Family Doctor Association commissioned these factsheets in response to requests from members. In this edition, Andrew considers more formal arrangements.

Introduction

NHS England has just launched a major consultation on future of general practice (August 2013). **'Improving General Practice: -a call to action'** looks at how best to develop general practice services at *"greater scale, for instance through networks, federations or practice mergers … but scales up in a way that preserves the greater relationship continuity that comes from individual practice units."*

In addition to federating arrangements designed to offer **the benefits of economies of scale,** practices may also decide to federate in order **to provide services**, where this will be financially beneficial. The two arrangements are not mutually exclusive and, in some cases, will be used together.

When putting a provider federation together, aside from the detail that will be needed in the corresponding documentation, there are probably four main areas that require consideration:

Partnership considerations

It is important to view a provider federation as a commercial organisation operating in the health service. If members of the federation are to support one another, each needs to work from a secure base. To this end, **a current and effective partnership deed is essential**. At present, only around 50% of partnerships have such a deed. Those that do not are 'partnerships at will' and can be dissolved at any time, by one partner giving notice, not necessarily in writing, to the others. If a partnership at will is a member of the federation and is suddenly dissolved, very possibly leaving behind a dispute, this could have a very destabilising effect on the work of the federation. This would be particularly detrimental where members of the dissolved partnership are prevented from contributing services after dissolution. The interest of the former partnership in the federation would also be uncertain, making operation of the federation difficult. An effective partnership deed for each member of a federation is therefore extremely important.

Profit considerations

With regard to profit, as a commercial organisation, a federation providing services will hope to make profits that are distributable on an annual basis. However, it is more likely that such profits will be distributable when the venture for which the federation was set up concludes. Great care must be taken in determining how any profits are to be shared and this must be done when the federation is set up. This avoids costly, time-consuming and damaging argu-

ments at the end of the process regarding the manner in which potentially large sums of money will be shared.

At face value, profits will be shared on the basis of capital introduced at the start of the federation. The proportions of capital introduced are likely to correlate with the number of patients in any particular practice as at the commencement date. However, substantial changes may occur in patient numbers whilst the provider contract is running, for example over a five year period. In order to allow for such changes, it may be necessary to include a mechanism that allows for the adjustment of capital and, ultimately, profit distribution in the federation agreement.

Voting arrangements

A subsidiary point that arises in connection with capital contributions relates to the voting arrangements within the federation. Again, at face value, one might work on the basis that voting power is directly proportionate to patient list size. However, in a federation comprised of, for example, 10 small practices and two large ones, the voting power of large practices may well be such that the small practices never have a say. In many federations this can be overcome by allocating a minimum number of votes to the smaller practices.

Potential liability considerations

For the members of a provider entity, **a potential for liability sits alongside the provision of services,** with federation members entering into sub contracts with the federation to provide clinical services. Such a contract should be covered by the practitioner's membership of a Medical Defence Organisation ('MDO'). There will, however, be a large number of possible non clinical liabilities that arise. This means that it is crucial that federations are established in a manner which protects members from personal liability where this cannot be covered by MDO insurance. Where a small federation of two or three practices is concerned, providing a very limited range of clinical service such as a leg ulcer dressing service, the risks that fall outside MDO cover are not likely to be great. Where, however, a larger federation operates, for example, an Out of Hours service, myriad responsibilities will arise which could give rise to liability.

In the former case *(leg ulcer dressing)* it might be possible to operate the federation as an unincorporated association, this being an association run very much along the lines of a small club. This may cause difficulties, as the association would not be a legal entity and could not therefore directly employ staff. However, on a small scale this could be overcome by seconding staff from one of the contributing practices.

Where, however, there is a substantial risk of liability, it is strongly advised that the provider entity is set up in the form of a **limited company.** Within a limited company, members of each participating practice would hold shares on behalf of the partners and/or members of the practice. T**he liability of the shareholders is then limited to their contributions in the company.** As a result, in the vast majority of cases, a company limited by shares will be the vehicle of choice. Alternatively, some federations may wish to use a Community Interest Company ('CIC'). This is an ordinary share company, registered specifically as a CIC, which must satisfy the 'community interest test'. It is important to consider the statutory limit imposed on the amount of dividend that a CIC can pay out. In addition, one should note that where a CIC is wound up, it must transfer its assets to another similar company and cannot be converted back into an ordinary company.

More Formal Federation Arrangements

Pension considerations

Pensions should also be considered when deciding on the structure of a provider entity. Whilst more senior practitioners may not be concerned, younger practitioners may wish their earnings from any provider organisation to be pensionable within the NHS scheme.

The provider entity will therefore require employing authority status. An unincorporated association is likely to qualify but, of the corporate entities, **only a company limited by shares satisfies the tests.** Although being able to provide an NHS pension may not be of crucial importance to practitioners, it will certainly be so to any staff members who are employed. Leading on from federation, in the final article in this series, we will consider the merger of practices.

Further resources

Useful reading: RCGP GP Federation Toolkit
Ideas: www.family-doctor.org.uk
Federation Agreements: www.lockharts.co.uk

The three Federation factsheets can be ordered from the Family Doctor Association.

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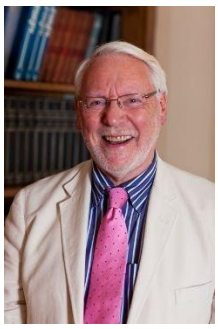

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FF09 Family Doctor Association Federation

See next page

Federation & GP Practices

Practice Mergers
Factsheet No. 3

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Factsheets on GP Federations
www.family-doctor.org.uk

Practice Mergers

This is the third and final fact sheet in our series looking at GP Federations written by Andrew Lockhart-Mirams at Lockharts Solicitors.

As an education charity the Family Doctor Association is happy to provide the facts for its members; it cannot advise on the suitability of federation or merger plan for individual practices.

In this edition, Andrew puts practice mergers in the spotlight. A merger may stem from a desire to establish larger practice. Alternatively, this may become the final logical step where practices are working together in a federation.

Reality check from Europe

Before examining mergers in more detail, it is important to note that, increasingly, practices that stand alone, or federations of whatever size, will only succeed if they are able to obtain a contract or contracts to provide services. To a large extent, the award of contracts is subject to EU regulation and must therefore be fair and transparent.

EU requirements will be restated in a new set of regulations, taking effect on 01 April 2013. As a result, save in a number of very limited circumstances, all contracts will have to go through a regulated procurement process. The main permitted exception to this rule will apply in cases of extreme urgency, where the contract has to be awarded to another provider.

If, for example, a single-handed practitioner were to be killed in a car crash one weekend, the NHS Commissioning Board would have to award a new contract immediately, in order that services could be provided on Monday morning. Generally, however, a provider entity seeking to secure a specific contract must go through the procurement process. This requires the investment of a considerable amount of time and effort in completing the documentation, with no guarantee of a return.

Any Qualified Provide (AQP) - the London black cab?

In addition to the implications of EU regulation, Any Qualified Provider (AQP) contract provisions must also be considered. These provisions fall outside the ambit of the EU regulation, as the availability of an AQP contract does not come with a guarantee of price or volume.

In a sense, an AQP contract can be compared to a London 'black cab'. The taxi itself is plated, showing that it has passed roadworthiness tests and that the driver is fully licensed. When the taxi is hailed, however, all that is known is that both vehicle and driver are fit for purpose; the duration of the journey and its cost are not known. Whilst a large number of AQP contracts are available where practitioners meet the requirements, it is important to consider capacity issues that might arise. Essentially, arrangements must be in place to cater for any number of patients that might wish to use the service at any one time.

Back to practice merger considerations

Practice mergers should be distinguished from the arrangements involved where a new partner joins an existing practice. Where a new partner joins, he or she is likely to have been selected

through an interview process and should have reviewed the existing partnership agreement and partnership accounts. Although some discussion may take place at this stage, the existing partners should carefully consider the terms available prior to advertising the position. This helps to avoid potentially damaging and destabilising negotiations at the beginning of a new professional relationship.

Merging two partnerships is entirely different, as each practice will have their own partnership agreement and their own arrangements. A compatibility assessment may be required at an early stage, in order to ascertain the feasibility of the merger. The first steps in the proposed merger should also be dealt with on a confidential basis; we would therefore suggest that a specific confidentiality agreement be put in place. Reaching agreement between the parties regarding the time frame for the merger will be important. It is also advised that careful due diligence is carried out by both parties, with a particular focus on the financial position of each.

Reconciling the financial arrangements in the two practices will require further consideration, with particular focus on the drawings and profit shares of partners, assets and capital of the practices and any outstanding debts. On a more practical level, it will be important to reach agreement on the structure of the new merged practice and the way that this will be managed. Particular difficulties can arise where there is a marked disparity between the practices in earning and/or partnership numbers.

When merging practices, particular problems may arise where the contract terms available to the staff in 'practice A' are different to those in 'practice B'. Whilst it may seem tempting to standardize the terms upon which employees are engaged, this should be approached with caution. By virtue of the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE), where there is a change in the legal identity of the employer responsible for the management of a business, the employment of individuals of the former business will automatically transfer to the new entity. Terms of employment may not be changed by reason of a transfer, but only in very limited circumstances for economic, technical or organisational reasons. This may cause issues where, for example, the employees of one practice are entitled to a greater number of days holiday, or a more substantial period of maternity or paternity leave.

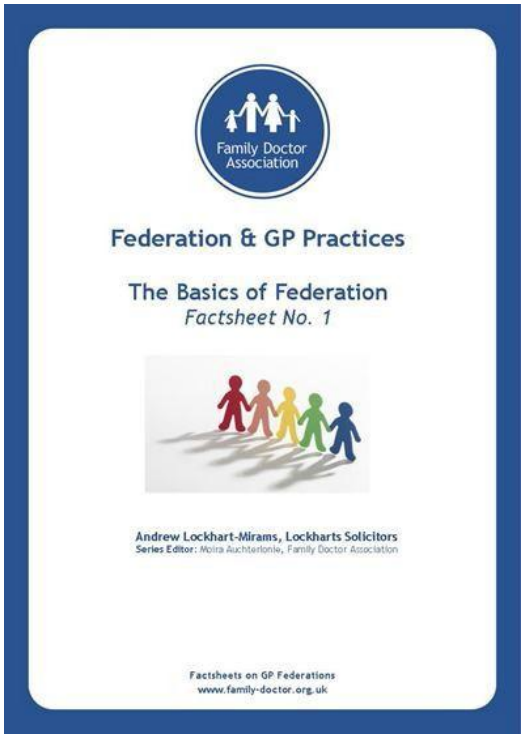
Practice premises — what to think about

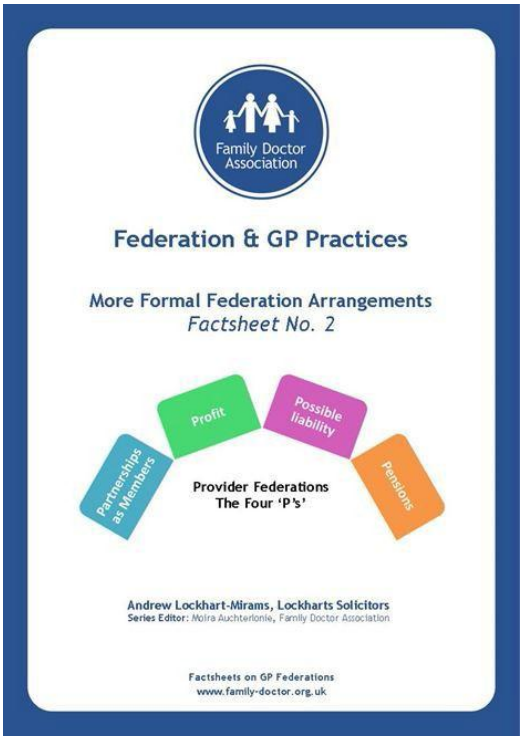
The premises in which the merging practices are based will require further consideration. Depending on whether these are freehold or leasehold, it may be necessary to arrange for the partners in one practice to 'buy in' to the property of the other practice. In order to achieve this, a valuation of the premises will be necessary and this must be carried out before the merger and recorded in the documentation. Where there are existing liabilities over the premises, arrangements for the new partners to take responsibility for the same may also be made.

Partnership deeds — again.

Finally, as a new, merged practice, an up to date and effective partnership deed will be required. Although, overall, a merger might seem like a complicated option, it offers many potential benefits. A larger practice is likely to offer a wider range of medical skills and greater specialisation and, as a result, will become more attractive to high calibre recruits. The merged practices may also stand to gain from economies of scale and the greater capacity and flexibility that they will be afforded.

Federation & GP Practices





Further resources

Useful reading: RCGP GP Federation Toolkit
Ideas: www.family-doctor.org.uk
Federation Agreements:
www.lockharts.co.uk

The three Federation factsheets can be ordered from the Family Doctor Association.

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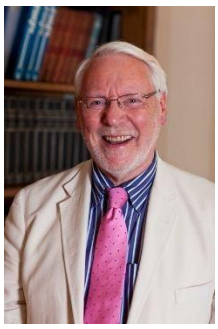
About the Author



Andrew Lockhart-Mirams
Andrew co-founded Lockharts in 1995 and has had 30 years of experience in primary care regulatory and contract work. For more than 20 years he acted for the General Practitioners Committee of the BMA on a wide range of regulatory and contractual issues affecting GPs, including the New GMS Contract in 2004. Andrew has a national reputation for his work in the development of PMS and APMS agreements. He has produced agreements for federations of practices, and shareholder agreements for provider companies wishing to provide to NHS bodies.

The Family Doctor Association

We are the national voice of frontline GPs and their practices. An educational charity founded in 1985, our members are GPs and practices that offer their patients the benefits of continuity of care; the cornerstone of UK general practice. Charity registration 299871.

Membership benefits include high quality events and updates for GPs and practice teams, a shared FDA brand and logo for member practices, and common sense updates on the myriad of NHS changes.

New Members Welcome |Practice & Individual Options| Contact moira@family-doctor.org.uk

FF10 Family Doctor Association Federation

See next page

Federation & GP Practices

GP Federations: A Reality Check

Factsheet No. 4

If not you, who? If not now, when?

Andrew Lockhart-Mirams, Lockharts Solicitors
Editor: Moira Auchterlonie, Family Doctor Association

Family Doctor Association GP Federation Series No. 4
www.family-doctor.org.uk

GP Federations: A Reality Check

This is the fourth in a series of factsheets for GPs and Practice Managers looking GP Federations. Written by Andrew Lockhart -Mirams, from Lockharts Solicitors. Andrew shares his thoughts and top tips, having worked on over 50 federations.

The Family Doctor Association commissioned these factsheets in response to requests from members. Full of tips for the unwary based on the collective experiences of other GP practices who have gone down the federation route.

Federation?

1. **If not you, who?**
2. **If not now, when?**

Introduction

So far, I have worked on over 50 or so federations and I have observed the workings of many others. I am constantly reminded of the two questions above and the realisation that if local groups do not federate, there are other large groups waiting in the wings to jump in.

Remember that once the contract has been placed by the CCG or a Local Authority, the work is lost to the local group for three or possibly even five years. Some groups start off small but increasingly I am seeing their aims expressed in terms of providing services locally "and to a wider area if the opportunity arises".

Federation Top Tips

There are some key points which I believe everyone must follow. Working from answers on a questionnaire can be helpful when it comes to detailed document preparation:

- There needs to be a **competent steering group** who are properly supported by the members. This should involve putative members agreeing to underwrite the costs, which the steering group will incur obtaining early Legal and Accountancy advice.
- Putative members have to understand the benefits of **operating through a share company** and the protection it offers shareholders in terms of limited liability.
- Groups intending to federate **have to keep the pressure up**, linking back directly to the two key questions above.
- An **early meeting between all interested parties** and key advisers is essential. At the outset, this can involve experienced lawyers; Accountancy advice can follow later.
- Obtaining proper project advice is also very valuable but this must be from a **consultant specialised in GP practice** and not merely a "business consultant".

GP Federations: A Reality Check

Federation Top Tips

- **Decisions have to be made at an early stage about funding.** CCG's may be able to assist with providing money for educational advice, but cannot fund individual projects.

- In most cases, **funding will be by subscription for shares coupled with loans** to the company. There is no set rule but 50p per patient seems to be the figure that many groups have settled on.

- Even if staff are not to be employed at the outset, the provider structure must ensure that it **can hold employing authority status** so as to be compliant with the NHS Pension Scheme for all staff.

- **Clear decisions** need to be taken about whether the provider entity aims to secure contracts for essential services type work from CCGs or Local Authorities or whether a company is to be established for work on a much grander scale e.g. operating an urgent care centre or an extended access provision. It may be difficult to put both types of operation together but identifying the aim is important, as it will have a substantial bearing on the share structure of the company.

- The **majority of entities have been formed to reclaim the old "essential services"** type work, which could be commissioned from a whole range of providers. In most cases, this is work which can be done by the local practices and be subcontracted to provide services. A company working in this way is unlikely to make a profit as such, as a large part of the contract price will be paid through to the providing practices. Only in the second case will the company be likely to make money. Advice needs to be obtained about the ways in which dividends can be distributed to members.

- When a provider entity has been set up, **provisions need to be made for "late joiners".** It is also suggested that all participating practices should stay in the company for a period of three years to allow it to become established.

- In almost every case, shares in the company are held for the benefit of the members of participating practices and I suggest that **a simple Declaration of Trust is completed**. This does not involve the revision of partnership arrangements.

- Often concerns arise about **potential conflicts of interest** between the provider company and individual practices, or between the provider company and other organisations in the area providing comparable services. These issues have to be addressed but participants should not be overawed with worry. **A simple test is would an ordinary person sitting on the top deck of a bus perceive there to be a conflict?**

GP Federations: A Reality Check

In Summary

Apart from preparing the documentation, your advisers should be able to guide you through the establishment of the company, first meetings of directors and the resolutions that need to be passed to comply with company law.

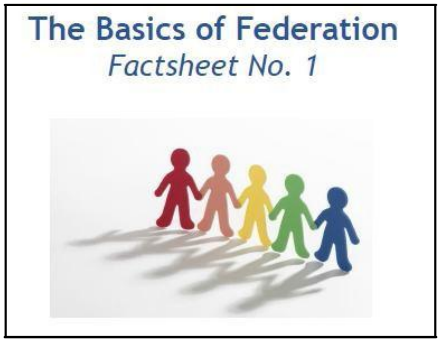
Finally, the greatest risk is to start with a lot of enthusiasm but then finding inertia creeping in.

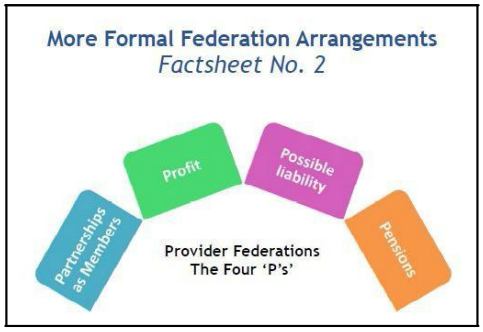
Federation?

1. **If not you, who?**
2. **If not now, when?**

Further resources

Family Doctor Association GP Federation Factsheet Series





Order the three Federation Factsheets written for busy GPs & PMs. Free to members.

Contact:
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Federation Agreements:

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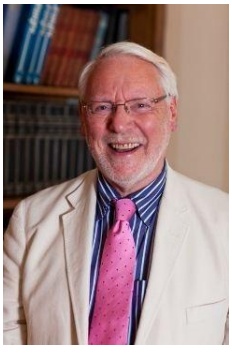

FF11 Care UK

Email dated 06 February 2015

I would be delighted to put forward 2 innovative services currently being piloted by Care UK

- Care UK was offered funding from the prime ministers challenge fund to pilot the GP super practice. We are piloting this on a 'national' scale providing patients with 24/7 access to their GP – we operate from a clinical hub based in one of our 111 call centres which provides us with the telephony platform to operate this innovative service. We have 8 participating practices. The pilot includes early access to speak to a GP, WebGP and interactive text – please see attached document. Patient feedback has been positive and patient appointments have been freed up for those that need it most.

- Care UK is currently piloting the utilisation of pharmacists within its Surrey Out-Of-Hours service. We recognised that at peak periods of OOH activity (particularly on weekends and bank holidays) we receive many dispositions from NHS 111 relating to repeat prescription requests and medication queries. We have therefore placed pharmacists working alongside operational co-ordinators and GP staff in our OOH call centre to deal with calls relating to these dispositions.

  In much the same way as a community pharmacist might give patients advice over the phone, OOH pharmacists can assess the urgency of repeat prescription requests and respond appropriately - in some cases the prescription is not immediately necessary and the patient can be advised to contact their GP in-hours. In other cases the pharmacist may be able to direct the patient to their commmunity pharmacy for an interim supply. If the prescription is immediately necessary, the pharmacist will take the patient's medical and medication history and pass the details on to an OOH GP who will write the prescription.

  Moving forward, we also recognise that many OOH calls from NHS 111 relate to relatively low acuity minor ailments and we believe that appropriately trained and experienced community pharmacists should be able to assess and advise these patients over the phone. We are in the process of creating this role, addressing training needs (such as OOH telephone consultation skills) and drafting a competency framework.

  In summary, we believe that pharmacists working in the OOH will be a cost effective resource to deal with medication issues and minor ailments, in keeping with the view that patients should be able to access the right healthcare professional for their needs at the right time.

I would be more than happy to discuss either innovation and to facilitate a visit.

Please feel free to contact me if you require any further information.

Many Thanks

Angie Hill

Angie Hill, RN, Queen's Nurse | Director of Nursing | Primary Care Division |
Care UK | 07880314198 | angie.hill@careuk.com | angiehill@nhs.net | www.careuk.com

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FF12 Care UK

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SUPERPRACTICES

Provide patients **24/7 access to a GP or other appropriate clinician.**

Solve **less urgent problems remotely**, freeing up face to face GP appointments for those that need them, when they need them.

Improve **ease of access** to medical advice and treatment.

Increased patient satisfaction as they don't have to leave home/workplace unless necessary, increased access and choice.

Reduce number of **missed/wasted appointments.**

Improve efficiency in GP practice processes.

46,000
patients covered

24/7
access to a GP

Prime Minister's Challenge Fund, February 2015

WebGP online tool

An online tool to allow patients to **manage minor illnesses and injuries themselves**, within the community or submit an e-consultation to their registered GP.

Patients can seek support and advice from **anywhere with an internet connection**, any time of the day or night.

Alleviates pressure on surgeries and hospitals by helping patients to help themselves.

Currently live at **four practices**, and will be rolled out to the remaining four practices this month.

24/7 access to medical advice

Using **remote phone consultations** to deal with health issues that do not require a face to face appointment.

Free up time for GPs to spend with the patients that require it.

Reduce pressure on **walk-in services and A&E.**

Improve **convenience** for patients; they don't need to leave their home or workplace to get care.

Utilised and adapted existing 111 call centre infrastructure for this new process.

Currently live at **two practices**, with a plan to rollout to all 8 by the end of June 2015.

"I was very impressed with such a quick turnaround, this was the best experience [of general practice] I've had yet"

8
Participating practices

94%
positive feedback

Interactive text service

Providing patients with a **reminder of their upcoming appointment(s)** to reduce DNAs.

Facility to **cancel appointments by text** – reducing calls into the practice & allowing appointments to be reallocated.

Patient focus groups revealed that text/email was a **preferable method of communication** to letters.

Customer feedback can be obtained via text.

Launching **health information** campaigns by text e.g. smoking status.

Interactive texting is currently live at **seven practices** and will be live at all eight this month.

FF13 HaRD CCG

REGISTRATION OF INTEREST

Q1. Who is making the application? **(What is the entity or partnership that is applying? Interested areas may want to list wider partnerships in place, e.g. with the voluntary sector. Please include the name and contact details of a single senior person best able to field queries about the application.)**
Harrogate District Foundation Trust Harrogate and Rural District CCG North Yorkshire County Council Tees Esk and Wear Valley FT Harrogate Borough Council Yorkshire Health Network (GP Alliance of all practices in the CCG area) This is a partnership application, however contact details for queries please contact: Amanda Bloor Chief Officer Harrogate and Rural District CCG Tel: 01423 779317 E-mail: Amanda.bloor@nhs.net
Q2. What are you trying to do? **(Please outline your main objectives, and the principal changes you are planning to make to change the delivery of care. What will it look like for your local community and for your staff?)**

Main objective:
Develop and deliver a comprehensive out of hospital model where:

- Prevention, self-care and independence are promoted
- When people need care, their needs take precedence over organisational boundaries, and people are cared for as close to home as possible
- Local health and social care system is clinically and financially sustainable for the future anticipated demands

We believe we have the conditions for success and that the model we have developed is both replicable and scalable. Each participating organisation has strong leadership, effective governance and ambition to secure a safe and sustainable future for people who contact and rely upon our collective services.

Key characteristics of our model are:

Community Hubs:
This is a key element of the model.

Each hub will integrate primary and community teams including GPs. Community nursing, adult social care, OT, physiotherapy, mental health and voluntary sector. It is envisioned that Harrogate itself will have a central Community Hub offering access 24/7, with a number of smaller rural hubs offering advice, access and care on an extended basis, including NHS services from 8-8, 7 days a week. There will also be a "Virtual Hub" offering advice and a single point of access for health, social care and the voluntary sector.

We will develop a Harrogate integrated care model, delivered through these hubs, which will include:

- Right information, advice and guidance available at the right time for the public and staff across all sectors, so that issues can be resolved at first point of contact where possible or appropriate signposting can take place

- Clear directory of services
- Access to advice and information for individuals in crisis/acute situation 24/7 – without defaulting to A&E
- Targeted prevention work to support people on the cusp of care, so, wherever possible, they do not need to use long term care services
- Common universal care plans for people who use care services
- Care co-coordinators for higher risk individuals
- Personal budgets for people with long term care needs
- Locally based integrated teams (GPs and practice nurses, community nurses and therapists, pharmacists, mental health services and social care. Voluntary sector services will also be engaged)

Principles of the model:

- Care at home is the default position – acute and residential and nursing home beds only needed when this level of medical intervention or high level of care is required. Holistic approach – brings fragmented services together
- Open up opportunities to develop integrated commissioning and service re-design, both at a macro-level (between the statutory and voluntary sector leadership partners) and at a micro-level (through personal budgets)
- Create possibilities to explore new service delivery models – for example around nursing home provision, extra care and domiciliary care
- Involve people who use services and carers at the heart of decision-making: in relation to care and in how together we design and deliver services

Benefits for people using services:

- Easy to access advice and resolution of issues at first point of contact wherever possible
- Support to remain independent, safe and well at home
- Streamlined access and referral arrangements

- Care and support planned on the basis of a single assessment and designed to meet holistic needs
- More timely and responsive services
- Access to telehealth/telecare solutions where appropriate

Harrogate Model of Care

Since being established as a CCG in April 2013 Integration of Care has been our priority work programme. Likewise, the County Council has a strong track-record for developing extra care and supported living and is planning further investment in these services and a range of Public Health-related interventions through its 'Stronger Communities' and targeted prevention programmes. The organisations submitting this bid are committed to the development of integrated community-based health and care services across Harrogate and Rural District.

Collectively, we have already made significant progress. The CCG and NYCC, along with partners, are now at a critical point in re-designing many of our community based services to deliver against our vision, with the express intent of securing a new model of care provision. Selection as a vanguard site would come at an ideal time in this work. The new models of care set out in the 5 Year Forward View reinforce our existing direction of travel. Becoming a vanguard site would act as a catalyst to the mobilisation of our model and enable us to accelerate the implementation of our vision for integrated care.

The CCG and its partners have undertaken considerable stakeholder engagement (the public across Harrogate and Rural District, colleagues from primary, community, secondary and social care sectors, and the voluntary sector) to help develop the proposals for Care outside Hospital and an integrated service model.

The engagement activity that has taken place has helped develop the model of care we wish to commission. Our focus is to build stronger and better services to support the needs of patients in the community as well as maintain safe, sustainable and effective hospital services.

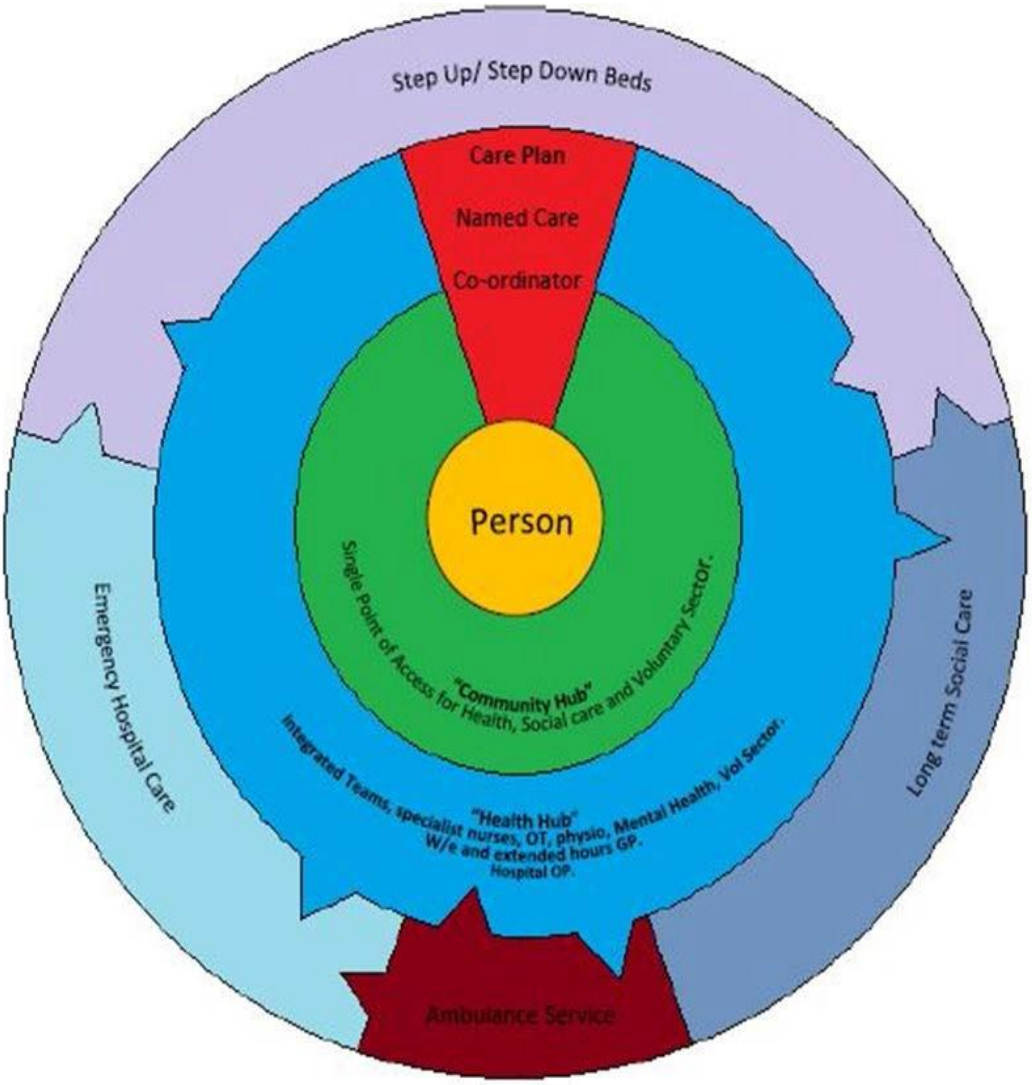
The partners bring together the expertise, economies of scale and good practice that they have established from the different footprints on which they operate: at neighbourhood level, across the Harrogate and Rural district, around North Yorkshire and beyond, as emphasised in our Better Care Fund plan:

- Promoting prevention and self-care
- Investing in primary and community services
- Ensuring sustainability in secondary care services and the protection of adult social care

People who use services and carers are a key part of the model - at an individual level and across the whole system.

Parity of esteem between emotional and mental health and physical health is at the heart of our model.

Our ambitions as a Vanguard economy will be focused on the individual person with services aligning around them as outlined below:



Q3. Which model(s) are you pursuing?
(of the four described)

Our focus has been on co-creating a radically different model to secure a comprehensive integrated, locality based solution using best use of technology, skills and local infrastructure. A key part of this has been adopting an outcome based approach.

We would, in the first instance, aim to develop a single contract across health services, closely aligned with NYCC contracts for domiciliary, residential and nursing care. Our ultimate ambition would be to derive a single contract for the totality of care provided to our population.

This is most closely aligned to the MCP model described although in reality is more likely to represent a blend of MCP and PACs and enhanced support for care homes

Early discussions with some of the trail-blazer sites and experts within the DH have contributed to a vison including:

- A single weighted –capitation, outcome-based contract for NHS services based on a defined population. This might be the top 4% of patients already identified as most vulnerable to non-elective admission or perhaps all patients in the locality suffering from multiple long term conditions. We are also looking with interest at emerging evidence for the use of an electronic frailty index to target patients at need
- Identification of current costs related to this cohort and pooling of monies to enable re-structuring of services
- An important part of our vision is to dissolve current boundaries between care sectors and design locality teams aligned to common goals and outcomes
- We are exploring opportunities as a system around risk management, aligning incentives to outcomes and exploring new contractual vehicles to create genuine partnerships
- Whilst the model we propose has clearly been developed locally, and reflects the specific needs of our population, we believe it also outlines a number of tangible elements which could be employed elsewhere within the UK as new models of care

Q4. Where have you got to?

(Please summaries the main concrete steps or achievements you have already made towards developing the new care model locally, e.g. progress made in 2014.)

Local system leaders are united on the common vision for services locally.

Extensive work has been undertaken with clinical and management teams across organisations to jointly develop the model.

There has been significant work engaging with patients and the public on the future direction of local services. Additionally the direction of travel and focus on prevention, self-care, integration and care closer to home are the underpinning driver in the North Yorkshire Better Care Fund Plan which has been signed off by the North Yorkshire Health and Well Being Board.

During 2014-15 the CCG and County Council have already implemented pilot schemes making a significant investment which support care outside hospital and are therefore already delivery and testing the elements and functions of the model for roll out across Harrogate and Rural District including:

- Extension of services to support people with rehabilitation and re-enablement needs in their own homes following hospital admission or attendance
- Extension of ambulatory care and rapid diagnostics to prevent the need for Hospital admission
- Psychiatric assessment and liaison service
- Additional capacity of therapy services in community hospital
- Additional resources to the voluntary sector

- Re-commissioning of an integrated community equipment service. This will result in an improved and more responsive 7 day service that will support our expected increase in activity to support patients/ clients in their homes.

We have made progress in aligning staff teams in one locality within the local patch, and this is working well.

We are working with the Academic Health Network and DH Connecting Team around data sharing and developing shared systems to redesign health and social care planning

Critical success factors for the vision have been identified, including the requirement for leadership and staff development, linked patient/customer level costing information, inter-operability between information systems, new skill sets and systems/processes in the out of hospital workforce, adoption of telemedicine and telehealth techniques.

A system wide bed utilisation audit was conducted in November 2014 (CAPA tool) which has provided tangible evidence of the scale of opportunity and the nature of unmet clinical need. All stakeholders participated in and own the outcomes of the audit.

The top 4% of vulnerable patients has already been identified, funded through the DES and the additional 2% through CCG investment. This cohort of patients all now has an Enhanced Care Plan in line with the RCGP Two-Visit Model.

We have the benefit of all local GP practices being part of a legally constituted GP Alliance which is capable of entering in to contracts with other providers.

Strong and effective leadership arrangements are in place in each partner organisation and clear governance for programme delivery is in place.

The health and local government systems have a proven track record of driving efficiencies. In its first year of being a statutory organisation the CCG eliminated a deficit of £1.8m inherited from its predecessor PCT. Harrogate and District Foundation Trust is a high performing small/medium sized vertically integrated Trust with a strong track record of innovation and sound financial performance. North Yorkshire County Council equally has a reputation for political and financial stability, high quality service delivery and the economies of scale to support sustainability.

Health and social care partners have already implemented enhanced care in the residential and care home sector with additional investment from the CCG. This includes having a single designated practice for each Nursing Home and enhanced support and training of care sector staff. Further work has commenced to develop the local nursing home market and new models of extra care are being introduced.

CCG and Public Health investment is being made into a network of universal and targeted prevention services – these include the Stronger Communities programme (focused on community asset-building and self-care), prevention officers (working with people on the cusp of care) and falls, bereavement and mental health preventative support services. All partners are working together to develop a shared approach to information, advice and guidance, including a local single point of access and the County Council's Customer Resolution Centre.

Q5. Where do you think you could get to by April 2016?
(Please describe the changes, realistically, that could be achieved by then.)

The main element of service change to deliver the new model of care is the integration of staff teams including GPs, working together in locality based hubs. This is about aligning staff with common work plans, objectives and accountability to work seamlessly around the needs of the individual, within a clear governance framework.

A key enabler to this and the drive for common care plans and access to information is in a common integrated IT system across the area.

By April 2016, subject to the right levels of support being available, we would anticipate:

- A single point of access for the new model of care
- Identification of a defined 'community of interest' i.e. the population to whom the new model of care will apply
- An aligned budget for this cohort of people. We anticipate a year of running in shadow with an open book approach to income and costs, and shared risk/gain agreement
- The creation of a novel Joint Venture partnership accountable for delivering the totality of NHS out of hospital care, aligning with social care and exploring opportunities for new joint approaches across the NHS and the County Council
- Systems for tracking cost across the patient pathway on a year of care basis.
- Agreed NHS contract currencies based on a blend of activity, outcome and stretching quality metrics
- Agreed thresholds for sharing risk within the NHS contract and with aligned social care budgets
- Case management methodologies including systems for tracking at risk and actual admissions enabling in-reach by the community locality team to expedite safe transition back to home and prevention of unnecessary admission to hospital or 24 hour care
- A single point of access for information, advice and guidance and a clear focus on keeping people independent and preventing the need for long term use of care services wherever possible
- An agreed Information strategy and delivery plan with the requisite investment planned for. Over the timescale of the plan (not all in the first year) this will support improved use of information facilitated by secure consent-based information sharing. This will enable patient (and cost) tracking, a single shared electronic record, predictive modelling for demand and capacity, efficient 'live' resource utilisation methodologies
- Shared leadership and development programmes for staff and, where appropriate, a shared approach to terms and conditions

Q6. What do you want from a structured national programme?
(Aside from potential investment and recognition: i.e. what other specific support is sought?)

We would like support in the following areas:

- systems modelling - to enable us to map through the expected system impact
- financial modelling - to break down the complexity of NHS tariff and social care funding to model tariffs for integrated care services
- contractual/procurement expertise– to explore contractual mechanisms for this new care provision including exploring the opportunities arising from APMS contracts and other flexibilities in relation to contractual models
- organisational development and support to engender the right professional culture to embed change. support to integrate personal health and social care budget where feasible
- support to explore new models of care delivery around joint ventures between the NHS and the County Council

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:

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

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

❑ Please tick

3. Lead contact details:

Proposal on behalf of:	Yorkshire Health Network Ltd (YHN Ltd)
Project Lead:	Dr John Crompton & Dr Peter Banks
Job title:	GPs & Directors of YHN Ltd
GP Practice/Organisation:	Yorkshire Health Network Ltd
Email:	John Crompton John.Crompton@gp-B82032.NHS.uk Peter Banks pbanks@yorkshire-health.co.uk
Telephone:	John Crompton Tel: 07765933130 Peter Banks Tel: 07712839963

4. Practices involved:

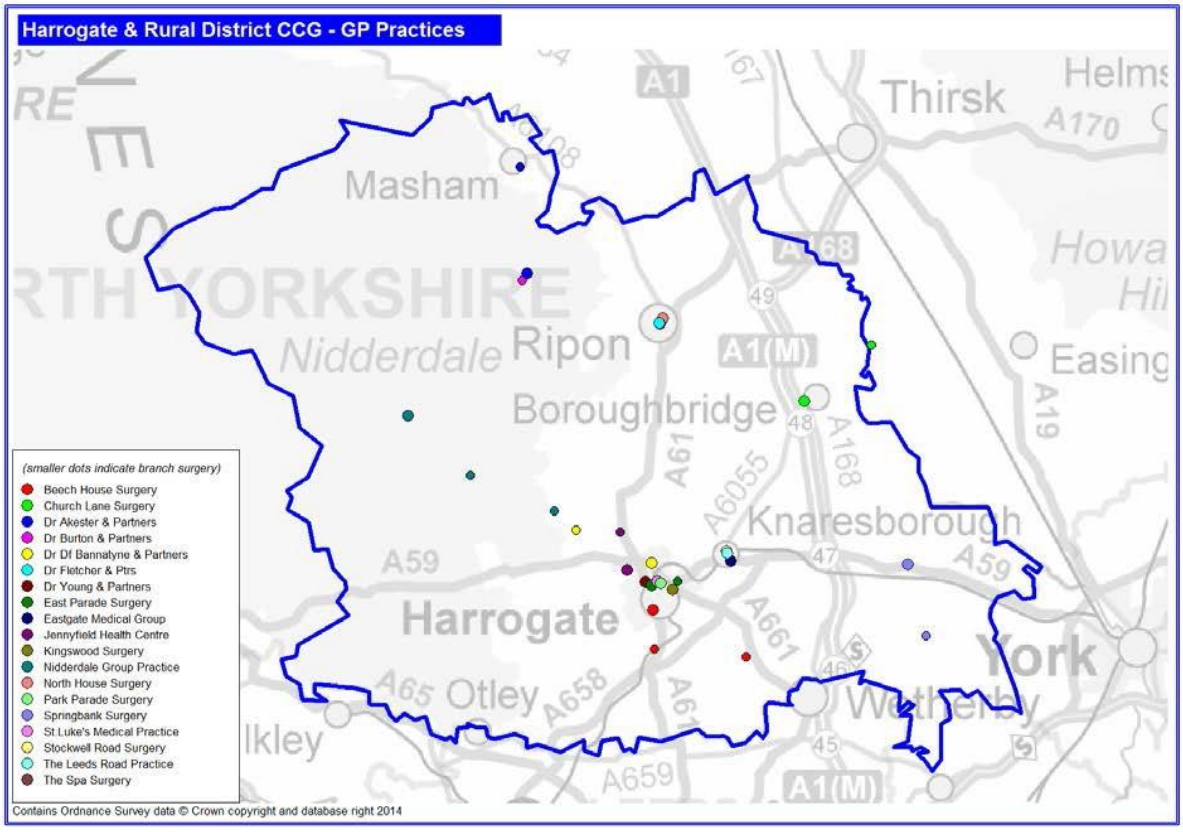
Please indicate which GP practices are covered, where they are located and approximate population size for each.

Practice name	Practice code	Post code	List size
Leeds Road Practice	B82012	HG2 8AY	13311
Moss and Partners	B82013	HG1 5JP	19907
The Spa Surgery	B82027	HG1 5AR	10181
East Parade Surgery	B82016	HG1 5AR	6955

St Lukes Surgery	B82076	HG1 5AR	5129
Park Parade Surgery	B82091	HG1 5AR	6330

Kingswood Surgery	B82014	HG2 7SA	6909
Dr Bannatyne & Partners	B82059	HG1 4HG	11150
Eastgate Medical Group	B82060	HG5 0AD	11569
Beech House Surgery	B82069	HG5 0UB	7876
Stockwell Road Surgery	B82067	HG5 0JY	6507
Springbank Health	B82057	YO26 8BN	5651
Church Lane Surgery	B82032	YO51 9BD	10121
Ripon Spa Surgery	B82010	HG4 2BE	6993
North House Surgery	B82008	HG4 1HL	9125
Dr Fletcher & Partners	B82036	HG4 2AX	7188
Dr Akester and Partners	B82030	HG4 4DZ	5511
Nidderdale Group Practice	B82004	HG3 5AT	10314

Total population covered	160,727



5. Other providers involved:

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

The following providers have been consulted and have given their support to this project:

Dr Ros Tolcher, Chief Executive,
Harrogate and District Foundation Trust (including OOH and Community Services)

Vince Larvin, Locality Director for North & East Yorkshire
Mark Inman, Head of Emergency Operations
Yorkshire Ambulance Service Foundation Trust

Richard Webb, Corporate Director
North Yorkshire County Council

Adele Coulthard, Director of Operations
Tees, Esk and Wear Valleys NHS Foundation Trust

Tony Collins, Chief Executive
St Michael's Hospice, Harrogate

Karen Weaver
Chief Executive
Harrogate & Ripon Centres for Voluntary Services

6. CCGs covered:

Please indicate which CCGs are involved in this application.

Amanda Bloor, Chief Operating Officer
Harrogate and Rural District Clinical Commissioning Group
1 Grimbald Crag Court
St James Business Park
Knaresborough
HG5 8QB
Tel: 01423 799300
Fax: 01423 799301
Email: hardccg.enquiries@nhs.net

7. NHS England Area Team:

Please indicate your NHS England Area Team.

Geoff Day, Head of Primary Care
Area Team – North Yorkshire and Humber
NHS England
Unit 3 Alpha Court
Monks Cross
York
YO32 9WN

Mobile: 07900 715484
Email: Geoff.Day@nhs.net

8. Patient satisfaction:

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

All 18 practices take part in the Extended Opening DES and have consulted their own patients through their annual patient surveys regarding preferences for opening hours. The practices have then provided the best fit for opening hours and these have been approved by the local area team.

The results of the GP Patient Survey for 2013-2014 for HARD CCG is displayed below. This indicates that whist there is high general satisfaction with services provided, almost 40% of the local practices are below the national average for satisfaction with opening hours and convenience of appointment times.

		Practice	Satisfaction with opening hours			Overall experience of making an appointment			Able to get an appointment			Convenience of appointment			Ease of getting through to someone at GP surgery on the phone			What did you do on that occasion? (Those unable to get an appointment are convenient appointment)
CCG code	Code	Name	% Satisfied (total)	95% Confidence Lower limit	95% Confidence Upper limit	% Good (total)	95% Confidence Lower limit	95% Confidence Upper limit	% No	95% Confidence Lower limit	95% Confidence Upper limit	% Not convenient	95% Confidence Lower limit	95% Confidence Upper limit	% Not easy	95% Confidence Lower limit	95% Confidence Upper limit	% who used another service or did not see or speak to anyone^
		Results for England as a whole	77%			75%			11%			8%			24%			23%
03E	B83004	NIDDERDALE GROUP PRACTICE	90%	82%	94%	100%	94%	100%	0%	0%	4%	1%	*	6%	5%	1%	8%	~
03E	B83006	NORTHHOUSE SURGERY	84%	75%	90%	85%	75%	91%	6%	3%	13%	0%	0%	4%	4%	1%	12%	~
03E	B83010	RIPON SPA SURGERY	75%	65%	83%	79%	69%	87%	13%	7%	23%	4%	1%	12%	10%	5%	18%	12%
03E	B83012	THE LEEDS ROAD PRACTICE	67%	57%	75%	85%	76%	91%	13%	6%	21%	16%	10%	25%	24%	17%	33%	9%
03E	B83013	DR YOUNG & PARTNERS	87%	78%	93%	91%	83%	96%	1%	0%	7%	8%	4%	15%	8%	3%	16%	13%
03E	B83014	KINGSWOOD SURGERY	75%	67%	81%	73%	65%	80%	13%	7%	21%	16%	9%	27%	11%	6%	18%	19%
03E	B83016	EAST PARADE SURGERY	74%	65%	81%	84%	76%	91%	5%	1%	10%	9%	4%	19%	9%	4%	17%	0%
03E	B83027	THE SPA SURGERY	85%	78%	89%	72%	62%	80%	7%	3%	13%	9%	5%	16%	10%	5%	18%	0%
03E	B83030	DR AKESTER & PARTNERS	81%	73%	88%	85%	77%	91%	7%	3%	13%	10%	5%	18%	4%	1%	9%	9%
03E	B83031	CHURCH LANE SURGERY	84%	76%	90%	88%	81%	93%	7%	3%	13%	1%	*	5%	5%	1%	9%	11%
03E	B83036	DR FLETCHER & PTNS	95%	88%	98%	99%	94%	100%	2%	0%	7%	1%	*	4%	5%	1%	12%	~
03E	B83037	SPRINGBANK SURGERY	78%	69%	85%	82%	73%	89%	10%	5%	18%	8%	4%	15%	10%	5%	18%	10%
03E	B83039	DR DP BANNATYNE & PARTNERS	65%	54%	75%	58%	47%	68%	10%	5%	19%	13%	6%	21%	42%	32%	53%	28%
03E	B83060	EASTGATE MEDICAL GROUP	78%	69%	85%	84%	76%	90%	7%	3%	14%	5%	2%	11%	29%	21%	39%	20%
03E	B83067	STOCKWELL ROAD SURGERY	84%	76%	90%	95%	89%	98%	4%	1%	11%	2%	*	6%	1%	*	6%	~
03E	B83069	BEECH HOUSE SURGERY	72%	63%	80%	81%	72%	89%	7%	3%	15%	5%	2%	14%	7%	3%	15%	28%
03E	B83078	ST LUKES MEDICAL PRACTICE	73%	63%	80%	77%	67%	85%	14%	8%	24%	10%	5%	19%	15%	7%	31%	21%
03E	B83091	PARK PARADE SURGERY	82%	73%	89%	84%	76%	91%	4%	1%	11%	4%	1%	10%	14%	8%	23%	~
03E	B83627	JENNYFIELD HEALTH CENTRE	69%	59%	77%	67%	58%	75%	8%	4%	16%	13%	7%	21%	11%	6%	18%	19%

* Indicates less than 0.5%
~ Indicates data suppressed due to small numbers
^ Respondents who indicated that they used another service (eg went to A&E) may also have seen or spoken to someone at their GP surgery

[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.

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.**

This project aims to develop a **primary care led responsive, integrated model of care** for those patients identified by validated risk stratification, as being at greatest risk of unplanned hospital admission. Developing and testing this new model for care provision **at evenings (6.30pm – 8pm) and weekends** will be the foundation for building a strong primary care and **out of hospital care system** benefitting the **entire CCG population of 160,000 patients**.

The project builds upon work already undertaken in the HaRD CCG area where in the last 6 months **enhanced care plans have been developed by the local GPs for 4%** of the most vulnerable patients across all practices. We have identified that this group, with complex co-morbidity, the frail elderly, care home residents, dementia, mental health and palliative care patients experience frequent, often prolonged, avoidable admissions, or A+E attendances, many occurring OOH. This is evidenced by a recent multi-stakeholder audit of bed utilisation which has confirmed a significant opportunity to reduce dependency on hospital beds. The current care plans, with consented access to share records and in many cases documented advanced decisions put us in a unique position to manage these patients differently. This can however only have a true impact on the local health economy if we can develop new ways of working and extend, and **reconfigure not only primary care but other community and support services**.

This model and bid has not been developed in isolation and we have the **key engagement of and share a vision with the local commissioners and providers** including: the CCG, secondary care, community services, ambulance, 111 and OOH services, palliative care, mental health services, voluntary sector and social care.

The new service will be a community based model, focused around enhanced local GP service provision working as part of a **Primary/Community collaboration** and supported by community nursing teams, with the aim of responding to medical need and where appropriate coordinating integrated care for this group outside standard working hours to manage the patient outside hospital. Initial access would be through the 111 system where calls identified for a vulnerable care plan patient would be transferred through early exit from NHS 111 to the new service. Following comprehensive GP clinical triage with access to records and care plans, GP response may be delivered in a variety of forms, with the increased use of **assistive technology including e-mail and potentially Skype and telemedicine.**

Building a responsive integrated care team around this new service is key to

success. This will require developmental work with social care, community nursing, secondary care, mental health and palliative care services. We will work closely with fast response and palliative care teams as well as social care, developing collaborative teams based around localities with the outcome aim of developing **new models of multidisciplinary locality based teams**. These teams will proactively manage risk patients in their own homes, and play an active role in facilitating timely discharge from hospital should admission be necessary. The recent bed audit has indicated that locally we need to be **more proactive in 'pulling' patients through the system with more planning for discharge**. Providers of these services have all been consulted and are engaged in the vision, recognising the specific needs of this vulnerable group and the current often inappropriate utilisation of resources by this cohort of patients, for whom we need to **develop truly shared care plans and records**, and manage in a new way.

A key element in this bid will be developing a robust model for the **sharing of patient records between all stakeholders.** This project will allow us to develop local systems to achieve fully interoperable information and technology. Locally the vast majority of practices, secondary care, palliative care and community services all have access to SystmOne. We have explored models currently available with **Digital Primary Care England** and believe we can develop interfaces to provide effective sharing of records across all agencies, creating a system that can then extend to in hours and to larger cohorts of patients.

This project has developed from a realisation that a major transformation of services is required if we are to meet the challenges of our local health community. In the Harrogate and Rural District we have high quality primary and secondary care services working at capacity to manage a patient group with a prevalent and increasing elderly population, with a large number of care home beds.

Because of historical lack of investment in community services in our area major development is necessary but this can only occur if we can pump prime changes in service delivery, shared IT and innovative new ways of working, which can then develop and grow. **This will be the first step in developing a new way of working in the HaRD CCG area, which can extend to in hours and ultimately 24/7.**

This service is designed around and will benefit **the whole CCG population**. Every patient across the CCG may at some point, identified through risk stratification, enter what we envisage will be an increasing cohort of enhanced need and be managed by the integrated team. Our urgent care systems are currently under severe strain because these more complex patients are not effectively dealt with, getting stuck in and blocking OOH, Ambulance, A+E services and secondary care beds. In many cases this results in a poor patient experience and fails to secure the best outcomes for individuals. Managing these patients effectively will **improve access to conventional OOH and A&E services for all**, so they can become more responsive and effective for the cohort they best serve. We also expect that it will release primary care capacity in appointments to other local patients not in this

cohort but needing to be seen in primary care.
Starting to address this fundamental issue will allow us to develop new models of in hours service provision across the CCG tailored to the needs of individual patient groups. This will be the start of developing services that move away from the one size fits all model of in hours and out of hours care with improved use of technology, flexibility of and responsiveness of access and shared working across practices and services whilst maintaining local delivery and accountability. **Crucially, it will drive up all aspects of quality by improving safety and responsiveness, patient experience and long term outcome.**

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].

Our project will be effective by **managing high risk and therefore high demand** patients, efficiently and effectively so that the whole system will benefit and the patient journey will be a better experience for all users. It will **break down barriers between organizations, help to develop comprehensive joint working** and pump prime a change in delivery to allow further development, integration, and a new way of working.
By involving patients, carers and relatives in the care that is received and by giving them better insight and understanding into the patient's condition we feel that **patients will have improved satisfaction**. Also **giving patients more involvement and control with regard to the treatment** they receive will allow more appropriate care to be given in a more appropriate settling.
Progress so far
In our CCG area we have already (using the RAIDR software) identified the top 4% of the population who are at most risk of needing an emergency admission in the next year. These patients have all been given a care plan by their registered practice. As part of this work **patients were asked if they were happy to consent to sharing their record**. Only a very small number of patients objected to this, so nearly all patients in this high risk group have already agreed to record sharing with other agencies involved in their care.
This work was undertaken last year and **we are currently evaluating outcomes**. We believe this will demonstrate that patients feel more involved and have a better understanding of their medical conditions. Patients are already being encouraged to share their care plans with other agencies and also to take ownership of them, adding information as appropriate.
The CCG share our ambition to continue this work and to expand the care plan

[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.

project next year by **collaborating with other providers and stakeholders to produce shared unified care**. This will help to bring together the work done by other agencies and providers thereby promoting integrated multidisciplinary working. For example there are already “palliative care” care plans and “community nurse specialist” care plans that will be added to this unified patient held care plan in the future.

Benefits of the new service

Patients & Carers

Patients and carers have told the CCG through extensive engagement that they want joined up services closer to home and not to have to repeat information to different agencies. The vulnerable patient group which includes those finding it difficult to access health care, will benefit by **receiving a responsive coordinated approach to their request for urgent care**. NHS 111 will identify the patient as being a “high risk” patient and will direct them to the new service where they will then receive **advice from a GP who has full access to the patient’s own primary care record and care plan**. This will allow the patient to feel more confident that the doctor with whom they are dealing has a good grasp of their medical problems as well as their wishes and desires regarding future care (for example their wish regarding resuscitation and related to hospital admissions).

As part of the care plan, patients will be informed as to how to access urgent care and so will feel more confident that they will receive appropriate and informed advice and care and so will **choose the new service over any other including A&E**.

All patients who require urgent care will also benefit as pressure will be taken off the out of hours and A&E services by the removal of the “high risk” complex patients (to the new service), thereby freeing up resources and reducing waiting times.

Secondary care services

With sight of the care plan **secondary care clinicians** will be able to more quickly and easily ascertain the patients’ medical problems, their social and carer support, as well as their **wishes and desires regarding their care**. This will allow patient care to be tailored to their wishes as well as leading to more joined up working and an earlier discharge. This is particularly important for palliative patients who may for example wish to die at home.

Primary care

An immediate benefit of the new service will be noticed by the out of hours service (OOH). As they will no longer deal with high risk complex patients during the 8am-8pm Monday-Friday period and day time at the weekends. Without full knowledge of the patients there has possibly been a tendency to send an ambulance or admit these patients when this might not have been appropriate if full access to the medical records was available. This is particularly likely when demand is high from other patient/user groups.

General practice will benefit in a less dramatic but a more evolutionary way.

Practices will have access to the IT infrastructure, available in the new service, on a daily basis which will allow day time home visiting with full live access to the medical record with the obvious benefit that this will bring. Primary care will also benefit by closer working with other agencies through their involvement in producing, unifying and sharing care plans. This will give more **efficiency gains in terms of GP time releasing appointments for other patients**. We see this new service as being a stepping stone towards **more collaborative, hub style, working throughout the 24hr period.**

Voluntary sector and social care

Social care and the voluntary sector will be closely linked to the care plans and the new service allowing a more integrated and responsive service from them at a time that the patient needs it most. We are hoping that with **closer working** the voluntary sector will be able to be more responsive putting in services at short notice to support patients in need.

The system as a whole

Following **engagement with the local population**, our health and social care stakeholders led by local CCG have developed a strategy and plans which reflect local view of the need to join up and provide care closer to home. We are currently working closely together to build a hub style integrated model for urgent care, thereby allowing joined up working leading to **admission avoidance** and **early discharge with more care being community based**. The new service we are proposing is a critical corner stone to this plan as it allows the foundations of the new model to be formed.

Changing the whole structure of the NHS locally is a difficult and complex task. **We see this new service as a stepping stone towards more integrated seamless care with services being better targeted at those most needing them.**

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.*

Service Hours

The new service will be run from **6:30-8pm Monday to Friday and initially on Saturday and Sunday 10am- 4pm** (allowing for one shift each weekend day). We would evaluate the effectiveness of the service on the weekends in particular and look to expand the working time, if likely to be effective, to encompass the 8am - 8pm time period seven days per week. The service would care for any patient in the at risk group, within the CCG, who requests urgent care during this time period.

Population/geographical coverage

The service will cover all the practices in the CCG area (18) which has a total

population of 160,000 patients. The CCG area aligns neatly with the local foundation trust with only some patients on the periphery of the CCG locality being referred or admitted outside of the area.

Staffing

Initially staffing of the service will be by GPs, health care assistants, and palliative care workers. We see this team as rapidly expanding to include specialist nurses, OTs, physiotherapists, mental health workers, voluntary sector and social care workers in line with vision and strategy of the local health community. Month on month intelligence, which we are already collecting, relating to A&E attendances and hospital admissions, will inform us of what capacity and skills will be needed as the service develops.

GPs providing the service will already work in the locality. They are already experienced in the care plan approach to patient care and in working as part of a multidisciplinary team. Our organization has already successfully recruited local GPs to run another project and we are aware that the GP out of hours service (OOH) is run on the whole by local GPs, so we feel **confident that recruitment of local GPs to the new service** will not be a problem.

We envisage the initial service would have at least two GPs on at any one time. One GP would cover Harrogate and the immediate locality whilst the other GP would cover the smaller rural towns and villages. The GPs would have the support of a health care assistant to help with managing patients and liaising with other services and organizations, performing basic nursing duties and helping with administration and notification back to the patient's practice/GP.

Other staff would be recruited and deployed based on our learning experience as the service becomes established.

IT

Fifteen of the CCG practices are on SystmOne as are the palliative care/hospice services, community nursing services, fast response team and specialist nurses. The remaining three practices in the CCG are with EMIS. As full integration between primary care systems is not yet achievable we need to do some work to find the best solution. **MIG** is a possibility with read and write back potential, there are **also SystmOne and EMIS viewers** that could be used or we could opt for having both SystmOne and EMIS available to staff who would be required to log onto individual practice systems as patients present. **Work on optimizing the IT infrastructure would be an early key part of our work.**

Integration with other agencies

The new service as an integral part of a health care hub will work closely with other providers, but in particular will have good communication with other agencies especially those working in parallel in the community. This will build on work being done during the "in hours" period and will allow and encourage standardization across the CCG area, with closer more efficient and aligned care being provided

across agencies generally. With standardization, patients and messages will be able to be passed between agencies efficiently and quickly allowing closer more efficient working of staff within primary care, the palliative care service, community and specialist nurses, OTs and physiotherapy services as well as the fast response team. There will also be better communication and working with social care, the voluntary sector and secondary care.

The patient Journey

The patient will contact the new service through NHS 111 and will be passed to the new service. The patient will then be triaged by the GP where further information can be taken. The following options will then be available to the GP and patient as needed:-

- Arrange a face to face appointment in the OOH Centre
- Arrange a home visit
- Advice given by telephone
- Referred on to other agencies
- Assistive technology contact:

  Skype call (or telemedicine) is arranged (initially this will be trialed with the care homes but if successful could be rolled out to other patients),
  SMS or email
  Having completed the episode of care an entry will be made in the GP record and a message passed to the practice notifying them of the contact and any further actions that might be needed.

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).

The key element to this project is that it focuses on the area of **highest resource utilisation** and that it integrates with the wider vision for how local services need to develop.

Emergency admissions have been shown to account for more than 70% of hospital bed days with 80% of admissions of duration greater than 2 weeks being in the over 65s (Poteliakhoff and Thompson 2011). The Kings Fund have identified the need for alternative options and the ability to offer rapid responses in the community would **avoid significant admissions** that currently are not clinically justified. An impact on just a proportion of these admissions will **free up resources** to maintain and develop the service.

The project is designed to develop **joint ways of working, integration and shared IT** solutions that can be adopted to develop in hours services across the CCG area.

We therefore believe it is **sustainable as part of a wider reconfiguration of services and the Primary–Secondary care interface**.

Sustainability can only however be achieved if we can deliver a new service effectively in year and begin to deliver results. Reasons we believe we can achieve this locally are;

- **Engaged local practices**, already working together who have been committed in developing over 6000 RCGP type 2 visit model care plans identifying their most vulnerable patients and support service redesign who have been consulted and support this bid.
- **An alliance of GP practices (Yorkshire health Network Ltd)** that is already established and up and running and managing 2 current contracts covering all 18 practices; conterminous with the CCG who have already engaged and working local services and drive forward and manage the project .
- **Established effective engagement** and close working with local stakeholders within the NHS and social care. HaRD CCG (our commissioners), Harrogate District Hospital NHS Foundation Trust (providing local secondary care, OOH and community nursing services), St Michaels Hospice (providing palliative care services), Tees Esk Wear Valley (providing mental health and dementia services), Yorkshire Ambulance Trust (NHS 111 and ambulance services) and North Yorkshire County Council (Adult social care) have all confirmed their clear shared vision and the leadership commitment to make it happen.
- **HaRD CCG strategic plan** sets the direction for commissioning and they have indicated that this bid **fits well with their plans**. YHN Ltd has a mature and developed working relationship with a proven effective CCG with **a shared goal** of developing high quality and responsive local services. We have done some work on primary care development with NHS IQ and found it really useful. This project, whilst developed by YHN Ltd, incorporates the knowledge and vision of the CCG governing body and its Council of Members on how services need to develop locally. It also picks up many of the themes outlined in the **NHS Five Year Forward View.**

We believe sustainability will also be achieved through **resources freed up from reduced A+E and hospital admissions and facilitated early discharge** and will be a key element in a new system of working moving forward. The model could also provide medical input into expanded intermediate (step up/step down) beds. YHN Ltd is committed to its success and the CCG is fully supportive of the bid with the aim to support the scheme moving forward if it can deliver **cost effective change**.

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?

NHS Harrogate and Rural District CCGs **five year strategic plan** (May 2014) contains the following aims

- An increase in community capacity and effectiveness including scaled up primary care
- A decreased reliance on admission for urgent care
- Working well together at operational level , integrating across boundaries with patient centred care
- Have IT systems that work effectively across all boundaries

The 5 year strategic plan challenges the workforce

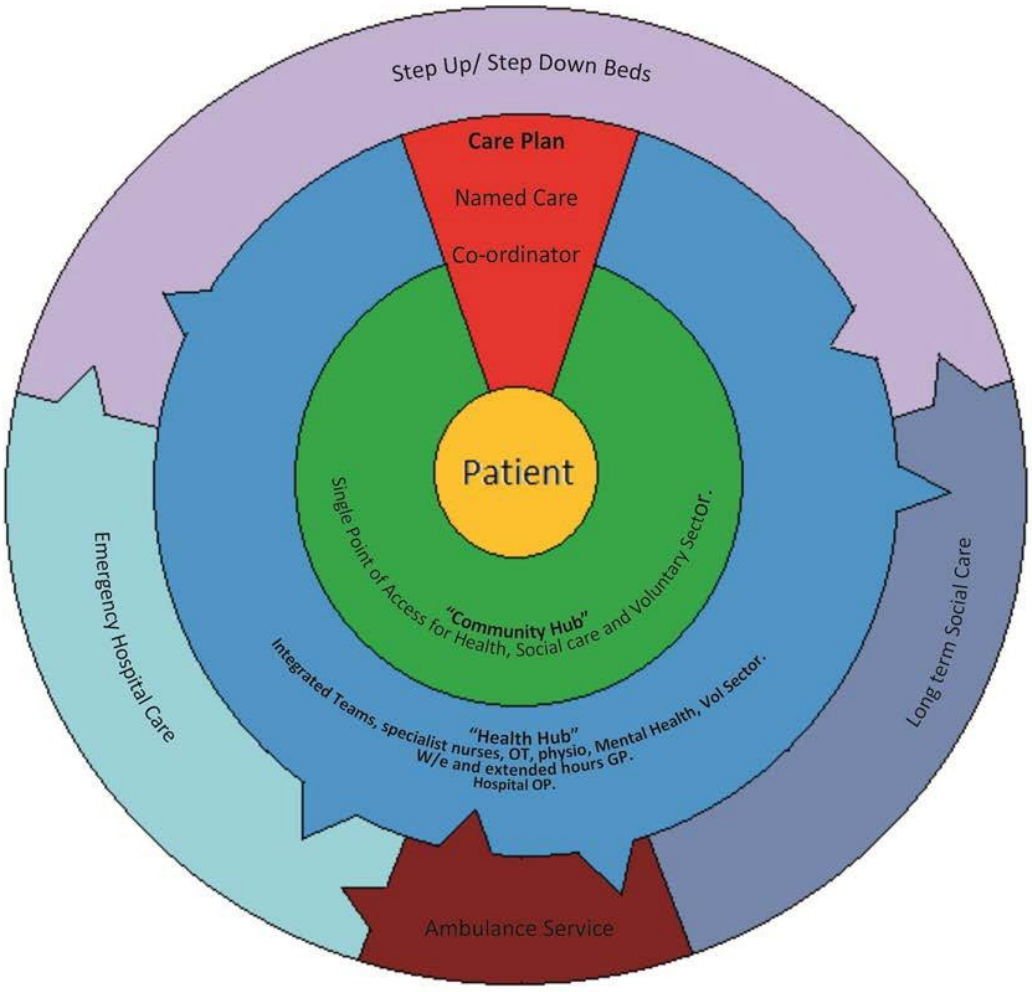
- To have the right capacity in the right place to deal with changing needs
- To embrace 7 day working
- To use assistive technology where appropriate

The CCG has been leading local stakeholders to develop **'Harrogate Vision for Out of Hospital Care' (see Figure 1)**

This bid addresses all these aims. The NHS, even locally, is a large and complex organization. When working at capacity change management can be difficult. We believe this project however can achieve these aims and force the pace of change by concentrating on a manageable cohort of patients and laying down the foundations for wider system restructure.

The bid clearly focuses on the development of the Harrogate CCG 'Vision for Out of Hospital Care by 2020' and **promotes continuity of care with access to full records** and provision of the service by **local GPs** and members of YHN Ltd. As described this project is part of a wider system change to improve quality and productivity of local NHS services. The risk profiling to identify patients likely to most benefit from care plans has identified the vulnerable elderly and mental Health patients who often are not served well by current systems, particularly in crisis times and OOH and this project would seek to address these inequalities.

Figure 1: Harrogate vision for care out of hospital by 2020



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?

The new service will have a significant impact on current patient pathways.

Planning

All the high risk patients, who will be involved in the new service, have been given a care plan which is reviewed regularly and updated as needed. This allows the patient, carers and relatives to have a better understanding of their health and how to respond to deterioration. The care plan also allows others involved in the patients care a quick and easy way of gaining an understanding of the patient's situation ideas concerns and expectations.

The acute situation

When urgent health care is needed the patient, via the care plan, will call NHS 111. When they do this they will be flagged as being a "high risk" patient and will be directed towards the new service and therefore away from A&E and the out of hours (OOH) service. This will then allow full clinical triage and fully informed decision making, via access to the full primary care record, to be available to the most at risk

patients. This patient group will be receiving **an urgent, GP led, community care response removing them from the 999 ambulance service**, **A&E and the OOH** (out of hours) services. Once triage the most appropriate member of the team be it the GP, specialist nurse, physiotherapist, OT or mental health worker, will **respond to the patient's needs.**

By preselecting patients into this high risk group we are targeting scarce health care resources at those most likely to benefit whilst at the same time ensuring that patients advanced decisions (e.g. DNAR and preferred place of death) are respected. **See Figure 2**

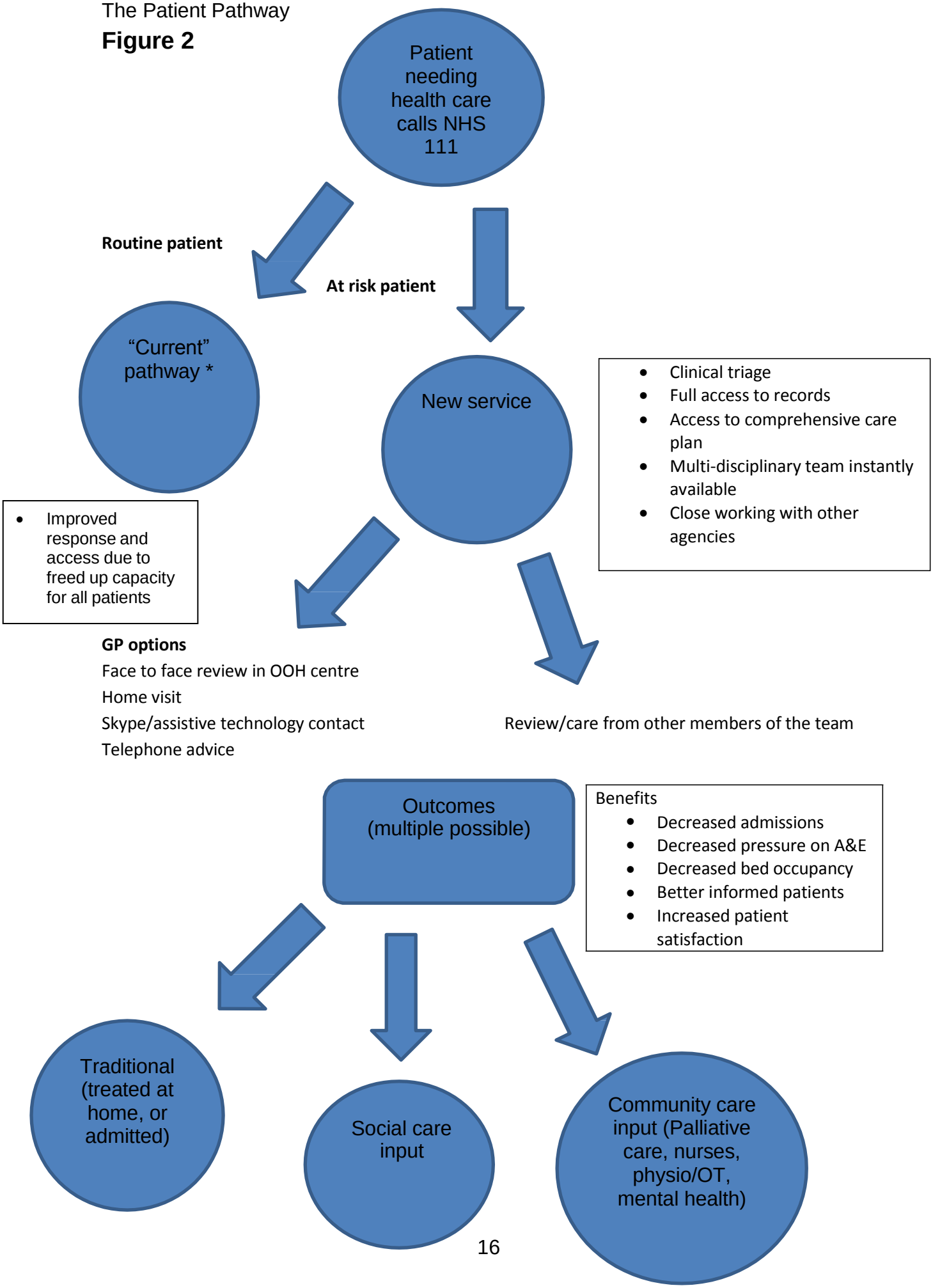
Success in this application will allow pump priming to effect **system change** but once started the scheme could be **expanded to cover the 24/7** time period and also to include an extended cohort of patients. The service could also be expanded to care for patients following discharge, thus allowing **hospital discharge to happen more quickly thereby freeing up "blocked" beds.**

Removal of these targeted patients from the current **OOH and A&E services will also free up capacity** in these services for other patients in need.

(See **Appendix A** for examples of changes to the patient journey)

The Patient Pathway

Figure 2



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.

This application is being put together primarily by **Yorkshire Health Network Ltd** (YHN) with the help of the local CCG and the support of the local Foundation Trust. Yorkshire Health Network is a limited company formed in 2014 by all of the GP practices in our CCG. The practices jointly own the company that has been formed in order to support and improve primary care. Some of our company principals are:-

- Support the consistent delivery of high quality and responsive patient centred care
- Drive an ongoing cycle of continuous improvement and innovation
- Deliver sustainable service change with compassion and integrity

As such the practices involved with this proposal **are supportive and encouraging for schemes that improve patient care and lead to better more integrated ways of working and promote the success and effectiveness of primary care.**

Our **patients have told the CCG** through extensive engagement that they want **joined up services and to be treated closer to home** and to not have to repeat information to different agencies. Our at risk **patients anecdotally are supportive of the care plan scheme and welcome record sharing** (to improve their care) and a more integrated approach. Our patient satisfaction survey results will be available later this year.

Care plans have been welcomed by **care home staff** as they help staff gain further insight into the patients care. They are also keen to have an extended access service allowing them a long period of time when GP services are available.

The directors of YHN have recently attended **a CCG led "Mapping the Future**" event where all the local stake holders were present including Harrogate and Rural Clinical Commissioning Group (HaRD CCG), North Yorkshire County Council (NYCC), Harrogate Borough Council, Harrogate and District NHS Foundation Trust (HDFT), Harrogate and Ripon Centre for Voluntary Services, British Red Cross, Age UK, Carers Resource, Tees, Esk and Wear Valleys NHS

Foundation Trust, Healthwatch North Yorkshire, Yorkshire Ambulance service, LMC and representative GPs.

Our proposals were discussed and welcomed by those involved and it was agreed that this service would integrate well with other service changes being proposed. We continue to **engage and liaise with leaders** from these organizations.

We have specifically discussed this bid and had support from:-

All local GP Practices

Amanda Bloor
Chief Officer
Harrogate & Rural District CCG

Dr Ros Tolcher, Chief Executive,
Harrogate and District Foundation Trust (including OOH and Community Services)

Vince Larvin, Locality Director for North & East Yorkshire
Mark Inman, Head of Emergency Operations
Yorkshire Ambulance Service Foundation Trust

Richard Webb, Corporate Director, Health & Adult Services
North Yorkshire County Council

Adele Coulthard, Director of Operations
Tees, Esk and Wear Valleys NHS Foundation Trust

Tony Collins, Chief Executive
St Michael's Hospice, Harrogate

Karen Weaver
Chief Executive
Harrogate & Ripon Centres for Voluntary Services

Andrew Jones MP
Julian Smith MP

As demonstrated above we already have direct links with practices and good rapport with other agencies especially the CCG and we will build on these as the project develops.

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.

Yorkshire Health Network is an established federation with Limited Company status already managing projects across the 18 local practices. **Local GPs from all practices** were involved in the development and set up of the federation with a number of GPs and managers in addition to those appointed to Director and Company Secretary roles have expressed an interest in becoming involved in new work streams**.** The five Directors and Company Secretary have weekly protected sessional time to manage the organisation with secretarial support. We are currently in the process of **CQC registration** for the organisation though clearly all member practices have individual registration.

New Recruitment

If awarded the fund YHN has identified the capacity to provide further dedicated managerial and clinical leadership, from the Directors of the board, to kick start this project and throughout the implementation year and beyond. **We have recruitment processes in place** for new management staff in addition to secured extended roles for existing staff from member practices. We have identified the need to work together and utilise the expertise of other stakeholders to ensure rapid implementation. As soon as the fund is awarded we would prioritise engaging all of these stakeholders including the CCG at the next level to develop the project to implementation.

We envisage quickly recruiting GPs and other clinicians with local knowledge and experience of the area to work within the new service. We know that the capacity is there as we have recently recruited for another project and had an enthusiastic response from local GPs who are keen to work with YHN.

We are already exploring IT solutions to create a workable interface between the 15 SystmOne practices and the 3 utilising EMIS web and are confident this can be achieved to have an operable system within 3 months. SystmOne is already operable with the other major clinical stakeholders.

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).

As part of implementing the extended care planning locally YHN Ltd has provided individual practices visits and educational support to keep practices engaged and involved and we intend to continue this. YHN Ltd have already sought and gained support from member practices to take forward enhanced care planning for the 4% cohort pending approval from the CCG. The ongoing development of the care plans will underpin the feasibility and success of the project. This scheme would help us to drive forward the quality and content of individual care plans, ensuring write up of anticipatory drugs and regular updating as clinicians become confident the plans will be effectively accessed and utilized.

The GP clinical leads within Yorkshire Health Network are all long term established local GP partners who all have experience in leading and representing practices via their positions in Local Medical Committees at both a local and North Yorkshire level. The lead practice managers within the organisation all work closely with other practices within the network and historically have done so for a number of years via a strong local practice managers group. All leaders of the organisation were chosen by and have the confidence and support of local practices.

YHN Ltd Board Members & staff:

Chief Officer:
Dr John Crompton BM, BS (Notts. 1989) BMedSci, DRCOG, MRCGP
John is a local GP Partner at Church Lane Surgery, Boroughbridge YO51 9BD and is a Director of YORLMC Ltd where he holds the position of Chair for North Yorkshire and is a Branch Member of Harrogate & Rural District Locality LMC. He has built up longstanding relationships with key stakeholders over many years' experience of working with local commissioners and providers negotiating and implementing change to benefit patients in the area.

Medical Director
Dr Peter Banks MBBS 1988 The Royal Free, DRCOG, MRCGP, FP Cert
Peter is the senior GP Partner at Leeds Road Surgery, Harrogate HG2 8AY and is a member of the Harrogate & Rural District Locality LMC. He has worked in the local area for over 18 years and has been involved in commissioning and fundholding developments. He developed strong working relationships with local providers and has experience of leading change - for example he has recently led a research project with local secondary care consultants implementing a pilot in

changing pathways for ENT.

Director

Dr Jim Woods MB ChB (Aug 1982) MRCGP

Jim is a senior partner at Dr Moss & Partners, 28 King's Road, Harrogate and has played an active role in the local development of health services over the past 22 years through his role as LMC Liaison Officer and Branch Member - Harrogate & Rural District Locality and his position as a stakeholder governor with Harrogate District Foundation Trust. He is well respected by his peers for his knowledge and skills in IT developments, conciliation and managing change. Jim has successful led the development and implementation of the local referral management system on behalf of YHN Ltd contract with HaRD CCG.

Director

Chris Watson has been Practice Manager at Dr Moss & Partners for the past six years. He is a Member of the Chartered Institute of Management Accountants with experience of working in central government and the local health service. He has ten years' experience of working with the Department of Health in a variety of finance roles. His last role was as a senior civil servant with responsibility for the development of 'payment by results' in the NHS. His skills lie in finance, IT development, project management and communication.

Director

Annette Given BA (Hons) in Combined Business Studies

Practice Manager at The Spa Surgery, Mowbray Square Medical Centre Harrogate for 10 years. Annette has over 25 years' experience of working in general practice as well as experience of working in secondary care, FHSA, voluntary sector and private sector. She was an assessor for the RCGP Quality Practice Award and her strengths lie in strategic management, project management, practice mergers, change management and premises development.

Company Secretary

Andrew King - Managing Partner at The Leeds Road Practice

Andy has worked in this primary care management role for the last six years. His background was in the Royal Army Medical Corps where he worked for 26 years in a medical support role, with skills in force deployment, marketing, recruitment and training.

Administrative Assistant

Laura Wilson currently employed by a local GP practice, Laura offers secretarial and administrative support for the YHN board.

It is the **strong local leadership of the federation** that has enabled us within 9 months, without any external financial or organisational support, to establish a robust company and board structure engaging all practices who have invested both in time and financially. The recent care planning work has shown a large piece of clinical work can be implemented quickly and **proven the practices commitment**. We have developed a sense of **joint working, ownership and momentum**. Locally we considered bidding for the first wave of the fund but realised we needed an effective vehicle to deliver it. We now have this in place. Success in this application will be key to moving forward **service redesign** for patients not just at extended times but really addressing the whole system and interface between primary and secondary care **24 hours a day and 7 days a week**.

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

We have a strong CCG that has a clear vision about the development of services in Harrogate & Rural District. **All elements of the local health care system share this vision and are committed to progressive change**. Success in being awarded this pilot is a key element in the YHN Ltd strategy to help deliver the 5 year plan. We believe this plan is workable and sustainable because it paves the way for and is integral to an ambition for wider system redesign. The ambition to upscale primary care needs to be coordinated and have strong cohesive clinical leadership and we need not only a vision of what it will look like in 10 and 20 years' time but then deliver this. **Local system leaders are focused on enhancing value of local responsive primary care and working together to lead and develop sustainable community based systems of responsive integrated care closer to patients' homes.**
Because the fund is non recurrent, the project not only needs to deliver in year, but also enable medium and long term change. The delivery of this in 2015/16 will not be in isolation but alongside other work streams to improve, develop and streamline services. YHN is committed in developing as an organisation to work as an equal partner with the secondary care trust, mental health, palliative care and social services. We will upscale to meet the challenge and believe we have the confidence and support of practices, the CCG and NHS England locally.

The Directors of YHN Ltd will not only lead the pilot but take the work forward as part of a wider strategy. Additional time commitment from those currently involved as well as involving other clinicians and stakeholders at both board and operational level is envisaged. **The ambition is to develop a new model of provision across the primary and community interface**.

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

Yorkshire Health Network recognises the challenges of implementing change within practices and across the wider health economy. This piece of work builds on the work developed in 2014 on local care planning and we are already working with the CCG to learn from best practice and develop the model to deliver optimal outcomes. This is not only providing an essential element of the system but is **embedding the development and change culture in the heart of each practice.**

Locally board members, GPs and practice managers have attended NHS IQ sessions on Developing Pathways in Primary and Secondary Care and Improving Productivity in General practice. We will continue to seek outside support to adopt established improvement methods such as LEAN. We embrace the benefits of change freeing up clinical and management time, reducing waste and duplication and ensuring that within the system the right individual is providing the right service at the right time. We have identified the potential to learn from neighbouring areas on lessons learnt, both positive and negative on introducing **8-8, 7 day working** and use of **Telemedicine at Airedale NHS Trust** and are already reviewing systems to develop our implementation strategy .

Local general practice is proven in providing safe effective care for its patients. The new system must build on this, identifying the retaining the most effective elements and developing the others. During the process of implementation and review we will utilize tools such as PDSA ensuring **patient and systems safety and reliability will be paramount**. Local clinicians are engaged in a vision of system redesign and throughout the implementation a key element will be the engagement at all stages and ownership of the scheme. The extensive **local sign up of all key organisations across health and social care** to this project increases the potential for success but carries with it challenges to keep all stakeholders onboard and for each to accept the short and long term impacts of major reconfiguration. Building an effective implementation team and breaking down barriers between organisations is a priority and is likely to require expert facilitation and support. Because this project engages already successful and proven organisations and has ambition to develop beyond 8-8, 7 days it has the

momentum and **ability to access expertise , skills and capacity of individuals within existing teams**.
This application is about new service delivery and building strong and long lasting foundations major service reconfiguration in the Harrogate and Rural District. The strength of this project is that, with the challenge fund, we can provide a short term increase in capacity from established organisations and clinicians, critically **working together and in a new way**. We will review, refine and expand the model in year, as it **creates capacity from other elements of the system**. Moving forward by 2016/17 as our patients see the benefits of change, the system can expand in hours and the **barriers** between organisations, budgets, and traditional primary and secondary care **diminish**, supported by the implementation structures we have developed.

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

Acute Hospital Bed Review – appropriateness of bed occupancy and compare with 2014-2015 figures.

Data collection plans (include costs in finance plans):

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.

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.

- We have enclosed a breakdown of costs which shows the breakdown of capital and revenue costs at **Appendix B**

- We will seek extended funding for maintenance and development of the enhanced care plan model from the CCG for the 4% cohort to be agreed (ie above 2% care plan supported by the DES).

- We intend to seek 50/50 match funding to support extension of palliative services for evenings and weekends by shared funding arrangement with St Michael's Hospice.

- We will progress discussions with HDFT regarding shared working and risk share arrangements around the most vulnerable high cost patients.

- We will negotiate with OOH on economies of scale in the parallel provision of this service (eg shared resources).

Our estimated breakdown of capital and revenue costs is attached.

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

Yorkshire Health Network Ltd

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.

Key Milestones		
Programme Plan to commence from 1 April 2015		
1	Appoint Project Team. Agree program structure and finalise program plan with robust reporting system in place for monthly report of achievements on key milestones and system drivers.	1 May 15
2	Engagement process and communication plan finalised for Patients, Practices and other Providers. Include case for change and strategic statements for discussions with partners and key stakeholders including the Health & Wellbeing Board.	30 May 15
3	Develop new internal and external assurance frameworks; including robust financial planning, Clinical Governance Framework, Information Governance, Legal Framework, Contracts and Procurement Framework, Indemnity cover, CQC registration, HR etc.	30 June 15
4	Develop and redesign community delivery model to provide extended evening & weekend working across the locality. This will include detailed workforce development planning alongside current OOH, ambulance and NHS 111 triage services	30 May 15
5	Initiate recruitment process for GP team leaders and other support staff including workforce development & training to build confidence and expertise to develop the process in year and beyond	30 April 15
6	Agree Community Services to align resources to practices which would include extended community nursing and Specialist nursing cover for the locality, deploying technology, aligning Therapy services and Physiotherapy services, amongst other key initiatives.	30 May 15
7	Agree extension to palliative care community support from St Michael's Hospice Macmillan nurse team to align resources within the locality	30 May 15
8	Agree extension to social care support from NYCC Adult services to align resources within the locality	30 May 15
9	Develop a technology strategy to support extended access to healthcare records and the new community delivery model which will allow full interoperability in sharing information between service providers. Procure and implement technology	30 June 15 but ongoing

	hardware / software solutions.	
10	Review and formal evaluation of the service and procedures to demonstrate early impact and future sustainability. This will include a report with outcomes, lessons learnt and improvement plans to develop the service and demonstrate potential medium and long term impact of the service.	March 16

25. **Attachments:**

Appendix A – Case Scenarios for proposed new service
Appendix B – Breakdown of Costs

- ❑ Attach map of geographic area covered (see Page 2)
- ❑ Attach letter setting out views of CCG(s) **Appendix C**
- ❑ Include (as a minimum) high level month by month programme plan **Appendix D**
- ❑ Also attached letters of support from:

Andrew Jones MP
Julian Smith MP
Richard Webb, Corporate Director NYCC
Karen Weaver, Centre for Voluntary Services

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*

FF15 Central Manchester CCG

GPs and Social Workers: Partners for Better Care

Delivering health and social care integration together

A report by The College of Social Work and the Royal College of General Practitioners

October 2014

THE COLLEGE OF SOCIAL WORK
The voice of social work in England

RCGP Royal College of General Practitioners

Royal College of General Practitioners

THE COLLEGE OF SOCIALWORK
The voice of social work in England

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Royal College of General Practitioners

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Foreword

GPs and social workers must work together for innovation and reform

One of the big questions for the NHS and local authorities is how and whether we can integrate health and social care to better serve people - and save money at the same time.

Our view as the voices of our respective professions is that we can, and must, work together to put GPs and social workers in the driving seat for practical reform and innovation.

Partnership between social workers and general practitioners is critical to the development of person-centred care and in addressing the looming financial crisis facing both the NHS and social care.

However, successful partnerships do not happen by chance. There are differences in funding, professional cultures, training, governance and accountabilities, all of which need to be recognised, understood and worked through to ensure that the right partnerships are in place and do the right things where it matters, in practice.

We must be mindful of escalating workload pressures facing both professional groups, alongside the need to develop person-centred and individualised care.

For GPs, the shift away from the treatment of specific diseases to multi-morbidities is not dissimilar to the challenges faced by social workers in developing personalised care which offers greater choice and control to the people using our services.

GPs and social workers share a common interest in leading and creating system change that will support better outcomes and be economically sustainable. Social workers have a vital role in building the strong, resilient communities that are needed.

This report demonstrates through evidence and case studies how we can work together as local leaders to make integration in local communities a practical reality.

Maureen Baker, Chair
Royal College of General Practitioners

Jo Cleary, Chair
The College of Social Work

GPs and Social Workers: Partners for Better Care
Delivering health and social care integration together

Executive Summary

1. One of the big questions hanging over the NHS and adult social care is how and whether they can be integrated so as to serve people better and save money at the same time. Our view as professional colleges is that the answer is "Yes," providing that GPs and social workers are in the driving seat.

2. If a catastrophe brought on by rising demand and dwindling funds is to be averted, a radical solution will be required. That solution is a new model of service delivery centred on the two professional groups in health and social care who are best placed to lead the transition to a more community-oriented service.

3. People with long-term conditions account for 50% of all GP appointments and 70% of hospital bed days, but there is mounting evidence that the heavy reliance on acute and long-term care is poor value for money both for patients and the public generally. This is where social work can contribute: whereas historically the medical care model may have tended to foster dependency, the social work model aims to promote independence.

4. The £3.8 billion Better Care Fund (BCF), a pooled health and social care fund to be introduced by the government in April 2015, is intended as a fillip to integration and implementation will be measured against a strict set of criteria, including demonstrable success in helping more people to live independently.

5. Several initiatives have already begun to show the way. Fourteen integrated care pioneer projects have been set up as BCF trailblazers and the Coalition for Collaborative Care has produced the "House of Care" model of long term conditions management, focusing on autonomy and self-care so as to improve the physical, social and emotional wellbeing of patients/service users and their carers.

6. In announcing changes to the GP contract a year ago, health secretary Jeremy Hunt promised a similar shift. NHS patients aged 75 or over would have a named GP to give older people the care they need while preventing unnecessary trips to hospital.

7. Both the Royal College of General Practitioners (RCGP) and The College of Social Work (TCSW) have welcomed these developments. The RCGP said they would help GPs get back to their "real job of providing care where it is most needed," while TCSW believes social workers have a crucial role to play in care reform, "giving people more choice, control and opportunities for active citizenship."

8. A survey by the Association of Directors of Adult Social Services (ADASS) and the NHS Confederation found that 46% of respondents said that integrated care had improved quality of life for people with long-term conditions, 41% said they had been assisted to live more independently, and 48% said it had resulted in financial savings. The "Home Truths" project, a study of relationships between GPs and social care, reckons that £1.6 billon could be saved annually by closer ties between them.

9. Early indications are that reductions of 15 – 20% in residential/nursing home placements and 20 – 30% in A&E attendance and hospital bed occupancy are achievable among people deemed to be at "high risk" of going into these forms of care. These figures are borne out by the five case studies presented here, where GP-social worker partnerships have started to save money desperately needed elsewhere by listening to what people actually want rather than automatically resorting to the tried and tested methods.

10. But the cultural divide between health and social care often gets in the way of these partnerships. Social workers and GPs regularly fail to understand each other's unique role, responsibilities and perspectives, barriers that may have to be dismantled through inter-professional education, co-location and informal networking, among other things.

11. Excellent leadership by GPs and social workers, locally by practitioners themselves and nationally by their respective professional colleges, will be essential if community solutions to health and social care needs are to be realised wherever possible.

12. The GPs and social workers showcased in our case studies have risen to the challenge. They are leading multidisciplinary teams, including nurses, allied health professionals and other practitioners, to construct a "team around the person" based on a GP practice or "clusters" of GP practices. Here is a short summary of each:

Case study 1: Central Manchester Practice Integrated Care Teams

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

Case study 2: Harrow multi-disciplinary groups

14. Six multi-disciplinary groups (MDGs) are each attached to a "cluster" of GP practices across the outer London borough. Social workers, nurses and hospital consultants also attend the regular meetings, where the aim is to support the 10% of the local population with two or more long-term conditions to live independently at home. Many of them can be steered away from residential or nursing home care.

Case study 3: Warwickshire 'Discharge to Assess' teams

15. The Discharge to Assess (D2A) scheme enables older people coming out of hospital to undergo a period of recuperation and rehabilitation in a nursing home before returning to their own home. Social work assessments are carried out in these intermediate care facilities, reducing delayed discharges and the overall spend on continuing health care. "It is too early to say whether we are successful in supporting more people to live independently at home rather than in hospital or a care home," says one of the GPs involved. "But I do think we maximise patients' chances of going back to their own homes.

Case study 4: Focus, NE Lincolnshire

16. As a social enterprise whose employees are social workers, Focus operates several collaborative projects with GPs. There are many people with complex health conditions who can cope independently in theory, but who are isolated or may have housing, debt or relationship problems and do significantly less well in consequence. This is where the social work skill set comes into its own and makes a unique contribution to the improvement of people's lives.

Case study 5: Ageing Well in West Cheshire

17. Two vital components of a broad strategy to reduce non-elective hospital bed use by 25 – 30% and residential/nursing home care by 15% are: integrated community care teams to promote independent living and a plan to develop stronger communities in which older people "are viewed as assets rather than deficits". Integrated teams identify older people at high risk of an unnecessary admission to hospital or long-term care, finding alternatives which ultimately allow them to remain in their own homes.

18. All five case studies are important evidence of progress in developing the common culture across health and social care that is expected to become the norm by 2018. The RCGP and TCSW see GPs and social workers as the linchpin of reform. Both colleges want to see local leaders emerge who are also determined to realise the ambition of seamless, community-oriented health and social care.

19. Radical change is necessary, but social workers and GPs working in partnership can make it happen. The future of health and social care depends, to a significant extent, on their success.

Introduction

20. By common consent radical change is required in health and social care if the system is to be prevented from imploding under the rapidly rising pressure of demand. On current projections the funding gap between demand and resources will reach £30 billion by the end of the decade in the NHS alone.

21. At the Royal College of General Practitioners (RCGP) and The College of Social Work (TCSW) we do not pretend that we have a complete solution to this looming crisis, but we do think that there is an emerging model of good practice which can form an important part of it. This model shifts the centre of gravity in health and social care towards the individual and the community, cutting across the traditional distinctions to integrate services in the interests of the people who use them.

22. In this paper we will describe the model, giving several working examples, and state the evidence for it. Social workers and GPs, working in partnership, are the axis around which it revolves but the model also involves nurses, OTs and allied health professionals. As the most prominent professional leaders adjacent to the boundary between NHS and local authority care, GPs and social workers are ideally placed to make radical change happen.

23. We need to see the integration of health, social care and housing in every locality if we are to make the health and social care system sustainable. The Health and Social Care Act 2012, by giving GPs a lead role in commissioning health services, has created an opportunity for new partnerships between general practice and social work. Here, we build on work already undertaken by the RCGP[i] and TCSW[ii] and explore some of the similarities and differences between the two professions.

Why integration is the 'cure'

ARGUMENTS AT A GLANCE

- Financial sustainability for health and social care requires a new model of service that promotes independence rather than fostering dependency;
- The Better Care Fund provides an opportunity to establish the new model, based on partnership between GPs and social workers;
- Care for long-term conditions accounts for 70% of acute and primary care budgets and the pressure on budgets is set to grow rapidly;
- A new model "would focus much more on preventing ill-health, supporting self-care, enhancing primary care, [and] providing care in people's homes and the community."
- Through collaboration social workers and GPs are ideally placed to shift the balance of care from acute to community settings.

24. A community-based health and social care service will need to strike a balance between formal, statutorily provided care and supported self-management. Cost effective community solutions will depend on enabling people to live as independently as possible for as long as possible. The all-important synergy between GPs and social workers lies here: whereas historically the medical care model may have tended to **foster dependency**, the social work model aims to **promote independence**.

Proactive planning for those at risk should be seen from two ends of the spectrum as we bring together the medical and social models into an approach that revolves around the person

25. Both models have their place in different circumstances, but with the increasing incidence of long term conditions, multi-morbidity and frailty, together with the opportunities provided by the Better Care Fund (BCF) to pool budgets, we believe it is time to bring these models together to better reflect the individual circumstances of the person. On the one hand **"care plans"** will set out formal, statutory care entitlements; on the other, **"care planning"** (as defined under NHS England's "House of Care," see below) will focus on autonomy and self-care, taking into account the physical, social and emotional wellbeing of patients/service users and their carers.

26. The need to reorient services around the double-headed arrow above arises from a grim statistical truth. This is that 15 million people in England have long-term health conditions, accounting for 50% of all GP appointments and 70% of hospital bed days. Providing treatment and care in these settings absorbs 70% of acute and primary care budgets[iii], yet there is mounting evidence that this is a grossly inefficient use of NHS resources and that more community-oriented forms of care and support are both more cost effective and better appreciated by patients/service users.

27. What is clear is that the current model of care is bust. "Multi-morbidity," when someone is affected by more than one long-term condition, is becoming widespread. By 2018 the number of people with three or more long-term conditions is expected to rise to 2.9 million, an increase of 50%, and if the care system is unreformed the additional cost will be £5 billion.

28. The numbers of people with a diagnosis of "frailty" are similarly set to rise rapidly in line with anticipated demographic changes. Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. This means the person is vulnerable to dramatic, sudden changes in health triggered by seemingly small events such as a minor infection or a change in medication.

29. Frailty affects 10.7% of the population aged over 65 years and the numbers are forecast to increase substantially from 8,660,529 in 2011 to 13,053,288 by 2051. It is a multidimensional diagnosis and therefore people can only be supported by bringing together the medical, social and psychological approaches[iv].

30. Though it is not the whole answer to the financial crisis, integration should help to stop care costs spiralling out of control - but how? As a spur to integration a pooled budget, the £3.8 billion Better Care Fund (BCF), has been established by the government by bringing together components of the health and social care spend. NHS and local authority money will be earmarked for promoting integration from 2015 and open the way for transformational change in austere times.

31. The coalition government has declared its determination to drive change, partly by establishing 14 integration pioneer projects as trailblazers for health and social care reform. The Labour party has said it is equally committed to reform. Shadow health secretary Andy Burnham told his party conference in September: "In the 21st century, the home and not the hospital needs to be the default setting for care."

32. The integration pioneers are bringing together nurses, GPs, social workers, hospital doctors, allied health professionals and others to provide better support at home and earlier treatment in the community, staunching the flow of people into emergency care in hospital or care homes.

33. The BCF is not new money, but delivery will be monitored against a strict set of combined health and social care metrics with the intention that integrated care becomes the norm by 2018. Success will to a large extent be measured by a reduction in admissions to residential care and nursing homes, effective reablement services, and fewer emergency admissions to hospital. This will be coupled with an expectation of positive experiences for patients/service users.

34. If the requirements of the BCF are to be achieved, GPs and community health practitioners will need to give timely medical help, while social workers and social care practitioners strive to promote people's well being as part of their neighbourhoods. Gradually these roles will intertwine and become mutually supportive.

35. The integration pioneers are proving that various approaches are possible and demonstrating the importance of integration across primary, secondary and social care. But in the view of our professional colleges there are many settings and situations where **social workers and GPs, working together, are best placed to coordinate the several efforts of health, social care and housing in the interests of service users.**

36. The King's Fund's influential report, *Where next for the NHS reforms? The case for integrated care*[v], argued that resources would have to be used much more efficiently to meet the needs of an ageing population, increasing numbers of whom had more than one chronic medical condition. A new model of integrated care, it said, "would focus much more on preventing ill-health, supporting self-care, enhancing primary care, providing care in people's homes and the community, and increasing coordination between primary care teams and specialists and between health and social care."

37. Among the exacerbating factors were the rise in single-person households living without the support of family members and the "shifting burden of disease," through which, while premature death rates from cardiovascular diseases and cancer have declined, chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease, heart failure, arthritis and dementia have become more prevalent.

38. The King's Fund called for a transfer of resources from acute hospitals to providing care in and closer to people's homes with the "triple aim" of **improved patient experiences, better health outcomes and more cost-effective care.** At the heart of the new integrated model would be "action to link primary care teams more closely with specialists and with health and social care professionals to ensure patients and service users receive care that is effectively coordinated."

39. Other prominent stakeholders have set similar aims. The Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and the Society of Local Authority Chief Executives (Solace) have all committed themselves to a "whole community" approach which "wraps" joined-up services around people's needs rather than organisational convenience and gives precedence to their independence and well being[vi].

40. Impelled by the integrative aspirations of the Health and Social Care Act 2012 and the Care Act 2014, versions of a new model of care have begun to emerge with GPs and social workers as the motor of reform. GPs are beginning to adopt more collaborative approaches to community care, while more and more social workers are forsaking care management to focus instead on promoting choice and control, supporting and empowering people to live independently as active citizens in their communities.

41. GP and social worker partnerships are starting to show how investment in social work as part of a remodelled community service can reduce costs across the health and social care economy. These partnerships are not new, but they have renewed potential in the current policy context.

42. **Through collaboration social workers and GPs are ideally placed to shift the balance of care from acute to community settings.** Such a dramatic shift, cutting across professional and organisational vested interests, will require strong professional leadership in both the health and social care spheres.

43. Sitting at the interface between health and social care, GPs and social workers can nurture a community infrastructure to help people live independently for longer and avoid spending time unnecessarily in hospital. This could unleash resources locked up in hospitals and long-term care to be used much more cost effectively in community settings. Personal budgets have a role here too.

44. Working together does require social workers and GPs to understand the similarities and differences between the two professions, as well as some of their historic baggage, if collectively they are going to develop better outcomes for people.

Building blocks of reform

ARGUMENTS AT A GLANCE

- RCGP and TCSW have endorsed the Coalition for Collaborative Care's "House of Care" model of long-term conditions management for delivering cost-effective services;
- House of Care would give people more control of their lives through person-centred care and support planning;
- The new model will require a much freer flow of funding across the health and social care economy;
- The two professions can seize the initiative as GPs move away from "box-ticking" and social workers are freed from the straitjacket of care management.

45. NHS England, supported by RCGP and TCSW within a wider Coalition for Collaborative Care, has endorsed the "House of Care" model of long-term conditions management that will be crucial to delivering cost-effective services as envisaged under the Better Care Fund (see diagram below). At the centre of the House of Care is giving people with these conditions more control of their lives through person-centred care and support planning, focusing on how communities, invigorated by community development social work, can help.

46. House of Care will require a fundamentally new approach if it is to succeed. It will require moving the NHS **away from hospital-based care towards community-based general practice.** GPs will be the expert medical generalists supporting people with multi-morbidity, departing from the traditional consultant-led single disease pathway model[vii]

47. The case studies below have begun to show that such approaches reduce hospital admissions, cut costs and improve service users' experience. It will require a much freer flow of funding across the health and social care economy and an end to the financial protectionism that hinders change. Announcing changes to the GP contract, in November 2013, health secretary Jeremy Hunt promised that four million NHS patients aged 75 or over would have a **"named GP"**. "This means giving elderly people the care they need and preventing unnecessary trips to hospital," he said.

48. The RCGP welcomed the announcement as "it will help us to get back to our real job of providing care where it is most needed rather than more box-ticking." It is proposed that GPs will oversee personalised care plans integrating all services, as well as supporting self-management plans which ensure that frail older people are better cared for in the community and hospital admissions are reduced.

49. The success of this policy of looking after more people closer to home will **depend on the contribution of social workers working alongside GPs** within the broader framework of health and social care integration. The College of Social Work will continue to champion this role of social workers, developing the arguments it has put forward in its "Business Case" series of papers.

50. TCSW's arguments were first set out in a discussion paper published in December 2012, *The Business Case for Social Work with Adults*[viii]. It argues that social workers have a **crucial role to play** in health and social care reform, giving people more choice, control and opportunities for active citizenship, and enabling more of them to live independently in their own communities rather than in long-term care.

51. Social work's roles and tasks are evolving as it moves away from inflexible care management to more fluid, more personalised modes of practice, a process that will gather pace as the Care Act is implemented. Modern social work is striking out "in new directions as the integration agenda being promoted by the government takes hold, joining up health, social care and housing, and shifting resource out of acute care into more cost effective community solutions," as the Business Case discussion paper puts it.

Benefits of integration

ARGUMENTS AT A GLANCE

- Hundreds of thousands of emergency admissions of older people to hospital every year are unnecessary;
- Integrated care has been shown to reduce unplanned admissions and delayed discharge while helping people to live independently for longer;
- There is a tendency to focus on the physical and practical aspects of rehabilitation rather than the social and emotional aspects of care;
- GPs are finding that social workers are able to produce more subtle, less expensive solutions to people's needs than the high-cost care they have often been given;
- Barriers to integration, including cultural differences, will have to be tackled if the policy is to succeed.

52. Many GPs and social workers recognise that there has been an unnecessary reliance on crisis or reactive services at the expense of investing in preventive or early intervention services that stop or slow down the development of high levels of need among patients/service users.

53. In its fourth annual *State of Care* report[ix], the Care Quality Commission suggested that at least 530,000 emergency admissions of older people to hospital in 2012–13 could have been prevented through better management of their conditions in the community.

54. A joint survey of local authorities and clinical commissioning groups by ADASS and the NHS Confederation[x] found that, where integrated care had been achieved, 46% of respondents said it had improved quality of life for people with long-term conditions. Additionally, integration had released the pressure on services in the following ways:

- 57% said there were fewer delayed discharges from hospitals;
- 42% saw a reduction in unplanned emergency admissions;
- 41% found that there were fewer interventions across health and social care;
- 41% saw an increase in the proportion of older people still at home 91 days after being discharged from hospital into rehabilitation;
- 48% said that it had resulted in financial savings.

55. Peter Thistlethwaite, in his study of integrating care in Torbay[xi], reported on the cost efficiencies from relying less on hospital, residential care and nursing home beds. Torbay's integrated management structure saved approximately £250,000 in the first year, money that was ploughed into the development of other services.

56. And in their paper "The Billion Dollar Question", Kerry Allen and Jon Glasby report that, by integrating health and social care, Torbay Care Trust achieved the lowest use of hospital bed days in the region and the best performance on lengths of stay[xii]. In particular:

- Use of emergency beds for people aged 65 and over was 2,025/1,000 population in Torbay, compared with an average of 2,778/1,000 population in the south-west region overall.
- In the south-west, Torbay had the lowest rate of emergency bed day use for older people with two or more admissions and the second lowest rate of emergency admissions for older people with two or more admissions.
- Residential care makes up the majority of adult social care spending, but Torbay had the second lowest proportion of people aged 65 or over discharged from hospital to care homes in the south-west.

57. Allen and Glasby lay emphasis on the contribution of social workers, suggesting that more allowance should be made for their role when people come out of hospital. They found that: '… **there also seems to be a tendency to focus on the physical and practical aspects of rehabilitation rather than broader social and emotional aspects of care'**.

58. Much of the pioneering work undertaken by the social workers and GPs involved in our case studies bears out these findings. Service users/patients and their carers are usually more satisfied because care and support are more aligned with their needs and the cost to the system is more sustainable. These GPs are finding that social workers and other community-based professionals are able to generate more subtle, cost effective solutions to people's needs than the expensive high-end care they have often been given in the past.

59. As the *Future Directions for Investment* report[xiii], published by TCSW as part of its Business Case series of papers, said:

> "Social workers are uniquely equipped to undertake the skilled and sensitive task of working alongside an older person to reach an understanding of the difficulties they are facing and to help them find ways (that suit them) of managing these to prevent their escalation. This is a nuanced and demanding activity which rests (often) on the development of empathy and an appreciation of the range and types of informal and formal support available.
>
> "It also depends on effective communication – perhaps with somebody who has impaired communication – engagement and relationship building skills with users and carers, the capacity to conduct a detailed and accurate assessment, and advocacy. These are core social work skills."

60. Of course, the integration of health and social care is not risk-free, nor are the benefits certain or easily achievable. As we have already seen it requires mutual trust between agency partners, strong leadership at all organisational levels and a clear vision of what is to be accomplished. Almost two-thirds of respondents in the ADASS/NHS Confederation survey said incompatible IT systems hindered integration while organisational complexity and leadership changes were also regularly cited as barriers.

61. For half the respondents, **cultural differences** were a major difficulty. In the case of social workers and GPs, the barriers are likely to be surmounted only with a renewed sense of purpose born of the conviction that there is much to be gained by doing so, not least in terms of better health and social outcomes for people.

Knocking down the 'Berlin Wall'

ARGUMENTS AT A GLANCE

- As our case studies demonstrate, the concept of partnership between GPs and social workers is enjoying a revival, quite possibly on an unprecedented scale;
- Professional relationships are critical to the success of partnerships;
- Reconciling the two cultures will require active intervention such as interdisciplinary education and shared forums for dealing with common concerns
- Dysfunctional GP-social worker relationships are, by contrast, costing health and social care dear;
- The Better Care Fund can finance the revolution needed to bring down the "Berlin Wall" separating the two cultures.

62. It will take something like a revolution to bring together the two cultures of health and social care, once described by a Labour secretary of state as separated by a "Berlin Wall". Integration will fail unless there is trust and mutual respect between social workers and GPs on one hand, and between senior management teams in clinical commissioning groups (CCGs) and local authorities on the other.

63. There are powerful historical reasons, of course, for the existence of these cultural barriers. The language of service user empowerment has long been current in social care, whereas in the NHS the language of "diagnosis" and "cure" remains prevalent. In one respect this is just as it should be, but it does mean that patients' voices are still often less well heard and heeded in health care than those of service users in social care. However, "patient power" in the NHS is a growing force, much boosted by the Francis inquiry into the Mid-Staffordshire Foundation Trust.

64. Contrasting governance arrangements and accountabilities have also allowed the two cultures to diverge, as have the differences in professional power and status. The kudos attaching to the health professions has not generally been replicated in social care. Instead of engaging in a dialogue between equal partners, social care has found itself dancing to the health service tune. But this too has begun to change as the professional stock of social work rises.

65. Now the omens are better than they have ever been. The "Berlin Wall" is gradually coming down as pressure mounts to pool more health and social budgets and share accountability across CCGs and local authorities. As our case studies below demonstrate, the concept of partnership between GPs and social workers is enjoying a revival, quite possibly on an unprecedented scale.

66. Sometimes multi-disciplinary teams coalesce around a single GP practice, sometimes around "clusters" of GP practices. In the latter case, for example, responsibility for pooled budgets could be devolved down to a GP practice cluster comprising three or four GP practices which come together to serve a population of 30,000 – 40,000 constituted by the registered lists of those practices.

67. Many new organisational arrangements are consistent with the cluster model and we expect a diverse range to emerge, from social enterprises, in which the GPs and social workers are equal partners, to loose federations of private GP practices to which social workers are seconded by their local authorities. Practitioners will have to find the structures best suited to local needs and resources. What is crucial is that this is done openly within a shared learning culture.

68. **Professional relationships will be the critical factor.** Reconciling the two cultures will depend on sound relationships between GPs and social workers where each is confident of the competence and contribution of the other. This won't be conjured out of nothing; it will require active intervention, for example, interdisciplinary CPD across health and social care as a prerequisite of re-registration with professional regulators.

69. In their literature review "New Conversations between Old Players[xiv]," Glasby and colleagues concluded that GPs and social workers often fail to understand each other's unique role, responsibilities and perspectives, and that opportunities should be sought for mutual engagement. These could include shared forums to address issues of common concern or informal networking.

70. They also saw inter-professional education as a way to develop better appreciation and understanding between the two sides, although the differing eligibility and catchment criteria that have to be met by their respective patients/service users could be a source of frustration for everyone concerned. A willingness to address these problems and invent **creative solutions** was seen as important; **co-location might be part of the answer to better joint working but was not a panacea**.

71. Work by the University of Birmingham and the consultancy iMPOWER corroborates many of these findings. They are engaged in a study with 11 clinical commissioning groups (CCGs) and local authorities, in what they have called the "Home Truths" programme, to examine the relationships between GPs and social care. Strong relationships could result in significant financial savings, they argue.

72. An initial report[xv] published in 2012 was ominously subtitled "How dysfunctional relationships between GPs and social care staff are driving demand for adult social care." It said:

> "Our research reveals that over 60,000 people a year could avoid going into residential care, with a saving of £600 million, even allowing for costs of alternative support, if we could influence a small number of GPs in every local authority area."

73. These figures were calculated on the basis of a 20% reduction in people in care, assuming half of them would require continuing intense support at home and 40% support at home with a smaller cost to the council. The remaining 10% would have no ongoing cost. The saving of £600 million was just in social care and Home Truths further estimates that more than £1 billion can additionally be saved from health budgets by improving relationships between social care and GPs.

74. A Home Truths evaluation[xvi] published in 2013 argued that unless more trust was established between general practice and social care, next year's BCF allocation of £3.8 billion would be wasted. Limited trust between GPs and social care professionals in particular, it said, meant that a flow of information between the two that might help to promote integration and improve outcomes for patients/services users was "severely hampered".

75. The 11 CCGs and councils taking part had begun to respond to these findings by opening up communications channels between the two sides, training GPs and consultants about social care services and processes, and embedding joint working between social workers and GPs. One site was setting up a new team of social workers to connect with clusters of GP practices, part of its purpose being to inform new general practice staff about the options available through social care.

76. **Overcoming these barriers between primary and social care will be crucial to the success of personalisation and the promotion of independent living.** Implementation of the BCF will be the ideal catalyst for working through the difficulties, providing it is enacted within an open learning culture. Social workers must be willing to argue for the benefits, through their collaborations with GPs and primary care professionals, of creative approaches to community-based services.

Collaborative leadership

ARGUMENTS AT A GLANCE

- Residential care is too often the default option when older people are discharged from hospital;
- Social workers and GPs will need to demonstrate joint professional leadership to alter fixed mind-sets which assume that the traditional methods are always best;
- Financial benefits of creative social work are just beginning to be quantified, eg through The College of Social Work's Business Case for social work with adults.

77. Leadership will emerge from whoever is best placed in community, professional and organisational networks to expand the imaginations of their colleagues by showing them that the realm of possibilities for independent living is much greater than they had thought.

78. As The College of Social Work said in its *Business Case for Social Work with Adults* discussion paper:

> "It requires social workers who think creatively (and cost effectively) about meeting the needs and aspirations of the population they serve. Restrictive care management processes do not allow social workers the autonomy to work with vulnerable people in this way, yet its potential for steering people away from high-cost, high-dependency residential and home care services is still unrealised in too many localities.
>
> "Councils still spend approximately half of social care funding on residential care for publicly funded clients, while self-funders often enter residential care unnecessarily, become dependent before their time, and later turn to the local authority to finance expensive placements for longer than would otherwise have been the case when their money has run out. Many of these people could live independently as part of their communities, given a more imaginative use of social workers by their local authority employers."

79. Residential care is also all too often the default option when older people are discharged from hospital. Social workers, working collaboratively with their GP partners, can do much to alter fixed clinical mind-sets, something they will be particularly well placed to do if, as seems likely, many more of them are located in GP surgeries. Collaborative leadership can create much-needed system change.[xvii]

80. It is one of the main arguments of the TCSW Business Case that the "social return on investment" that can come from good social work is often neglected in the standard cost-benefit analyses. **Strong, inclusive communities** with resilient individuals living as *part* of them – and the emphasis here is significant – can contribute to the public purse, whereas dysfunctional communities are a drain on it.

81. That is the whole point of allowing social workers, as the *Caring for Our Future* White Paper[xviii] put it, "to focus on promoting active and inclusive communities, and empowering people to make their own decisions about their care." The financial benefits of creative, new styles of social work in our communities are only just beginning to be quantified.

Collaborating with people who need health and social care

82. New collaborations between GPs and social workers are beginning to attend to the broader social and emotional aspects of care, as the case studies below indicate. They have had notable success in reducing non-elective admissions to hospital and making people at high risk of unnecessary hospital admissions feel better supported.

83. Most of the sites in the Home Truths programme referenced above expected that they could make financial savings from more integrated interventions, although the initial evaluation also said it was "too early to judge whether the planned interventions will have an impact on reducing the numbers of people entering residential care."

84. However, one of the sites had set itself a target of saving £716,000 from the social care budget and £614,000 from the health budget, to be achieved by better use of social care support to delay entry to residential care and reduce health visits. As we have seen, Home Truths estimates that overall savings could reach a yearly total of more than £1.6 billion nationally.

85. These hopes are reflected in the case studies below as GP-social worker partnerships start to achieve savings by **listening to what people actually want** rather than automatically resorting to the tried and tested methods. On the basis that supporting someone to live independently at home is more cost-effective than keeping them in hospital or placing them in a care home, the figures are significant.

86. Financial evaluations are in progress, but early indications are that reductions of 15 – 20% in residential/nursing home placements and 20-30% in A & E attendance and non-elective hospital bed occupancy are achievable among selected "high risk" groups.

87. One of our collaborative case studies estimates that, as a rule of thumb, alternative forms of care and support can be provided at one third of the cost of an acute hospital bed and 40% of the cost of a residential care/nursing home bed.

88. Such advances depend on an integrated health and social care economy otherwise the costs incurred in one part of the system will not be compensated by the savings in another part. This is why health and social care budgets will have to be pooled with local authorities and CCGs sharing accountability for expenditure.

89. Ultimately what matters is the experience of service users and patients. Research among service users consistently shows that they value person-centred care and the skills and qualities that lie at the heart of the best social work and GP practice. When Peter Beresford, chair of the service user organisation Shaping Our Lives, addressed a TCSW conference in 2012, he spoke about the "crucial role" of social work in integrated care.[xix]

PARTNERSHIPS: FEATURES IN COMMON

- GPs and social workers coordinate care and support in their own localities as part of multi-disciplinary teams;
- Social workers ensure that the social and emotional aspects of care are kept in view;
- Service users/patients and their carers are listened to and their views and wishes are respected;
- Wherever possible people are supported to live healthy, independent lives in their communities;
- Information sharing and mutual understanding between professional groups are much improved;
- Fewer older people in hospital acute beds, attending A & E or going permanently into long-term care;
- Hard-pressed public services are better able to manage rapidly rising demand by freeing up capacity and reducing per capita costs.

90. Integrated arrangements, Beresford said, "need to build heavily on the positive outcomes achieved by social work's relational basis and also its social orientation. In this way, integrated services can at last fully take on the holistic approach that we know matches service users' preferences and perceptions and which truly makes support services person-centred and fit for purpose."

Five case studies: GPs and social workers in partnership

Case study 1: Central Manchester Practice Integrated Care Teams

91. In central Manchester, Practice Integrated Care Teams (PICTs) are being developed in partnership with Central Manchester Foundation Trust and Manchester City Council to deliver an integrated model of care for some of the city's most vulnerable people.

92. In November 2012 the first integrated care teams began trying out new cross-border ways of working together, refining them as they went along. Further teams have come online since then and now 32 of the 34 GP practices in the area are working with an integrated approach to patient care.

93. The ambition is that integrated care teams across the city will eventually work with 800 patients assessed as at high risk of admission to hospital or residential care, or of attendance at A&E. So far they are working with approximately 500 patients.

94. Every "core team", comprising a GP, nurses and a social worker, considers care and support options for the **high risk patients/service users** on their caseload. It is premised on the belief that people should have the right support to live active, healthy lives in their communities with fewer avoidable stays in hospitals and care homes.

95. Each Practice Integrated Care Team has four priorities:

- People to feel more confident and in control of their lives;
- People are seen as a whole ("whole person approach"), whatever the complexity of their needs;
- Health and social care work more effectively together;
- Improved care planning to stabilise health, reduce crises and improve response in an emergency.

96. The GP selects patients (with their consent) for discussion at a regular meeting of the team, one of whom is then designated as the key worker depending on how well their skill set is suited to the particular individual's needs. The key worker is the primary point of contact between the patient/service user and the team, and is responsible for drawing up an integrated care plan with the individual and implementing it.

97. But it is not a long-term relationship and the key worker's role is to enable the individual to take as much control over their health and well being as possible. Key workers are specifically instructed **not to foster dependency** and can draw on the skills of a variety of other professionals in an associated specialist team when required.

HOW THE PICTs WORK FOR SERVICE USERS AND PATIENTS

A typical service user/patient

Jack is 72 and lives alone. He has chronic obstructive pulmonary disease, arthritis and high blood pressure. He has family nearby who help him when they can. He gets out once a week but struggles with walking or standing. He is scared of falling but wants to remain in his own home.

What it means for Jack

- Better coordination of care with a single point of contact (keyworker) for him and his family;
- One concise, integrated care plan that addresses all his needs and informs him and his family what to do if he is unwell;
- Less duplication of assessment and less need to repeat information;
- More community-based support helping to reduce the need for hospital admissions;
- Assistance to him and his family to learn about his conditions and how he can manage his health with their support to live more independently;
- More joined up service and greater continuity of care;
- More advice and support for carers.

What it means for professionals

- Better joint working and greater understanding of the roles of others;
- Shared knowledge and ownership of issues;
- Greater awareness of resources, enabling more effective choice;
- Greater shared risk management and more creative responses to need;
- Increased focus on prevention and less reliance on formal support;
- Fewer avoidable hospital admissions, A&E attendances and care home admissions.
- Much faster access to all relevant information;
- A proactive rather than reactive service;
- Mechanisms for integrated team working, often via monthly meetings so that no one should fall down the gaps in the service;
- Better development of skills and knowledge;
- Breaking down barriers between services, making life easier for patients/service users.

98. For social workers the advantages are that they can **focus on the strengths and coping abilities of service users and their families,** using the social model of disability, and they can promote well-being in terms of relationships, income, leisure, occupation and accommodation. Benefits for GPs include a reduction in crisis episodes among their patients and the ability to call on the skills of a wide range of other professionals to ensure that the right care and support solutions are found.

99. An independent evaluation of the integrated care teams by Hall Aitken, published in January 2014, was generally positive. GPs played a central role, it found, but the teams were becoming progressively more "democratic" with a greater contribution from other members.

100. Indicative of this democratising trend was that **teams had moved from being "predominantly medicine and health care based to a more rounded discussion of wider social needs."** However, the evaluation also identified some opportunities for development, including the fact that the importance of patient involvement in care plans was not always properly understood by team members.

FINANCIAL ANALYSIS OF THE PICTs

- Targets for PICT patients: 20% reduction in hospital admissions; 20% reduction in hospital bed days; 20% reduction in A&E attendances; 15% reduction in residential/nursing care.
- 178 patients joined the integrated care team caseload, in the six months 1/9/2013 to 28/2/2014, who had secondary care activity recorded in this period. Activity in relation to 116 of these patients, who were assessed as at high or very high risk of A&E attendance or non-elective admission to hospital, shows:
    - Both A&E attendance and non-elective hospital admissions fell by 22% for evaluated patients over the period;
    - A&E costs reduced by 21% and non-elective hospital bed costs went down 32%.

101. It was perhaps a sign of this lack of involvement that many practitioners found striking a balance between cost savings and patient/service users' quality of life challenging. The evaluators commented: "Many [practitioners] feel that quality of life is improved by reducing the need for hospital visits. But some patients may feel isolated and hospital contact may improve their quality of life."

102. However, it was plain that social workers and their fellow practitioners were increasingly comfortable in what had once been an unfamiliar environment. **"**Where patient needs are discussed in more detail then more rounded care plans are being developed," the evaluation says. "This has been noticeable as social service partners in particular have 'found their feet' at meetings. Their knowledge of wider social and family issues for patients is proving valuable in deciding care plans."

103. Social worker Nusrat Satwilkar, who worked on a PICT with GP Dr Lucy Campbell (see box), describes it as an "immensely positive experience". She says:

> "The regular meetings have allowed all multi-agency professionals to develop an improved understanding of each other's practice. This from my social work perspective has made our links more efficient and improved timescales, resulting in less repetition of certain referrals to services and, more importantly, better services for the people we are trying to enable and support.

"I think GPs feel more comfortable referring to local services and have more understanding of the role of social work in the community and the value of greater independence for the people who use services. The meetings have strengthened our community response and are a vital source of information on the customers and patients we collectively serve."

Dr LUCY CAMPBELL, GP, MANCHESTER: "EACH WANTED TO LEARN FROM THE OTHERS"

"Our Practice Integrated Care Team (PICT) was multidisciplinary and included myself as the GP and our social worker Nusrat.

"The team had monthly meetings, which were well structured and minuted, but still relaxed in that there was no hierarchy and all opinions were listened to, respected and discussed. There was no specific 'medical model' or 'social model' but we each wanted to learn from the others.

"Nusrat had a clear idea of where she, with her skills, training and remit, could help a situation and she worked very practically where this was appropriate. The advantages of working more closely with social workers are numerous.

"We as GPs often struggle with sorting out the social aspects of a patient's situation, whether housing, mobility issues, or social care. It was great to have a named, interested and conscientious social worker to call on. Although I have moved on from my particular PICT now, the overall system in Manchester continues to work well.

"The monthly meetings encourage open discussions about the patients and Nusrat's suggestions were great, often lending a different perspective, and she was very practical about what could or could not be offered. She and I shared a determination to keep our frail elderly at home where possible because they did so badly once they had to move out of their homes.

"She gave me an insight into what was available and how to utilise other teams, where appropriate. She was very easy to get hold of outside of the meetings and would pass on useful phone numbers. We often communicated by phone or email about individual patients.

"Patients and their families were positive about the PICT. I do believe that this model of working would have great cost benefits to the health service. Were we able to support more people to live independently at home rather than in hospital or a care home? Yes, definitely. This was our aim and we achieved it in many cases.

"However, we felt that we failed in some cases where the patient just couldn't cope at home, or where it was not appropriate. It was a learning curve for all of us, but we certainly made an impact. We talked to each other, were interested in the patients, and the patients were people to us, not just 'work'.

"It was a rewarding way to work, both personally and professionally, and I believe it was great for the patients. It was proactive working, troubleshooting before the trouble started, and it is always more enjoyable to work as a team rather than alone, especially when the patients are so complex, so very frail, and as GPs we would struggle with carrying them in the community alone."

Case study 2: Harrow multi-disciplinary groups

104. In Harrow, the Integrated Care Programme (ICP) has been under way for two years. The intention of the ICP is to create a more responsive, supportive community service for people with complex needs.

105. Social work can often be the gateway to this kind of support. The 10% of the local population which has two or more long-term conditions and needs coordinated care and support to live independently at home is the target group for this work.

106. Six multi-disciplinary groups (MDGs) are each attached to 'clusters' of GPs across the outer London borough, and cover approximately 250,000 patients. The role of social workers is vital in the cases discussed at the MDGs, helping to keep people out of hospital and living independently in their own homes for longer.

107. The MDGs each cover approximately six GP practices, and monthly meetings are attended by GPs. A service manager from a social work team in Harrow and a district nurse representative attend the meetings, as do hospital consultants (including a psychiatrist). This attendance is funded through the programme.

108. At each meeting cases are discussed where the patient/service user has either been identified by the GP practice using a risk assessment tool, or through a referral to the GP for care planning by district nursing or the social work team. The social worker for the service user may attend. Often, these are cases where there are complex health and social care needs. The patient/service user may be a frequent attender at a hospital or GP practice, or they may not engage with services at all.

109. "Sometimes it's a concern about the service user resisting social care input, or the need for more social care input due to a deterioration in their condition, or the pressures facing a carer and the impact of this on the relationship between the service user and the carer, and we discuss what we can do about that," says Anne Mosley, service manager. "Or it might be a concern about medication, where the GP is seeking advice from colleagues."

110. An important aim of the MDG meetings is to inform doctors of the range of options to enable people to remain in the community, and to keep the adult social care priority of promoting independence central to the discussion.

111. As the emphasis is firmly on supporting people to live independently, the MDGs consider a broad range of community provision for each case. This range includes a varied assortment of equipment, adaptations and support in the person's own home and in the community..

VIEWS ON INTEGRATED CARE IN HARROW: "FACE-TO-FACE CONTACT IS INVALUABLE"

Sue Young, MDG Manager, Harrow ICP: "Since the launch of the Integrated Care Programme (ICP) in Harrow in August 2012, social workers have played an essential role in the arrangements for the care of patients with complex conditions. Attendance and participation at multi-disciplinary group (MDG) meetings has been prioritised, and this has made for a strong working relationship. A majority of complex cases discussed at these meetings have been shown to have high social as well as medical needs. The networking and face-to-face contact with all members of the multi-disciplinary team has proved invaluable."

Anne Mosley, Service Manager: "We operate a social care model where we promote independence, and we respect the fact that people have choice and control. We strive to enable people with higher levels of need to live independently, alongside playing a key safeguarding role."

Shaun Riley, Service Manager: "Social work values and empowerment are at the forefront. You hear the professional view at a case conference, but we go back to the grassroots: what is the service user's opinion, what would they want for their outcomes?"

Dr Chris Jenner, GP, Elliott Hall Medical Centre: "The Integrated Care Programme has provided a unique opportunity for whole system working in community care. This occurs at two levels. At a strategic level the most senior commissioners and leads for providing care meet and discuss/explore concerns and issues. We are all cemented by our aim to provide patient centred care, and this transcends the health/social care bureaucracy we face on a daily basis.

"At an operational level the MDGs provide a forum for looking at the most challenging cases which individual health and social care practitioners have been unable to resolve. Some miraculously have solutions and many do not, but the practitioner who has shared the case always feels supported and is usually armed with new ideas and skills.

"Interestingly the traditional 'medical model' has been reshaped with the sharing of care plans and the recognition that a holistic, patient-centred anticipatory care plan is the way forward."

Dr Meena Thakur, GP, Honeypot Lane Medical Centre: "The MDG meetings have brought together professionals from health, social care, community nursing teams, mental health and hospital consultants, all of whom have previously contributed to patient care with no communication between them. The patient's care plan is discussed together with particular problems that patients are facing, and the team shares knowledge and experience to find solutions where possible, which may relate to health or social care needs.

"The greatest benefits from this have been the breaking down of barriers and forging links between the different professionals caring for patients, particularly between health and social care, personal accountability of each professional and team, and, importantly, putting the patient at the centre.

"There has been an enormous amount of learning about the wide range of resources available in the community, previously unknown to many health professionals."

112. Full consideration is also given to the familiar contemporary methods like reablement, personal budgets, telecare, and support for carers, all of which are available to promote independent living. Housing solutions such as mainstream sheltered accommodation and extracare accommodation are looked at alongside "Shared Lives" and a range of respite care options.

113. "As is the case nationally, some people do overuse emergency services in Harrow," says Mosley. "This causes concern and there is a lot of pressure to prevent this from happening.

114. "Residential care can sometimes feel like 'the obvious' solution to this for GPs, particularly if their patient is having multiple admissions to hospital, and especially when this is due to the patient being non-compliant with treatment.

115. "The MDG meeting is a very useful forum to discuss the concerns and to formulate a multi-professional care plan to support the service user and their carer/family.

116. "The MDGs promote better co-ordinated care for the most complex service users, and improve joint understanding and working between social care and GPs. The risk management is shared and there is a joint approach to meeting outcomes, including a reduction in unplanned hospital admissions."

117. The financial case for using GP-social worker relationships as an engine of integration is compelling. Better support for people with long term conditions living independently in their own homes is significantly less expensive than the cost of a non-elective hospital stay or a residential/nursing care placement.

118. A significant proportion of the borough's community care funding – in fact, the highest level in London - is spent on cash personal budgets. The emphasis on personalisation provides an effective model of social care which, alongside the prioritising of safeguarding, is embedded into the multi-disciplinary group approach.

Case study 3: Warwickshire 'Discharge to Assess' teams

119. The Discharge to Assess (D2A) scheme enables older people coming out of hospital to undergo a period of recuperation and rehabilitation in a nursing home for up to six weeks prior to returning to their own home. Because assessments are conducted in these intermediate care facilities, the aim is to reduce delayed discharges and cut the overall spend on continuing health care.

120. It has been established in the context of sound working relationships between primary, secondary and social care in Warwickshire, based on mutual trust and respect, and is part of a broader community service redesign.

121. Under D2A older patients with complex care needs, who require a continuing health care assessment, are discharged to one of 30 earmarked nursing home placements across the county. This gives patients and their families more time to make an informed decision about their future while ensuring that hospital beds are used optimally.

122. A 2012 evaluation of the overall redesign, based on figures from a hospital in the south of the county, showed average lengths of stay in hospital falling by one-third and hospital discharge rates up by more than 30%.

123. "We have redesigned our community services so that we can provide a guarantee of early supported discharge for 50 patients per week from the acute hospital and provide an emergency community response within two hours of a frailty crisis in the community," said Ian Philp, medical director of South Warwickshire NHS Foundation Trust, in an article[xx] for the British Geriatrics Society published at the same time.

124. "We have coped with an 11% increase in emergency presentations in all adults to Warwick Hospital because we have been able to **manage the care of older people more efficiently, reducing the need for acute hospital care for this group.**

125. "We have also seen a 24% reduction in mortality in older people admitted to hospital, which gives us some assurance that our efficiency gains have not been achieved at the expense of quality of care. We have also seen a modest reduction in readmission rates and an increase in the proportion of older people able to return to their former residence."

126. Social worker Schola Sjurseth says she has had a positive experience of working with GPs on the D2A team in the Stratford upon Avon area. "Previously the patient would have gone straight into a care home permanently or back home with a care package, possibly before they had fully recovered. May be an infection hadn't cleared up completely so that they became confused and went back into hospital," she says.

127. "Under D2A, after two weeks in the nursing home they have stabilised, the infection has cleared up and they're off antibiotics. Rehabilitation is therefore much more effective. **People can recover in a safe environment** with access to a GP, social workers, OTs and physios on a daily basis."

128. Much of the D2A team's focus is on "pathway 3" of the scheme, which deals mainly with patients who are likely to have continuing health care needs. Sjurseth typically does an assessment in the third week of their stay in the nursing home, by which time living independently with the right support is often a more serious option than it would have been immediately after discharge.

129. "One example is a lady that the GP thought should go into residential care because she wasn't engaging much with the occupational therapist in the D2A programme. I took the view that, on the contrary, there was nothing wrong with her physically or mentally and that if she went home she would present differently," Sjurseth says.

130. "This lady really wanted to go home. She wasn't engaging in the care home because she was unhappy there, not because she was incapable of doing so. Our role as social workers is to **look at people holistically**, to advocate for them and look at all the services and everything else that's available to support their outcomes."

131. Georgina Everitt first qualified as a nurse but later became a hospital social worker when she realised it would give her more time to talk to patients and find out about them. "D2A is a far more dignified way to make big decisions about your future than in hospital where you have very little control and feel unwell and disorientated," she says.

132. Each of the D2A nursing homes has its own GP who works as part of a multi-disciplinary team (MDT) including a social worker, senior nurse, home manager and discharge coordinator. The MDT meets once a week.

133. "I might come to the MDT meeting having met the client and relatives and having asked them what outcomes they want, what their history is, and what they wish to see happen," Everitt says.

134. She adds:

> "We've always tried to be positive about what people can do and promote their independence. You've got to try to build on their strengths and not be negative about what isn't there.We often have healthy disagreements at MDT meetings. We had a meeting today where someone said that an individual needed 24-hour residential care but wanted to go home instead. I intervened to say he's got to go home because that's what he wants. The GP agreed that I was right; the patient had capacity and ought to go home."

Dr DAVID RAPLEY, GP, KENILWORTH: 'COMPASSION, CARING AND DIGNITY'

"My general practice looks after 12 beds at the Kenilworth Grange nursing home as part of the Discharge to Assess scheme (D2A). Another practice in Stratford upon Avon looks after the other 18 D2A beds in Warwickshire.

"The idea is that patients who would have been 'bed blocking' at South Warwickshire Hospital Trust are assessed from a continuing health care point of view and if they meet the triggers are offered six weeks in one of three nursing homes to prepare them for future discharge, either into another nursing home or back to their own homes.

"The D2A beds are supported by a social work and nursing team, occupational therapists, and physiotherapists, plus a GP who visits daily. We have a multi-disciplinary team meeting every Thursday morning.

"When discharged from the nursing home many of the patients are in a much better condition, better nourished, more communicative, and genuinely happier than when they first came into the nursing home on discharge from hospital.

"The degree of compassion, caring and dignity is so much greater in the nursing home than would be achievable with a patient in a hospital bed waiting to move on. The look of relief on many patients' and relatives' faces that they are not in hospital is priceless.

"Social workers understand the logistics of funding and the care needs of patients, plus their relationships with families. The whole team listens and contributes to the MDT meetings. We often change our preconceptions during these meetings. It is very much a team approach; we don't go in for paternalism!

"It is too early to say whether we are successful in supporting more people to live independently at home rather than in hospital or a care home. But I do think we maximise patients' chances of going back to their own homes.

"There are 150 patients who have gone through the 30 nursing home beds in the last year. 40% of these 150 were found to be in the last year of life.

"One might argue that it would be cheaper to put patients in residential care-based moving-on beds, which cost around £450 per week per patient as opposed to D2A beds which are around £800 - £900 a week. But to give patients this degree of service in a moving-on bed would require an awful lot more support from physios, OTs, social workers and GPs, and costs would rocket. To be honest, GP practices probably wouldn't volunteer.

"The new D2A system has been well thought through and piloted for 9 months and is working well."

Case study 4: Focus, North-East Lincolnshire

135. Focus is a social enterprise whose employees are social workers and which emerged from the clinical commissioning group in North-East Lincolnshire. As one of the Social Work Practice pilots, supported by the Department of Health, it has sought a close working relationship with GPs in the region.

136. One of its projects aims to stem the flow of A&E admissions and enable hospital discharges where appropriate at the weekend. A GP is based in A&E and sees patients who may not need hospital/consultant intervention, which has turned out to be effective in diverting people to more appropriate advice, information or, if necessary, medication.

137. A Focus social worker works alongside the GP and is able to get involved to commission home care, to link the person with luncheon clubs and befriending services, or to discuss and advise on social and personal issues. Although the project has not been formally evaluated, this holistic approach is clearly reducing the number of hospital admissions while connecting people up with more appropriate resources and services.

138. In another initiative a large GP practice has agreed to pilot a health and social care coordinator role working with 50 people with complex conditions to deliver a proactive and preventative service. If the pilot is successful Focus will look to extend the model to other practices.

139. When the care coordinator role in GP practices was first considered everybody had their eye on people with complex health conditions, but what is clear is that it is often social factors rather than the specific health conditions which determine whether someone has complex needs.

140. There are many people with similar health conditions who manage and live with their symptoms well, but people who are isolated or for example have housing, debt or relationship problems, often do significantly less well. **This is where the social work skill set comes into its own** and makes a unique contribution to the improvement of people's lives.

141. More recently, Focus and its partners have stepped up their efforts for people with complex/multiple conditions with the result that two "extensivist" teams are being developed in two geographical patches.

142. Core teams will consist of a GP, social worker, nurse and coordinator, each having a cohort of around 500 people with the most complex/multiple conditions. Teams will take a proactive and preventative approach, trying to support and treat people in their own homes and following them in and out of hospital to minimise their stay and maximise positive outcomes.

Case study 5: Ageing Well in West Cheshire

143. An ageing population is one of the main triggers for reform in West Cheshire and Chester, where the number of people aged 65 or over is expected to increase by 26% between 2010 and 2020 and those 85 or over by 41%.

144. There will be a corresponding rise in the incidence of long-term conditions and pressure to think again about how best to provide care and support. Like their counterparts elsewhere agencies in the locality are seeking alternatives to hospital on the grounds that 25 – 30% of older people in hospitals are admitted unnecessarily.

145. Overseen by a partnership of clinical commissioning groups, NHS foundation trusts and the local authority, the intention is to reduce non-elective hospital bed day use by 25 – 30% and placements in residential/nursing home care by 15%. It is anticipated that other kinds of care and support can be provided at much less cost: to be precise, one third of the cost of an acute hospital bed and 40% of the cost of a residential care/nursing home bed.

146. So what are these alternatives? Two of the most interesting are integrated community care teams to promote independent living and a strategy to develop stronger communities in which older people "are viewed as assets rather than deficits".

West Cheshire: Integrated teams

147. The integrated community care teams are drawn from a broad range of professionals from the statutory and independent sectors: GPs, social workers, pharmacists, practice nurses, district nurses, community matrons, and community therapy, community mental health and reablement staff, among others.

148. These teams are responsible for identifying older people at high risk of an unnecessary admission to hospital or long-term care and finding alternatives which enable people to live independently and healthily at home wherever possible (see chart below). They offer a variety of interventions: care management, intermediate care, reablement, urgent response and end of life care.

149. Each team covers a practice population of 30,000 to 50,000 and provides urgent response "step up" care to prevent unnecessary hospital admissions and "step down" care to speed up discharge and promote rehabilitation and reablement.

150. A real-life example illustrates how integrated working has benefitted people who use services and the public purse at the same time. A 90 year old man was the main carer for his 89-year-old wife who had dementia. He required an eye operation as a day case at the local hospital but this was complicated by the fact that he had to bring his wife with him. The hospital was unable to look after his wife and the operation had had to be cancelled twice.

151. Faced with the husband's deteriorating eye condition, the integrated team co-ordinated a conversation with the acute trust, arranging for the operation to be rescheduled and giving the social worker time to build up a trusting relationship with the wife. On the day of the surgery, the social worker took both husband and wife to the hospital and sat with the wife throughout.

152. Arrangements like these would not have been possible prior to the integrated team. Care and support could now be coordinated across the system as a whole. In consequence, the husband was able to have his operation and return home to resume his caring duties.

Keeping People Healthy in their own Homes	Presentation and Assessment of Condition	Diagnosis, Needs Identification, Treatment and Care Plan delivery	Return to normal place of residence	End of Life Care
Information that allows people to remain healthy in their own homes will be clear and joined up	Community based pathways identified if safe and appropriate	Assessment for long term residential care is not normally carried out in an acute hospital environment	Plan for discharge on admission (Pull approach)	Opportunities for people to identify their preferred priorities of care and that these are met
Opportunities are identified to invest in community wellbeing, preventative and community services	People will be provided with the opportunity for rehabilitation and reablement prior to identifying the need for any future service interventions	Diagnosis and needs identification is completed as close to the community as possible	People will not be cared for in hospitals or Long Term Care for longer than is necessary	
Proactively identify individuals at high risk and provide suitable services and assistive technology	Assessment takes place as close to the community as possible	**Treatment regimes are delivered** in the least intensive appropriate setting	People will be provided with the opportunity for rehabilitation and reablement prior to identifying the need for any future service interventions	
Promotion of and signposting to Self management techniques and self care	Information is captured once only; built upon and shared across all agencies (Single Assessment Process)	Care is holistic and co-ordinated and integrated where appropriate	Remain at home	

Design principles of West Cheshire delivery model

INTEGRATED TEAMS: POINTS TO NOTE

- More trust between professionals across health and social care;
- Single, centralised information, referral and intake service across health and social care;
- Each referral is allocated to the team member with the most appropriate skills;
- Common assessment tool supports the sharing of information across professionals and agencies;
- Holistic assessments covering physical, mental, social and spiritual health needs;
- Services at any time of the day or night support people to remain in the community.

STRONGER COMMUNITIES: POINTS TO NOTE

Role of local area coordinators is to:

- Provide information and assistance to older people and carers;
- Assist people to use personal and community networks to find practical ways to meet goals and needs;
- Ensure that services are equitable and inclusive, so as to reduce inequalities and improve quality of life;
- Support older people to identify their own needs and help them access local activities and services to pursue their preferred lifestyle;
- Work with communities to increase their capacity to meet the needs of older people, their carers and their families.

West Cheshire: Stronger communities

153. Building community capacity by strengthening mutual support and promoting small scale community businesses ought to be part of the social work skill set and in some parts of the country already is. In West Cheshire plans are afoot to try out "local area coordination," an Australian model already piloted in England, as a way of "providing opportunities to address individual's needs, facilitate mutual support mechanisms, build resilience, unlock community resources and **bring people and communities together**."

154. This ties in with TCSW's *Business Case for Social Work with Adults* discussion paper, which argued that social workers were well placed to take on the role envisaged for local area coordinators. As already noted, one of the motives for removing social work's care management straitjacket is precisely to free it to focus on promoting active and inclusive communities which empower people to make their own decisions about their care and support.

155. Local area coordinators (LAC) are seen in West Cheshire as the "missing link," complementing other professionals by acting as a community information source, support and facilitator, and working in partnership with integrated community care teams. One LAC, costing up to £35,000 a year, can support around 60 older people and help to tip the balance away from statutory assessment and services to building people's capacity to become more self-sufficient and independent.

Conclusion

KEY MESSAGES

- GPs and social workers, working in partnership, are ideally situated to create much more cost-effective, integrated health and social care;
- Integration is essential if the aims of the Better Care Fund are to be achieved expeditiously in the interests of people who use services;
- Professional leadership will be necessary at all levels if GP-social worker partnerships are to be the engine of integration: RCGP and TCSW will seek ways to develop and promote the model as part of a joint work programme;
- Savings of £1.6 billion annually in health and social care could be the prize;
- A common culture will need to emerge over the next four years and both of our Colleges will encourage the development of local leaders who are equally committed to the ambition of seamless, community-oriented health and social care.

156. It has been the purpose of this paper to argue that the public will be much better served by integrated health and social care, and that GPs and social workers are best placed to join them up. A community-oriented NHS will result in happier patients; NHS-oriented social care can lead to a more cost-effective use of resources for service users.

157. We know that health and social care will sink under the weight of demand unless action is taken to avert disaster. It is not merely a matter of *whether* integration happens, but *how* it happens and who is going to captain the ship as it steers a treacherous course towards a safe harbour.

158. **In the view of our professional colleges, GPs and social workers are ideally situated at the interface between health and social care. Using their complementary skills and powers in partnership, they can support many more people to lead less crisis-prone, more independent lives.**

159. Professional partnerships of the kind illustrated in our case studies are no longer optional. They are a necessity if integration is to progress smoothly, the aims of the Better Care Fund are to be realised, and the interests of patients and service users are to be protected and promoted. The best outcomes for patients/service users, as frailty increases and demand rises inexorably, will depend on sound professional relationships.

160. Our case studies provide a model of partnership which demonstrates how GPs and social workers, as partners for better care, can work in community settings to respond more effectively to people's medical and social needs. These needs are no longer seen in isolation, as they are so often under the current system, but as components of a continuum of need. It is a whole person, whole community approach.

161. Of course, this is not about GPs and social workers alone. It is vital that nurses, allied health professionals and hospital doctors including consultants have a full stake in this new way of doing things. It is about putting the "team around the person" instead of (as it were) "dividing" the person up between the team.

162. But the respective leadership roles of social workers and GPs are essential if care and support are to draw on the strengths of individuals, families and communities so that these strengths are enhanced rather than blunted by formal care plans. "Care plans" must be set in the balance with "care planning," as envisaged in the House of Care.

163. An important lesson from the case studies is that this model gives service users/patients a better experience of services and enables them to live healthier, more independent lives in their communities. At the same time information-sharing between professional groups improves, as do mutual understanding, respect and trust.

164. The net result is fewer older people needlessly occupying acute hospital beds, attending A & E or going permanently into long-term care, liberating capacity and funding to meet rising demand from other older people equally cost effectively. According to the Home Truths programme, quoted earlier, savings could reach more than £1.6 billion annually across the health and social care economy.

165. **Both the Royal College of GPs and The College of Social Work are committed to GP-social worker partnerships as the model of service integration best placed to improve the lives of patients/service users and to do so economically. We will seek ways to develop and promote the model as part of a joint work programme.**

166. Where there is a "culture clash" between general practice and social work, steps should be taken to overcome it. It will require interdisciplinary education, reciprocal placements, informal networking and other measures to cultivate the trust between the two sides which is all too often missing. Only then will they come to understand each other's unique role, responsibilities and perspectives.

167. As our case studies demonstrate, this is eminently achievable. The doctor in one case study admits: "We as GPs often struggle with sorting out the social aspects of a patient's situation, whether housing, mobility issues, or social care. It was great to have a named, interested and conscientious social worker to call on." And the social worker is equally keen: "The regular meetings have allowed all multi-agency professionals to develop an improved understanding of each other's practice."

168. A common culture across health and social care will have to become the norm during the next four years. Accomplishing it will depend on the combined efforts of national and local leaders. The RCGP and TCSW see GPs and social workers as the linchpin of reform. **Both Colleges want to see local leaders emerge who are also determined to realise the ambition of seamless, community-oriented health and social care.**

169. Radical change is necessary, but social workers and GPs working in partnership can make it happen. The future of health and social care depends, to a significant extent, on their success.

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Practice Integrated Care Teams

Article Title Page

Title : Practice Integrated Care Teams – Learning for a better future

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Author Biographies :
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Keywords :
Health and social care, integrated care, integration, Living Longer, Living Better, LLLB, outcomes

Article Classification :
Case study

Structured Abstract

Purpose
The purpose of this paper is to present a case study of one element of the integrated work which has taken place in Central Manchester, the development of multi disciplinary Practice Integrated Care Teams. The report will show how working together has become a practical reality for members of these teams, and is forming the building blocks for further integration across neighbourhoods.

Design/methodology/approach
This paper draws on the author's experience of working in the PICT project from 2012 to 2014. The report will draw on the evaluation work which took place during the project, and will include reflections from others involved in the project and members of the teams.

Findings
The integrated care teams which have been developed in Central Manchester have started to make significant changes to the ways that professionals work together, to the experience that patients have and to the costs of urgent care provision. Whilst there is still a long way to go, there have been many learnings from the PICT. These include:

- Improved patient outcomes and experience. There has been an overall reduction in secondary care activity for patients the teams have

been working with, with the largest reduction being in emergency admissions. Alongside this patient feedback has reinforced the value of this personalised approach and increased overall satisfaction with the care and advice received from health and social care professionals.
- .Improved professional experience. Evaluation has demonstrated that amongst professionals involved in the team there is a strong commitment to the principles of integrated care and that the confidence, skills and capacity of the teams have strengthened since this way of working has been introduced.
- Improved use of resources. As monitoring of financial impact continues to develop, cost savings from secondary care, particularly around emergency unplanned care are encouraging.

Originality/value

This article draws on the recent experience of designing and delivering integrated care across a range of multi agency, multi professional partners. The model which has been developed centres around the role of general practice, and has enabled primary care to take a key role in the development of an out of hospital integrated care system. This has enabled community professionals such as nurses and social workers to build a much stronger relationship with general practice and enable system linkages which will be essential to the delivery of joined up health and social care in the future.

The project has been accompanied by thorough and ongoing evaluation to support the validity of the learnings which have been reported.

Introduction

There are high levels of deprivation across Central Manchester and increasing numbers of people living with multiple long-term conditions, frailty and dementia. Life expectancy at 65 is significantly below the national average although it is estimated that by 2030 there will be 26% more people aged 65 and over with a limiting long term illness living in Manchester, many of whom are likely to need care and support to help them (and their carers) to manage as independently as possible (Manchester City Council, Joint Strategic Needs Assessment)

In terms of hospital admissions for the residents of Manchester these are 40% higher than the national average for those aged 65 and over, the length if stay is 18% higher and total bed days are 21% higher. (Manchester City Council, Joint Strategic Needs Assessment), therefore highlighting a current and expected growing pressure in the future.

In this context the challenge for commissioners has been to ensure that people have the right support to live active, healthy lives in their communities, with fewer avoidable stays in hospitals and care homes. This has included a broad range of activities, such as the development of an intermediate care

service, increased focus on social care re enablement and the promotion of specific long term condition pathways in areas such as COPD and heart failure.

To take forward some of these challenges and opportunities the CCG has developed a long-term vision for integrated care in partnership with Central Manchester Foundation Trust, Manchester City Council and Manchester Mental Health and Social Care Trust. This integrated care programme is amongst the largest and most ambitious ever undertaken in the city. It aims to make a significant shift towards providing care out of hospital for patients with long-term conditions, either through prevention of ill health or community service provision.

As a part of this programme, a project was developed to support the design and implementation of integrated care, focussed around general practice, which works across the CCG's four localities.

In this paper the project manager of the Practice Integrated Care Teams (PICT) will set out how the integrated teams developed, and provide an overview of the outcomes achieved, reflecting on both the experience of patients and professionals involved as drawn from the evaluation activities which accompanied the project. The next steps for integrated approaches to health and social care delivery will also be set out, building on the learnings from the PICT work which has taken place so far.

Background and Context

Central Manchester is a vibrant area, with a health and social care leadership who are committed to the promotion of its economic growth and the creation and maintenance of neighbourhoods where people want to live work and bring up their families. However, the area has some of the most economically deprived communities in the country and some of the worst health outcomes. Alongside this there are also a growing number of people with complex health conditions; more people accessing hospital based urgent care, and more pressure on the budgets available to provide services. All of these factors create a foundation for reform, for doing things differently, and for doing so without delay.

Yet despite widespread acceptance that health and social care must change in order to meet the needs of today's society, there has been less acceptance on what change is required and how this change should be delivered. In October 2014 the NHS England Five Year Forward View (NHS England, 2014) went some way to setting out a clearer direction for the way that health care will change, with a focus on partnerships being needed across communities, local authorities and employers. Importance was also given to the need for far more care to be delivered locally through more integrated

systems, although this document clearly recognises the challenges that need to be overcome. Within this document the scale of change which is discussed is radical and as a result is likely to be fraught with potential pitfalls, however, as stated by the NHS Future Forum in it's 2011 recommendations to English government,

> 'We need to move beyond arguing for integration to making it happen, whilst exploring the barriers' (DoH, 2011*)*

Therefore whilst the model of integrated care may not be agreed, or the means for achieving it, the importance of integrated health and social care is clear and now repeatedly reinforced and as such should be a given baseline for health and social care systems to develop from. Our focus must now be on developing a learning and evidence base which will support the transformational change required, the change which will make integrated care a reality. We must test new ways of working and learn from what works and from what doesn't work.

In the context of this growing move towards the need for integration Central Manchester embarked on a range of initiatives, with the development and implementation of Practice Integrated Care Teams (PICT) being one of the key areas of focus. The project itself was initiated in June 2012, with the target being for the teams to become fully operational by October 2013, in order for returns to be seen in budgets and further re-investment in the following financial year. It was accepted that this plan would require some degree of courage and acceptance of shared risk, but accepted by all partners that Central Manchester was up for this challenge and driven in wanting to explore opportunities to support communities to be the healthiest they can be.

Overview of PICT

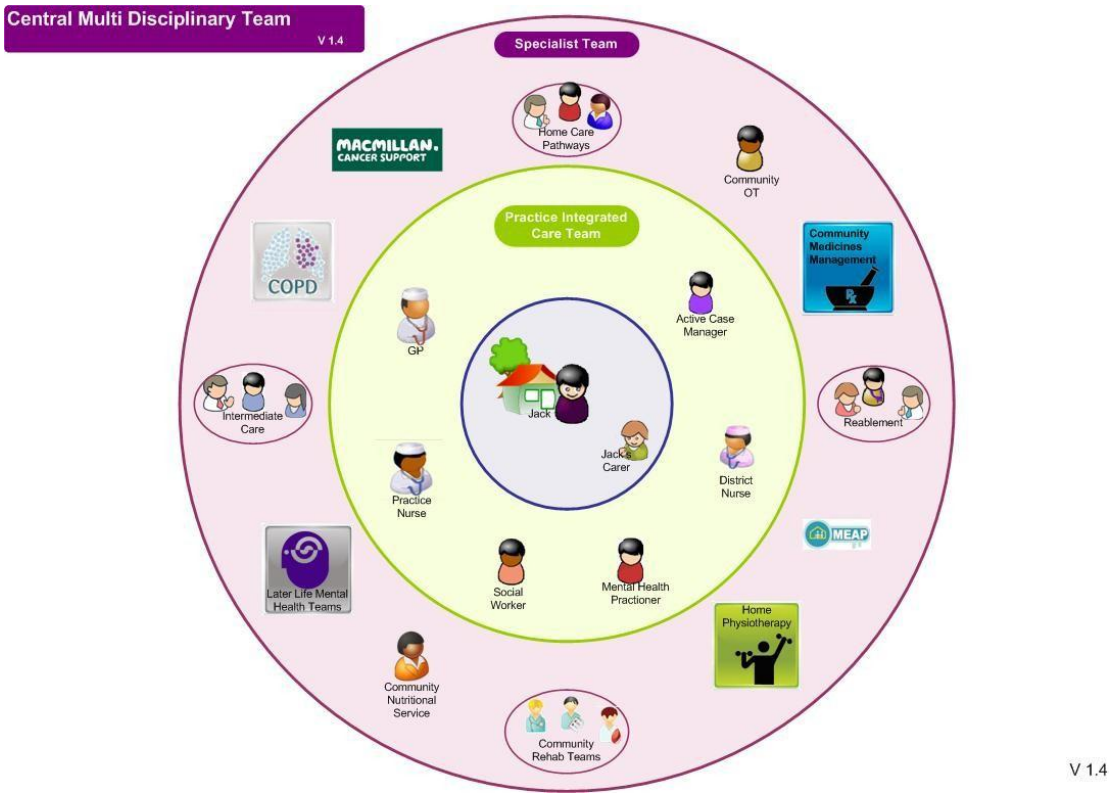
The integrated teams which have been established in Central Manchester are designed to deliver a coordinated, patient centred model of care to some of the most vulnerable people in Central Manchester. The focus is on those people who commonly have a range of complex health conditions and social issues, who are at high risk of unscheduled and often lengthy periods in hospital, and for whom there are significant threats to their capacity to live independent and healthy lives.

The vision for this work is:
Control - for the people that the teams work with to feel more confident and in control of their lives
Whole person - for people to be seen as a whole, whatever the complexity of their needs
Working together - for health and social care to work together better and more easily

Planning ahead - for people supported by the teams to have improved care planning to prevent a deterioration in their health and social care, to reduce the likelihood of a crisis and to enable themselves and others to respond better to an emergency should this happen.

How the teams work:
The PICT core teams (see diagram 1) include a GP, practice nurse, social worker and community health practitioners, such as a district nurse and an active case manager, who work together, calling on input from specialist teams as and when required.

Diagram 1 The Central Manchester Practice Integrated Care Team Structure



High-risk patients are identified using the Combined Predictive Model risk stratification tool along (DoH, 2006) with clinical judgement of who would be most likely to benefit from this approach, and assessed against the PICT criteria. Once selected, patient consent is requested and patients are assigned to a key worker from the team; this is usually the person that has the most trusted relationship with the patient.

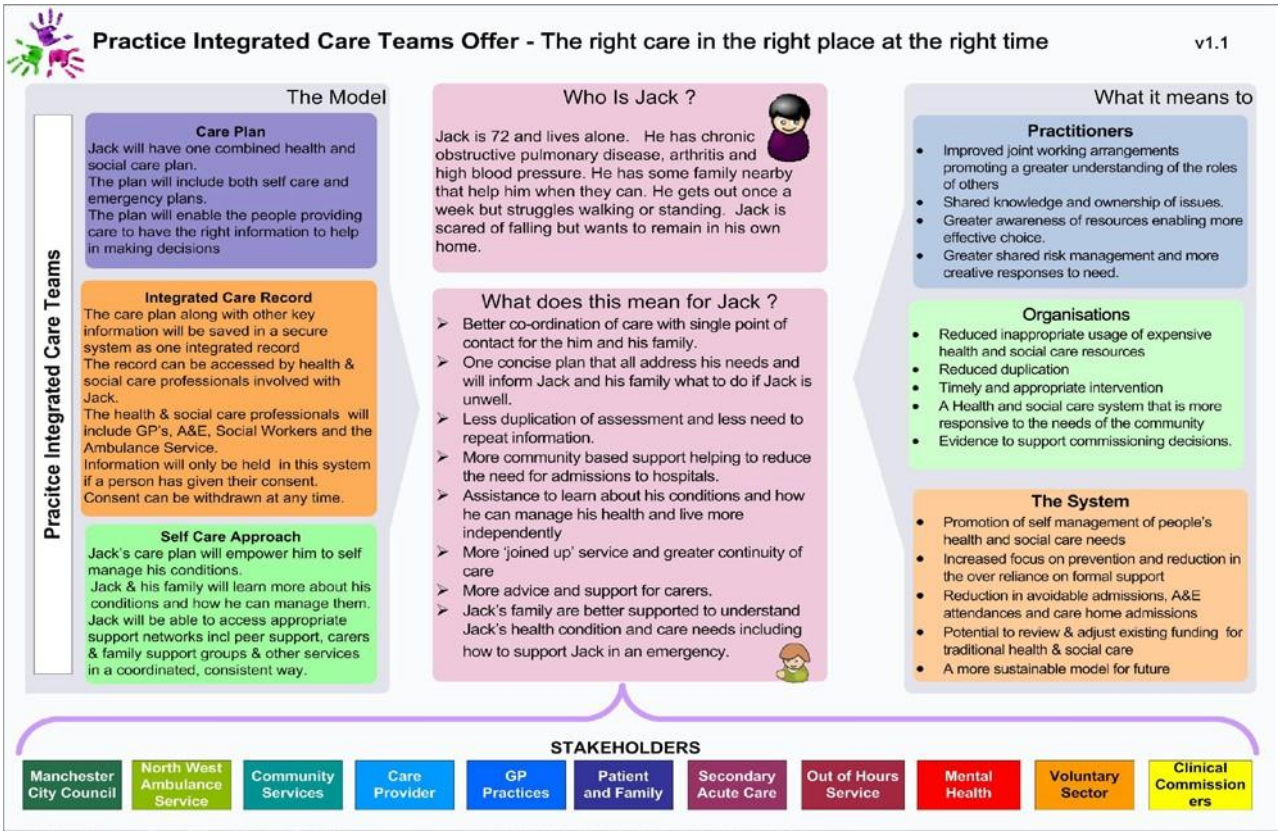
Key workers then help patients to develop their own personal care plans, setting goals and determining actions required for achievement. The care planning process covers both preventative and crisis planning, and aims to help engage people in decisions about their health and social care.

Personal care plans are held on the patient's electronic Integrated Care Record, which is managed by the key worker and shared with the rest of the PICT, who can also make contributions. Importantly the patient also holds their own paper copy of the plan so that they are able to use this as a live document to help inform their own decision making, for example reinforcing who to contact if they have concerns about their health.

PICTs usually meet on a monthly basis to discuss caseloads. More broadly than this however, the meeting time together is an opportunity to share learning and has facilitated the building of more trusted relationships across professions and services.

Key elements of the design:
There are a number of key elements of the team 'offer' which have contributed to its form, which are summarised in the following diagram :

Diagram 2 Practice Integrated Care Team 'Offer'



In order to then deliver on this offer a range of features within the team design and ways of working can be seen to have had importance, these include:

Involving professionals in the design of the process

The team design was led by a group of clinicians from within Central Manchester who stepped up to share their views, experience and knowledge of what they understood would support successful multi disciplinary team working. The professions represented included GPs, community nurses and social work, alongside a range of other specialist services such as dietetics and speech and language therapy. Representatives from these key groups have maintained their involvement in leading the direction of change, helping to provide appropriate challenge where this has been required and enabling the work that has taken place to capitalise on real opportunities and tackle the most pressing barriers. As a result the design process was flexible and responsive to the need for continuous change whilst being firmly rooted in the experience of practitioners.

Delivering more coordinated services

A key issue for the teams to address was the lack of coordination between services, including a lack of knowledge around services available, and the roles and responsibilities of providers within the health and social care sector. The approach within the PICT work was not to set about structural change in order to achieve such improvement, but to establish an environment which values and encourages shared working. This builds on the principles within the House of Care, which forms the framework for improving coordinated care for people living with long term conditions (NHS England, 2013,). Within this approach there is recognition of the need for professionals to be supported to collaborate, for team work to be strongly embedded, and for work to be clearly focussed around the individual needs of the patient, as being one of the central tenants of integrated, person centred planning. Within the PICT this has meant professionals being brought together by neighbourhood rather than discipline, thereby enabling teams to start to work together across traditional boundaries where they may previously have had little direct contact.

Care Delivery

Within the team design the onus has been placed on professionals shifting the way they work away from a heavy reliance on crisis intervention and a paternalistic approach which disempowers patients. Instead there has been a recognition that crises occur and therefore need to be planned for, but that more effective outcomes can be achieved by an approach which actively seeks to prevent dependency and places patients at the centre of their own care and support. Within the team structure this has meant professionals coming to work together in a very different way, with a much more careful consideration of the goals they will be supporting patients to work towards and the actions they will need to take in order to support them in achieving these. This has been one of the most significant cultural shifts required of team members, and one which continues to develop, with some professions being more ready to work within this approach than others. For example feedback from teams has demonstrated that there is variable confidence in working to an outcomes based approach, and that to work to prevent a relationship of dependence developing is a very real day to day challenge for some team members. As such work to embed an outcomes based approach within all

aspects of an individuals care will continue to be a priority for further development.

Information Technology

Sharing of information was also set out as an important priority for the teams. This was in recognition of the value of information systems in reducing duplication, in promoting timely and effective decision making and in enabling patient and professional encounters to be focussed on activities which are of most benefit. In recognition of this need the Department of Health in the 2013 document 'Integrated Care and Support :Our Shared Commitment' (DoH, 2013) stated that data relating to an individuals need should be shared both with the patient to enable self management and build independence, and between front line workers 'to enable coordination and continuity of care'. Alongside this the need for health and social care agencies to share information when it is in the best interests of individuals, has been highlighted within the 2013 review of the Caldicott Principles, (DoH, 2013) which now includes the additional principle that,

> 'The duty to share information can be as important as the duty to protect patient confidentiality'

By placing significant focus on the development of an integrated shared IT solution which builds on these principles the PICTs now have access to a software system which has joined together key data sources from health and social care systems for the first time, and has the potential to radically change the way that we make use of information.

Patient centred care planning

The overarching principle behind the care planning process the teams developed was for the plan to be driven by the patient and their individual needs. This has been an adoption of the narrative for person centred coordinated care communicated by National Voices, which states that as a patient

> 'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me' (National Voices, 2013,)

For the patient and their carers their own outcomes must therefore be at the centre of the service design. This involves a care planning approach centred around the goals and priorities of the patient, with the focus being on what is important to them and their motivations, planning to achieve the goals which are meaningful within their lives. The plan which is then developed uses the clinician's knowledge and expertise around their condition and the support options available, however uses the patient's experience of their condition and the circumstances within their life to build an agreed plan (Collins, A. and Collins, A. 2011)

Focus on self care

The teams have been developed on the premise that patients should be empowered to self manage their conditions, to learn more about their needs and to have a key role in managing their own health and health care. This approach sees the patient as an expert in their own right, who should be

supported to have the right skills and information to manage their own care. This sits very firmly within a context that health and social care must move away from episodic urgent care to a more preventative focus, with the need to help patients to choose more healthy behaviours and to be more in control of their own health outcomes (Naylor, C., Imision, C., Addicott, R. et al, 2013)

Cost efficiencies

Whilst the financial drivers around health and social care resources are a national priority the development of the teams has also needed to be within the context of improving well being for patients within a challenging financial envelope. As such it has been important that money is used as effectively and efficiently as it can be. The initial investment fund set aside by stakeholders to support the embedding of this approach has been important in enabling the teams to develop with focus, urgency and with a commitment to ensuring that the approaches that develop are sustainable within existing resources. So whilst during the development of the project opportunities for additional investment were considered there has also been a need to ensure that investment has had the potential to enable a balanced shift of resources, and that the continuation of the model of care developed has not been limited by early over investment.

Evaluation Process & Findings

Evaluation Process

The evaluation process included three main elements, action learning, a performance dashboard used to track a range of quantitative data sets and indepth interviews with patients who the teams worked with.

1. Action Learning

In December 2012 Manchester City Council and Central Manchester Clinical Commissioning Group (CMCCG) awarded a year long contract for the provision of Action Learning to Hall Aitken. This Action Learning was to support practitioners with designing and refining a model of practice integration that works and can be replicated before embarking on the research phase of the model's evaluation.

Hall Aitken held meetings with a selection of practices to observe similarities/differences in working practices, focussing on the degree of adherence to processes and whether cultural issues, for example joint ownership across teams and shared understanding were being addressed. Monthly summary reports of lessons learnt were then produced for the Evaluation Workstream.

In addition a series of 3 Workshops were facilitated by Hall Aitken and were attended by representatives from all multi disciplinary teams and professionals. These workshops focussed on areas of particular interest during the design phase, and included risk stratification, care planning and

preventative multi disciplinary working.

The findings from each stage of the action learning were used to refine the team ways of working, and have been important on an ongoing basis in framing the next steps for development.

2. Quantitative Measures – Performance Dashboard

A Performance Dashboard was created to report delivery of the key measures identified;

- Patient outcomes – Reduced unplanned admissions and readmissions into hospital by the cohort
- Reduced length of stay
- Reduced bed days
- Usage of community services, including care home placements

Work is on-going to ensure that the entire costs to the system are understood and appropriately captured and will continue to be developed using the best evidence available, being replaced as better evidence becomes available. It is accepted that there are limitations with the methodology used within this section of the evaluation. As such it is important to note that changes in activity have been seen for the cohort when compared against a preceeding timescale for the individual and not compared with a control group, whether randomised or cohort. For example changes in activity could be argued to be due to random variation, regression to the mean or some other influence on keeping patients out of hospital. Despite these caveat's the dashboard has been used in order to keep track of measurable activity for patients the teams have been working with.

3. Qualitative Measures - Patient Engagement

Patient diaries – these were initially distributed to patients and carers as a means of providing feedback on health and social care experience, however the take up of this mechanism was low, and on review was decided to be replaced by focussed patient interviews

Patient interviews – an external body was commissioned to complete semi structured interviews with patients and carers about their experiences of the new model of care. The findings of these were presented to the project team, resulting in a relatively small number of patients being able to provide feedback, however very detailed content from these interviews.

Evaluation Findings

Whilst the focus on measurement of outcomes has been a priority throughout the development of the PICT there have been significant challenges around how this measurement takes place. These have included issues around

information sharing and access to service utilisation data. In addition the question of how to evaluate the impact of a team which is one part of a system of new ways of working being developed concurrently has at times been a struggle. As such the evaluation findings are presented with recognition that there are some limitations to the conclusions that can be made, however the content is of value in demonstrating a number of key themes.

1. Improved patient outcomes

Patient outcomes have been measured in terms of the opportunity for patients to access support around their needs in a planned way and for this to be delivered close to home, as opposed to urgent care delivered within a hospital setting. Reporting on this basis shows that there has been an overall reduction in secondary care activity of 9% for patients who have an integrated plan in place via the teams, with emergency admissions seeing the largest percentage reduction in terms of activity (22%) (Data to November 2014). As the patient group the teams are focussed on are those at greatest risk of admission, then this also suggests that health inequalities for this most vulnerable of patient groups are being improved. Further work is planned to expand on the value of these measures by building in the impact on social care usage for the same cohort of patients, as this will give a greater understanding as to the outcomes being experienced by patients.

2. Improved patient experience

Reports from team members have indicated that patients like the approach of integrated working, that this has reduced duplication and led to better and more timely decision making. These findings have been reiterated by patients themselves in a series of semi structured interviews which were carried out during the project, the aim being to gain an in depth understanding of patient and carer experiences of the PICT. These interviews showed that in general patients had a positive response when asked about their overall satisfaction with the care and advice they had received from their health and social care professionals and that they were happy with the teamwork displayed.

The evaluation of patient outcomes also recognised the ongoing opportunity for embedding the role of the keyworker and for ensuring that the patient is well linked in with support within their local communities which will enable them to be more in control of their well being. Factors such as these will be progressed further in the future ongoing development of integrated care under the Living Longer Living Better programme which is now developing across the City of Manchester.

3. Improved professional experience

An independent evaluation by Hall Aiken (Hall Aitken, 2014) which reported in December 2013 concluded the following key messages:

- There is strong commitment to the principles of integrated care.
  There is widespread acceptance that the model of integrated working is an excellent way of improving the way services work. And there is evidence to suggest that this is happening.

- The confidence, skills and capacity of the teams have strengthened as the project has progressed

    Teams have become more ‘democratic’ as the project has progressed, with greater contribution from team members on cases discussed. The process is developing much stronger formal and informal networks. Across multi disciplinary teams participants reported the positive impact this had had n their understanding of services and how they could support people.
- Significant progress has been made in the period the project has operated

    Over the period of the project the benefits of integrated working have been felt more strongly and there is broad consensus on the positive impacts of this way of working.

The report also went on to make a number of recommendations to support the ongoing successful development of integrated care. These included the need to strengthen an understanding of self care, to continue to increase the functionality and ease of use of the integrated IT software and to expand the opportunities for involving other teams and services in this approach. All of these recommendations are now being taken forward as important elements in the next stages of the programme.

4. Improved usage of resources

Ongoing reporting continues to take place for a group of patients who have an integrated care plan in place via the teams. This shows that to November 2014 2003 patients have an integrated care plan in place, and measurement available for 688 of these patients demonstrates that costs have reduced overall by 17%. Emergency admissions have sent the largest percentage reduction in terms of costs (22%), with cost savings in emergency admissions accounting for 96% of the savings so far.

The cost savings from secondary care usage are encouraging, and whilst recognised as only one part of the system costs potentially attributable to this group of patients, the data is able to give an encouraging sign that cost reduction in one of the highest demand areas is being managed for these patients.

Discussion

The PICT in Central Manchester has been an evolving model even from the point of initial design, with learnings and feedback continually reviewed and the model adapted as necessary in response. This flexibility has enabled the PICT to adapt to take advantage of opportunities which have come from the constantly changing health and social care landscape. These have included the need to refine the model to fit with the delivery of nationally commissioned general practice services, along with taking forward changes which are currently underway in order to respond to local workforce issues.

Overall the PICT has achieved many successes, such as the strengthening of joint working arrangements, increased trust between professional disciplines and the development of a better shared approach to risk management. However alongside this there have been areas which have still proved a challenge, and which will continue to be areas of development as the integrated programme of work progresses. Such areas include the embedding of effective person centred planning, maximising the potential of patient self care and enabling practitioners to make a positive shift away from crisis management to more preventative approaches.

Some reflections of particular note which have been learned through the design and embedding of the PICT approach are given here:

Involving patients and carers in the design process
The teams have been set out with patients and their carers as central to the whole design of the service, however despite this there has been recognition that the involvement of individuals within the service delivered could be more effective. As such the next stages of design are being structured with greater focus around this need, to enable strong and effective voices from those within our neighbourhoods to inform the services which develop and the way in which these are delivered.

Valuing the role of the community and voluntary sector
Whilst there have been significant developments in core professionals developing trusted relationships and working together better to the benefit of patients the role of the community and voluntary sector within this support structure has been under valued. Further work is required in order to ensure these organisations are full partners in the design and delivery of person centred care (National Voices, 2013)

Leadership
The value of strong senior leadership throughout the project has been critical, both in terms of the momentum of the work that has taken place and the formation of trusted ongoing relationships across all of the involved organisations. This has enabled decisions to be made quickly, whilst ensuring the right level of scrutiny and ownership.

A common need
The establishment of a common need amongst partners has been important in enabling shared risk taking at a senior level along with a recognition of shared benefits across the system should the approach be successful. Partnership working across all aspects of the teams' development has reinforced this joint commitment, and has helped in reducing some of the organisational barriers that may otherwise have become a hindrance to creativity.

Cultural change
For some participants the changes which have come along with integrated working have been difficult to manage. In part this has been down to perceived threats to role and the uncertainty of developing new skills, for

others this has been a lack of belief in the need for reform or the somewhat limited evidence base for the emerging change. All of these anxieties have been valid, and were a key concern of the project throughout the development of the integrated teams. Organisational development and support through change will continue to be one of the major needs for the emerging integrated system, both in Central Manchester and elsewhere for the implementation of new approaches to truly be considered successful.

Finance system

Underpinning the development of the PICT was the establishment of an investment fund, the expenditure of which came under the scrutiny of an integrated care board at which all major stakeholders and partners were represented. The opportunity presented by this structure was to create a virtuous cycle of investment, shifting care and resource into community settings, reducing demand upon secondary care services and thus, in turn, creating a further funding stream for future year's investments. The challenges in 'making real' the shift in resources into the community from secondary care remain, however the financial environment within which the PICT sits have facilitated the reform which has taken place so far and continue to enable work aimed at effective community asset building.

Diagram 3 Summary of lessons learnt

Lessons Learnt	
Do's	**Don'ts :**
• Involve team members in the team design • Build on existing strengths • Enable the design to be flexible and develop continuously • Keep the patient and carer as central to the process • Value strong leadership • Use evaluation evidence to support future work	○ Evaluate too soon, many outcomes need a longer term shift ○ Be put off by challenge, this can be valuable in improving ways of working

Conclusion

The work of the PICT can be seen to be on a relatively small scale given the population of Central Manchester. This work has been targeted very clearly at those with the highest level of existing and immediately foreseeable risk, for whom an intensive approach has been of most benefit. However the plans are now to grow this way of working, to enable more patients to benefit from an integrated health and social care system and for partners to build the scale and pace needed to take this ambition forward.

As such Manchester's 3 CCG's, along with the council, the three acute trusts and the mental health trust are now committed to the development and delivery of a place based care model over the next 5 years called Living

Longer Living Better, which will radically redefine our communities expectations of health and social care and the support that is delivered. These are exciting times, and the learnings from the PICT are forming one of the cornerstones for this new programme and the way in which local people will be supported to receive high quality, personalised and coordinated services which help them to manage their own conditions and live long, healthy lives.

There are though already a number of important learnings which have come from the PICT work which have taken place in Central Manchester. These include:

- High level commitment from stakeholder organisations
- Continuous review and change to adapt the model, in response to feedback from patients and carers and professionals involved in the teams
- Making the most of opportunities for joint working using informal arrangements which may already be in place,
- Working closely with patients and their carers, to ensure a person centred and relevant service
- Taking opportunities to scale up successful elements from a project phase to enable further larger scale change.

The PICT approach has made a range of practical, real improvements to the way that health and social care works and to the experience of both patients and carers and those working in the system. The challenge of how we can continue to refine our approach, embed learnings and make systems better will continue, but with the understanding that things have come a long way and that there is the drive to keep going further.

Word count 5804

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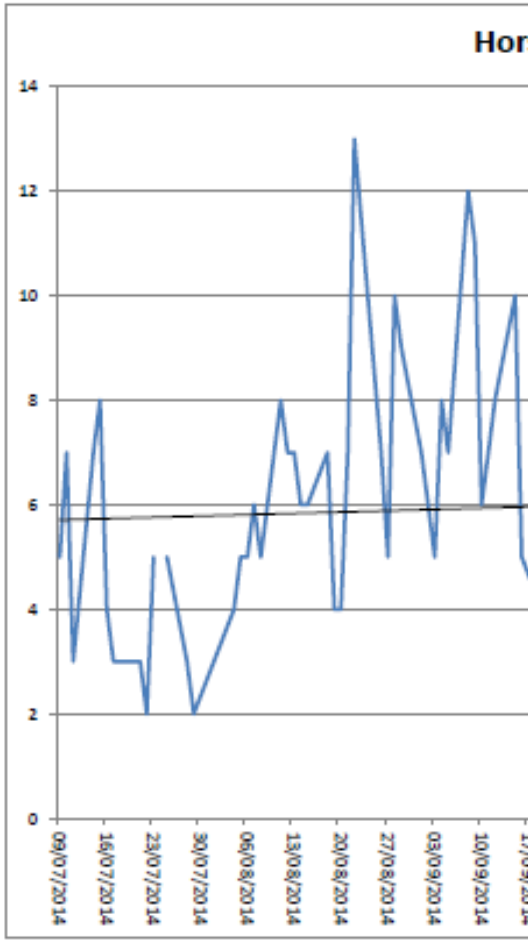
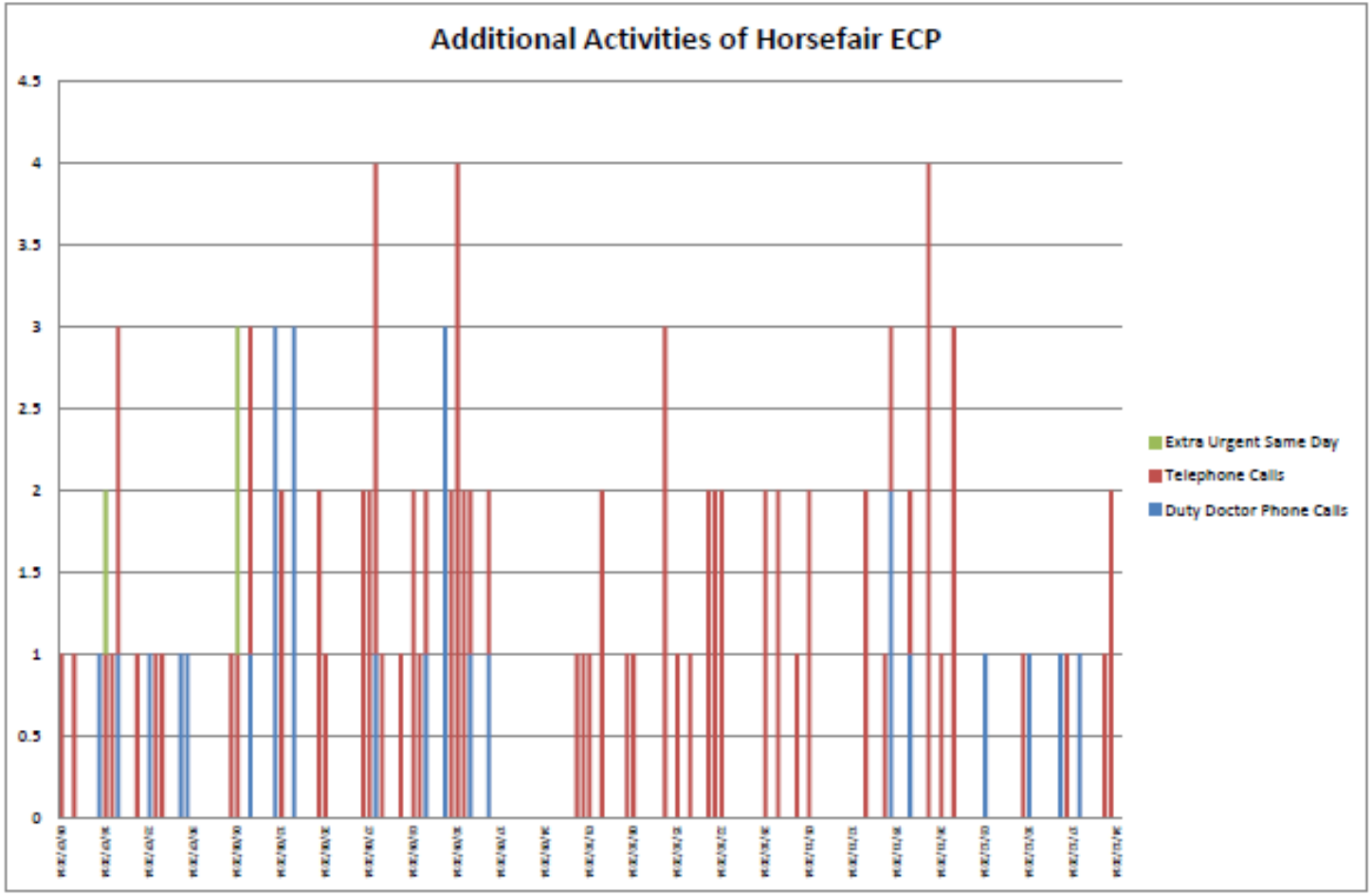




	Home Visits	Duty Doctor Phone Calls	Cancelled Appts	Telephone Calls	Extra Urgent Same Day	**Grand Total**
09/07/2014	5			1		**6**
10/07/2014	7					**7**
11/07/2014	3			1		**4**
14/07/2014	7					**7**
15/07/2014	8	1				**9**
16/07/2014	4			1	1	**6**
17/07/2014	3			1		**4**
18/07/2014	3	1		2		**6**
21/07/2014	3			1		**4**
22/07/2014	2					**2**
23/07/2014	5	1				**6**
24/07/2014				1		**1**
25/07/2014	5			1		**6**
28/07/2014	3	1				**4**
29/07/2014	2	1				**3**
04/08/2014	4					**4**
05/08/2014	5			1		**6**
06/08/2014	5			1	2	**8**
07/08/2014	6					**6**
08/08/2014	5	1		2		**8**
11/08/2014	8					**8**
12/08/2014	7	3				**10**
13/08/2014	7			2		**9**
14/08/2014	6					**6**
15/08/2014	6	3				**9**
18/08/2014	7					**7**
19/08/2014	4		1	2		**7**
20/08/2014	4			1		**5**
21/08/2014	7					**7**
22/08/2014	13					**13**
26/08/2014	7			2		**9**
27/08/2014	5			2		**7**
28/08/2014	10	1		3		**14**
29/08/2014	9			1		**10**
01/09/2014	7			1		**8**
02/09/2014	6					**6**
03/09/2014	5			2		**7**
04/09/2014	8			1		**9**
05/09/2014	7	1		1		**9**
08/09/2014	12	3				**15**
09/09/2014	11			2		**13**
10/09/2014	6			4		**10**

11/09/2014	7			2		**9**
12/09/2014	8	1		1		**10**
15/09/2014	10	1		1		**12**
19/09/2014	4					**4**
22/09/2014	4					**4**
23/09/2014	8					**8**
24/09/2014	2					**2**
26/09/2014	6					**6**
29/09/2014	6			1		**7**
30/09/2014	5			1		**6**
01/10/2014	7			1		**8**
03/10/2014	5			2		**7**
06/10/2014	9					**9**
07/10/2014	3			1		**4**
08/10/2014	6			1		**7**
13/10/2014	7			3		**10**
14/10/2014	7					**7**
15/10/2014	4			1		**5**
17/10/2014	6			1		**7**
20/10/2014	7			2		**9**
21/10/2014	4			2		**6**
22/10/2014	7			2		**9**
24/10/2014	7					**7**
27/10/2014	4					**4**
28/10/2014	7					**7**
29/10/2014	5			2		**7**
31/10/2014	8			2		**10**
03/11/2014	7			1		**8**
04/11/2014	3					**3**
05/11/2014	4			2		**6**
14/11/2014	9			2		**11**
17/11/2014	9			1		**10**
18/11/2014	7	2		1		**10**
19/11/2014	9					**9**
21/11/2014	4	1		1		**6**
24/11/2014	6			4		**10**
25/11/2014	6					**6**
26/11/2014	3			1		**4**
28/11/2014	9			3		**12**
01/12/2014	7					**7**
02/12/2014	6					**6**
03/12/2014	8	1				**9**
04/12/2014	4					**4**
09/12/2014	6			1		**7**
10/12/2014	6	1				**7**
15/12/2014	3	1				**4**
16/12/2014	1			1		**2**
17/12/2014	6					**6**
18/12/2014	6	1				**7**

19/12/2014	6					**6**
22/12/2014	10			1		**11**
23/12/2014	8			2		**10**
24/12/2014	2					**2**
Average	6	1.4	1	1.6		1.5

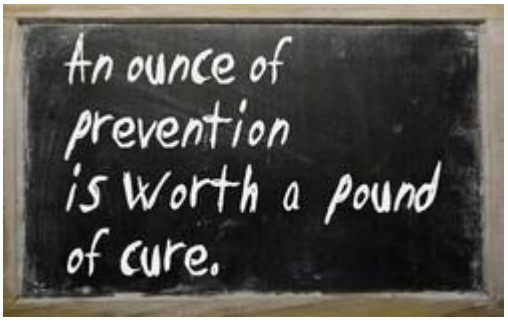
Milton Keynes CCG.
Transformation Fund Application

Using an Emergency Care Practitioner to reduce unplanned admissions in patients 75 and over

Dr Luke James, Caroline Rollings, Kieron Tanner (ECP)

The Core; Collaboration; "working in positive association with others"

….."being able to keep the patient in the most appropriate place…their home…or family's home…not in an A &E department" [i]



Contents

1.How does this support the Better Care Fund Initiatives?

"***General practice provides the majority of urgent care and small changes to improve overall access and a consistent approach to urgent care requests, especially to older people, is likely to have a significant effect both on ED (A & E) attendance and hospital admissions. Improved access to timely integrated health and social care services in the community is also likely to have a significant impact on hospital admissions, length of stay, discharge and re-admission rates."*** [i]

This initiative enables the practice to include an Emergency Care Practitioner (Advanced Paramedic) in its team to provide rapid, early assessment of our most vulnerable patients needing unscheduled care, to reduce admission to hospital and improve outcomes. It is based on the Modern Model of Integrated Care that supports a senior clinician taking responsibility for active co-ordination of care. Dr Luke James will be the clinical lead for this initiative[ii]. The initiative also includes an education component, to increase quality in emergency management across both clinical and non-clinical teams .The aim of the Better Care Fund, supported by this initiative, is

"to deliver better outcomes and greater efficiencies through more integrated services for local older and disabled people" [iii] .

This initiative builds on our first proposal by implementing co-ordinated care for elderly patients with urgent and emergency care needs in the community, at home, or in nursing homes. It uses early intervention to avoid ED (A & E) and hospital admissions by extending our collaboration further across the health care system and working with an Emergency Care Practitioner in order to reduce A & E attendance and hospital admissions. There is good evidence that "reducing hospital admissions, emergency readmissions and length of stay, for older people in particular, is increasingly recognised in social care as being a significant factor in reducing or delaying admission to residential and nursing home care" i p54. This initiative aims to impact residential and nursing home admissions as well as supporting patients to remain in their own home through joint team working. v

"Primary care is pivotal in the delivery of urgent care, with GP practices providing the bulk of the urgent care response. Improving both the access and the urgent care response to same day urgent requests in general practice and reducing variation, is key to influencing patients' attendance at ED (A & E) and hospital admissions" *i p53.*

"One in 400 of all people a doctor sees ends up in hospital, but one in 20 of all home visits end up as admissions".

The Primary Care Foundation advocates that every person phoning to request a home visit should receive a phone call back within 20 minutes and, if needed, be seen within the hour in order to increase the probability that, if admitted, they will get out the same day. [iv] The evidence shows that through prompt treatment and response visits first thing in the morning it is possible to offer effective and quality care, which reduces admissions for overnight stay in secondary care. This initiative will enable us to meet that need.

Additionally our list size is growing rapidly. Practices around MK are being forced to close due to large patient lists and lack of space and resources. This initiative enables us to continue taking on patients through the use of appropriate skill mix, enabling our multi-disciplinary team to care for increasing numbers of patients needing scheduled care, including those aged over 75 and those with multiple Long Term Conditions.

Newport Pagnell Medical Centre has a high number of patients aged 75+, compared to the rest of Milton Keynes, and low A & E and emergency admission rates. However, there is room for improvement. From our PBB data we can see that our predicted full year outturn for patients attending A & E requiring no investigation and receiving no significant treatment is at present at 63 patients over plan. Our Emergency admissions for musculoskeletal system 44 over plan and urinary tract 19 over plan.

During a time of increasing patient numbers and increasing access requirement, we would like to see further reductions through this initiative.

What does good urgent and emergency care look like?
Good urgent and emergency care is:
• Patient-focussed.
• Based on good clinical outcomes, e.g. survival, recovery, lack of adverse events and complications.
• A good patient experience, including ease of access and convenience.
• Timely.
• Right the first time" [i].

2. Service description

Key areas of work for the ECP:

- Work in compliance with quality and safety standards, e.g.CQC, NICE, HCPC and Royal College standards, to improve patient access to urgent same day appointments and free up our doctors to manage the more complex cases on our increasing list.

- Work with the patients they care for to support improved self-care. "Self-care and prevention strategies for the elderly and those with mental health needs have featured less prominently in the urgent and emergency care strategies of commissioners, yet the potential impacts are significant. Similarly, the evidence for the impact of anticipatory care in long-term conditions to reduce hospital admissions is substantial, although this has not been exploited" for example "alcohol misuse often presents in the ED or as unscheduled admissions. In the general hospital setting, heavy drinkers who are counselled about their drinking have a significantly better outcome than controls when followed-up 12 months later." [I]

- Provide continuity of care as the ECP will work closely with the whole team.

- Work with patients to improve medication concordance/compliance.

- Respond to patients who fall, using self-care and prevention strategies when appropriate[v].

- Work closely with teams leading on end of life care, care homes, COPD patients, community matron and our other Transformation Funding scheme, in order to maximise the spread of improved emergency care. For example we believe we can improve the joined up working between SCAS and the practice, in terms of end of life plans in order to reduce inappropriate admissions.

- Work with patients identified as being frequent callers and/or attenders and enable proactive case management to reduce their admission frequency.

- Work with the HIT team to improve urgent care.

- Work, using and contributing to the patient's Care Plan. The ECP will further develop care plans, and explore alternative care pathways, whilst being mindful of risk management. The aim is to improve on crews attending 999 call outs who, due to lack of information and a resulting risk aversion, send patients to hospital.

- Work preventatively with people with diabetes who have called an ambulance for hypo/hyperglycaemic episodes, to reduce repeat call out.

- Reduce ambulance calls (and subsequent avoidable A & E attendance) to care homes through relationship building and working with carers to build trust in calling the ECP instead.

- To provide a link with SCAS and direct dial mobile number to discuss unplanned A & E conveyances prior to SCAS crews leaving scene (when appropriate) with patients who may be safely, effectively and appropriately managed within their own homes.

- Improve patient outcomes in the over 75s by means of rapid, structured assessment and early treatment of conditions such as sepsis and severe community acquired pneumonia through GP/ECP

collaboration to reduce mortality and morbidity, in line with national standards and guidance. (See Appendix 2: The recognition and Initial Management of Sepsis in Adults.)

- Admit relevant patients early to AECU in order for them to receive relevant care, such as IV, antibiotics and be discharged the same day, thus avoiding the costs and disruption to the patient of an overnight stay.

- Use Ambulance Anticipatory Care Plans (AACP) See Appendix 1.

3.How does the proposal transform the care of older people and reduce avoidable admissions and support the accountable GP?

Relevant Evidence (continued) ***Action points for practices*** [vi]***:*** 1. *Ensure patients with urgent conditions will receive timely care however they access the service.*	**How the initiative is designed to meet the need identified** The ECP will work closely with our Reception Team to monitor this.
2. *Ensure processes minimise avoidable peaks in demand*	The hours the ECP will work will be planned to coincide with maximum peak time.
3. *Make sufficient appointments available to meet demand from patients*	Regular review of appointment availability to ensure we are meeting our patients' needs in order to minimise A & E and urgent care attendance
Relevant Evidence (continued)	**How the initiative is designed to meet the need identified**
4. *Review how the practice would identify and respond to a range of urgent cases. Look at both symptoms that might indicate urgency and consider particular groups of patients that may need to be handled differently*	This will be part of the job role of the ECP, working jointly with the doctors and the Operations Manager.
5. *Training. Review receptionist training to ensure the front line team understands and uses the right processes to identify and handle urgent calls. Where required, run refresher sessions for both clinical and non-clinical staff*	Part of the job role of the ECP
6. *Define our practice standard for the length of time from the patient first ringing to assessment by a clinician and to appropriate clinical intervention*	The project will define a standard and monitor our performance against that standard. It will also audit quality and consistency of our telephone response, consultations and decision making of the ECP
7. *Any patient or carer requesting an urgent home visit should be offered a rapid assessment by a clinician. Normally on the phone, but in some cases the clinician may choose to plan an early visit*	Part of the job role of the ECP At present the pathway involves nurses being sent out, doing ECG etc. and then bringing the results back, waiting for GP assessment and possibly a visit after 12.00. This pathway would be smoother and more efficient, resulting in reduced use of secondary care.
"If patients are seen quickly, rapidly and effectively it has a profound effect. The converse is true too - if general practice is not working well, patients go elsewhere and secondary care feels the impact" [iii]	Ensure our team keeps managing emergency care to the optimum level possible

4. How does the proposal complement the new GMS requirements and the Enhanced Service?

The proposal takes reducing hospital admissions one step further through including an emergency care specialist in the team. The initiative is based on good evidence around the role that they can play in reducing A & E and overnight stays. (See "Key areas of work for the ECP:") It will also work in conjunction with our other Transformation Initiative for The Better Care Fund "Multi-disciplinary care for patients 75 and over", adding another layer of expertise to the multi-disciplinary team in order to further reduce admissions.

5. How does this service support integration with other health and social care services?

The service works jointly with SCAS. Through joint working with primary care, we see the opportunity to share the learning from the initiative with general practices across MK and SCAS among other agencies.

6. Costs for 7 months of the project (September 2014 to end of March 2015)

Item	Cost:
ECP	£27,335
Equipment: • Second hand 12 lead ECG with print out and AED capability • Service of nebuliser kept in store for emergencies to enable use • SpO2 probe	• £900 • £120 • £50
Total Costs:	**£28,405**

7. What does success look like – what outcomes does this services deliver?

- Education of the primary health care team in order to improve emergency management.
- Increase practice capacity to care for registered patients, including those aged over 75 and those with multiple long term conditions.
- Reduction in secondary care, A & E, and nursing home admissions through:
    - Proactive case management.
    - Working with patients to improve self and anticipatory care.
    - Preventative work with frequent attenders, falls and end of life patients among others.
    - Working with patients to improve medication concordance/compliance.
    - Working with the HIT team to improve urgent care.
    - Working with nursing homes, both patients and staff, to reduce call out.
    - Increase in the number of patients dying in their own home rather than secondary care
    - Rapid, early assessment of patients needing unscheduled care with enhanced treatment at home or early transport to AECU to prevent overnight admission.
    - Joint working between emergency and primary care.
    - Encouraging relatives who act as primary carers to consider completion of Emergency Care Plans should they themselves unexpectedly be unable to provide patients daily care requirements.

8.Metrics:

We will be using both quantitative and qualitative evidence to monitor the initiative.

- We aim to adopt a consistent approach to ECP consultations through the use of clinical audit.

Quantitative: (Read coded and templated)

- Unscheduled care responses by ECP and outcomes from visit requests from patients at home.
- Unscheduled care responses by ECP and outcomes from requests from residential care and nursing homes.
- Appropriate use of ACAU with same day home discharge rather than late night MAU discharge/admission.
- Outcomes of work by ECP with frequent 999 callers/ admissions.
- A & E attendance.(PBB data)
- Secondary care admissions. .(PBB data)
- Monitor performance against The Primary Care Foundation standard of emergency care for general practice: Requests for visits receive a phone call back within 20 minutes and, if needed are seen within the hour.
- Proportion of older people still at home 91 days after discharge from hospital[vii]
- Create a baseline for future audit of the number of home visits that end up as admissions.

Qualitative:

- Patient/carer reported outcome measures. We will do this using a focus group which will include patients, carers and the team to enable in depth learning, with implementation of learning points.
- The quality and consistency of our telephone response, consultations and decision making of the ECP.
- Feedback sheets from training evaluation.
- HIT team interaction and outcomes

9.References:

[i] RCGP Guidance for commissioning integrated URGENT AND EMERGENCY CARE A 'whole system' approach P` 2011

[ii] NHS England. Everyone Counts, p13/14 para 32-34

[iii] Annex to NHS England Planning Guidance. 2013 Developing Plans for the Better Care Fund. P1http://www.england.nhs.uk/wp-content/uploads/2013/12/bcf-plann-guid.pdf

[iv]HSJ supplement. 24/11/11 Improving Urgent Care. The Beast of Many Heads. Blackledge, C.

[v] NHS Outcomes Framework

[vi] DH. Urgent Care. A practical guide for transforming same-day care in general practice, 2009.

[vii] Annex to NHS England Planning Guidance. 2013 Developing Plans for the Better Care Fund. P1

Emerg Med J. 2014 Aug;31(8):673-4. doi: 10.1136/emermed-2013-202415. Epub 2013 Jun 19. Patient experiences of an extended role in healthcare: comparing emergency care practitioners (ECPs) with usual providers in different emergency and urgent care settings.
O'Keeffe C, Mason S, Knowles E

10. Appendix 1: Ambulance Ambulatory Care Plan

South Central Ambulance Service NHS
NHS Trust

AMBULANCE ANTICIPATORY CARE PLAN (AACP)				V2TC
PATIENT DETAILS		**GP DETAILS**		
Surname:		GP Name:		
First Name:		Practice Name:		
Date of Birth:		Practice Code:		
NHS Number:				
Phone Number:		Phone Number:		
Mobile Number:		Direct Number:		
Address:		Address:		
Postcode:		Postcode:		

CONDITIONS	MEDICATION	PATIENTS USUAL OBSERVATIONS RANGE				
		Pulse Rate	From		To	
		Respiratory Rate	From		To	
		Peak Flow	From		To	
		SPO2 on Air	From		To	
		SPO2 on O2	From		To	
		BP Range	From		To	
Arrhythmias		BM Range	From		To	

GENERAL MEDICAL AND SOCIAL HISTORY

USUALLY PRESENTS AS (SPECIFIC PRESENTATION AND CONDITION)

EXISTING NURSING OR CARE PROVISION *at home address*

Provider Name		Mon	Tues	Wed	Thur	Fri	Sat	Sun
	am/pm							
	am/pm							
	am/pm							
	am/pm							
	am/pm							
	am/pm							

South Central Ambulance Service NHS
NHS Trust

EMERGENCY PLAN FOR AMBULANCE CREWS AND AMBULANCE NURSES
Ambulance crews/nurses: Check the Patient's identity matches the Patient's details on the AACP

End of Life Plan? Yes / No *Attach relevant documentation to AACP*	**DNACPR? Yes / No** *Attach relevant documentation to AACP*

URGENT MEDICAL AND CARE CONTACTS				
Name	**Role**	**Phone Number**	**Mobile Number**	**Contact Times**
	Monitoring Provider			
	Next of Kin			
	Friend			
	Neighbour			

Care Plan Author:		Role:	
Provider:		AACP Date:	
Phone Number:		AACP Review Frequency (3, 6 or 9 months): (reviews by AACP authors)	
Mobile Number:			
Email Address:			
AACP approved by GP? Yes / No		GP Name:	
Copy to Patient's GP by AACP Author		***Copy to Patient's Home by AACP Author***	
Location of AACP in Patient's Home:			
AACP Author to send electronic copy to the following :		tim.churchill@nhs.net	

SCAS			
Entered on SCAS system by:			Date:
SS or Feature entered on CAD by:			Date:
AACP Review Reminder Date:		By email to AACP Author	Date:

11. Appendix 2: The recognition and Initial Management of Sepsis in Adults.

file_view.pdf

Milton Keynes CCG.
Transformation Fund Application. Multi-disciplinary care for patients 75 and over

Contents

1. **How does this support the Better Care Fund Initiatives?**

The aim of the Better Care Fund, supported by this initiative is to "improve the lives of …the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support and, in doing so, providing them with a better service and better quality of life"[i] The initiative aims to use "effective collaboration across the health and care system" to reduce emergency admissions.[ii]
This initiative aims to achieve that aim for our patients by-

- Joint working with social care services by using a more integrative approach, assessing both health and social care needs together, resulting in health benefits.
- Giving control to the patients and their carers through education and the use of Holistic Care Planning.
- Using multidisciplinary team skills, including counselling, to increase confidence and reduce the fear present for many older people over 75.
- offering a supportive environment for patients at home as would be found at Orchard House or WICU in order to avoid admissions
- Using in depth, holistic care planning to empower patients so that they are able to work jointly with health professionals to make their own care choices.
- Joint working between a flexible, multidisciplinary team working together with the patients. Their aim is to increase patients' sense of control and quality of life by putting them at the centre of their own care.
- Intensive working with this group of key patients.
- Reducing inappropriate admissions of older people in to residential care.
- Using an in house care team, working closely with an existing agency for immediate support available 24 hours a day to avoid admissions.
- Involving our domiciliary physiotherapist where appropriate

The initiative will enable NPMC to expand care within our community setting to our most vulnerable and most hidden groups of patients, including patients not seen for over a year, living in isolated villages or who have been homeless and now living in our area. Newport Pagnell Medical Centre has a high number of patients aged 75+ compared to the rest of Milton Keynes

The team will work actively with secondary care as soon as a patient is admitted to start planning their discharge, building on previous work [ii]

2. **Service description**

The initiative will create a caseload of the most vulnerable people over 75 years of age.

- This will include patients already identified as at risk of frequent and avoidable admissions or attendance at A&E.
- Patients who are isolated without a support network.
- Patients unable to self manage.
- Patients who are at risk of falling (NHS Outcomes Framework)
- Patients who have social deprivation (Social Care-related quality of life from the Outcomes Framework)
- Patients who are medically phobic and therefore get lost to the system.
- Patients who are vulnerable through mental illness.
- Work closely with relevant patients to reduce inappropriate admissions in to residential care[ii]

The service will be comprise three main parts;

1.1.1. Working with patients in crises
1.1.2. Managing discharge
1.1.3. Case management
The team will work closely with other clinicians at NPMC. When a patient does not require the intense management of the team they will be cared for by their Accountable GP.

The team will comprise:

- GP Dr Emma Thorncroft. BSc (2001),MRCP (2007),MRCGP (2011),DRCOG (2009). Dr Thorncroft's specialist skills include being a member of the Royal College of Physicians (MRCP) and having specialist geriatric experience, including two years working in secondary care Geriatrics in Cardiff.
- Community Matron Karen Russell. An experienced Community Matron, she holds a Diploma in Gerontology, a Diploma in Integrative Humanistic Counselling and a Diploma in Cognitive Behavioural Therapy (CBT)
- Community Nurse
- Social Worker
- Care worker

3. How does the proposal transform the care of older people and reduce avoidable admissions and support the accountable GP?

This initiative supports the accountable GP by creating a skill-mixed team, to work intensively around the patient. The team will include a specialist lead GP who will be accountable for the care of this group of patients.

It is based on the following evidence to underpin its aim to reduce avoidable admissions

Relevant Evidence	**How the initiative is designed to meet the need identified**
"Unreported need found in 36% of a group of patients over 75 who had not been seen in over a year."	The initiative will search out patients over 75 who have not been seen in over a year.
"Around 75% of suicides are men and in almost all cultures, the suicide rate rises with age. The highest rates of suicide in the UK are among people aged over 75. Certain factors are known to be associated with increased risk of suicide. Including social isolation, poverty and family breakdown" [iii]	Mental health has been found to be a key component of our patients who have unplanned admissions to hospital. We have identified patients who are isolated, living on very low incomes and who have no carers to that end. The Community Matron on the team has specialist training to support these patients.
"In primary care, higher continuity of care with a GP is associated with lower risk of admission".[iv] .	We already operate a named GP system for all our patients. The patients identified and part of this initiative will be cared for by the team which includes a GP.
"Integrating health and social care may be effective in reducing admissions."[iv] |	This project works jointly with social care.
"Developing a personalised health care programme for people frequently admitted can reduce re-admissions. " [iv]	This initiative uses care planning to achieve this aim.
"Patient self-management seems to be beneficial". [iv]	This initiative educates and supports patients to self-manage.
84 years plus most at risk. [Iv]	We will use this information to inform our case finding.
"Structured discharge planning is effective in reducing future re-admissions" [iv]	The team will have time to work actively with secondary care as soon as a patient is admitted to start planning their discharge.

ACS admissions (which are potentially avoidable) make up one in every five emergency admissions. Five conditions account for half of all ACS admissions. Three of these disproportionately affect older people (urinary tract infection/ pyelonephritis, pneumonia and chronic obstructive pulmonary disease (COPD))[v]	We will use this information to inform our case finding.

4. **Operational information to support how the project will transform the care of older people in our practice and reduce unplanned admissions**

The initiative will give patients within the scheme the following:

- Guaranteed access to team members for the patients and carers on the caseload. This will include weekends. We will do this by working with our District Nurse team.
- Regular reviews by a weekly "ward round" of all the patients and subsequent visits to those who are causing concern.
- Frequent monitoring, assessment for deterioration and speedy access to equipment and care support for those who are unwell or presenting with problems. Carers' health will be monitored, reducing the well documented morbidity among carers as a direct result of the caring role.
- Improved liaison for those in hospital with secondary care will enable faster, more secure and reliable discharge
- Daily triage of those attending A&E will enable early discharge for those admitted and a prompt home visit to those who were not admitted, with the necessary interventions made.
- Greater confidence in the service will improve both the health and quality of life of patients and carers.
- Education for patients and carers about their health condition will enable better self management and encourage use of the wider community services, where appropriate.

5. **Further information**

- The scheme will enable us to backfill the GP for 2 sessions a week, allowing the GP to have adequate time for the in depth care required, most of which will be in the patients home, and for essential multidisciplinary team working.
- We have found that patients who have confidence in their team are more likely to accept community services. This scheme will build on that for these patients
- The team will share the learning from the initiative amongst the wider clinical team at NPMC, enabling timely and patient specific interventions for all patients.

6. **Personalised Care Planning – at the heart of the initiative**

This initiative uses 'Personalised Care Planning'. "In personalised care planning, clinicians and patients work together using a collaborative process of shared decision-making to agree goals, identify support needs, develop and implement action plans, and monitor progress. This is a continuous process, not a one-off event.

An important feature of the approach is the link between care planning for individuals and commissioning for local populations; it aims to make best use of local authority services (including social care and public health) and community resources, alongside more traditional health services."

There are important differences from the traditional Care Planning approach: "The …model differs from others in two important ways:….. it assumes an active role for patients, with collaborative personalised care planning at its heart. Implementing the model requires health care professionals to abandon traditional ways of thinking and behaving, where they see themselves as the primary decision-makers, and instead shifting to a partnership model in which patients play an active part in determining their own care and support needs". [vi] Our experiences using this method support the evidence of improved self-management and patient care achieved.

7. **How does the proposal complement the new GMS requirements and the Enhanced Service?**

The Initiative goes above and beyond the above requirements. It does this by enabling the practice to fund a multidisciplinary team, including a social worker and a specialist GP to work in a new way. Using evidence based information they will target those over 75 at high risk of emergency admission and those with complex needs, thus increasing the effectiveness of this initiative whilst ensuring that those not within the initiative do not experience any decrease in service. Please see section 3, p2

There are some similarities in that the initiative also uses risk stratification to identify those at risk, uses proactive case management and reviews all unplanned admissions.

8. How does this service support integration with other health and social care services?

The addition of a social worker and Carer worker team to the pilot team supports integration at the highest level, this enables the best professional to be allocated to the task in hand and reduce unnecessary referral portals. Liaison with, knowledge of and mutual respect for local voluntary services, social services, non statutory services and community groups is already high within the community matron team, this can be shared among the initiative team promoting even better integration. It also helps with case finding and improved integration, leading to better knowledge of our patients by those concerned in the wider community. The skill mix in the team enables efficient use of resources.

9. Costs for 7 months of the project (September 2014 to end of March 2015)

Team:	**Cost:**
Dr Emma Thorncroft	**Backfill costs.** **Hours**: 8 hours. 1.5 on 4 days of the week, plus 1 hour team meeting but 1 hour admin time weekly **Costs**: 2 locum sessions a week between September and March using a salaried GP presently employed by the practice to ensure full cover. **Costs:** £25,496
Community Matron – Karen Russell	**Backfill costs** for extra HCA support to free up Community matron time for the initiative. Hours:16 **Costs**: £6,129
Mental Health Worker	**Hours:** Two 4 hour session a week. Top band 7 **Costs**:£6,447
Community Staff Nurse	**Hours:** 15 hours **Costs:** £7,687
Care Worker	**Hours**: 2 hours a day, 1 hour evening, for one week for patients in crisis, estimated to be needed 2 weeks in every month. **Costs:** Day time rate £18.50 ph, evening rate & weekend rate £19.00 ph Total: £5,516
Total Costs:	**£51,275**

10. What does success look like – what outcomes does this services deliver?

- Improved patient experience.
- Crisis management at home, avoiding admission to intermediate or secondary care
- Fewer avoidable attendances at A&E.
- Identification of deterioration at an earlier stage – reduction in admissions.
- Earlier and better interventions for patients and carers.
- Increased identification and treatment of poor mental health in the over 75s.
- Reduction in carer morbidity and stress.
- Support for those unseen by primary care.
- Better and earlier discharges.

- More cohesive working among local statutory, non statutory and voluntary services.
- Improved job satisfaction for those working on the pilot.

11. Metrics:

We will be using both Quantitative and qualitative evidence to monitor the initiative.

Quantitative:
(Read coded and templated)

- Holistic Care plans in place
- The interval between referral and service delivery
- Numbers of admissions to Secondary care, Intermediate care, Residential care and A&E
- Numbers of patients seen who previously had not been seen for a year
- Outcomes of patient care
- Discharge planning outcomes
- Number of falls within the group of patients
- Feedback from 'named GPs
- Patient self-management successes
- Weekend input required
- Number of visits/contacts

Qualitative:

- Focus group
- Action points from meetings
- Feedback from 'named GPs
- Patient self-management successes
- Outcomes from A&E triage
- Input from community services
- Minutes from shared team learning (The team will share the learning from the initiative amongst the wider clinical team at NPMC enabling the use of timely and patient specific interventions for all patients)

12. References:

[i] Annex to NHS England Planning Guidance. 2013 Developing Plans for the Better Care Fund. P1http://www.england.nhs.uk/wp-content/uploads/2013/12/bcf-plann-guid.pdf

[ii] The Kings Fund. 2014. Evidence Summary. Making Best use of The Better Care Fund. Spending to save? http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf

[iii] Mental Health Foundation. Suicide. http://www.mentalhealth.org.uk/help-information/mental-health-a-z/S/suicide/

[iv] The Kings Fund.2010. Avoiding hospital admissions. Purdy, S. http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf

[v] The Health Foundation. Focus on preventable admissions. Trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013. Blunt I

[vi] The Kings Fund. 2013 Delivering better services for people with long-term conditions. Building the house of care Coulter, A; Roberts, S; Dixon,A. p1. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

FF20 Royal College of Emergency Medicine

This document ascribes the accountable bodies for implementing the recommendations of **Acute and emergency care: prescribing the remedy** within the health and social care system of England.

	Recommendations	*Key*
Access and alternatives	**1. Every emergency department should have a co-located primary care out-of-hours facility** *Responsibility and accountability for implementing this lies with Urgent Care Boards and Clinical Commissioning Groups*	**L**
	2. Best practice that directs patients to the right care, first time, should be promoted across the NHS so as to minimise repetition of assessment, delays to care and unnecessary duplication of effort *NHS England is responsible for sharing best practice whilst implementation and accountability is with Hospital Executives, ambulance services and Clinical Commissioning Groups*	**N**
Skill mix / case mix	**3. All trainee doctors on acute specialty programmes should rotate through the emergency department** *Health Education England, Medical Royal Colleges, Shape of Training Review and the GMC are responsible for preparation and implementation*	**N**
	4. Senior decision-makers at the front door of the hospital, and in surgical, medical or paediatric assessment units, should be normal practice, not the exception *Responsibility is with Hospital Executives and Medical Directors*	**L**
	5. Emergency departments should have the appropriate skill mix and workforce to deliver safe, effective and efficient care *Hospital Executives and Clinical Commissioning Groups are responsible*	**N**
	6. At times of peak activity, the system must have the capacity to deploy or make use of extra senior staff *Medical Directors, Hospital Executives and Emergency Department Clinical Leads are responsible*	**L**
Integration and communities	**7. Community and social care must be coordinated effectively and delivered 7 days a week to support urgent and emergency care services** *Responsibility lies with Social Care Services including Social Workers, Care Homes, Local Government, Primary Care and Clinical Commissioning Groups*	**N**
	8. Community teams should be physically co-located with the emergency department to bridge the gap between the hospital and primary and social care, and to support vulnerable patients *Responsibility lies with Social Care Services including Social Workers, Local Government, Mental Health Trusts, Primary Care and Clinical Commissioning Groups*	**L**
Seven-day service	**9. The delivery of a seven-day service in the NHS must ensure that emergency medicine services are delivered 24/7, with senior decision makers and full diagnostic support available 24 hours a day, including appropriate access to specialist services** *Emergency Department Clinical Leads, Directors of Acute Care, Medical Directors, Allied Health Professionals, Hospital Executives and NHS England are responsible*	**N**
Funding / fair reward	**10. The funding and targets systems for emergency department attendances and acute admissions are unfit for purpose and require urgent change** *Responsibility for tariffs is with Monitor and for targets the Department of Health*	**N**
	11. Delivering 24/7 services requires new contractual arrangements that enable an equitable work–life balance *Governments, Employers, BMA, Hospitals and Clinical Commissioning Groups are responsible*	**N**
Information technology	**12. It is essential that each emergency department and acute admissions unit has an IT infrastructure that effectively integrates clinical and safeguarding information across all parts of the urgent and emergency care system** *Responsibility lies with NHS England, Hospitals and Clinical Commissioning Groups*	**L**
	13. If configured properly with significant senior clinical involvement and advice, NHS 111, NHS 24, NHS Direct and equivalent telephone advice services can help to reduce the pressures on the urgent and emergency care system *NHS England, NHS 111 and Clinical Commissioning Groups are responsible*	**N**

Key: **L** = local recommendations, **N** = national recommendations

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Under embargo until 09.30 on 25 November 2014

PRESS STATEMENT **25 November 2014**

STEP Campaign:
Rebuilding the emergency medicine service step by step

The College of Emergency Medicine today launches its STEP campaign in England. The College speaks for doctors and consultants working in A&E departments across the UK and Ireland. We have been calling for action to address the significant challenges facing A&Es, and whilst some progress has been made, there is much work to do to provide a safe and efficient service for our patients.

To rebuild the Emergency Medicine service the College is calling for four steps to be taken:

STEP 1: Safe and sustainable staffing levels must be achieved

STEP 2: Tariffs and funding must be fair and effective

STEP 3: Exit block and overcrowding must be tackled

STEP 4: Primary care facilities must be co-located with A&E services

The College President, Dr Clifford Mann, said:

"This campaign is critical to providing relief and securing the future for A&Es. Our hard working doctors need tangible action to support them to stop the leaching of talent to Australia and New Zealand; patients deserve better access to care with primary care services being co-located with the A&E; „exit block" needs to be a thing of the past; and the funding systems must stop penalising hospitals for treating the acutely ill and injured."

The College urges Government, politicians and NHS leaders to work together to take the four steps needed to rebuild emergency care. These steps are set out in more detail below:

Staffing - safe and sustainable

The numbers of Emergency Medicine specialist doctors and consultants working in A&E departments remain insufficient to deal with the rising numbers of patients seeking urgent and emergency care.

The College has for many years called for staffing levels to match patient flows. To achieve 7 day coverage of consultants between 8am and midnight this means calling for a minimum of 10 consultants in each Emergency Department, rising to 16 or more in larger units. The College recognises that there is local variability in the size and scope of some Emergency Departments and a one-size fits all approach is not the answer. That is why we will soon be launching some additional toolkits to help with resource planning. However, when we last surveyed our Members and Fellows we found that on average there were only 7.6 consultants per Emergency Department. Whilst the trend is towards improvement, it is not moving ahead fast enough.

The shortages of doctors and consultants are being filled in part by locum doctors. But this wastes in excess of £120m at a time when NHS resources are scarce. Efforts to increase recruitment, with additional training posts being created this year, seem to be having a beneficial effect, yet shortages of trainee doctors remain as not all posts are filled. Until this year we have seen only 50% of trainee posts filled for the previous 3 years. Even now with better recruitment in 2014, there remains a critical shortage of doctors working in A&Es.

Coupled with this is the issue that more doctors and consultants are emigrating to work abroad. Our Members and Fellows tell us that they are being worn down by the relentless workload from understaffed departments. The stress of working in facilities where the desired quality of care is not possible because the team is under-resourced is significant. The cost to the British taxpayer of training doctors who ultimately end up working in Australia alone is around £130m, we estimate.

The College calls for safe and sustainable staffing of A&Es. This means addressing the work/life balance for those working in A&Es, and recognising the demands of all acute specialties through reviewing their terms and conditions.

Failure to address this will result in a haemorrhaging of the acute workforce. Doctors will vote with their feet and exit the specialty.

Tariffs & Terms - Fair & Effective

Making sure the system is providing adequate funding for Emergency Departments is vital. Whilst the funding systems in each nation within the UK are different, the principle of fair and effective funding should apply to the whole of the UK.

In England the National Tariff Payment System (the national tariff) for the NHS covers national prices, national currencies, national variations, and the rules, principles and methods for local payment arrangements. It is not working effectively. Acute trusts are being penalised for each and every non-elective admission into hospital. Similar issues are seen across the rest of the UK.

The College of Emergency Medicine re-iterates the point it has made repeatedly: current tariffs make provision of urgent and emergency care uneconomical, and create perverse incentives that drive patients towards Emergency Department care, rather than preventing it.

This means in practice that acute trusts lose money on their Emergency Departments and have to subsidise this by increasing the number of elective care operations they undertake. This in turn increases the pressure on hospital capacity, and reduces the numbers of beds available for patients.

The combined effect is to see hospitals operating at full capacity and with under-resourced Emergency Departments.

The College calls for action in the form of an end to the perverse incentives that are producing a dysfunctional system.

The College of Emergency Medicine regards correct and fair implementation of the Payment by Results system in Emergency Medicine using accurate Reference Costs as the quickest, fairest and most logical first step in any payment reform. The practical difficulty in accurately costing Emergency Department reference costs means that a sentinel site approach should be used to determine costs, like the approach used in Australia.

The College of Emergency Medicine believes that Monitor must state as one of its core principles the understanding that acute care and elective care must have equity of funding. Monitor must demonstrate that it understands that the currently accepted notion that elective care will subsidise acute care results in systematic prejudice against acute care that results in direct harm to patients.

In Wales, Scotland and Northern Ireland, although a different payment system is used, the principles of achieving equity of funding remain appropriate for acute care and elective care.

Exit Block

A condition called 'exit block' is harming patients: they are put at risk when 'exit block' occurs. This happens where you cannot transfer patients from Emergency Departments into a hospital inpatient bed. Exit block is explained in more detail in this video: Exit Block: What it is and why it is dangerous.

Over 500,000 patients a year are affected by exit block. The College of Emergency Medicine says that this is unacceptable.

The College calls on hospital Chief Executives and their Boards to make sure that this issue is on their agenda. To help with tackling this issue the College has issued guidance: Crowding In Emergency Departments. NHS England, Monitor, and the Trust Development Association have all endorsed this in their own winter planning guidance for this coming winter.

We are concerned about patient safety. When the A&E becomes crowded because of Exit Block we know that patients do less well. We know that crowding kills. It is simply not acceptable to let this situation continue which is why we are on a mission to urge hospital Chief Executives and their Boards to make sure they have plans to deal with this issue.

Primary Care Facility - co-located with A&Es

We know that 15% of patients attending Emergency Departments could be treated outside A&E by GPs. We know this from our own research which we published in May 2014.

Rather than blame the patients for attending A&Es, when they may have difficulty accessing other alternatives, we believe a new approach is required. Efforts to encourage patients to seek assistance over the phone or to go elsewhere over the past 15 years have not reduced the flow of people to A&Es. So we believe the issue should be dealt with by positioning services where the patient is attending, by co-locating Primary Care facilities with A&Es.

This approach is supported by NHS Providers (formerly The Foundation Trust Network), the Royal College of Physicians, the Royal College of Surgeons, the NHS Confederation, the Royal College of Paediatrics and Child Health, NHS England and the Department of Health (England).

Co-location will:

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

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

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

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

5. **Allow other services such as emergency dentistry and frailty units to be co-located on the same site.** This has obvious benefits for both patients and the health economy.

-Ends-

Contact

For further information, or to speak with a media spokesperson for The College of Emergency Medicine, please contact Matt Chorley on +44(0)20 7067 1275 or email matt.chorley@collemergencymed.ac.uk.

About the College of Emergency Medicine

The College of Emergency Medicine is the single authoritative body for Emergency Medicine in the UK. Emergency Medicine is the medical specialty which provides doctors and consultants to (Accident &) Emergency Departments in the NHS in the UK and other healthcare systems across the world.

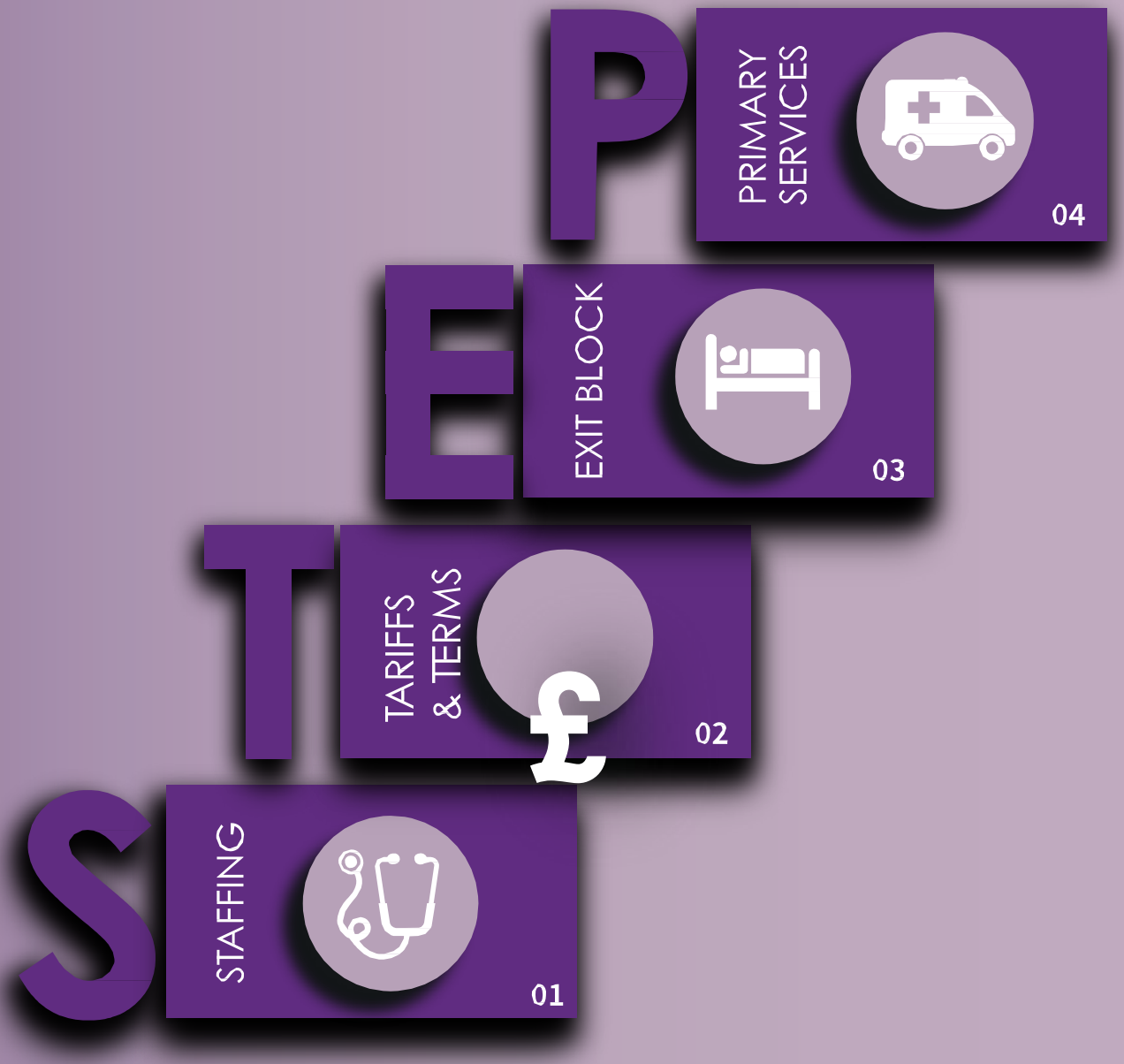
The College works to ensure high quality care by setting and monitoring standards of care, and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

The College has over 4500 fellows and members, who are doctors and consultants in emergency departments working in the health services in England, Wales, Scotland and Northern Ireland, Eire and across the world.

The STEP campaign is currently for England only. We are working in Scotland, Wales & Northern Ireland on similar initiatives which will be announced in due course.

The Royal College of Emergency Medicine

RCEM's steps to **rebuilding** emergency medicine



The Royal College of Emergency Medicine

RCEM's steps to **rebuilding** emergency medicine

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RCEM's steps to **rebuilding** emergency medicine

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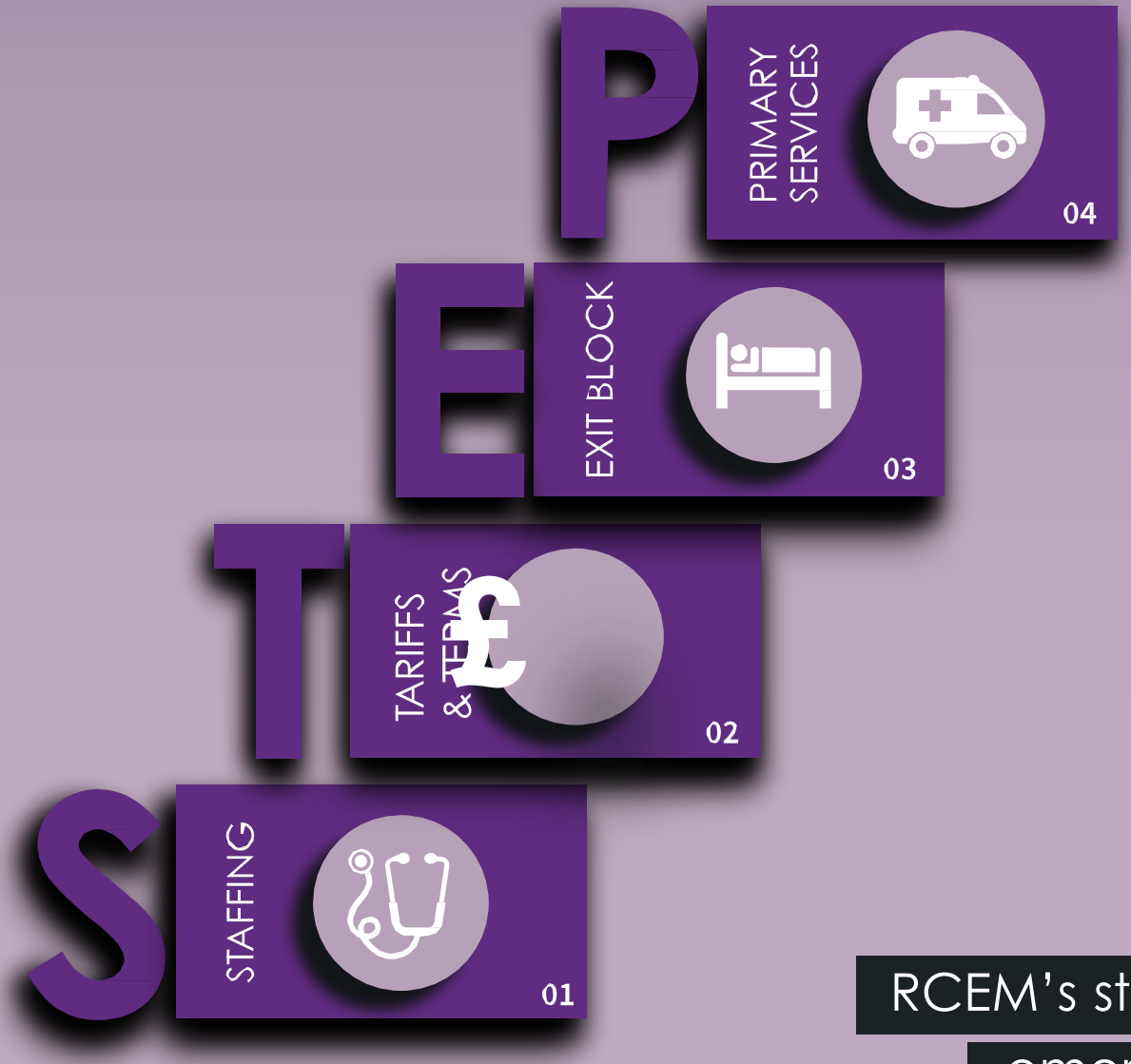

RCEM's steps to **rebuilding** emergency medicine

FF23 Halton CCG

See next page

"Meeting my Community Wellbeing Officer has helped me to gain more confidence and develop coping skills. I have now become a wellbeing volunteer and have joined in with local events and activities."

John from Widnes

The Community Wellbeing Practices initiative is provided by Wellbeing Enterprises CIC.

Wellbeing Enterprises is an award winning social enterprise – our mission is to support individuals and communities to achieve better health and wellbeing.

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Halton community wellbeing practices

Want to feel happier and healthier?

Talk, Connect and Take Action

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What is a Community Wellbeing Practice?

It is a GP practice that offers you time with a Community Wellbeing Officer. The role of a Community Wellbeing Officer is to give you the chance to talk, connect and take action:

Talk – you talk and we will listen. Sit back, relax and have a confidential conversation that focuses on you. We will discuss the things that are bothering you but we will also discuss the things that make you smile.

Connect – we will connect you with others. We will help you find practical help and connect you to fun social activities. It could be someone to help with a money worry or it could be someone you share a talent, interest or skill with.

Take Action – together we will make a plan that helps you do more of the things that make you smile and get help to deal with the issues that are bothering you. It's all about making you happier and healthier.

What's on offer?

As a patient of a Community Wellbeing Practice you can access the following **FREE** services:

Wellbeing Review

An opportunity to develop your own plan to deal with issues that are bothering you and do more of the things that make you smile.

Wellbeing courses and activities

Take part in a wide range of fun, practical and creative courses happening in your area. Chances to connect, meet people, learn new skills and discover new interests.

Volunteer opportunities

We have a variety of volunteering roles for you to develop new skills and give back to your local community.

"Attending a Wellbeing Review helped me to look at my life in a different way. I found out about activities running in my local area and it gave me back my energy and enthusiasm – I feel like I can do anything now!"

Margaret from Runcorn

How can I get involved?

Contact the Community Wellbeing Officer for your GP Practice, who can help you to access any of the services in this leaflet.

Call

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FF24 Halton CCG

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FF25 Halton CCG

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- How to use laughter to turn bad days in to good days
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Widnes
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Thursday 26th Feb 1.30pm-3.30pm

Previous attendees have said:

"Enjoyed all of it – relaxing and a great atmosphere. It was really funny, and more people should know about it!"

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