Supporting evidence

Contents page

FF51 Royal Pharmaceutical Society 3
FF52 Royal Pharmaceutical Society 9
FF53 Health Education East of England 19
FF54 Health Education East of England 27
FF55 Health Education East of England 40
FF56 Health Education East of England 53
FF57 Health Education East of England 54
FF58 Health Education East of England 59
FF59 Health Education East of England 78
FF60 Health Education North West 81
FF61 Health Education North West 98
FF62 Health Education North West 101
FF63 Health Education North Central and East London 103
FF64 Health Education North Central and East London 107
FF65 Nuffield Trust 111
FF66 Health Education South London 131
FF67 Health Education South London 141
FF68 Health Education South London 156
FF69 Health Education South London 165
FF70 Health Education South London 205
FF71 Health Education South London 225
FF72 Health Education South London 228
FF73 Health Education North West London 302
FF74 Health Education North West London 308
FF75 Health Education North West London 417
FF76 Urgent Care Commission 473
FF77 South East CSU 491
FF78 South East CSU 496
FF79 South East CSU 508
FF80 South East CSU 526
FF81 South East CSU 537
FF82 South East CSU 555
FF83 South East CSU 567
FF84 South East CSU 588
FF85 South East CSU 628
FF86 South East CSU 630
FF87 South East CSU 632
FF88 South East CSU 634
FF89 George Freeman 635
FF90 BAcC 638
FF91 BAcC 654
FF92 BAcC 670
FF93 BAcC 817
FF94 BAcC 848
FF95 NHS England 884
FF96 NHS England 890
FF97 BASW 896
FF98 BASW 902

FF99 RCN 906
FF100 Health Education North West London 914

FF51 Royal Pharmaceutical Society

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Shaping pharmacy for the future

Pharmacists improving care in care homes

The Royal Pharmaceutical Society believes that better utilisation of pharmacists' skills in care homes will bring significant benefits to care home residents, care homes providers and the NHS.

Introduction

There are approximately 431,500 elderly and disabled people in residential care of whom 414,000 are aged 65 and over[1]. Due to an ageing population and policies to encourage elderly people to stay in their homes longer care home residents are generally older and frailer. The elderly are particularly at risk from errors with medicines as they can have a high level of morbidity, with multiple health problems and are often prescribed several medicines. The Royal Pharmaceutical Society (RPS) believes pharmacists should have an embedded role in care homes with overall responsibility and accountability for medicines and their use.

Recommendations

Better utilisation of pharmacists' skills in care homes will bring significant benefits to care home residents, care homes providers and the NHS.

- Pharmacists should have overall responsibility for medicines and their use in care homes
- One community pharmacy and one GP practice should be aligned to a care home to ensure co-ordinated and consistently high standards of care
- Pharmacists should be given responsibility to ensure patient safety, leading a programme of regular medicines reviews working in an integrated team with other healthcare practitioners.

[1] http://www.pensionsage.com/pa/mar14-pensions-to-fund-care.php

Background

Medicines Review

In 2014 NICE published their 'Managing Medicines in Care Homes'[2] full guideline, the purpose of which is to provide recommendations for good practice and medicine management in care homes. Key recommendations from the report state that:

'Care home providers should ensure that the following people are involved in medicines reconciliation:

- *the resident and/or their family members or carers*
- *a pharmacist*
- *other health and social care practitioners involved in managing medicines for the resident, as agreed locally'.*

and also that:

'Health and social care practitioners should ensure that medication reviews involve the resident and/or their family members or carers and a local team of health and social care practitioners (multidisciplinary team). This may include a:

- *pharmacist*
- *community matron or specialist nurse, such as a community psychiatric nurse*
- *GP*
- *member of the care home staff*
- *practice nurse*
- *social care practitioner'.*

The RPS believes these recommendations should also include stipulations regarding the process of supplying medicines to residents.

The Care Home Use of Medicines Study (CHUMS) examined a random sample of 256 patients in 55 care homes. The study found that 70% of care home residents experienced at least one error associated with their medicines which the report described as "unacceptable"[3]. The study suggests that in order to prevent errors, pharmacists should regularly review residents, their medicines and rationalise regimes to help home staff work more safely. Such measures will identify and prevent such vast amount of errors. A four month trial in a care home in London where a pharmacist was given full responsibility for medicines management saw a 91% reduction in errors associated with medicines[4]. The RPS believes that the presence of a pharmacist at a care home would make a positive and measurable impact on patients.

[2] Managing medicines in care homes (2014) https://www.nice.org.uk/guidance/SC1/chapter/what-is-this-guideline-about-and-who-is-it-for
[3] CHUMS http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS025CHUMS-FinalReportwithappendices.pdf
[4] http://drugsinfonewslineireland.wordpress.com/2010/09/page/32/

We know that currently medicines use is suboptimal and research in 2004 on the amount of patients admitted to the hospital from bad reactions to their medicines showed that these unintended reactions accounted for 6.5% hospital admittance, of which 70% could have been avoided. Additionally the BMJ Quality and Safety Journal[5] conducted a survey with data collection performed on 258 patients from 23 community pharmacies. Eligible patients participating in the survey were 75 years old and over and were starting a new long-term medicine. The report showed ten days after starting a new medicine, 61% of patients require more information and guidance around the medicine, with 50% of people experiencing considerable problems with their medicines. The study concluded that patients need more support when starting a new medicine for a chronic condition.

Current contracting of services for care homes is mainly limited to supply of medicines, and care homes are often served by multiple GP surgeries and pharmacies. 'Pharmacy Advice Visits' have been seen in some locally commissioned services. These provide a number of services including; reviews of medicines for residents, training of staff and advice on proper use of medicines. The RPS believes that this is the minimum service provision.

As a basis for change the RPS believes that one community pharmacy and one GP practice should be aligned to a care home[6] to enable the provision of a co-ordinated and consistently high standard of care across all service users. This is in line with the views of the Royal College of General Practitioners and the British Geriatric Society.

Medicines Safety

In recent years the NHS has become increasingly concerned about medicines safety in care homes. The RPS believes that pharmacists should be responsible for the safety of some of the most vulnerable members of our society and guarantee safety of the whole medicines system in care homes. The CHUMs study found that care home residents took an average of 7.2 medicines and at least one error occurred in 69.5% of cases. Errors were found at: prescribing, monitoring, dispensing and administration[7]. "Therapeutic misadventure" resulted in 19% of admissions to hospital in elderly care home residents. In some cases, such errors could have serious consequences[8].

Medicines safety could be improved if patients' clinical information was shared between GPs, community pharmacists and other care providers, and by supplying medicines in their original packs in care homes. After undertaking 58 interviews the CHUMS report found that not knowing a resident, prescribing without computerised notes or prescribing software led to poor communication between primary and secondary care which led to prescribing errors that had a negative impact on patients' health.

[5] BMJ Quality and Safety (2003) http://qualitysafety.bmj.com/content/13/3/172.full.html
[6] http://www.rpharms.com/promoting-pharmacy-pdfs/rpscarehomereportfinalmarch2012.pdf
[7] CHUMS http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS025CHUMS-FinalReportwithappendices.pdf
[8] CHUMS http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS025CHUMS-FinalReportwithappendices.pdf

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Polypharmacy

At least 25% of people over 60 years old have two or more LTCs which means that there a number of patients in Care Homes on a multitude of medicines. Such multiple medicines (polypharmacy) is driven by an ageing, increasingly frail and multimorbid population and although in some patients it be clinically appropriate, it can increase clinical workload and clinical complexity. Polypharmacy can also be problematic, where multiple medicines are prescribed inappropriately or where the intended benefit of the medicine is not realised. Harms associated with polypharmacy include risk of errors associated with medicines (including prescription, monitoring, dispensing and administration errors), adverse drug reactions, impaired medicines adherence and compromised quality of life for patients. There are costs not only in terms of morbidity and mortality, but also of pharmaceutical products (including waste) and health service utilisation.

Growing concerns around polypharmacy led to the publication of 'Polypharmacy and medicines optimisation: Making it safe and sound' by the Kings Fund in 2013[9]. This report highlights the implications of multi-morbidity and polypharmacy for clinical practice, services and policy, and calls for actions to facilitate the management of complex multimorbidity and systems to optimise medicines use. This report states that 'Multi-morbidity and polypharmacy increase clinical workload. Doctors, nurses and pharmacists need to work coherently as a team, with a carefully balanced clinical skill-mix'. Pharmacists, as experts in medicines use, can play a significant role in the reduction of problematic polypharmacy.

A recent Health Foundation project[10] undertaken in Northumbria demonstrated the benefit of pharmacist interventions in Care Homes. Using pharmacist prescribers employed by the local NHS Trust to carry out medication reviews with residents and their families they demonstrated a cost effective model which could be undertaken in other areas. The key results from the study were:

- 422 resident reviews carried out
- 1,346 interventions made, the majority of which were to stop medicines.
- 1.7 medicines stopped for every resident reviewed
- The main reasons for stopping medicines were there being no current indication or residents' request to stop
- The net annualised savings were £77,703, or £184 per person reviewed
- For every £1 invested in the intervention, £2.38 could be released from the medicines budget.

[9] http://www.kingsfund.org.uk/publications/polypharmacy-and-medicines-optimisation
[10] http://www.health.org.uk/areas-of-work/programmes/shine-twelve/related-projects/northumbria-healthcare-nhs-foundation-trust/learning/

Brighton and Hove CCG have contracted an independent medicines optimisation organisa- tion to undertake medication reviews for 2000 care home residents on behalf (and working closely with) all GP surgeries. The scheme has been very successful, well received by GPs, Care Homes and residents, and is now in its third year. Quality of care and risk reduction is the main drivers for this scheme but value is also important. Savings last year due to medicines stopped were over £300K and about the same again estimated as savings from avoided admissions.

Antipsychotics

The RPS has expressed concern about the amount of medicines patients in care homes take and is particularly concerned about the use and overuse of psychoactive medicines and antipsychotics. These are considered to be powerful medicines, the misuse of which could lead to harmful side effects that in some cases could be permanent, worsen over time or lead to death. At the same time, Dr Sube Banerjee in his report on the use of antipsychotics for the Minister of State for Care Services suggested that reducing the usage of the antipsychotics for people with dementia and ensuring patient safety when they are needed should be made a clinical governance priority across the NHS[11].

In the UK 700,000 people live with dementia, a figure which will double over the next 30 years. The behavioural symptoms of dementia are traditionally treated with antipsychotics, which are associated with 1800 excess annual deaths in the UK[12]. The RPS states that where a person requires antipsychotics, the lowest dose, for the shortest time must be prescribed, with regular review.

People living with dementia in care homes are more likely to receive low-dose antipsychotics than people living at home, one review found that 75% of residents in care homes were on psychoactive medicines while 33% were taking antipsychotics. Pharmacist input has a significant impact on the use of antipsychotics. A pharmacy-led programme within GP surgeries in Medway demonstrated that pharmacy interventions in antipsychotics led to withdrawal or dose reduction in 61% of cases[13].

[11] The Use of Antipsychotic medication for people with dementia: a report for the minister of state for care services by professor Sube Banerjee Nov 09
[12] http://www.ic.nhs.uk/dementiaaudit
[13] http://www.biomedcentral.com/1471-244X/12/155

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Medicines Waste in Care Homes

Research undertaken in 2009 by the York Health Economics Consortium and the School of Pharmacy, University of London, estimated that medicines wastage in England cost £300 million each year. Of this £300 million, £50 million is medicines that are disposed of unused by care homes so wastage of medicines is particularly prevalent in care homes[14]. Based on one study most of the wasted medicines are laxatives, paracetamol, calcium supplements, aspirin and omeprazole. The NHS Reducing Waste Medicines report states that medicines supplied on prescription in primary care, were estimated to cost the NHS £7.6 billion in 2006/2007[15]. The estimated cost of unused or unwanted medicines in the NHS is around £100million annually[16]. At the same time, with the number of prescribed medicines growing by 5.3% annually, it appears that even more money could be wasted on medicines in the future[17]. The RPS believes that good medicines optimisation by pharmacists in care homes will help to solve the issue of waste medicines, improve efficiency and provide better health outcomes for care home residents.

[14] http://eprints.pharmacy.ac.uk/2605/1/Evaluation_of_NHS_Medicines_Waste web_publication_version.pdf [15] The Department of Health (2008). The Pharmacy White Paper: Building on Strengths – Delivering the Future [16] Managing medicines in care homes (2014) http://www.nice.org.uk/nicemedia/pdf/CG76FullGuideline.pdf
[17] http://www.nhsbsa.nhs.uk/PrescriptionServices/Documents/Volume_and_cost_year_to_Mar_2010.pdf

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Pharmacists and GP surgeries

The Royal Pharmaceutical Society (RPS) believes that primary care patients should have the benefit of a pharmacist's clinical expertise similar to that currently experienced by patients in hospital

Introduction

There are many good examples of innovative practice in primary care that integrate the skills of pharmacists as part of coordinated care to improve patient outcomes and safety whilst also reducing prescribing and downstream care costs. This is delivered in a number of ways: from an enhanced role for the pharmacist in a community pharmacy through arrangements for sessional working within surgeries or care homes and also partnership with GP surgeries. We believe there is a compelling case for it to become normal practice to have pharmacists working much more closely with GPs across England. With current and future shortfall in GP[1] and nurse[2] numbers, pharmacists are ideally placed to support their fellow professionals and improve the quality of care for patients.

Recommendations

The RPS is asking:

- General Practitioners to embrace the potential that pharmacists can bring to the care of their patients
- Local Commissioners to include pharmacist expertise in all care path ways that use medicines including the formal involvement of community pharmacists in local care pathways
- NHS England to support the spread of good practice and the dissemination of evidence which shows the benefits of pharmacist input in GP surgeries

[1] Pulse, 1st August 2014: http://www.pulsetoday.co.uk/your-practice/practice-topics/employment/practices-offered-400k-emergency-fund-to-ease-gp-short age/20006729.article
[2] Nursing Times, 26th November 2013: http://www.nursingtimes.net/nursing-practice/specialisms/practice-nursing/new-gp-inspector-warns-of-nurse-shortage-in- primary-care/5065823.article

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Background

We know that patients are currently experiencing suboptimal care in relation to their medi- cines:

- Up to 50% of medicines are not taken as intended by the prescriber[3]
- Between 5 to 8% of all unplanned hospital admissions are due to issues related to medicines (this figure rises to 17% in the over 65s)[4]
- Medicines waste is a significant issue; reported as £300 million in primary care alone, about half of which is avoidable. In addition an excess of £500 million per annum is the estimated opportunity cost of the health gains foregone because of incorrect or inadequate medicine taking
- Medicine safety data indicate that we could do much better at reporting and preventing avoidable harm from medicines[5]
- Multi-morbidity and inappropriate polypharmacy in frail elderly people can be problematic[6]. These patients need regular review of their medicines to ensure that all medicines prescribed, or bought over the counter, are safe and appropriate. As a patient's physical health declines, he or she is at increased risk of adverse events such as falls or side-effects. Pharmacists have much to contribute to the care of these patients and are experts in assessing whether benefits of continuing medication outweighs risks
- There is often a communication breakdown at the point of discharge from hospital resulting in prescribing errors. These errors can lead to damage to health, much time wasted for administrative and clinical teams in primary care and potential re-admission to hospital. Pharmacists are well placed to improve care across the interfaces between specialist providers and the wider primary and community care teams including GP surgeries and community pharmacists
- From the patient perspective, with increased focus on patient-centred care, there is much more to be done to allay concerns about polypharmacy and address the lack of support with medicines taking. Pharmacists are specifically trained to be experts in the optimal use of medicines in multi-morbidity. These skills ideally complement the role of GPs and practice nurses and add to the range of knowledge available in GP surgeries to manage increasingly complex care.

There is increased demand on general practice caused by demographic changes, more complex health needs, and some care moving out of hospitals which is contributing to unsustainable pressures on the service. GPs are reporting a worrying impact on their delivery of care to patients. The BMA's General Practitioners Committee campaign, *Your GP Cares*[7], highlights the issue of a lack of GPs available to meet the current workload.

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[3] http://www.nice.org.uk/nicemedia/pdf/CG76FullGuideline.pdf
[4] http://www.kingsfund.org.uk/publications/polypharmacy-and-medicines-optimisation
[5] http://eprints.pharmacy.ac.uk/2605/1/Evaluation_of_NHS_Medicines_Waste web_publication_version.pdf
[6] http://www.kingsfund.org.uk/publications/polypharmacy-and-medicines-optimisation
[7] http://bma.org.uk/working-for-change/your-gp-cares

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The 2010 PINCER[8] study found that pharmacists play a critical role in reducing medicine errors in general practice. The study implemented a pharmacist-led information technology intervention (PINCER) composed of feedback and educational outreach to a randomised subset of 72 primary care practices in the United Kingdom. Six months after the intervention, patients in the PINCER group experienced substantially reduced frequency of clinically important prescription errors (e.g. beta blocker in a patient with asthma) and medicine monitoring errors (e.g. ACE inhibitor in an elderly patient without assessing
electrolytes). The interventions made were acceptable to practices and pharmacists and were seen as cost effective by decision makers.

In 2012 a further study, the PRACtICe study[9], found that 1 in 20 prescription items contained either a prescribing or monitoring error, affecting 1 in 8 patients. Although the majority of errors were judged to be either of mild or moderate severity, 1 in 550 of all prescription items contained an error judged to be 'severe'. The report recommended that pharmacists can play a greater role in mitigating the occurrence of error, through reviewing patients with complex medicines regimens at a practice level and in identifying and informing the GP of errors at the point of dispensing.

Pharmacists can deliver safe, high quality, effective and efficient care to patients. As experts in medicines and their use, they play a crucial role in supporting patients to take those medicines as part of a shared decision making process, as well as ensuring patients get the right medicines.

Having a pharmacist as part of the clinical team within a practice can relieve work pressure on GPs to free up time for the GP to spend with patients with complex medical needs.
Pharmacists can play a significant role in managing patients with long term conditions such as asthma, diabetes and hypertension but can also be a resource in managing patients with complex medicines requiring frequent monitoring, patients with problematic
polypharmacy or those with special medicine needs, for example in patients with poor kidney function. There are many examples of this occurring across the country and feedback from the multidisciplinary team has welcomed the pharmacist's expertise in managing risk in patients with complex care.

The role of the pharmacist as a clinician has been strengthened by the development of prescribing rights, allowing both supplementary and independent prescribing for pharmacists. Utilising the skills of an independent pharmacist prescriber within a GP practice was highlighted by Dr Keith Ridge, Chief Pharmaceutical Officer at NHS England who shared Rachel's story[10]. Rachel is an independent pharmacist prescriber in a GP practice. She runs her own clinics, undertakes research and supports her fellow clinicians in "all things medicines".
Initially employed on a sessional basis, her support to the team became invaluable and led to her becoming a partner in the practice.

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8 http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS024PINCERFinalReportOctober2010.pdf
9 http://www.gmc-uk.org/about/research/12996.asp
10 http://www.england.nhs.uk/2014/06/10/keith-ridge/?app_data=%7B%22pi%22%3A%2255153_1402407541_827037958%22%2C%22pt%22%3A%22twitter%22%7D

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The role of pharmacists working with GP surgeries

The impact pharmacists can make on patient care in general practice are huge and varied, and just some examples are listed below;

Resolving problems with medicines:

- Working closely with the GPs to resolve day to day medicines issues (similar to pharmacists working on hospital wards)
- Liaising with relevant hospital, community and primary care colleagues to en sure correct medicines follow up on transfer of care
- Working with practice teams providing clinical medicine advice to care homes and domiciliary care support
- Ensuring that problems highlighted during medicine use reviews in community pharmacies, particularly for those patients experiencing polypharmacy, are followed up
- Working closely with local community pharmacists to resolve problems with prescriptions
- Running chronic disease clinics and liaising with practice nurses on changes of medicines

Prescribing:

- Managing a cohort of patients, if appropriate, within a particular area of expertise
- Advising on polypharmacy, suggesting alternatives and helping to reduce wastage within the practice
- Responding to discharge from hospital and liaising with local pharmacies
- Supporting a programme of medicine reviews within the practice
- Education and training for GPs on complex prescribing problems
- Leading on high risk prescribing to ensure safety e.g. methotrexate / warfarin
- Rationalising repeat prescription lists to avoid waste and duplication
- Assisting on transfer to electronic prescribing and maintenance of the system
- Leading the practice repeat prescription service and dealing with queries from reception staff and patients

Audits and processes:

- Prescribing audits
- Delivering 'Prescribing Incentive Scheme' targets
- Supporting Quality Outcome Frameworks.

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The RPS considers that such roles will fundamentally improve the safety and integration of the medicines pathways, ensuring that excellent communication and collaboration between pharmacist colleagues working in both primary and secondary care helps to positively impact on the many medicines related problems that occur, particularly at the point of transfer between care settings.

Pharmacists in general practice can be a vital source of clinical care especially if they are independent pharmacist prescribers. They contribute hugely to patient care and support the medicines optimisation agenda. Patient empowerment is enabled via the medicines optimisation clinics and patients have a forum whereby complex medicines related queries are answered thus supporting adherence and improvement in health outcomes.

GP based pharmacists can also support the contractual elements of the contract such as the implementation of the enhanced services, preparation for CQC, training of staff in repeat prescription process, medicines information for other clinicians and access to an expert in complex, polypharmacy issues.

Utilising community pharmacists

The Community Pharmacy Future (CPF) project[11], a collaboration between Boots UK, The Co-operative Pharmacy, Lloyds Pharmacy and Rowlands Pharmacy looked at a deeper role for community pharmacy in long term conditions. The evaluation concluded that community pharmacy can save the NHS over £470 million each year if services were rolled out across England.

The project included three schemes: a 'four or more medicines' support service in Wigan for patients over 65 taking four or more medicines; an award winning[12] chronic obstructive pulmonary disease (COPD) support service in the Wirral and a COPD case finding service also in the Wirral designed to identify undiagnosed COPD patients. This service has changed the way of working between professional colleagues. One of the GPs involved in the service said "*'Together, we were able to devise a process from screening patients for COPD all the way through to diagnosis. It was invaluable to have the pharmacy involved as it meant that patients were no longer being lost between the screening and diagnostic stages. The service also benefited the surgery by helping existing patients to manage their condition.*"

[11] http://www.communitypharmacyfuture.org.uk/
[12] BMJ respiratory team of the year 2014

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Making it work in practice:

Scenario 1:

A pharmacist could be employed by an individual GP practice. This was the case in Greenwich CCG where Rena Amin, a pharmacist prescriber specialising in respiratory medicines, was initially employed by a local GP practice. They found her contributions so useful that she is now a partner in the practice.

'I think Rena personifies the notion of community integration: a pharmacist, a partner in a general practice, and a commissioner leading on medicines management. She has a wealth of knowledge relating to medicines optimisation, and can influence the care for patients at a local level (through her practice, and patient interaction), and at a population level through her work as a commissioner (supporting her membership of practices; and providing innovative QIPP initiatives which are both practical, patient centric, and whole system related).

Looking to the future of primary care I hope we have more people like Rena in the system to act as integration catalysts: to further support the collaboration (federation) between general practices and pharmacists, creating a community model of care delivery, with a focus on improving patient outcomes'. Dr Junaid Bajwa, GP, CCG Board Member NHS Greenwich, Member of the Lon- don Clinical Senate

In Rena's practice the QOF performance for LTCs has always been optimal and bar a few exceptions (due to frailty, patient dissent) all patients are reviewed at least annually or more in some patients. Medicines optimisation is promoted and patient centred care is provided to individual patients. Their practice budget for prescribing and hospital spend is well within the accepted range for the CCG and under spent. The practice's referral data shows that compared to the other specialties, referral to respiratory medicines is minimal thus showing that patients in primary care are fully optimised to the level it is appropriate for their care.

In Bristol, another pharmacist prescriber has also been made a partner in a GP practice. The pharmacist focuses on diabetes and hypertension and she has improved the care of these patients without increasing the prescribing costs. Having a pharmacist prescriber as a partner in the practice has enabled them to stay within their prescribing budget despite an increasing list size, and also maintain an average cost per prescription item (£5.92) which is significantly lower than the local (£7.49) and national (£8.20) averages. The patients have welcomed the pharmacists' input as they realise the benefit of having a medicines expert within the practice who they can contact with queries. Patients seeing the pharmacist have 20 minute appointments so a longer time to discuss their issues and sometimes multiple conditions. The pharmacist works closely with the local diabetes teams and refers on when necessary. She refers patients to various secondary care services including endocrinology, urology, dermatology, cardiology, rheumatology, weight management services etc.

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Scenario 2:

Pharmacists could be employed by a Clinical Commissioning Group (CCG) to provide clinical input to their GP surgeries. These pharmacists would provide a purely clinical role over and above switches of medicines and monitoring of prescribing.

Anna Murphy, a Consultant Respiratory Pharmacist at University Hospitals of Leicester NHS Trust has been commissioned by one CCG in Leicester to support GP COPD services.
Over the last 15 months, Anna has delivered a respiratory clinic within a GP practice, helping to support patient accurate diagnosis, medicine optimisation and patient self-management.
Educational sessions to all GP staff on inhaler technique and medicine optimisation have been delivered throughout the year. Outcomes from this post are currently being evaluated.

Scenario 3:

A social enterprise could be set up involving a number of healthcare professions across the primary care team.

In NHS Gateshead, NHS South Tyneside and NHS Sunderland CCGs they have set up a model akin to a social enterprise, although the parent company is a company limited by guarantee. They are a not for profit organisation that covers 116 GP surgeries. The pharmacy team are paid to deliver a set number of hours for a fixed annual price and are made up of
a mix of employed and self employed pharmacists and pharmacy technicians. The contract specifies a percentage of the time has to be covered by a pharmacist rather than a pharmacy technician. The not for profit setup helps them to achieve this even with long-term established (aka high band / salary / hourly rate) pharmacists. Some members of the pharmacy team have been part of this work for many years. This benefits practices and ultimately their patients due to continuity and long term relationships.

In Birmingham Cross City CCG a social enterprise was established to provide support to patients at home who nearing the end of life. The team included 3 pharmacists, 2 of whom were independent prescribers, and 1 pharmacy technician. The organisation support patients to die at home and are able to provide symptom control and pain relief via the pharmacist members. The pharmacy team can visit any patient in their preferred place of care with a GP from the area. They also offer an advice only service to healthcare professionals dealing with patients outside of the local area. Their records are held electronically so there is the potential to pull off data where needed on patient encounters, interventions, contact methods etc. All of their patients have an estimated prognosis of six months of life or less at the time of referral to the pharmacy team.

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Scenario 4:

A pharmacist could be contracted with on a sessional basis to provide clinical input into one or more GP surgeries. This could include working with local community pharmacists.

In Bath and North East Somerset a team of practice pharmacists (approx. 1 session per week per practice) has been established across the 27 practices. They are mostly sessional pharmacists and their agenda is a blend of the CCGs priorities: Effectiveness, Safety and Cost
Effectives in use of Medicines, plus the practices agenda plus the agenda they develop in their various situations. This model has been embedded over the last 6 years and the pharmacists are very much appreciated and respected within their practices. The pharmacists come from a variety of backgrounds: Community, Hospital and ones who are making practice work their primary career.

Scenario 5:

Residents living in Care Homes are often more vulnerable than those living in their own homes. Studies have shown that 7 in 10 residents in Care Homes have a problem with their medicines at any one time[13]. This report, 'Care Homes Use of Medicines Study', spoke about lack of ownership of the whole medicines system and leadership in reducing medication errors. We believe that having a pharmacist who is responsible and accountable for the management of medicines within that setting would reduce medication errors as they would provide the oversight across the whole system. Pharmacists could be contracted with to provide particular services such as provision of a clinical service to Care Home patients which would include reviews of patients medicines.

A recent Health Foundation project[14] undertaken in Northumbria demonstrated the benefit of pharmacist interventions in Care Homes. Using pharmacist prescribers employed by the local NHS Trust to carry out medication reviews with residents and their families they demonstrated a cost effective model which could be undertaken in other areas. The key results from the study were:

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- For every £1 invested in the intervention, £2.38 could be released from the medicines budget.

[13] http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/cfhep/psrp/finalreports/PS025CHUMS-FinalReportwithappendices.pdf
[14] http://www.health.org.uk/areas-of-work/programmes/shine-twelve/related-projects/northumbria-healthcare-nhs-foundation-trust/learning/

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Pharmacists could also be contracted with to provide domiciliary visits to those patients who are housebound and often taking a number of medicines. In Croydon, community pharmacists, trained and supported by primary care pharmacists, delivered domiciliary medicine use reviews (MURs) to patients in the local area. The interventions demonstrated better patient care and avoidance of hospital admissions. A summary of activity for 13/14 shows that 322 reviews were conducted, estimated to have avoided 83 emergency admissions giving a cost avoidance of £234,000. Data for the first six months of 13/14 has been analysed to see the actual impact of the service on emergency admissions. The number
of emergency admissions for six months before and after each review has been compared for 124 people who received the service from April to September 2013. 24 patients showed a reduction in emergency admissions following the review and 75 patients had no emergency admissions during this period implying no deterioration. Overall there was a net reduction of 84 bed days.

Brighton and Hove CCG have contracted an independent medicines optimisation organisation to undertake medication reviews for 2000 care home residents on behalf (and working closely with) all GP surgeries. The scheme has been very successful - well received by GPs, Care Homes and residents - and is now in its third year. Quality of care and risk reduction is the main drivers for this scheme but value is also important. Savings last year due to medicines stopped were over £300K and about the same again estimated as savings from avoided admissions.

Scenario 6:

As GP surgeries federate to provide a more efficient and effective service to patients across a wide area, local pharmacists and pharmacies could become part of those federations.

The Prime Ministers Challenge Fund model being developed in Brighton and Hove is a net- work of GP surgeries working closely with community pharmacies. The pharmacists working in the community pharmacies will have read and write access to patient records, with patient consent, and can treat a range of conditions that would commonly have resulted in a GP appointment or A&E attendance.

Scenario 7:

Local community pharmacists could come together in a number of ways to provide services to GP surgeries. For example they could use the model of two pharmacists per pharmacy in order to enable flexibility so they could be more involved with the local GP surgeries.

A pharmacy in Bromley by Bow has a Local Pharmaceutical Service (LPS) contract and has led the formation of a pharmacist federation which covers 40-50,000 population. They are in early stages of developing pharmacists within the federation to become prescribers, particularly looking at delivery of common ailments services throughout the locality. The federation consists of seven community pharmacies who are working collaboratively to support local commissioners to deliver high quality clinical care to patients. The pharmacists are also closely involved in local care pathways.

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Shaping pharmacy for the future

The Medicine Use Review (MUR) and New Medicine Service (NMS) provided by community pharmacists in England need to be integrated into care / patient pathways so that they become part of normal practice. A recently published national evaluation of the NMS service[15] demonstrates the added benefit this brings to patients and the overall cost saving this provides to the NHS. Local community pharmacists and GPs should work closely together to ensure that the patients targeted for these services are a priority for commissioners. These services are already funded via the national pharmacy contract.

[15] http://www.nottingham.ac.uk/~pazmjb/nms/

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FF53 Health Education East of England

Examples taken from The Royal Pharmaceutical Society report "Now or Never: Shaping pharmacy for the future"

- **The chronic medication service**

The chronic medication service (cms) introduced in 2010 is a service for patients in Scotland with long-term conditions that enables a community pharmacy of their choice to manage their pharmaceutical care. The patient must choose to opt into the service. Once a patient registered for the service the community pharmacy it system alerts the patient's GP. A pharmaceutical care plan is developed by the pharmacist and the patient that includes details of review and monitoring arrangements. GPs can also choose to enter into a shared care arrangement with the pharmacist that allows the patient's GP to produce a serial prescription for up to 48 weeks and which is dispensed at appropriate time intervals to be determined by the patient's GP. Patients can choose to opt out of the service at any point or change to a different pharmacy.

- **Minor ailment service**

The minor ailment service, introduced in Scotland in 2006, aims to support the provision of direct pharmaceutical care on the NHS by community pharmacists to members of the public presenting with a common illness. Utilising it to support registration with a specific pharmacy the minor ailments service requires people to register with and use their community pharmacy as the first port of call for the consultation and treatment of common illnesses. The pharmacist advises, treats or refers the patient according to their needs.

- **Community pharmacy prescribing clinics**

Community pharmacists, working in partnership with GPS have since 2007 had access to Scottish government funding for community pharmacy supplementary and independent prescribing clinics.

- Green light pharmacy and the walk in centre are co-located with a GP practice (in London). Co-location has enabled the pharmacy team to work closely with all members of the general practice team (both clinical and administration). The good working relationships and excellent communication benefit the pharmacy, the GPs, the walk-in centre and ultimately the walk-in centre patients. People who don't need to see a doctor or nurse are signposted to the pharmacy for self-care, either for advice, to buy medicines or to obtain them through the local minor ailments scheme (pharmacy first). Patients through pharmacy first do not need to pay for medicines that they would otherwise have needed a prescription from the GP/nurse to obtain free of charge. The triage to pharmacy for self-care and the pharmacy first scheme frees up walk-in centre appointments for people with greater need, which in turn prevents them from having to go to the local accident and emergency department.

- On the Wirral, four of the large pharmacy multiple groups, Boots, Co-operative pharmacy, Lloyds and Rowlands have come together with independent and supermarket pharmacies in a pilot to provide a programme of structured practical support for patients to help them get the best outcomes from their medicines and thus support their condition. Patients undergo an initial assessment once they have joined the service. This involves a COPD test (COPD assessment test) and dyspnoea score. Public health advice and information on lung health, diet, exercise and lifestyle are provided and interventions such as smoking cessation signposted where appropriate. Patients' symptoms and adherence with medication are monitored regularly to improve medicine optimisation and inhaler technique is checked to ensure they are receiving maximum benefit. This typically happens when patients come into

the pharmacy for their prescriptions. A patient held personal record card is provided and this is checked and updated. Targeted medicines use reviews are provided as part of the service and the provision of a rescue pack for rapid intervention is provided if necessary. Patients undertake an annual health assessment with measurement of outcomes and patient satisfaction, alongside appropriate seasonal interventions, for example flu vaccinations.

- Long-term conditions clinic in a GP practice at Hartland way surgery in Croydon a pharmacist prescriber (who is also a partner in the practice) runs clinics twice a week for patients with long-term conditions (cardiovascular disease, respiratory disease and hypertension). The clinics aim to optimise the patient's medicines use by providing structured support that gives them a better understanding of their condition, improves the way they take their medicines, reduces their chances of hospital admission, allows for timely intervention if their condition deteriorates or relapses, and provides appropriate referral to other agencies when needed. The pharmacist also manages medicines issues related to any hospital admissions, ensuring that on discharge from hospital, any changes to the patient's medicines, or queries about medications, are picked up early.

- Chronic pain management clinic in a community pharmacy a pharmacist prescriber with a specialism in pain management ran an NHS pain management clinic from a community pharmacy in Essex. Patients were referred to the clinic by GPs from a local health centre. Patients referred had unresolved chronic pain and would normally have been referred to a secondary care pain team. The community pharmacist had full access to the patient record (via a laptop pre-load with system one software) and could issue printed NHS prescriptions for repeat medication or initiate new medication as appropriate. Patients prescribed a new medicine during the clinic had the option to see the pharmacist during the day without an appointment to discuss any follow-up issues. The clinic gave patients quicker and more convenient local access to care than the alternative of travelling to, and waiting for, a hospital out-patient appointment. It reduced the number of GP appointments for patients with chronic pain and patients who previously would have used A&EE accessed the pharmacy as the first port of call.

- Patients taking an anticoagulation medication can choose one of seventeen pharmacies in Brighton for their regular blood test with appointments available at flexible times that include one early morning and on alternate weeks either a late evening or a Saturday clinic. The pharmacist tests the patient's blood levels of medication and can adjust the dosage of medication there and then if necessary. Appointments usually last around ten minutes. The previous hospital service required patients to make an appointment at a hospital with limited opening times, blood was taken in one part of the hospital and then the patient had to go to another department to have their levels interpreted. The service is commissioned using a community service contract with Boots as the lead provider and the other community pharmacies as sub-contractors. It is supported by a team of general practitioners with a special interest in anticoagulation.

- Enfield has one of the highest populations of older people in London, with 30,000 people aged 65 or older, and the borough has 110 different residential care facilities. Enfield council and Enfield clinical commissioning group jointly employ a pharmacist who sits in the CCG's medicines management team and who both provide pharmaceutical care to residents and respond to safeguarding alerts relating to medicines in any of the care facilities. The

pharmacists' clinical priorities are to ensure that all residents have medication reviews and to make sure that the medicines they are taking are all still needed, can be taken together, and are optimal for the individual patient. At the same time the pharmacist offers education and training for care home staff to help improve the use and handling of medicines. When a safeguarding alert related to medicines is raised, the pharmacist carries out a risk assessment on the care facility. An implementation plan to correct problems with medicines governance is developed and the home is followed up against the plan.

- Northern Devon healthcare NHS trust has pharmacists and pharmacy technicians as core members of multidisciplinary complex care teams comprising health and social care staff. The pharmacy team provides a domiciliary medicines optimisation service to adult patients to try to reduce medicine-related hospital admissions and improve patients' use of their medicines and their understanding of why they are taking them. Interventions made by the pharmacy team are fed back to the patient's GP and a follow up visit or telephone call is arranged where necessary.

- For older or vulnerable people who are housebound, the model of domiciliary pharmacist or pharmacy technician visits is beginning to emerge as a means of offering medicines management support. In north-west London, domiciliary medicines reviews for older patients taking four or more medicines are commissioned from central London community healthcare to support patients' medicines use.

- A range of initiatives set up by former primary care trusts or strategic health authorities entailed standardised training for community pharmacists to deliver structured interventions for patients with asthma and/or COPD, sometimes linked to public health interventions such as stop smoking initiatives, with the intention of improving care and reducing hospital admissions.

- Across a range of other long-term conditions, a model of care which is becoming more common is the use of pharmacist-led clinics in both primary and hospital care. This model has developed primarily for patients where medicines are fundamental to how they manage their conditions on a day-to-day basis. in primary care, examples include GPs referring patients to their own practice-based pharmacist for on-going management of hypertension and cardiovascular disease.

- In a hospital setting examples that include: rheumatologists referring patients to pharmacist- led clinics for support in the choice and use of specialist medicines to help control rheumatoid arthritis; haematologists and nurses referring patients on chemotherapy to a pharmacist-led symptom control clinic; pharmacist-led clinics for patients with HIV where the pharmacist provides assessment, prescribing and support for medicines taken; and pharmacists running clinics for adults with attention deficit disorder. Similarly, in some areas community mental health teams are able to refer patients based in the community directly to specialist mental health pharmacists for advice, review and prescribing.

- Pharmacists working with hospices and with patients to support them with medicines use as they near the end of life; for example, in Hull, Macmillan pharmacists are working in a

specialist community palliative care clinic, and with the local hospice and hospital to ensure best use of medicines and seamless transfer of care for patients between these settings.

- In Croydon the local authority has commissioned local community pharmacists to visit people at home to undertake medicines use reviews. Housebound patients who need additional support with medicines use are identified by the community pharmacist or by the GP, who refers directly to the community pharmacist. Patients are also identified by teams in the local hospital (accident and emergency nurses and the pharmacy team) who are referred initially to the pharmaceutical team at the clinical commissioning group, who then refer patients to the community pharmacist if adherence to medicines has been highlighted as a possible issue. The contract for the domiciliary medicines use review service is funded by the local authority and managed by the CCG. The service is open to any community pharmacist who has attended the training and is accredited to deliver the reviews. The impact of the service has been demonstrated by recording the interventions made as part of the medicines use review, and assessing whether the intervention could have avoided an emergency hospital admission. The interventions are peer reviewed and then quantified in terms of cost avoidance using current cost of an emergency admission in Croydon.

- In East Lancashire hospitals patients who need additional support with their medicines are given the opportunity to have a direct referral of their medicines information and care from the hospital pharmacy team to a community pharmacist of their choice. A newly developed system for the trust called refer-to-pharmacy allows patients to identify their local community pharmacy, and a referral, together with a copy of their hospital discharge summary, is sent directly to the community pharmacy. Patients are asked to give consent and shown a short film to inform them of why the system has been developed, and what benefits they can expect to gain (this can be viewed at www.elht.nhs.uk/refer). The referral will then be followed up by the community pharmacist. An audit function allows the hospital team and community pharmacists to monitor performance and analyse the effect of referral on re-admissions to hospital. Refer to pharmacy e-referral links the care patients receive in hospital to that in the community to help them get the best from their medicines and stay healthy at home.

- Flu vaccination in pharmacies. This is now provided by pharmacies throughout most of the East of England.

- The healthy living pharmacy programme was originally developed by Portsmouth primary care trust and the Hampshire and Isle of Wight local pharmaceutical committee. It aimed to create pharmacies committed to provide public health and lifestyle improvement services, commissioned on the basis of local need. The services provided included smoking cessation, sexual health advice, and guidance on lifestyle changes to combat obesity. A key theme was building on the essential and advanced services already being provided. Leadership training was provided for pharmacists, each pharmacy was required to have a team member trained as a health champion to Royal Society of Public Health standard, and consultation rooms were equipped to deal with new services. The regularity of contact with the public in community pharmacy was used to give health advice at every opportunity. The programme showed significant results, particularly in smoking cessation and related illnesses. Seventy

per cent of patients with a respiratory condition showed improvement in their ability to manage their illness, with the total number of people stopping smoking exceeding agreed targets by 42%. The health living pharmacy concept has now been rolled out to 721 pathfinders nationwide. A recent evaluation found evidence that similar gains were made for populations served by the wider group of healthy living pharmacies. these data also show that it is not only pharmacists who can provide effective stop smoking services, with similar quit rates achieved by other trained pharmacy team members, allowing more effective use of skill mix for this service.

- Green light pharmacy in Euston is a partner in the west Euston healthy communities project which is supported by the new opportunities fund (now the Big lottery). It operates a training programme for volunteers, who then encourage local people to complete a series of questions about their health. Based on the results of the questionnaire, individuals may then be invited to the pharmacy for health checks and health education, for example, about diet and smoking cessation.

- Jhoot's pharmacy chain is a key partner in a social enterprise (community interest company) called innovation health and wellbeing. The partnership includes Walsall council, Walsall housing group, Jobcentre plus and Walsall college and brings together the expertise of all partners in the development of interventions that aim to improve the health and wellbeing of local communities. as part of this aim a life style and weight management Qualification has been jointly developed and piloted jointly by Walsall college, Jhoot's pharmacy and Walsall housing group within local communities and will soon be accredited for wider national use. It aims to improve residents own health, but also for those interested in a health-centred career, to provide them with a qualification that will help them with their ambition to secure employment.

Pharmacy in Northumbria healthcare foundation trust:

- All pharmacists are required to undertake post graduate development with an expectation to progress beyond clinical diploma training to achieve a prescribing qualification. Pharmacists are currently prescribing for 44% of all patients admitted to the hospital.
- All managers and middle grade pharmacists, and technical managers are required to undergo management and leadership development.
- Ward-based pharmacy technicians support pharmacists and the wider health care team with medicines reconciliation, patient counselling, medicines supply and clinical audit.
- Support from pharmacy extends into primary care, with pharmacists identifying and managing elderly patients at risk of readmission before and after discharge.

Examples taken from The Royal Pharmaceutical Society report "Seven day services in hospital pharmacies" : http://www.rpharms.com/support-pdfs/rps---seven-day-report.pdf

- Pharmacists working in Accident & Emergency. In terms of workforce, we have a glut of pharmacists coming through and a shortage of accident and emergency doctors and nurses (there is a Health Education England group looking at this chaired by Anthony Sinclair from Birmingham Children's Hospital)
- Pharmacist prescribers working with physician assistants

- A pharmacist based in Accident & Emergency and Medical Admissions Unit seven days a week. They see patients waiting who have epilepsy, Parkinson's or diabetes to arrange that doses of important medicines are not missed, those who will be admitted for early medicines reconciliation, all those over 70 and on three or more medicines, all those on warfarin, those with renal impairment. In Worcester Hospital, a pharmacist is present from 8am–7pm Monday to Friday and 10am–4.30pm Saturday and Sunday.
- We are working with local clinical commissioning groups to offer band 7 pharmacists sessions in GP surgeries and then ensure they take an independent prescribing course. We are looking to further develop our independent prescribing with an advanced clinical practitioner course.
- We are looking at how we might implement a preceptorship for our band 6 pharmacists to start to develop them for this clinical service.
- We also plan to further develop our pharmacy technicians to really take the lead on assurance, operational management and leadership by working closely with colleagues in nursing, as well as further expanding their roles in areas such as production.
- optimising pharmacy skill mix, e.g.:
- use pharmacy technicians to undertake medicines reconciliation on the wards
- use band 7 pharmacists to deliver extended hours service on wards
- more advanced generalists rather than advanced specialists
- creating new/extended roles, e.g. pharmacy prescribers/ transcribers of discharge medication and using pharmacy undergraduates as bank pharmacy assistant staff for weekend and evening work

Other initiatives

Pan London: Pharmacy Urgent Repeat Medication (PURM) service referrals from the 111 service

- 460 Pharmacies active since December 1st with another 80 registered pending NHS Mail check
- Criteria: open Saturdays and active NHS Mail plus Sundays as per agreed hours. Referrals made 24/7 according to opening hours
- 28 days medicines supply
- Referral by phone and email with pharmacist call back within 30 minutes
- Targeting locations near Emergency Departments
- 36% of all repeat prescriptions sent to PURM service
- Evaluation by Newcastle University

North East: LPC collaborative www.northernpharmacy.net

- 324 pharmacies signed up since December 17th
- Only available during OOHs period, i.e. 6.30pm- 8am weekdays and 6.30pm Friday to 8am Monday
- NHS 111 call handlers enter data in to Phamaoutcomes in call centre and pharmacies check system every 30 minutes
- 400 referrals up to 22nd January

- 7 day's supply
- 51% of all referrals accepted and completed
- Available as direct walk-in service: 624 patients use service
- Direct access: 9% would have used A&E, 37% UCC/GPOOHs
- Evaluation by Durham University

Pharmacist in the NHS 111 contact centre

Yorkshire Ambulance service

• Lead pharmacist and bank of 10 pharmacists working shifts weekends and evenings Integrated

Care 24 (IC24)

- Two pharmacist prescribers working across 111 and GPOOHs Care UK (Dorking)

• Independent pharmacists working across 111 and GPOOHs Local Care West (LCW) London Urgent Care

• Community pharmacists (5) working weekends handling calls via IVR routing across all 111 providers

Role of pharmacist

• Handling medicines enquiries, e.g. administration and dosage problems, interactions, pain relief advice

- Advising call handlers
- Advising NHS 111 clinicians: paramedics, nurses, dental nurses
- Managing repeat prescription request referrals
- Providing self-care advice to patients/callers for common minor illness
- Prescribing? In GPOOHs/ NHS 111 / Community pharmacy4

Pharmacists in Emergency departments Expressions of interest for national pilot

- Letter for national LETB Pharmacy Leads and Chief Pharmacists
- Medicines focused clinician, focused on minor injury and minor illness, independent prescriber.
- Build on West Midlands work (HEWM and regional partners)

• 400 presentations, over 5 weeks training week + 4 weeks observation, 3 days a week • 1-3 per LETB, closed 23rd January 2015

NHS 111 phase 2 Projects

Area NHS 111 provider Partners Improving utilisation of community pharmacies Aylesbury vale South Central Ambulance Service Bucks LPC Central Southern CSU Bucks CCGs

Improving utilisation of community pharmacies Oxfordshire South Central Ambulance Service Berks and Oxford LPC Central Southern CSU Oxfordshire CCG

To enhance the use of pharmacist and pharmacy support staff skills both within the NHS 111 call centres and as a referral end point Yorkshire and Humber Yorkshire Ambulance Service Greater Huddersfield CCG Community Pharmacy West Yorkshire (LPCs)

West Midlands Pharmacy integration, Sandwell CCG West Midlands Ambulance Service Arden and Worcester LPC, Celesio, Boots

Pan-London Pharmacy Hub within an NHS 111 contact centre, and Dental Triage Hubs external to NHS 111. (Evaluation only)

London region London Ambulance service Care UK Partnership of East London Cooperatives London and Central West Unscheduled Care Collaborative (Lead)

Care UK (Smile -dental) Kings Healthcare dental service Barts dental service Pharmacy London (LPCs)

NHS

Health Education East of England

Primary Care Transformation within Health Education East of England - November 2014

Report of:
Rob Bowman, Deputy Managing Director and
John Howard, Head of Education and Quality for Primary Care and Deputy Dean

Executive Summary

Primary care is facing a serious challenge due to a shortfall in available GPs and practice nurses. These circumstances are likely to continue until at least 2020 with a deficit of at least 10% of the required projected number of GPs. This document provides brief details of the primary care workforce projections for HEEoE within the context of Midlands and East and the supportive impact of national activities.

As a result of previous HEEoE Board discussions, the HEEoE Primary Care Programme Board (PCPB) was established and has now been in operation for 6 months. The PCPB has coordinated activity across Workforce Partnerships; the first phase of operation has been engagement with primary care and system leaders to scope local problems, understand stakeholders and the role for HEEoE. The PCPB have developed a number of potential work streams which are being tested locally. An example was a recent workforce summit led jointly with NHS East Anglia which shared our understanding, potential interventions and sought commitment from across the system including secondary care to work together as a response to the crisis to transform primary care. The work has also been developed in parallel with joint work with NHS England since August looking at coordinating work across Midlands and East.

This paper therefore seeks the Board's affirmation for the PCPB's proposed strategy and a consequent longer term funding requirement. The costs overall are small; we suggest potential sources of funding. We believe, using a resourced programme approach, a total spend of around £1m per annum over the next 3-5 years would significantly aid the transformation of primary care; the Board is asked to consider supporting the PCPB's strategy and the further development of these options. The proposed investment will secure the provision of excellent primary care in the East of England in to the future, supporting both general practice and the development of wider primary care at scale as envisaged within NHS England's recent publication "NHS Five Year Forward Look".

1.1Introduction

1.2 Following a number of reports[1,2,3], HEE and NHS England nationally have begun working to support workforce transformation in primary care. The evidence suggests that not only is there likely to be a severe shortfall in the number of general practitioners over at least the

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[1] East of England Multi-professional Deanery General practice and Primary care Taskforce, March 2013
[2] Patients, Doctors and the NHS in 2022 - Compendium of evidence, RCGP - http://www.rcgp.org.uk/policy/rcgp-policy-areas/general-practice-2022.aspx accessed 21/3/13
[3] Centre for workforce Intelligence. In depth review of the general practitioner workforce. July 2014 www.cfwi.org.uk

next 6 years but that there is a similar shortfall in the availability of trained general practice nurses and practice managers.

1.3 HEEoE has initiated a Primary Care Programme Board to manage developments across its four constituent Workforce Partnerships. Each has discretionary transformation funds available to invest in parallel with NHS England's transformation plans for primary care[4]. Each Workforce Partnership has developed strong engagement with local communities and are considering consequent work programmes.

1.4 The Primary Care Programme Board has developed an overall draft work programme matrix that has been used to both model and coordinate prospective primary care transformation activities. As discussions have progressed the list of possible actions has coalesced so that similar themes and plans have emerged in all workforce partnerships. NHS England Area Teams and Workforce Partnerships recognise both organisations must work closely together to facilitate effective change in primary care, but that in workforce planning and educational matters HEEoE will lead system change.

2.1 HEE 2014-15 Mandate requirements

2.2 The mandate requirements for HEEoE as a LETB are:

- Ensure 50% of medical trainees leaving Foundation enter specialty training for general practice
- Increase return to practice schemes for general practitioners and nurses (currently up to 12 funded GP places for the induction and returner scheme are available in HEEoE; funding varies in other LETBs and there is no nursing returner scheme)
- Lead commissioning of education and training based on robust workforce planning
- Leading improved capability within the care assistant workforce, through a robust career development framework
- Increase access to health care careers, widening participation and flexible methods to enter training and employment

3.1GP Specialty Trainee Recruitment and GP supply in the Midlands and East Workforce

3.2 In 2014 the following were the GPST recruitment results for HEEoE and for comparative purposes across HEEM and HEWM:

August 2014-15 recruitment including ACFs	HEEoE	HEEM	HEWM
Vacancies	292	259	342
Selected candidates	271	162	317
% Fill	94%	62.5%	93%

There was a national reduction in applications of 15%, thought to be due to a slight increase in secondary care specialty training places, negative media attention for general practice and an increase in doctors deciding to explore different roles prior to selecting a training programme. In 2008-9 19% of GP trainees were "lost" to primary care after CCT, of which

[4] Improving general practice – a call to action – NHS England, August 2013

2.8% had left medicine or the UK, 14.5% were working in other specialties recorded on ESR and 1.5% were working in medicine but not on ESR.

3.2 In an attempt to fill the 2014 vacancies, several work streams have been developed:

- A "pre-GP year" has been introduced in the East and West Midlands and the North West commencing in August 2014, where those who failed in GP recruitment could undertake a year in the vacant ST1 posts as locums for service but with educational support from HEE. The aim is to see if performance in the GP recruitment process will improve with experience and clinical maturity. Applications nationally were less than 20.

- HEE has undertaken Round 3 of GP recruitment, held in West Midlands in September aiming for a February start. The outcome was:

LETB	P	O	A	R	F i
Health Education East Midlands	5	1	1		2
Health Education East of England	1	4	4		2
Health Education West Midlands	8	3	3		3
National Totals	**2**	**4**	**4**	**2**	**2**

All applicants stated that they would have applied to commence GP specialty training in August 2015, which questions the feasibility of undertaking this third round of recruitment in the future.

3.3 **Expansion to weighted capitation targets** for the 3 LETBs is planned for the 2015 GPST recruitment round. This will expand the LETB intakes to (2013 actual recruitment numbers in brackets):

HEEM 280 (242) HEEoE 332 (273) HEWM 360 (335)

This will produce a total of 972 GPST programmes across NHSME, an increase of 79 programmes compared to 2014. Concerns have been expressed about whether there are sufficient candidates to fill these programmes; this has significant consequences; significant deficits such as the 97 unfilled programmes in HEEM in 2014 will impact adversely on service continuity in all sectors and thus patient safety.

3.4 These concerns about the supply of doctors in training combined with the evidence about GP demographics and planned retirements have led HEE to commence a number of other programmes to support an increase in the supply of GPs on the GP register. These include:

- A revised **return to practice** scheme agreed between the RCGP, NHS England and HEE. This will fund an additional 150 GP returners per year across England. This is intended to increase the return to active practice of those who have left for a variety of reasons.

- HEE has with the support of the GMC introduced a scheme for trainees who will have completed up to 2 years in another specialty training programme enabling transfer of relevant competences in to the GP Specialty training programme. Transferring trainees must apply through the GP recruitment process declaring they wish to **Accredit Transferable Competences** (ATC). If accepted and with previous satisfactory performance trainees can then reduce the length of the hospital component of their programme by up to 6 months to 2.5 years.

3.5 The impact of these measures in Midlands and East is unknown but the current projections for GP numbers for England suggest that there may still be a deficit in the FTE numbers of GPs in the system until at least 2020 – assuming the recruitment rounds from August 2015 fill completely. Options to fill the programme from overseas are limited; past

experience suggests that recruiting GPs from other health care systems is unhelpful as the cultural impact on consultation skills means extensive re-training is required. Even then the long term success rate is poor with small retention rates and a higher rate of GMC referral in this group. Additionally the shortage of GPs is a worldwide phenomenon and the market for primary care staff is competitive, so this tactic also deprives other more deprived countries of general practitioners. Overseas recruiting is not therefore likely to be a satisfactory solution.

3.6 If the measures being undertaken to secure the supply of GPs do not succeed there may be a number of consequences:

- There will be an acceleration in the workforce crisis in general practice as the availability of GPs reduces further
- The combined impact of projected financial reductions, increases in demand and a reduced clinical workforce will force some practices to close, adding pressure to surrounding practices – the “domino” effect
- There will be a need to accelerate the transformation of primary care from a GP provided service to a GP led service, rapidly developing the supply of other clinicians (e.g. nurses, physicians and HCSWs)
- There may need to be work to increase the number of secondary care specialists and other clinicians working in primary care
- GP training budgets will be underspent

3.7 Therefore, the HEEoE Primary Care Programme Board has been debating contingency plans to attempt to mitigate an under fill in GP specialty training in the next few years. These ideas have been developed across all 4 Workforce Partnership Groups and most recently tested with NHS East Anglia in a workforce summit in October 2014.

4 National and Regional Developments

4.1 Nationally HEE is setting up a Commission on the Primary Care Workforce under the chairmanship of Professor Martin Roland, an academic GP based in Cambridge with whom the PCPB has strong links. The focus is to be the evidence and best practice models of primary care and the required primary care work force for the future. We will contribute locally to the Commission, but anticipate that whatever the outcome it is likely to report on the need for a wider clinical workforce. The PCPB’s view is that strong engagement by the Workforce Partnerships will be necessary to implement and put in to operation any recommendations; further, there is a need for action now which will support a system under severe strain.

4.2 Working jointly with NHS England in the Midlands and East, an initial scoping on the position and required work programme has been undertaken. As both HEE and NHS England complete their current reorganisations this joint work needs formalising as a sustained work programme. Plans for this are being developed as part of the next steps of Beyond Transition for Midlands and East. The PCPBs view on this is that it will reinforce the agenda developed in HEEoE.

5.1HEEoE/NHS East Anglia Workforce Summit

5.2 In order to explore the issues with system leaders, HEEoE and NHS East Anglia jointly organised a workforce summit held on Friday 17th October. The summit included 25 leaders from CCGs, NHS East Anglia and HEEoE, other primary care clinicians and some representation from secondary care. The day, which used small groups and plenary

sessions, was the first time that such an open discussion between all stakeholders had been held in the East of England. The discussion and themes generated provide a helpful illustration and summary of the work happening across all the Workforce Partnerships

5.3 The outcomes of the day were:

1. A recognition that the model for the delivery of primary care would need to change from a GP delivered system to a GP led system. There was general agreement that primary care should be led from general practice.

2. Universal agreement that practices would need to federate as subsequently set out in NHS England's "NHS Five year Forward Look"[5], but that services must continue to be based on the registered list. For the public primary care must look and feel like an evolution of the current service, still being free at the point of use. Key features should remain longitudinal continuity of care, immediate access allowing the presentation of unsorted clinical problems, population based health promotion and the local management of chronic disease/multiple morbidity, all within a general practice setting.

3. That primary care transformation required all present to be involved in the design of appropriate services for local needs. The actual model may depend on local culture and services; for example the provision may vary between an inner city area with good transport links but few GPs, to a rural area where there may be more GPs spread over wide areas. Furthermore the organisations facilitating federation between practices will vary; in some areas CCGs may be appropriate, whereas in others GP federations or clusters of practices and the LMC are trusted system leaders.

4. That new clinicians in addition to GPs and innovative ways of working, were necessary now. There was absolute acknowledgement that the pressures in the system risked a "domino effect" de-stabilising practices across localities without urgent action, and that although areas of high health need were at greater risk, service reduction could occur across all areas.

5. That secondary and community care needed to be involved in system re-design.

6. That the group in the room wished to continue to work together to re-configure services across Cambridgeshire, Norfolk and Suffolk.

5.4 HEEoE put forward the ideas contained in the PCPB work plan, aiming to help to support service transformation and produce a more rapid growth in clinical capacity. It was agreed that there was an opportunity for HEEoE to use transformation funding to set out costed plans, with the support of the Board, to mitigate the workforce crisis and the threat to the primary care service. It was also felt that given HEE's expertise in workforce planning and development and our local workforce partnership structure and engagement, we were the key organisation capable of leading the response to the crisis in the service.

6.1 The Development of the non-GP workforce across East of England

6.2 Given the likely gap between the demand and available supply of GPs until at least 2020, the following could be increased to compensate:

- Apprentices and Health care support workers (HCSW, formally Bands 1-4) – who can under the direction of a registered nurse or doctor undertake specific clinical assessments/investigations and basic treatments such as vaccinations, dressings etc. Apprentices are currently being offered to all CCGs and practices through workforce partnerships.

[5] NHS Five Year Forward Look – October 2014 – see http://www.england.nhs.uk/ourwork/futurenhs/

- Practice nurses – who can undertake chronic disease management clinics, basic emergency consultations, vaccinations, dressings, and other similar work
- Advanced nurse practitioners – who can triage, see unselected patients as first or second contact and manage significant disease areas and patient pathways
- Associate physicians/Physicians assistants – who can support GPs clinically and administratively; PAs can diagnose, examine but not prescribe; there are a limited number of these practitioners in UK general practice at the present time
- Advanced Care Practitioners – this grade has evolved in Emergency Medicine to support first contact care given the shortage of emergency medicine medical staff. This grade has not yet been utilised in UK general practice.

6.3 There are significant challenges; because UK general practice has developed based on individual practice provision to support local circumstances and populations, there is no one successful model for the skill mix and staff necessary to provide appropriate care to a specific population size. Instead there are multiple models, ranging from a single GP managed extensive multi-disciplinary team to an Accountable Care Organisation capable of providing secondary and community care services. Local services have their own longstanding cultures, reflecting their communities, in which there is huge community trust and goodwill. Seeking radical change to a one size fits all model is not politically possible or culturally appropriate.

6.4 Primary care has no available workforce data at a system level and it is apparent that the model of care delivery must change. Thus it will not be possible to produce a single estimate of the number of new clinical staff required to make up the deficit, or even the take up of new staff types produced. The development of work force planning for new staff groups will require close local engagement with CCGs, LMCs, Federations and perhaps individual practices, as developed through the PCPB. Resources will need to continue to be committed within Workforce Partnerships to ensure dialogue and transformation through engagement.

6.5 There is an opportunity for local Trusts to work with Workforce Partnerships to support this work. For example, HEEoE is the lead LETB for HCSW development and is able to offer apprentices to practices and to support training needs. Because the tasks undertaken by HCSWs are generic, training packages could be offered shared between Trusts (who will already have satisfactory training packages in place) and CCGs or federations. Workforce partnerships could facilitate such links and the development of shared programmes.

7.1 Developing HEEoE Primary Care Transformation Programmes

The HEEoE Primary Care Programme Board has themed developments in to the following areas:

- Workforce planning
- Training and Education
- Workforce recruitment and retention
- Primary care career support
- Organisational development

A. **Workforce Planning**

7.1 In the last 6 months, HEEoE has made good use of the NHS Census information and supported all 4 Workforce Partnerships in working with their local CCG bodies to understand

current workforce headlines. This has been integrated into HEEoEs Workforce Planning activity in 2014

7.2 This broad data source and approach has been supplemented by more detailed local work, for example the Beds and Herts Workforce Partnership have been supporting local CCGs to understand the structure of their workforce and begin to consider future needs ahead of a new national data collection system commencing next March. From an initial participation of just 19% of practices there is now full participation by 75% of practices in the **Herts Valleys CCG**. The impact of this is that the CCG has been able to quantify there expected need for GPs over the next five years – with the realisation that this need is unlikely to be met. The local system has been galvanised in to seeking solutions such as those detailed in this paper and believes it must oversee a transformation of primary care in order to deliver service continuity. We are working to enable similar understanding and engagement in other areas.

7.3 This work needs sustaining into 2015 and aligning with developments in co-commissioning of Primary Care with CCGs.

B. Training and Education

7.4 **Physicians Assistants/Associates** – In order to bolster clinician capacity in primary care the development of physicians assistants/associates is recommended, as happens in other countries. These clinicians have two roles; firstly to undertake specific clinical tasks such as specific examinations and assessments – but not to prescribe – and secondly to undertake administrative roles supporting GPs in consultations. The possibility of commissioning these three year courses from local HEIs within appropriate costs is being explored.

Examples – Pan East of England framework in development, working closely with the HEEoE Emergency Care Programme Board

7.5 **HCSWs and Apprentices** – Health care support workers are currently unregulated, and as such can undertake simple clinical tasks within the limit of the training and authority afforded to them by their practices. This group can be increased in the workforce quickly and cheaply; training in either secondary or primary care is more generic and less context specific because of the reduced complexity of their work. Therefore training programmes can be undertaken in primary or secondary care. Seeking the assistance of local Trusts may be one way of increasing the supply of this group of workers for CCGs; these arrangements can be facilitated by Workforce Partnerships. The availability of apprentices and the national target to increase recruitment from apprentices makes this group an attractive offering if physical capacity is available within CCGs and practices. This work needs to be developed in parallel with the focus on Primary Care Nursing and a wider view on the transformation agenda in Primary Care.

C. Workforce Recruitment and Retention

7.6 **Fellowship schemes to attract and retain new GPs to a locality -** Fellowship schemes should be constructed between the local CCG, a local HEI, the local Trust and the HEEoE WP. Typically these might be for a two year contract with the doctor from the point of acquiring a CCT with the CCG. Typical content would include experience in at least 2-3 practices, working 7 clinical sessions per week. A further session is for private study and there will be a session per week for academic development in association with the HEI. The final session would be worked flexibly for the CCG. Out of Hours would normally be expected at 6 hours per month.

The HEI component might be to provide a PGCertMedEd, PGCert in Leadership or commissioning. The flexible session could include working in the Trust, perhaps in a community clinic (paediatrics, psychiatry or front of house EM) and could include training in higher levels skills (gastroscopy, bronchoscopy, diabetes care, epilepsy management, parkinsons, urology, minor surgery) that could subsequently be used in a community clinic. The doctors would be supported through a peer facilitated networked group supported by a GP Tutor. Salary for the new doctor would be c£80K but could be flexed depending upon the area. Cf. Consultants starting salary £78k +fees and salaried GPs range of £55k-£83k)

The partners would contribute as follows:

- CCG would pay the salary with contributions from practices (c £56kpa plus on costs)
- CCG would also plan the workforce needs to coordinate the role, arranging sessions (usually for at least 8 months) in individual practices for the 7 clinical sessions and negotiate with the Trust to arrange the flexible element
- The Trust would pay for the flexible session (£8kpa)
- The OOH provider would pay for the OOH session (c£5kpa)
- The HEI would coordinate individual courses and provide a discounted educational cost (c£4kpa)
- The WP would pay the educational costs (c£4kpa plus admin support - ? £7kpa)
- The GP School would provide a GP Tutor to support individuals and the networked group. The Tutor would also be able to mentor the individuals; coaching would also be available. Finally, support for appraisal and revalidation would be provided. (GP Tutors in place)
- The WP and CCG would jointly advertise the post and the WP with the Trust would provide HR and legal support.

Total cost for HEEoE c£10k per clinical fellow plus administration and miscellaneous costs.

Examples – Luton (currently small scale); Herts Valleys are keen to adopt this across the CCG

7.7 **Enhanced retainer scheme** – this established NHS scheme for GPs allows doctors to drop their sessional commitment to between 1-4 sessions per week with subsidised costs and some salary support. We currently have 21 in the East of England at c£5k each. Selected, approved practices contract to provide some education and support with the GP School and the retained doctor. The problem with the scheme is the protected employment rights of the doctor at the end of the 5 year scheme, so that practices cannot end the employment contract.

One solution is to make the contract with the PCG/educational federation rather than the practice. The total cost over the five years per trainee to HEEoE is c£47,500, or £9.5k pa.

The GP School would like to expand this scheme with a further 10 doctors or advanced nurse practitioners per annum, i.e. £100kpa.

7.8 **Induction and returner scheme** – this scheme is being developed nationally as discussed above. As a LETB that has always supported this scheme, HEEoE would be pleased to host an increased cohort. Current discussions are likely to suggest a lead LETB – we propose that HEEoE should bid for this role.

Example – National Proposed scheme and Pan East of England through the GP School

D. Primary Care Career Support

7.9 **Nursing careers** – It will be apparent from the above that a key requirement is to increase other clinicians available to primary care to assist with transition from a GP provided to a GP led service and to mitigate the impact of the reduced number of GPs available. At present nurses undertake up to 30% of consultations in primary care. Nurses could enter primary care immediately post registration or some years after; in the past experienced secondary care nurses have tended to move to primary care for career change or lifestyle reasons with little planning to train and develop cohorts of nurses to work in primary care. There is no reason why HEE, Trusts and CCGs should not cooperate to commission and support appropriate numbers of nurses for secondary, community and primary care. It is suggested that good practice would be for all pre-registration nurses to experience primary care and for specific training to be given for nurses wishing to work in each sector after registration. HEE has a key role in leading such developments to ensure the adequate numbers and training of nurses for the NHS as a whole. In this context urgent development of primary care nursing will require the following:

- Placement of all pre-registration nurses in primary care
- Placement of post-registration nurses wishing to specialise in 1 year posts in practices with associated weekly half day release course and support for CPD, diplomas and other clinical educational input – e.g. personal portfolio, peer group networking and facilitation
- Adoption of the Portsmouth/RCGP Foundation curricula and standards
- Provision by an HEI of a post-registration basic and advanced practice nurse course
- On-going CPD
- A Practice Nurse network coordinated through NHS England with HEE educational support.

These steps require the following investments:

- Practice placement – non-medical tariff (c£75 pw). It is suggested this is supplemented - £60 per week supplement (total cost c£5.4k pa). The current non-medial tariff is not a sufficient incentive due to the loss of mentor time.
- Reduced face to face contact time for nurses and mentors – currently 15 hours per week (local agreement with university)
- Free mentor courses for practice's intending nurse educators and nurse mentor fee – c£3800 pa
- Increased support costs for GP half day release courses (minimal change in overall costs)
- WP to commission and fund HEI courses – c£750pa per student?
- Nurse mentor to coordinate group - ? cost – could be co-ordinated by local Trust non- medical Clinical Tutor

The likely HEEoE cost of training a practice nurse for a year would be c£10k per nurse per annum, pre or post-registration. Most nurse placements pre-registration are for a maximum of 6 months. Nurses immediately post-registration are likely to require placements of one year. Experienced nurses from other sectors could be trained for primary care within six months. Thus, for federations with full nursing provision the cost for 10-20 nurse post-registration learners might be £100,000 and 10 pre-registration learners £50,000. It should be noted that other LETBs are already running similar schemes, e.g. HEY&H and HEWM.

To increase commissions and develop and increased supply of nurses sufficient to meet safe nursing numbers would take three years.

Examples – in development in Norfolk/Cambridgeshire

E. Organisational Development

7.10 **Educational Federations** – These are a way of adding value and capacity to primary care clinician training. The principle is that instead of contracting with individual practices for one clinician's training – e.g. a GP trainee – the CCG or other grouping would hold an SLA with the GP School. The SLA would specify the standards and educational requirements along with the number of placements for a number of disciplines – although we might start with GP trainees and nurses. The federation would include training practices, but because the group includes non-training practices the use of these facilities can be included in the contract – providing they meet the standards for the environment set out by the GP School. This would mean that training practices could share learners with these environments – which might be wider than in the past, for example optometrists, pharmacists and community clinics could be included.

For the Federation it means that they could manage distribution of learners more easily, and given exchange with previous non-training environments capacity could be increased. Key developments allowing this innovation include standards for the environment, named clinical supervisors and educational supervisors in primary care. In addition, making these standards common with undergraduate schools of medicine and nursing schools would reduce the need for multiple inspections. The contribution of these learners to the workforce and the shared working between practices and individuals will be essential to create a sustainable model for the future, both benefiting the service by the provision of additional service capacity. The system would allow coordination of placement of medical students, pre or post-registration nurses and medical trainees.

The GP School would undertake to approve environments as now but cede coordination of the learners with TPD/Tutor support to the Federation; the Trainer grants, ESR fees, a programme support fee and placement fees would be paid centrally up front. Full support would be provided for the half day release educational programme, coordination of the hospital element of training, administrative support for trainees (through Southend) and trainees in difficulty. We believe this system would facilitate development of the half day release to include post registration nurses. NHS England may need to assist with capital input for premises.

HEEoE costs would relate principally to administration – This would be in the order of £10k per arrangement in staff/support time

Examples – Norfolk Federation – developing workforce plan for HCSW

Suffolk Federation – now runs North Essex Diabetes service

7.11 **Workforce Development Centre –** because of the nature of primary care with multiple small practices, there is a need to support organisational development within local systems. With co-commissioning CCGs are commissioning primary care services, but CCGs do not have the expertise to support workforce planning, workforce career advice and bank or locum services. In addition, HEEoE can assist with organisational development through educational interventions; expertise in recruitment supporting the "branding" of localities, and acting as a neutral facilitator to lead development and support local leaders. Workforce Partnerships are taking on this role to varying extents depending on the needs within their local systems.

Example – Essex Workforce Development Centre

9.1Other factors

9.2 The proposals discussed above are all activities that could be undertaken now. None will cure the primary care workforce crisis immediately but all will aid transformation rather than simply sustain a system in difficulties.

Other activities that partner organisations could undertake include:

- Investing service transformation funds to attract new GPs (e.g. paying off student debt) or retain those retiring in wider or different roles (e.g. paying memberships, indemnity and educational costs)
- Reducing reporting requirements (e.g. QOF) to free clinicians time
- Provision of capital funding to renovate or extend property, particularly with the aim of enhancing educational capacity in primary care
- Providing more female friendly work spaces and working practices (62% of medical students are female)
- Assisting practices to come together and undertake strategic area reviews as a federation or commissioning group
- Coordinated working between HEIs, NHS England and HEEoE to provide a consistent and single message, as opposed to fragmented arrangements. An example of this is the development of shared standards and joint visiting

This wider focus needs progressing jointly with NHS England and CCGs.

9.3 Even with all these proposals the development and growth potential in primary care will be challenging.

10.1Proposed Strategy

10.2 There are three strategic trajectories that could be taken by HEEoE and the PCPB. These are:

- **Conservative** – to continue current commissions and work to national GP recruitment plans, assuming that there will be an increase in the supply of GPs and that market forces will bring about primary care transformation.

Risks - that there will be local service collapse in some areas with high pressure on secondary care services as a result. Furthermore this will also not result in transformation of a system that is unlikely to meet future needs.

- **Evolutionary** – to work with NHS England, CCGs, Federations and other system leaders to support GP recruitment and retention, offering support for increased primary care nurses and workforce development centres, allowing change to occur in localities where system leaders feel able to implement this.

Risks – variations in service provision, innovation but not at scale and pace and the possibility of inadequate supply of new clinicians

- **Transformational** – a formal programme approach applied in each Workforce Partnership with adoption of the activities outlined in section 8 and the commissioning of new primary care clinician pathways working with local systems to explicitly transform primary care provision through workforce and educational initiatives

Risks – higher expenditure (? C £1m pa), potential variable take up of the new clinicians, potential lack of engagement, changed future public policies.

10.3 Expenditure on a formal programme could be funded from a number of sources. If GP trainee recruitment does not fill there will be significant unspent funds; annual spend per trainee is c £31k per annum in hospital and c£72k in general practice. Having under-filled in 21 programmes in 2014 and created an additional 40 programmes in 2015 there is a significant risk that we may not fill completely. In addition, Workforce Partnerships will need to focus a proportion of their use of Transformation and CPD funds on this agenda. Therefore it is likely that any commitment to a formal programme approach could be resourced from within the current budget.

11.1Conclusion

11.2 This paper outlines the work of the Primary Care Programme Board over the last 6 months and discusses possible future strategies and actions. It seeks to assure the Board that HEEoE is acting to support the continued development of primary care in the East of England and in particular that this is an active local agenda

11.3 There are many other aspects that need further discussion, for example the role of local Trusts in the process of transformation. However the PCPB believes that a transformational approach is necessary and justified by the data and logic presented in this paper. The Board is asked to:

1. Approve a direction of travel that is transformational in approach and for this to be developed into a formal work programme.
2. Sanction the further development of the proposals set out in this paper that will achieve the transformational agenda.
3. To provide in principle authorisation for additional investment subsequent to satisfactory formal business plans being drawn up and approved.

11.4 The PCPB believes that a commitment now and over the coming years to fund additional work streams in primary care will support the achievement of HEE mandate targets and HEE’s work to strengthen the training and recruitment of general practitioners. In addition, these work streams support the current problems in general practice and the development of wider primary care at scale as envisaged within NHS England’s recent publication “NHS Five Year Forward Look”.

Fellowship schemes 1 Introduction

Fellowship or preceptorship schemes are a means to provide a supported 1, 2 or 3 year salaried post immediately post specialty training for clinicians in primary care. These posts provide the consolidation of clinical skills within a supportive environment while also offering educational opportunities with reduced personal administration required of the clinician. The purpose of such schemes is to attract new graduates to an area, supporting their professional growth such that they decide to settle and contribute to the local health care economy in the long term. There is evidence that such schemes are more attractive than the unstructured jobs market currently in place in primary care. A pilot scheme in Luton, an area of marked deprivation and therefore service challenge, has been successful in recruiting high quality GP recruits and HEEoE now wishes to promote this concept to other local health systems throughout the east of England. This paper uses the GP pilot as an example but the principles are equally applicable to preceptorship schemes for nurses in primary care.

2 Developing a Scheme

Typically a GP fellowship scheme might be constructed between the local CCG, a local HEI, the local Trust and the HEEoE WP. Usually these might be for a two year contract with the doctor from the point of acquiring a CCT with the CCG. Content would include experience in at least 2-3 practices, working 7 clinical sessions per week. A further session is for academic development/ongoing education, perhaps in association with the HEI. The final two sessions would be worked flexibly with the local Trust or CCG. Out of Hours would normally be expected at 6 hours per month, and could be within the contracted hours or in addition. These are suggestions only; the actual content will be dependent on local needs and for negotiation between the stakeholders.

The HEI component might be to provide a PGCertMedEd, PGCert in Leadership or commissioning. The flexible sessions could include working in the Trust, perhaps in a community clinic (Paeds, psychiatry or front of house EM) and could include training in higher levels skills (gastroscopy, bronchoscopy, diabetes care, epilepsy management, Parkinsons, urology, minor surgery) that could subsequently be used in a community clinic. It could also include paid sessions in a CCG or federation or out of hours provider. The doctors would be supported through a peer facilitated networked group supported by a GP Tutor.

3 Finances

Salary for the new doctor would be c£70-80K but could be flexed depending upon the area; c.f. Consultants starting salary £78k +fees and salaried GPs range of £55k-£83k). Appendix 1 contains the job description in operation in Luton (NB a larger scheme would require a narrower cost base per doctor and the backfill component in the Luton scheme is not affordable in these circumstances).

The partners could contribute as follows:

- CCG/Federation/employing organisation would pay the salary with contributions from practices (c £56kpa plus on costs)
- CCG/Federation would also plan the workforce needs to coordinate the role, arranging sessions (usually for at least 8 months) in individual practices for the 7 clinical sessions and negotiate with the Trust/CCG/others to arrange the flexible element
- The Trust/CCG would pay for the flexible sessions (£14kpa plus on costs)

- The OOH provider would pay for the OOH session (c£5kpa)
- The HEI would coordinate individual courses and provide a discounted educational cost (c£4kpa)
- The HEEoE WP would pay the educational costs (c£4kpa) plus admin support - ? £7kpa per doctor in total?
- The GP School would provide a GP Tutor to support individuals and the networked group. The Tutor would also be able to mentor the individuals; coaching would also be available. Finally, support for appraisal and revalidation would be provided. (GP Tutors in place)
- The employing organisation would jointly advertise the post with the partners and the WP with the Trust would provide HR and legal support.

Total cost for HEEoE c£7k per clinical fellow to include administration and miscellaneous costs.

4 Rationale for a Fellowship scheme

Advantages:

- GPs post CCT want a secure clinical environment in which to develop their clinical skills. It is in this phase of their career they are prepared to consider management, political, educational and leadership skill development, but only within the context of consolidating their clinical abilities
- Therefore Fellowship schemes, without the burden of administration required to be a locum or a partner, are attractive to doctors post CCT and may provide the start of a long local career if the local work and leisure environments are attractive
- There is no regulatory requirement – we can negotiate whatever will attract new GPs and can be sustained locally
- The scheme can utilise current non-training practices (although the GP School would wish to ensure the environment is conducive to learning)
- In attracting new GPs the scheme sustains workforce immediately
- Funding shared between partners makes costs reasonable
- Quick to establish
- Encourages joint working between WP, GP School, University, OOH provider and CCG

Disadvantages:

- The current pilot in Luton is small. Larger pilots will require funding for administrative support
- Timescale for negotiation short for August 2015
- Clear lead organisation required as multiple partners can be difficult to coordinate

5 Fellowship schemes combined with Practice nurse post-registration Preceptorship schemes

A GP Fellowship scheme provides an opportunity for local stakeholders to collaborate. It would be easy to build on this collaboration by adding a similar scheme for nurses for one year post-registration. Such a scheme would provide newly qualified nurses who could undertake clinical work from day 1 for the local CCG/Federation; the precise

number of sessions per week would be for negotiation. Again, with GP School support, post-registration nurses could be placed in non-training practices. Typically they might work for 8 sessions in the practice; the GP School would offer attendance at the GP half day release scheme with trainees allowing some multi-professional small group work; one other session would be to undertake a University provided practice nurse course.

A second optional year would lead to Advanced Nurse Practitioner status, having undertaken a nurse prescribing course, Nurse practitioner training and mentoring and perhaps a diploma in chronic disease management, e.g. diabetes. This group could be invited to attend the Fellowship scheme GP peer network meetings.

Therefore a model for a combined GP fellowship/nurse preceptorship educational programme might be:

Year one post CCT (GP) – practice 1	Year two post CCT (GP) – Practice 2
GP – six sessions in GP, two sessions in provider unit/secondary care, private session, academic session plus OOH/EM? Nurse –7/ 8 sessions in practice, education session funded, attends GP half day release further session	GP – six sessions in GP, two sessions in provider unit/secondary care, private session, academic session plus OOH/EM or different mix according to career wish/progression Nurse – 7/8 sessions in practice (? Same), attends GP half day release, continues education session ?masters
Year one post registration (nurse)- Primary care preceptorship year or secondary to primary conversion year	Year two post registration (nurse) - Advanced nurse practitioner training

Advantages:

- Curriculum for practice nurses now available
- Common criteria for approval of primary care clinical environments for educational use have been agreed between the GP School and the undergraduate Clinical Schools – indications are that nurse teachers would also accept these criteria (see appendix 2). No other regulatory requirements
- Simple to administer building on the Fellowship scheme
- Produces a prototype on which to build an educational federation
- Several Universities (ARU, UEA) have suitable practice nurse courses ready to run
- Would encourage multi-professional working and hence service transformation
- Would encourage cooperation between nurse and GP quality management which could lead to a School of Primary Care
- Little investment required
- Easy to extend placements to pre-registration nurses where education occurring in practices

Disadvantages:

- Physical capacity required in practice - ? NHSE funding
- Some pump priming in terms of tariff – type payment required for practices
- Training and support for Mentors required
- Commitment from all parties to support and rapid implementation now for August 2015
- Administrative support for CCG and GP School would be required

6 Proposed Timelines

Work stream	January	February	March	April	May	June	July
Fellowship scheme	WP to discuss: CCG/federation, Trust, OOH provider, HEI and GP school to agree outline plan with numbers and budget, criteria, standards and outcomes	Negotiation with CCG re practices and Trust re sessions. Approval from GP School for host practices, business plan sign	Funding agreed; heads of agreement signed; educational course options explicit	First adverts to be available; academic courses/secondary care options publicised; outline full programmes agreed	Interviews and recruitment processes; evaluation and QM processes clarified; organisational working relationships explicit	Employment and academic preparations	Preparation for first cohort
Preceptorship Scheme	WP to discuss: CCG/federation, Trust, HEI and GP school to agree outline plan with numbers and budget, criteria, standards and outcomes	Negotiation with CCG re practices Approval from HEI/GP School for practices, business plan sign off,	Funding agreed; heads of agreement signed; educational course options explicit	First adverts to be available; academic courses/secondary care options publicised; outline full programmes agreed	Interviews and recruitment processes; evaluation and QM processes clarified; organisational working relationships	Employment and vocational preparations	Preparation for first cohort

7 Further developments

Once such a scheme was underway it would be easy to add expanded experience in general practice/primary care for pre-registration nurses. The combination of pre- and post-registration support, depending upon capacity, would allow CCGs/practices and nurses to gain experience of each other so that there could be continuity of employment. Practices post-registration would know that they are getting someone in the post-registration phase who has GP experience, and nurses could opt to go in to primary care on the basis of their pre-registration experience and relationships. HEEoE would fund administrative costs, mentor training and other education costs.

Similar schemes could apply to other clinicians, such as physiotherapists, dieticians and occupational therapists. The combined organisations may also wish to consider the formation of an HEEoE School of Primary Care in due course.

8 Conclusion

This paper describes the potential for Fellowship schemes to support both the workforce in general practice and a first step in a transformation of the way in which primary care education is organised.

John Howard February 2014

Appendix 1 – Job description used in Luton

LUTON FUTURE GP LEADERS CAREER DEVELOPMENT SCHEME JOB DESCRIPTION

POST TITLE: **Future GP Education Leader** **TENURE:** Fixed term (3 years)

LOCATION: Clinical sessions: [name of practice]
Educator sessions: University of Bedfordshire Faculty of Health and Social Sciences Masters Degree: University of Bedfordshire & Home

ACCOUNTABLE TO: Clinical sessions: lead partner in practice (or their nominated deputy)
Educator Sessions: Professor Mike Cook (or their nominated deputy)
Masters Degree: masters supervisor (or their nominated deputy)

JOB PURPOSE: To work as a salaried GP at [name of practice]
To provide education to healthcare students at the University of Bedfordshire as part of the Faculty of Health and Social Sciences
To achieve a masters degree in medical education

JOB ACTIVITY: The postholder will provide general medical services to the practice population and educational support and teaching to healthcare students at the University of Bedfordshire. At the same time, the postholder will be expected to use their protected time to achieve a fully funded masters degree in medical education by completion of the post

SALARY: Salary £72,000 per annum
Salaried post paid monthly by Bank Credit Transfer

HOURS OF WORK:40 hours over 4½ days per week as follows:

Clinical work (25 hours)

2 full days in practice (08.30-18.30) plus a half day in practice (either 08:30-13:30 or 13:30-18:30 by mutual agreement)

Educator Work (8 hours)

1 full day per week
(usually 09:00-17:00 but occasional important evening meetings)

Study for Masters Degree with The University of Bedfordshire (7 hours)

7 hours paid per week (any additional study time required is undertaken in your own time)

ANNUAL LEAVE: Clinical Work: 15 days per year Educator Work: 6 days per year
Masters studies: 42 hours per year leave from your masters studies

NHS

Health Education East of England

Luton Future GP Leaders Career Development Scheme
Future GP Education Leader Post Person Specification

REQUIREMENT	ESSENTIAL	DESIRABLE
EDUCATION/ QUALIFICATIONS/ TRAINING	Primary medical degree	
	Full registration with the General Medical Council	
	Membership of the Royal College of General Practitioners OR (if still in ST3) evidence of the likely achievement of GP competences to CCT level by end	
	Either holds a current valid driving licence and has use of a motor vehicle, or provides at own cost an appropriate alternative transport means for efficiently fulfilling the requirements	
	On GP performers list & undergoes NHS Appraisal	
KNOWLEDGE/ SKILLS/ EXPERIENCE	Evidence of continuing professional	Evidence of a successful self directed approach to learning
	Evidence of continuing personal development	Evidence of activities and skills outside medicine
	Evidence of recent medical audit activity	Evidence of involvement in research and/or publication and/or academic conferences
	Understanding of the different healthcare educator roles and of the organisation of primary care education	Recent experience of teaching/facilitating/mentoring learners
	Commitment to delivering & improving quality of care	An understanding of health inequalities and other issues particular to delivery of urban primary care in multi-cultural
	Evidence of having used leadership skills in the past	Some previous experience in change management
	Evidence of self directed working and use of initiative	Evidence of having worked with long timescales in the past and having completed these tasks on
	Evidence of successful team working	Excellent negotiating skills
	Excellent verbal and written communication skills	Experience presenting to groups, facilitating groups and disseminating own written material to
	Problem solving abilities and a flexible, practical approach	Has strategic planning skills
BEHAVIOURS	Enthusiasm to be involved with urban multi-cultural general practice	

AND VALUES	Enthusiasm for medical education	Appreciates the benefits of a learning culture
	Flexibility of approach to post applied for	Commitment to working
		partnership
	Demonstrates value, respect and dignity for others.	
	Working together for patients. Compassion.	
	Commitment to NHS constitution & values	

Appendix 2 – Shared primary care Environment/ Educator standards for GP training

CRITERIA FOR PRACTICE ENVIRONMENT AND EDUCATORS – EAST OF ENGLAND

Introduction

Individual General Practices and educators within them often host learners from different institutions. Members of the GP School in Health Education East of England and the Universities of Cambridge and East Anglia have therefore collaborated to develop a shared list of criteria for Practices and Educators (whether undergraduate medical, postgraduate medical, nursing, or other AHP educators).

Criteria are mapped to the Academy of Medical Educators framework, are based upon criteria agreed by the Committee of GP Education Directors (2014) and encompass criteria described in: Cotton P, Sharp D, Howe A, Starkey C, Laue B, Hibble A, Benson J (2009) 'Developing a Set of Quality Criteria for Community-based Medical Education in the UK'. Education for Primary Care (20) 143-51. In this document:

Section 1 describes common Practice Environment criteria (these are identical for all educators).

Explanatory note

Criteria P15, 21 & 33 refer to this explanatory note. Different organisations will have their own guidelines for obtaining patient consent, learner attendance at practice meetings and educational recording of consultations relevant to different groups of learners.

NHS

Health Education East of England

Section 1 - Practice Environment Criteria

Please either specify yes/no from knowledge of practice operations, or offer brief supporting evidence / assurance, where requested.

Practices should:

Criterion		Yes/No
General		
	P1 Be formally approved and regularly re-approved by the GP School board (for PG) or the Medical School (for UG) *(Hereafter referred to jointly as 'The School').*	
	P2 Be accredited for no more than two years when first accredited. Re-accreditation thereafter should normally take place at least every five years.	
	P3 Inform the School and go through a re-accreditation process if they undergo major change, e.g. entry into an arrangement with a private provider.	
	P4 Ensure that those undertaking agreed educational roles have sufficient practice availability to fulfil both these roles and their clinical commitments: substantive absences due to national roles, new out of practice commitments, and major leave periods should be reviewed and if necessary discussed with the educational agencies involved. ***Evidence/Assurance:***	
	P5 Ensure that list size and workload is such that there is the potential for the learner to experience all aspects of their curriculum in their daily work.	
P6	Normally be able to cope with its patient load effectively with or without a learner.	
P7	Provide a named education lead and deputy. ***Name of Lead: Name of Deputy:***	
	P8 Be a good learning environment for a wide range of learners: for example, students, learners, overseas, refugee, and EU doctors in clinical placements, GP retainers, GP returners and Flexible Careers Scheme doctors.	
	P9 Demonstrate enthusiasm to teach or support teaching as a whole practice, with a commitment to provide protected time for learning, teaching and teacher development. ***Evidence / Assurance:***	
	P10 Collectively maintain a safe environment for learners, including the provision of appropriate clinical supervision at all times.	
Practice Management		
P11	Provide a named management/administrative lead. ***Name of Admin. Lead:***	
	P12 Maintain clinical records which conform to the standards set out in "The Good Practice Guidelines for GP Electronic Records v4, chapter 6 "High Quality Patient Records"	

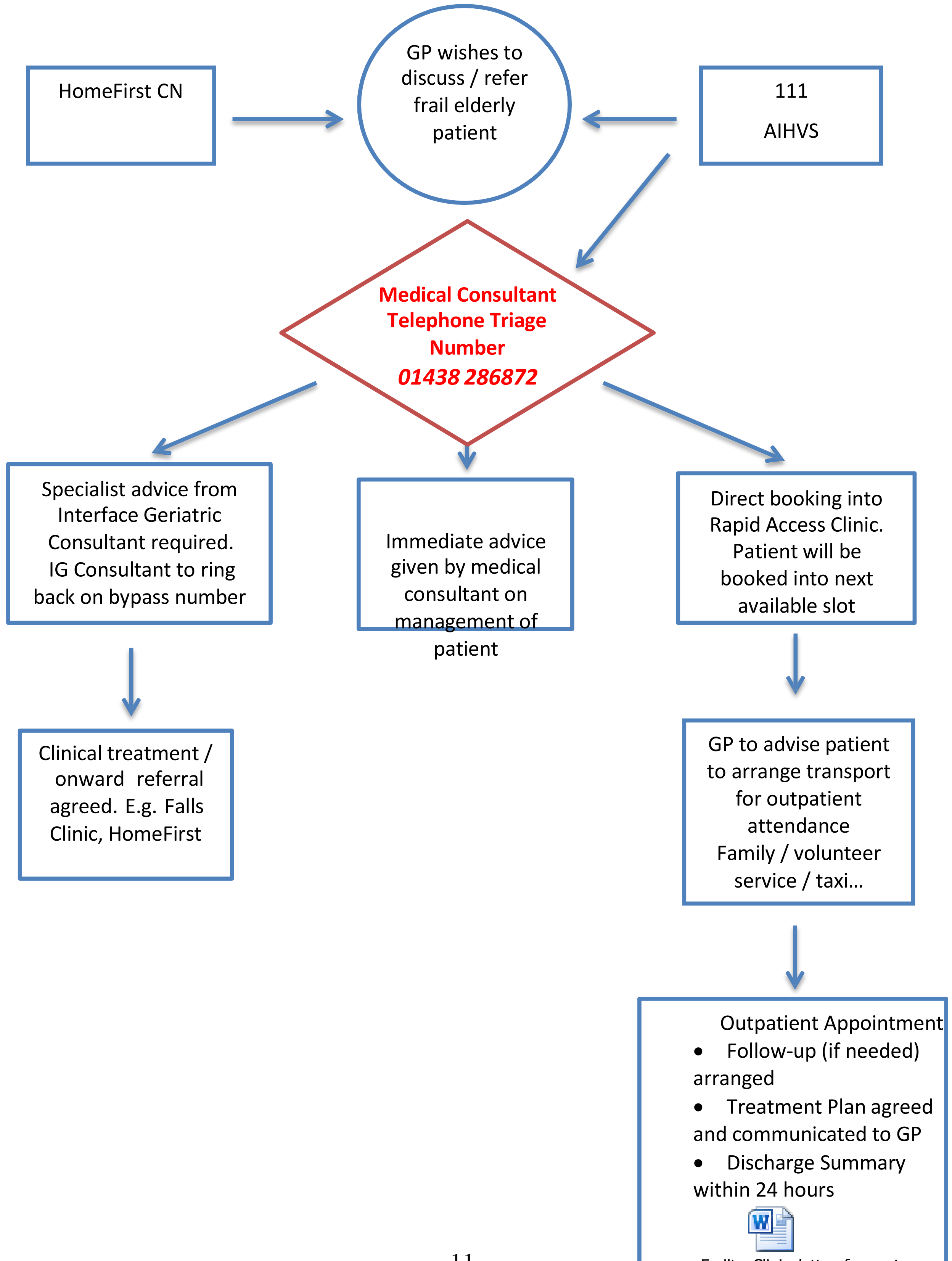
	P13 Show that it is committed to providing a good, comprehensive, cost effective and continuing service to patients, including the use of effective and economic prescribing methods and referrals to secondary care and diagnostic tests.
P14	Have established clinical governance procedures.

P15	Have procedures for obtaining patient consent for teaching (including use of chaperones) *(see explanatory note).* ***Evidence / Assurance:***	
16	Have up to date and effective policies for home visiting, continuity of care for patients, emergency care and out-of-hours cover.	
P17	Make provision for preventive care and health promotion.	
P18	Be able to show effective use of the entire primary healthcare team.	
P19	Have a policy to support regular staff appraisals and training.	
P20	Engage in regular quality improvement activities, including significant event analyses and audit.	
P21	Have regular practice meetings, which the learner should attend where educationally appropriate, and at which practice management and the management of patients are discussed *(See explanatory note).*	
P22	(For post-graduate training) be organised to ensure that the learner obtains satisfactory, supervised experience of all aspects of out of-hours work in accordance with COGPED guidelines.	
P23	Have a well-run appointments system that meets the standards specified in the contract agreed with the primary care service commissioner.	
P24	Carry out and act upon the results of annual patient satisfaction surveys.	
P25	Have a well thought through and well publicised patient complaints procedure.	
Performance Review		
P26	Support educators approved by the School for teaching to have personal development plans that cover their work as educators.	
P27	Regularly review educational performance, including records of feedback from learners, to maintain the quality of the education provided. ***Evidence / Assurance:***	
Premises		
P28	Provide the learner with access to a well-equipped room that meets School standards.	
P29	Provide the learner with his/her own space and facilities in the practice to secure personal items safely.	
P30	Inform patients that it is a training practice, particularly with reference to: a) the recording of consultations b) the existence of consultations for educational purposes c) inspection of medical records by learners and for the purpose of educator accreditation, School and GMC quality assurance activities.	
P31	Comply with legislation on the storage of digital data.	
P32	Provide IT support, including a computer with appropriate search facilities, internet and electronic reference data access as well as facilities for private study. Learners must have supervised access to patient records and ensure patient confidentiality.	
P33	Provide easily accessible equipment for recording patient consultations, where educationally appropriate (*See explanatory note*)	
P34	The learner must have access to the drugs and equipment needed to provide effective emergency and out-of-hours care.	
P35	Hold public liability insurance	

Health Education East of England

ENHT Interface Geriatric Service Referral Pathway

Service Available: 9.00 – 5.00 Monday to Friday



FF57 Health Education East of England

Project Proposal	**Interface Geriatrician Service**
Service Provider	**East & North Hertfordshire NHS Trust**
Contact	**Michael Harper** **Dr Catherine Rippingale**
Service Commencement	**September 2014**

Area of Benefit : East & North Hertfordshire CCG

Client Group: Frail elderly people

Service description:
Currently the elderly care department at East & North Hertfordshire NHS Trust provides inpatient elderly care for 84 beds as well as consultant input to the isolation ward and medical outlier patients across 4 surgical wards. Within the Trauma and Orthopaedic department the Geriatrician team co-manage all patients with hip fractures. There are a variety of outpatient clinics running across 3 sites, both general elderly medicine and specialist clinics such as falls reviews and Parkinson's disease.

The aim is to provide the additional services outlined below through the appointment of two additional Geriatric consultants to compliment ENHT existing 6 consultant workforce. All consultants in the team would then rotate through the additional services provided to community and social care to ensure robust cross cover and maximise good clinical governance and audit.

The new posts would be to support the provision of:

- **Rapid access weekday acute comprehensive geriatric assessment (CGA)**
  CGA is a 'multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up.

  Development of daily weekday outpatient sessions will be made available to support face to face rapid CGA as required within 24 – 48 hours of referral.

- **Monday to Friday 9-5 access to senior geriatric medical telephone advice (via existing number) and assessment in conjunction with clinical navigators.**

The additional resource enables a consultant to be rostered to be available for these calls. This service would be available daily M-F 9am - 5pm to GP's, ED and community matrons and would also link in with the existing clinical navigators

- **Geriatric Consultant interface sessions via weekly MDM's to Intermediate Care Beds (4-5 sessions)**

The consultant may also undertake regular 'teaching' ward rounds.

The MDMs and ward round teaching will help enhance patient outcomes and bed throughput in the community setting.

- **Geriatric Consultant interface to high risk nursing homes, attending weekly MDT etc**

The 'target' nursing homes would be agreed with the CCG.

Aims of the Service:

This basis of this proposal is to enhance the role of Consultant geriatricians across the acute, community and social care boundaries. As hospital length of stay has shortened over the years, it has become increasingly important to ensure that care pathways are developed across primary and secondary care to ensure effective continuity of the care.

The importance of 'vertically integrated' care pathways across primary and secondary care is highlighted in a recent review of several integrated care pilots in the UK (National Evaluation of the Department of Health's Integrated Care Pilots; RAND Europe, Ernst & Young; March 2012).

Geriatrics is a branch of general medicine concerned with the clinical, preventative, remedial and social aspects of illness in old age. The challenges of frailty, complex comorbidity, different patterns of disease presentation, slower response to treatment and requirements for social support call for special medical skills which are not just applicable to the acute setting.

Presentations of illness in old age are often non-specific: geriatricians focus on falls, immobility, incontinence and confusion as well as adverse drug reactions. They can see a broad range of illnesses, particularly stroke, heart disease, infections, diabetes, delirium, and the dementias. Some Geriatricians deal with the whole range of geriatric problems, particularly those who spend time working in the community. Others specialise in areas such as Orthopaedic Geriatrics, Stroke, falls and syncope, cerebral ageing and Parkinsonism.

At its core, Geriatrics requires comprehensive assessment of ill and disabled old people. This involves close interdisciplinary working with nurses, therapists, pharmacists, dietitians, social workers and many other health professionals. Geriatricians work closely with GPs, old age psychiatrists and many hospital clinical specialists to ensure that old people receive the highest possible levels of care.

The proposal will provide more Consultant Geriatrician leadership and input into community and social care environments thereby enhancing the guidance, skills and experience of multi-disciplinary colleagues in these settings as well as providing the opportunity to see and review patients before a crisis precipitates to an acute

environment. Many health economies are now seeking to progress similar initiatives. The approach is supported by the British Geriatric Society, Age and Ageing (2011), and the British Journal of Hospital medicine (2010).

Objectives of the Service:

- A joint approach to developing care pathways across primary and secondary care to ensure effective continuity of care
- Provide Consultant Geriatrician leadership and input into community and social care environments
- Provide and opportunity to see and review patients before a crisis precipitates to an acute environment
- Improve communications and signposting across the whole health and social care system
- Avoid acute admissions where possible
- Reduce 0-1 day LoS for care home residents over 75
- Reduce LoS in Intermediate Care community hospitals

Referrals:

Referrals to the service will be made directly to the service provider. Referrals will be accepted from:

- General Practitioners
- Lister Hospital Accident & Emergency Department (in conjunction with clinical navigators)

Referral / Assessment Process

Service Outcomes

Increased provision of Consultant Geriatrician leadership and input into community and social care environments thereby enhancing the guidance, skills and experience of multi-disciplinary colleagues in these settings.

Offer an opportunity to see and review patients before a crisis precipitates to an acute environment.

Liaison with other professionals:

Length of Service:

Responsibility of Health and Social Care Professionals

Responsibility of Provider

Exit strategy

Key Performance Indicators:

- Calls taken and outcomes i.e. attendance avoidance or advice given*
- Monitor uptake of referrals into rapid assessments clinics over 6 month period
- Increased patient and staff satisfaction in community and social care settings where interface geriatrician initiative is deployed
- Reduction in unplanned conveyances from targeted nursing homes

- Reduction specifically in 0-1 length of stay conveyances from targeted nursing homes
- Reduction in Length of stay in targeted intermediate care community hospitals

*This data will include either the NHS number or local patient id to enable when requested the CCG to map the patient journey (if applicable). Source of contact such as telephone and via email is also required including the outcome of each intervention.

Cost of Service

The financial commitment is outlined below for full and part year effect.

- 2 x mid point consultant (Cat A) with on costs = £231,101 FYE (£57,775 PYE for 3 months)
- Admin support 0.5WTE mid point band 4 = £11,921 FYE (£2,980 PYE fro 3 months) both including on costs.

Capacity & Commencement:

Consultant 1 to take up post in mid September 2014 and consultant 2 to take up post during December 2014. Commencement of the service will be in two stages.

- Stage 1 – September to December 2014

  Set up the new Interface Geriatric Service at Lister Hospital and make geriatric medical telephone advice available during working hours 9-5 via the Acute Medical Physicians Phoneline.

- Stage 2 – January 2015 onwards

  Start geriatric consultant interface sessions for high risk nursing homes and intermediate care beds. Nursing homes and IC beds will be agreed by the IG Project Team.

NHS
East and North Hertfordshire
Clinical Commissioning Group

Agenda Item No:	Additional Paper
Date of Meeting:	31st July 2014

Governing Body Public Meeting

Paper Title:	Business case: Active Case Management for Patients >75 years

Decision ☒ **Discussion** ☒ **Information** ☐ **Follow up from last meeting** ☐

Report author:	James Gleed AD Primary Care Projects Dr Edward Bosonnet, Dr Robin Christie & Dr Deborah Kearns Rachel Joyce Medical Advisor ENHCCG
Report signed off by:	John Webster Director of Commissioning ENHCCG Alan Pond Director of Finance ENHCCG

Purpose of the paper:	The purposes of this paper is to provide a business case for investment of the £5 per patient for the over 75s patient fund in proactive holistic health checks in primary care. The paper sets out the associated internal/external drivers, needs, benefits and costs. The latest iteration of this paper reflects the comments received when it first went to the Governing Body on 26th June 2014

Conflicts of Interest involved:	Some of the authors are primary care clinicians (GPs) working in East & North Hertfordshire. However the allocation of £5 per patient to general practices to provide enhanced care to patients over 75 years is a government initiative and is not a local commissioning decision. The way in which general practice uses the money to enhance care is a local decision.
Recommendations to the Board / Committee	• To consider, discuss and approve the business case • To consider and agree the proposed pricing structure.

Business case for Utilisation of the £5 per patient over 75

Fund Meeting Date 31st July 2014

1 National and Local Drivers

1.1 The NHS planning guidance 'Everyone Counts' set out an expectation that every CCG should identify £5 per patient from its allocation 2014/15 and use this to support practice plans for improving services for older people.

1.2 The CCG is now at month 4 and requires a plan for how this money will be utilised. A number of discussions regarding this funding stream have been held, which have generated a range of proposals for its best use. These proposals have all been relatively aspirational, contingent upon new integrated models of working and resource; these may therefore form the basis of new medium-term projects.

2 Scope of Service

2.1 The proposed short-term and immediately available solution to enhance the care for patients over 75 years of age is to increase primary care capacity. The funding will be released to provide additional sessional capacity within practices. The additional sessions will create the capacity in primary care for staff to carry out proactive holistic health checks for the over 75s and develop personal health plans for these patients.

The purpose of the Health Check is to augment preventative care for this cohort of patients through ensuring that patients are on the correct care pathways and also identifying gaps in the current pathways. The health check will comprise of:

- Height & weight = BMI; weight loss enquiry (last 3 – 6 months)
- Blood pressure – sitting and standing
- HbA1c, Creatinine, U & Es and cholesterol in accordance with NHS Health Check (Diabetes Filter) *
- Smoking – advice & signposting
- Alcohol – advice & signposting
- Fracture risk: Frax score
- Falls risk: basic Cryer screening tool (Islington model) plus Gait Speed Test
- Malnutrition screen: MUST score *
- CVA prevention: pulse *
- Hearing: whisper test (if +ve refer to audiology)
- Sight – signpost to eye test
- Cognitive screening: general enquiry if +ve bring back with a carer to do GPCOG
- Frailty assessment: BARTHEL questions and if difficulties identified ascertain whether receiving assistance *
- Identify whether has a carer or next of kin
- Social isolation screening question: 'are you lonely'?

- Vaccination history – pneumococcal and influenza
- Medication review *

2.2 The national guidance on the use of the money is explicit - this is additional funding to provide enhanced services for the over 75 patient population. ENHCCG's objectives would be improving health outcomes and reducing unplanned and unnecessary hospital attendance.

The funding is not to support the implementation of the unplanned admission national DES. The proposed new service set out in this paper is an enhancement beyond the scope of the DES.

The 2% of patients identified as being at highest risk of admission through the national DES would also benefit from this additional service and therefore will be eligible for inclusion.

The proposal being put forward complies with the national guidance.

2.3 Practices could choose to make a proposal to collaborate in order to deliver this service.

2.4 It is believed that this model would also facilitate winter bid schemes. By having a stable locum baseline across practices throughout the year it would be possible to flex up this resource during winter months to meet the additional capacity requirements of winter schemes.

2.5 The Health Check should be GP led, but may have practice nurse and HCA input. The most appropriate model of delivery in terms of the healthcare staff involved may vary according to location i.e. whether it is practice based or community assessment of patients. Each practice must ensure that all staff involved in delivering the health checks have received the appropriate training and have been assessed as competent. Any part of the health check requiring clinical interpretation and/or clinical classification must be undertaken by a GP or Registered Nurse and not a HCA. These include but may not be limited to all those activities marked with an asterisk* in the list above.

3 Intended Benefits

3.1 The anticipated benefits are:

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

4 Service Costs

4.1 Allocation of funding

The guidance states that around £5 per head of population should be made available to practices to improve care for patients over 75 years of age. For the average registered population this equates to approximately £50 per patient over 75 years of age. In East & North Hertfordshire this equates to approximately £63 per over 75 patient.

In East and North Hertfordshire CCG there is variation in the age profile at locality and practice level. Whilst there is no national guidance on the extent to which this investment should be proportionate to age profile, clearly the only logical option would to be to allocate the funding according to the number of over 75s.

There is a decision to be made regarding whether to allocate the equivalent of £5 per head worth £63 per patient over 75 or allocate the nationally estimated £50 per head. These are our most vulnerable patients and the proposal is that we should therefore allocate the full £5 per patient.

We are now in M4 and consequently there is a reduced amount of time available to complete all of the health checks required within this financial year (2014-15). It is felt appropriate therefore to structure the period of operation to address this part-year effect. It is also recognised that practices will require some immediate resource to be able to deliver this service during the first month that the scheme is in operation.

It is proposed that:

- £20 per patient over 75 be provided as a pump primer to enable practices to position themselves to immediately start delivering the service

- In addition £50 per health check will be awarded for every health check that is completed.

The scheme will operate over a 12 month period, starting in August or September 2014 (depending on when the scheme receives final approval). Every patient that is over 75 during the 12 month period that the scheme is in operation, may be screened a maximum of once only. Practices will therefore have the potential to earn the full 2014-15 allocation over a full 12 months by delivering the service beyond the 2014-15 fiscal year (into the first half of 2015-16).

4.2 Case example:

Practice with list size = 16,077 patients

Practice over 75s list size = 1,550 (excluding nursing home residents)

£20 per over 75 patient pump prime = £31,000

£50 per health check on every over 75 patient = £77,500

Total remuneration if health check for every >75 patient = £108,500

If we achieve 100% practice up-take and eligible patient coverage the scheme will require an investment of £70 per over 75 patient. This would be against the CCG allocation of £63 per patient. The scheme assumes eligible population coverage of 86% or less.

Should a practice fail to evidence a level of engagement sufficient to ensure that virtually all patients over 75 were offered a health check during the 12month period that the scheme was operating the initial £20 per >75 pump prime payment will be recovered.

It is proposed that Care Home patients be excluded from the resource allocation framework on the basis that enhanced care for this cohort of patients is already delivered and funded through the *Care Homes Service.*

The investment of the >75 fund 2015-16 allocation will need to be considered as part of next year's commissioning intentions. No decision has been made at this point that the fund or any part of it will be invested in health checks for over 75s, although the expectation is that it will be directed towards creating additional capacity in general practice.

5 Activity and Outcomes: Monitoring & Payment Mechanism

5.1 The expectation is that at the outset practices will submit their forecast activity setting out the expected number of health checks per month.

Practices will invoice the CCG for the number of health checks undertaken.

In accordance with good governance practices the CCG will audit the service during the year and for this, practices will be required to provide evidence of:

- The procurement of additional clinical capacity
- The number of patient reviews undertaken during the audit period including the number of personal health plans completed for patients over 75 years of age

5.2 Where plans are not achieved practices will be required to submit an exceptions report and action plan that is agreed with their locality leads.

5.3 Outcomes will be measured through existing monitoring and reporting arrangements:

- Reduction in unplanned admissions
- Reduction in unnecessary A+E attendance

It should be noted that whilst impact on mortality & morbidity is uncertain there is evidence to suggest that older adults whom have undergone a health check feel better able to self-cope and manage.

An important outcome will be the identification of gaps in service provision and incorporation in future years' commissioning intentions and strategic planning.

5.4 However it is recognised that due to the wide range of concurrent initiatives, which are all expected to have an impact on the above it will likely not be possible to establish a certain causal relationship between these new additional health checks and any changes observed in the data.

6 Risks and Mitigating Actions

Risk	**Mitigation**
Member practices may be unhappy with decision re allocation of money. Practices may have planned delivery of services based on receipt of this money in full	Discussed in detail at 'Clinicians Meeting' Options thoroughly explored and debated and decision made by Governing Body that has cross-locality clinical leadership Locality leads engage their practices e.g. through locality meetings
Inability to evidence and articulate benefits derived from the investment made LOW	Clear outcomes, monitoring arrangements and expectations clarified as part of the business case
Uncertain evidence base for preventative healthcare in the over 75s improving outcomes LOW	Literature search has been undertaken & examples of good practice identified Proposal reviewed by Falls Group and changes made in line with advice received Monitor local outcomes and review service with appropriate degree of methodological rigour before committing 2015-16 resource to scheme

Insufficient GP locum workforce to create capacity in practices LOW	Ensure appropriate use of non-medical staff Use of fixed-term appointments
Insufficient premises space to accommodate the additional activity LOW	Some activity will be undertaken in the patient's home Creative use of existing premises Co-commissioning with Local Area Team and development of premises plans over coming months

7 Terms / Acronyms Used in the Report – this section is mandatory as papers are made available to the general public

Initials	In full
Frax score	'Fracture Risk Assessment Tool
MUST score	Malnutrition Universal Screening Tool
Cryer score	Falls risk assessment tool
CVA	Cerebro-Vascular Accident (Stroke)

8 Conclusion

8.1 The authors believe that, at this point in the year, the enhancement to general practice services described in this paper is the most appropriate way to invest the additional money that is required to be invested in the care of the over 75s.

9 Recommendations

9.1 The Governing Body is asked to:

- Approve the proposed investment of the £5 per patient in primary care to deliver a new holistic health check of the scope defined in this paper, to patients over 75 years of age

- Approve the proposed scheme payment structure

10 Appendices: Health Check Guidance and Resources

A. FRAX SCORE (online tool) http://www.shef.ac.uk/FRAX/tool.aspx?country=1

Calculation Tool

Please answer the questions below to calculate the ten year probability of fracture with BMD.

Country: UK Name/ID:
About the risk factors

Questionnaire:

1.
Age (between 40 and 90 years) or Date of Birth Age:

Date of Birth: Y:
M:
D:

2. Sex
Male Female

3. Weight (kg)

4. Height (cm)

5. Previous Fracture No
Yes

6. Parent Fractured Hip No
Yes

Current Smoking No

Yes

8\. Glucocorticoids No

Yes

9\. Rheumatoid arthritis No

Yes

10\. Secondary osteoporosis No

Yes

11\. Alcohol 3 or more units/day No

Yes

12\. Femoral neck BMD (g/cm^2)

Select BMD

Risk factors

For the clinical risk factors a yes or no response is asked for. If the field is left blank, then a "no" response is assumed. See also notes on risk factors.

The risk factors used are the following:

Age	The model accepts ages between 40 and 90 years. If ages below or above are entered, the programme will compute probabilities at 40 and 90 year, respectively.
Sex	Male or female. Enter as appropriate.
Weight	This should be entered in kg.
Height	This should be entered in cm.
Previous fracture	A previous fracture denotes more accurately a previous fracture in adult life occurring spontaneously, or a fracture arising from trauma which, in a healthy individual, would not have resulted in a fracture. Enter yes or no (see also notes on risk factors).

Parent fractured hip	This enquires for a history of hip fracture in the patient's mother or father. Enter yes or no.
Current smoking	Enter yes or no depending on whether the patient currently smokes tobacco (see also notes on risk factors).
Glucocorticoids	Enter yes if the patient is currently exposed to oral glucocorticoids or has been exposed to oral glucocorticoids for more than 3 months at a dose of prednisolone of 5mg daily or more (or equivalent doses of other glucocorticoids) (see also notes on risk factors).
Rheumatoid arthritis	Enter yes where the patient has a confirmed diagnosis of rheumatoid arthritis. Otherwise enter no (see also notes on risk factors).
Secondary osteoporosis	Enter yes if the patient has a disorder strongly associated with osteoporosis. These include type I (insulin dependent) diabetes, osteogenesis imperfecta in adults, untreated long-standing hyperthyroidism, hypogonadism or premature menopause (<45 years), chronic malnutrition, or malabsorption and chronic liver disease
Alcohol 3 or more units/day	Enter yes if the patient takes 3 or more units of alcohol daily. A unit of alcohol varies slightly in different countries from 8-10g of alcohol. This is equivalent to a standard glass of beer (285ml), a single measure of spirits (30ml), a medium-sized glass of wine (120ml), or 1 measure of an aperitif (60ml) (see also notes on risk factors).
Bone mineral density (BMD)	(BMD) Please select the make of DXA scanning equipment used and then enter the actual femoral neck BMD (in g/cm2). Alternatively, enter the T-score based on the NHANES III female reference data. In patients without a BMD test, the field should be left blank (see also notes on risk factors) (provided by Oregon Osteoporosis Center).

Notes on risk factors

Previous fracture
A special situation pertains to a prior history of vertebral fracture. A fracture detected as a radiographic observation alone (a morphometric vertebral fracture) counts as a previous fracture. A prior clinical vertebral fracture or a hip fracture is an especially strong risk factor. The probability of fracture computed may therefore be underestimated. Fracture probability is also underestimated with multiple fractures.

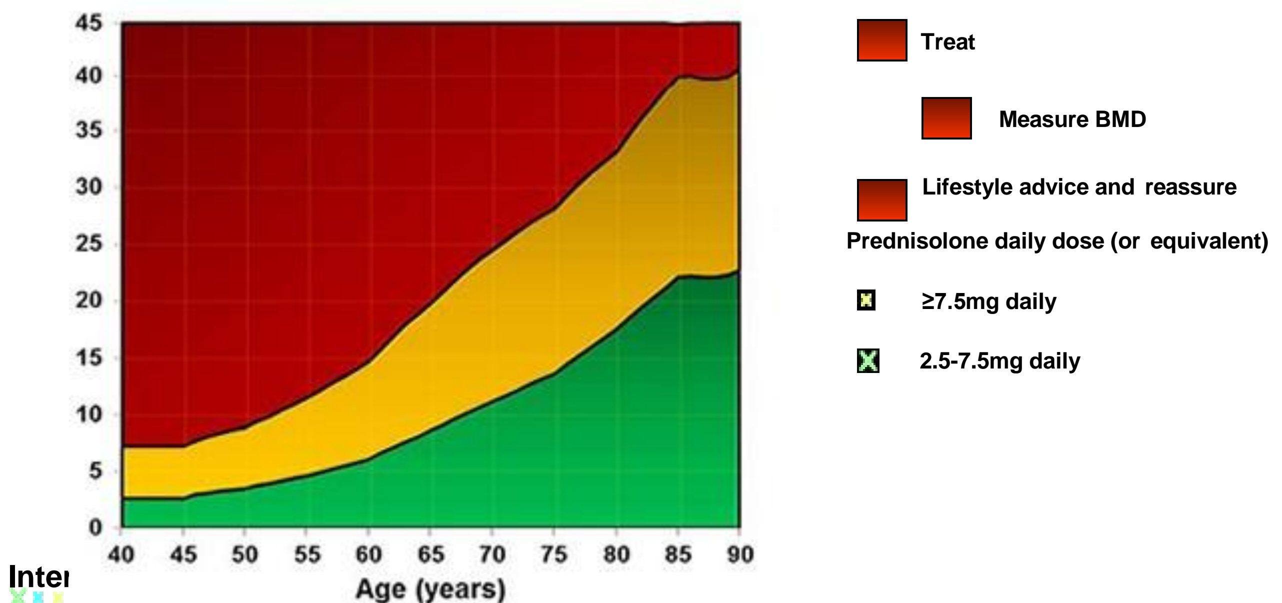
Smoking, alcohol, glucocorticoids
These risk factors appear to have a dose-dependent effect, i.e. the higher the exposure, the greater the risk. This is not taken into account and the computations assume average exposure. Clinical judgment should be used for low or high exposures.

Rheumatoid arthritis (RA)
RA is a risk factor for fracture. However, osteoarthritis is, if anything, protective. For this reason reliance should not be placed on a patient's report of 'arthritis' unless there is clinical or laboratory evidence to support the diagnosis.

Bone mineral density (BMD)
The site and reference technology is DXA at the femoral neck. T-scores are based on the NHANES reference values for women aged 20-29 years. The same absolute values are used in men.

Assessment threshold - Major fracture

10 year probability of major osteoporotic fracture (%)



Following the assessment of fracture risk using FRAX® in the absence of BMD, the patient may be classified to be at low, intermediate or high risk.

- Low risk – reassure, give lifestyle advice, and reassess in 5 years or less depending on the clinical context.
- Intermediate risk - measure BMD and recalculate the fracture risk to determine whether an individual's risk lies above or below the intervention threshold.
- High risk - can be considered for treatment without the need for BMD, although BMD measurement may sometimes be appropriate, particularly in younger postmenopausal women.

NB - These thresholds are for guidance only and the final decision to assess BMD or to initiate therapeutic intervention lies with the individual clinician.

Management

- For a more detailed description of investigations, supportive measures and treatments, please refer to the Executive Summary
- No trials have been designed and powered to detect differences in the magnitude of fracture reduction between different treatments. Thus the choice of agent is determined by the spectrum of anti-fracture effects across skeletal sites, side effects and cost.
- Treatments have been less extensively evaluated in men with osteoporosis than in women, though there is no evidence that skeletal metabolism in men differs fundamentally from that of women.
  - Alendronate, risedronate, zoledronate and teriparatide are approved for the treatment of osteoporosis in men.
  - Secondary causes of osteoporosis are commonly found amongst men, so this population requires thorough investigation.
  - Consideration should be given to referring men with osteoporosis to specialist centres, particularly younger men or those with severe disease.
- The low cost of generic alendronate, which has a broad spectrum of anti-fracture efficacy, makes this the first line treatment in the majority of cases.
- In women who are intolerant of alendronate or in whom it is contraindicated, other bisphosphonates, denosumab, strontium ranelate or raloxifene may provide appropriate and cost-effective treatment options.
- The high cost of parathyroid hormone peptides restricts their use to those at very high risk, particularly for vertebral fractures.

B. BASIC ISLINGTON CRYER SCORE & GAIT SPEED TEST

East and North Hertfordshire
Clinical Commissioning Group

ISLINGTON STAGE ONE SCREENING TOOL(CRYER)

Client's name:	Client's address:	Assessor's name:
D.O.B:		Assessor's designation:
		Assessment location:
Interpreter required: No / Yes	Language:	Date of assessment:
Please comment if there are any known risks to health workers visiting this client at home:		

RECENT FALLS ANALYSIS

Date/Time of recent fall:	Location:
Activity:	Injury:
Cause of fall: Please tick Not known or likely medical cause e.g complaining of blackouts, loss of consciousness or is unable to recollect the mechanism of falls (not due to memory) ❒ Environmental e.g clear slip / trip / loss of balance ❒	

	CRYER SCORE	YES (1)	NO (0)
1	**Is there a history of more than 1 fall in the past 12 months?** Ask the client / carer		
2	**Is the client on 4 or more medications per day?** Ask the client / carer		
3	**Does the client have a diagnosis of Stroke or Parkinson's Disease?** Ask the client / carer		
4	**Does the client report any problems with their balance?** Ask the client / carer		
5	**Is the client UNABLE to rise from a chair of knee height, WITHOUT USING THEIR ARMS?** Ask client to stand up from a standard height chair without using their arms- inability indicates poor lower limb strength and/or poor balance.		

CRYER SCORE: **HIGH RISK YES / NO** **(high risk if score of 3 or above)**

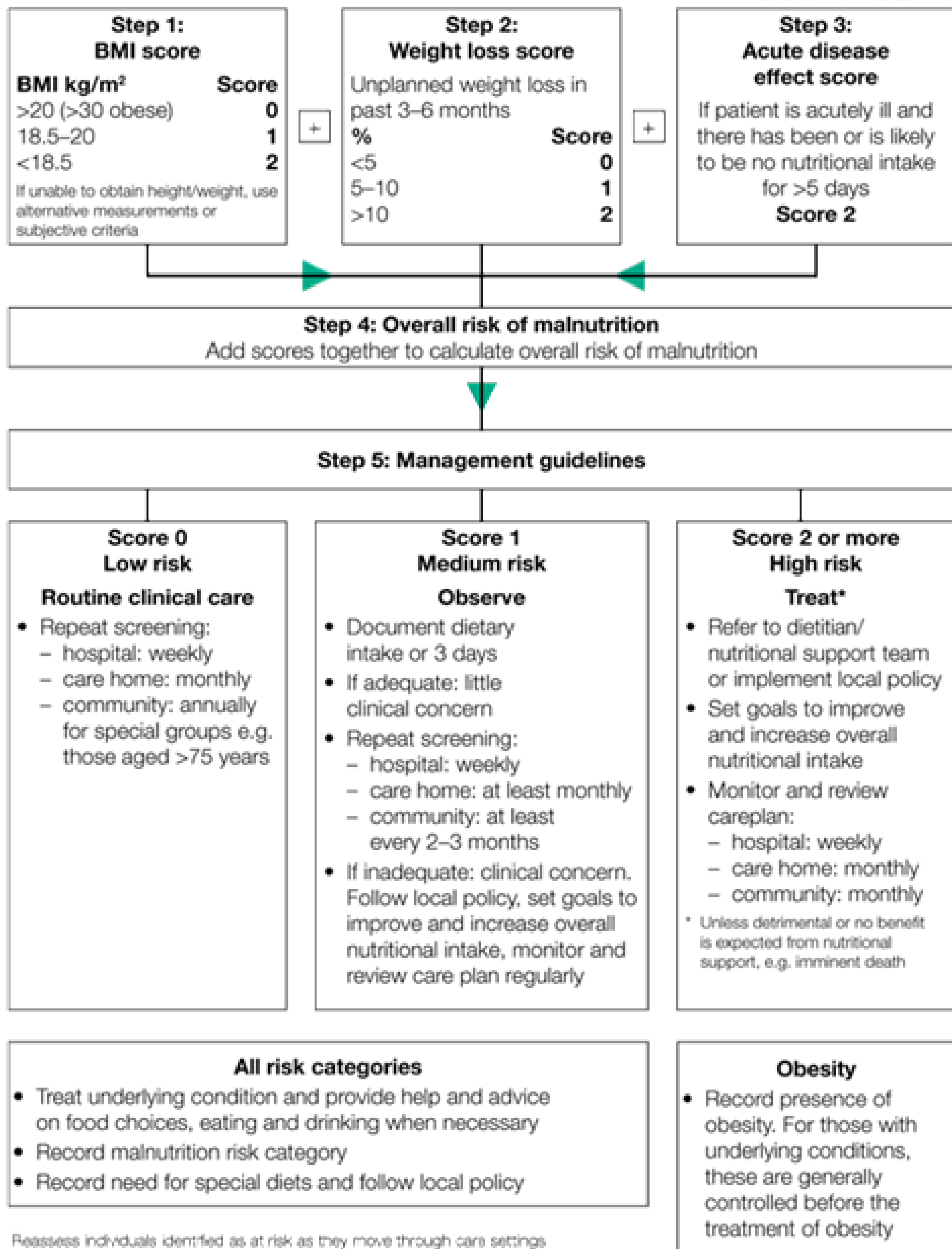
PLEASE NOW FOLLOW ISLINGTON FALLS PATHWAY

Gait speed test

Average gait speed of longer than 5 seconds to walk 4 metres is an indication of frailty. The test can be performed with any patient able to walk 4 metres using the guidelines below.

1. Accompany the patient to the designated area, which should be well-lit, unobstructed, and contain clearly indicated markings at 0 and 4 metres.
2. Position the patient with his/her feet behind and just touching the 0-metre start line.
3. Instruct the patient to "Walk at your comfortable pace" until a few steps past the 4- metre mark (the patient should not start to slow down before the 4-metre mark).
4. Begin each trial on the word "Go".
5. Start the timer with the first footfall after the 0-metre line.
6. Stop the timer with the first footfall after the 4-metre line.
7. Repeat three times, allowing sufficient time for recuperation between trials.

C. MUST SCORE

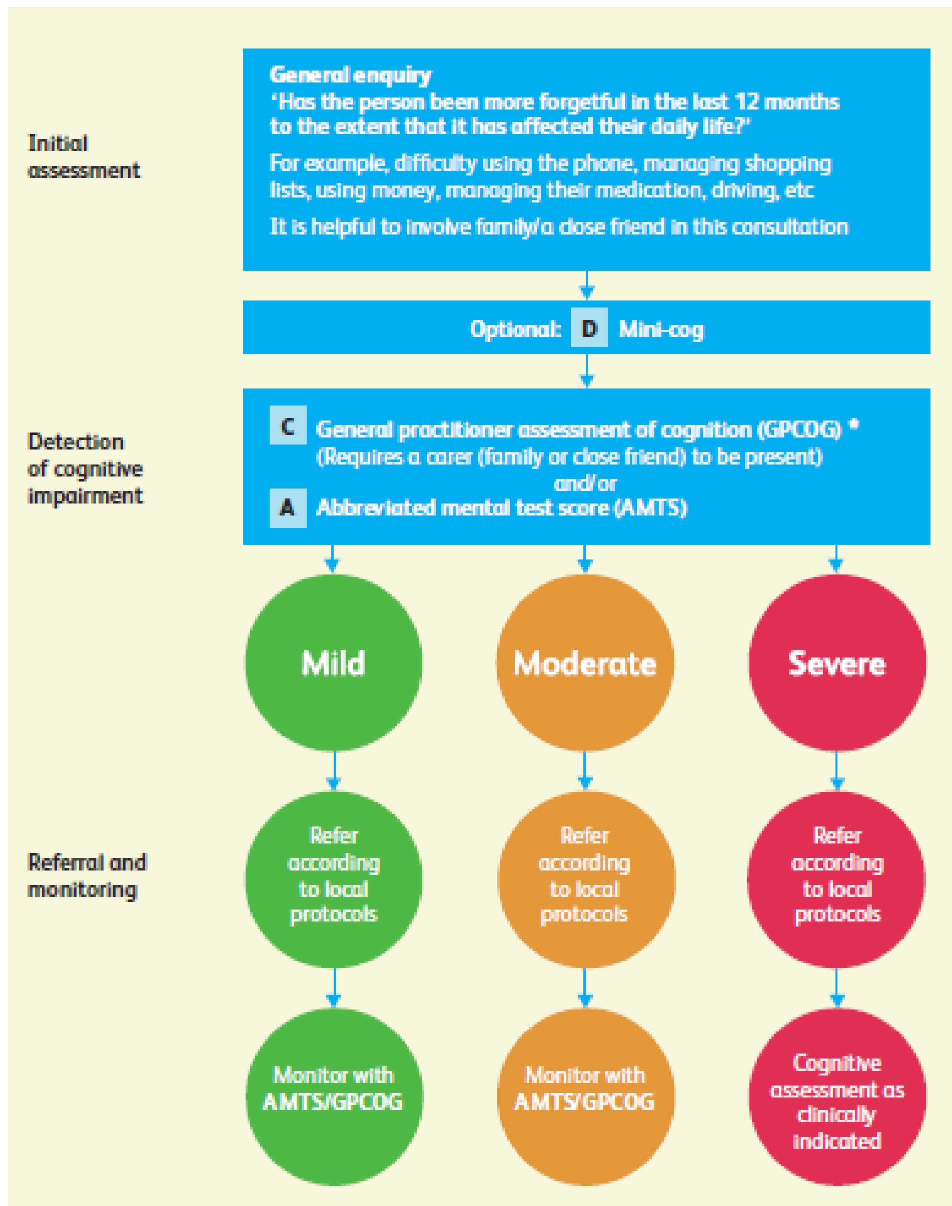


D. WHISPERED VOICE TEST

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1239718/?page=1

- The examiner stands at arm's length (0.6 m) behind (to prevent lip-reading) the seated patient and whispers a combination of three numbers and letters (for example, 4-K-2), and then asks the patient to repeat the sequence.
- The examiner should quietly exhale before whispering to ensure as quiet a voice as possible.
- If the patient responds incorrectly, the test is repeated using a different number/letter combination. The patient is considered to have passed the screening test if they repeat at least three out of a possible six numbers or letters correctly (i.e. 50% correct).
- Each ear is tested individually, starting with the ear with better hearing. During testing the non-test ear is masked by gently occluding the auditory canal with a finger and rubbing the tragus in a circular motion.
- The other ear is assessed similarly with a different combination of numbers and letters.
- One source of variability in the test is the loudness of the whisper. One study has shown that experienced practitioners are on average 8-10 dB louder than those without experience and they have shown higher sensitivity and specificity when administering the test.

E. COGNITIVE SCREENING: GENERAL ENQUIRY



F. BARTHEL INDEX

http://physical-therapy.advanceweb.com/Article/The-Original-Barthel-Index-of-ADLs.aspx

Patient Name:________________ **Rater:**____________________ **Date:**___/___/______:___

Activity	Score
Feeding 0 = unable 5 = needs help cutting, spreading butter, etc., or requires modified diet 10 = independent	0 5 10
Bathing 0 = dependent 5 = independent (or in shower)	0 5
Grooming 0 = needs to help with personal care 5 = independent face/hair/teeth/shaving (implements provided)	0 5
Dressing 0 = dependent 5 = needs help but can do about half unaided 10 = independent (including buttons, zips, laces, etc.)	0 5 10
Bowels 0 = incontinent (or needs to be given enemas) 5 = occasional accident 10 = continent	0 5 10
Bladder 0 = incontinent, or catheterized and unable to manage alone 5 = occasional accident 10 = continent	0 5 10
Toilet Use 0 = dependent 5 = needs some help, but can do something alone 10 = independent (on and off, dressing, wiping)	0 5 10
Transfers (bed to chair and back) 0 = unable, no sitting balance 5 = major help (one or two people, physical), can sit 10 = minor help (verbal or physical) 15 = independent	0 5 10 15
Mobility (on level surfaces) 0 = immobile or < 50 yards 5 = wheelchair independent, including corners, > 50 yards 10 = walks with help of one person (verbal or physical) > 50 yards 15 = independent (but may use any aid; for example, stick) > 50 yards	0 5 10 15
Stairs 0 = unable 5 = needs help (verbal, physical, carrying aid) 10 = independent	0 5 10
TOTAL (0 - 100)	

The Barthel includes 10 personal activities: feeding, personal toileting, bathing, dressing and undressing, getting on and off a toilet, controlling bladder, controlling bowel, moving from wheelchair to bed and returning, walking on level surface (or propelling a wheelchair if unable to walk) and ascending and descending stairs.

An overall score is formed by adding scores on each rating.

Several authors have proposed guidelines for interpreting Barthel scores. Shah et al. suggested that scores of 0- 20 indicate "total" dependency, 21-60 indicate "severe" dependency, 61-90 indicate "moderate" dependency, and 91-99 indicates "slight" dependency.[2] Most studies apply the 60/61 cutting point, with the stipulation that the Barthel Index should not be used alone for predicting outcomes.

G. DIABETES, CHRONIC KIDNEY DISEASE AND CHOLESTEROL FILTER

www.healthcheck.nhs.uk/document.php?o=339

Perform blood test for HbA1c, creatinine, U and Es and cholesterol if:

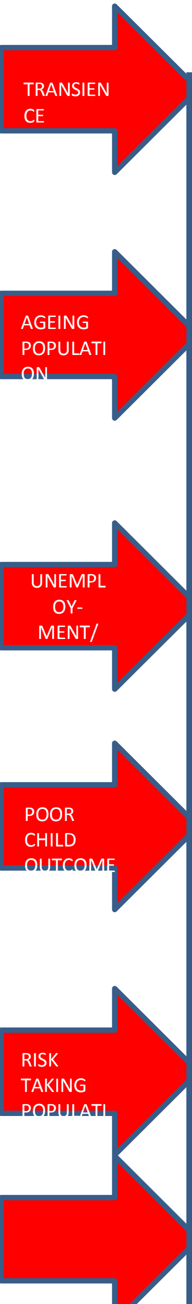
BMI is in the obese range (**30** or over, or **27.5** or over in individuals from the Indian, Pakistani, Bangladeshi, Other Asian and Chinese ethnicity categories)
Or
Blood pressure is at or above **140/90mmHg**, or where the SBP or DBP exceeds 140mmHG or 90mmHg respectively

It is important to consider the situation of the individual person, as some people who do not fall into the categories above will still be at significant risk. This includes:

- people with first-degree relatives with type 2 diabetes or heart disease
- people with tissue damage known to be associated with diabetes, such as retinopathy, kidney disease or neuropathy
- women with past gestational diabetes
- those with conditions or illnesses known to be associated with diabetes (e.g. polycystic ovarian syndrome or severe mental health disorders)
- those on current medication known to be associated with diabetes (e.g. oral corticosteroids).

FF59 Health Education East of England

Next page



"Together we will make Blackpool a place where all people can live longer, happier and healthier lives by commissioning better health care"

Additional years of life

Improve quality of life for patients with LTC

Reduce avoidable hospital admissions

Increase the number of people living independently

Positive experience of hospital care

Positive experience of General Practice and community care

SELF CARE

- Support to empower patients to manage their own conditions
- Telehealth/ telemedicine
- Focused use of social media
- Lifestyle/ health coaching

GP PRACTICE

- Enhanced Primary Care
- Community Orientated Primary Care
- Unscheduled primary care
- Improved access
- Co-commissioning of primary care

NEIGHBOUR-HOODS

- Groups of GP practices co-ordinating care needs
- Integrated Mental Health teams
- Development of the workforce skill
- Developing Co-commissioning to deliver the new agenda
- Asset based community development
- Community health workers

PARITY OF ESTEEM

COMMUNITY SERVICES

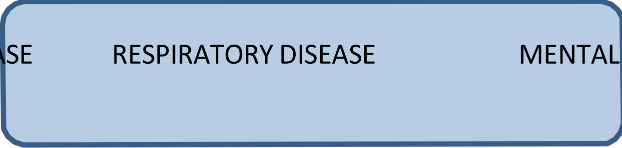
- 7-day working
- Supported by Extensivist for high risk patients
- Out-of-hospital strategy
- Increase use of technology
- falls reduction
- promote self care
- pressure ulcer & HCAI reduction

HOSPITAL

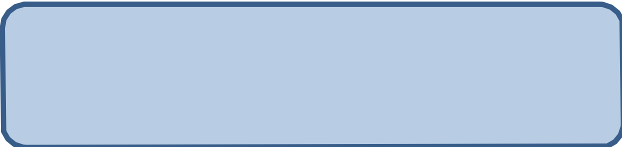
- Care in hospital when it is not safe to deliver similar care elsewhere

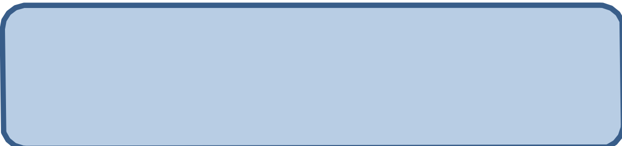
- Smaller local hospital

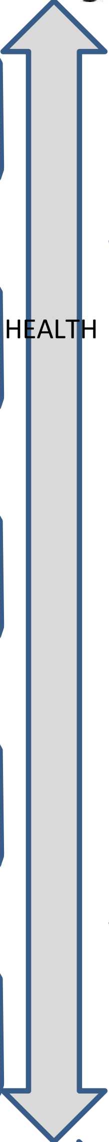
Eliminating avoidable hospital deaths

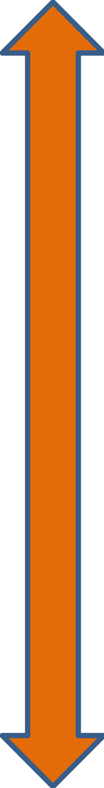


CARDIOVASCULAR DISEASE RESPIRATORY DISEASE MENTAL HEALTH









FF60 Health Education North West

Health Education North West

Project Initiation Document (V0.6)

Project Name:	Workforce for the Future: Portfolio Careers to address Workforce Gaps
Project Sponsor:	Dr Ann Bowman, Greater Preston Clinical Commissioning Group
Project Manager:	Joanne Platt (joanne.platt@chorleysouthribbleccg.nhs.uk)
Project Start Date:	1st October 2014
Target Completion Date:	31st March 2015
PID agreed by:	Project Team
Date agreed:	10th November 2014

In Partnership with

Background

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

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

On top of this we have a legacy of under investment in the primary care workforce and premises in comparison to other areas of Lancashire. We are also a 'City Deal' area with an expected increase in our population of 14,000 residents in 5 years. This poses an obvious challenge and a need to focus on modernising our workforce and the services we provide across social and health care settings.

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

We recognise that these issues are affecting other areas equally, and although the research carried out in this Project will be targeted at Lancashire, the learning from the Project will be shared across the region and nationally.

We will also bring learning to this Project in relation to workforce retention initiatives, via our links to Health Education North West (HENW) which is represented on the Project Team.

Strategic Context

The 5-Year Plan of NHS Chorley and South Ribble and NHS Greater Preston Clinical Commissioning Groups ('the CCGs') has at its heart 'care closer to home' and the strategy to achieve this is to shift emphasis away from hospital based care. This project is a key element of delivering this strategy.

We have already gone a long way down the planning for this and are now in the delivery phase. 11 Integrated Neighbourhood Teams are in place and are starting to deliver care alongside GPs. We need other key teams aligning to this approach including mental health, social care and specialist teams e.g. COPD.

Critical to this strategy is the workforce and this project will support delivery of the strategy and embed different ways of working across the local health and social care economy.

The project is closely aligned to the key aims of the CCGs' two main healthcare providers - Lancashire Teaching Hospitals Foundation Trust (LTHFT) (to enhance the workforce through education, research and innovation) and Lancashire Care Foundation Trust (LCFT) (to employ the best people).

The Business Case

We need to address the workforce challenges that exist today and in particular the gaps that exist in the clinical and social care workforce and the difficulties we have in recruiting to and retaining expertise in key clinical and social care posts.

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

Overall, we must ensure that we have the right levels and range of skills available to deliver our plans in the next 5-years, and to sustain this over at least the next 10 – 15-years.

Project Scope

The project is to undertake a piece of research across the local health and social care economy. The research will consist of two key Work Streams.

Work Stream 1 largely focuses on a quantitative analysis to identify the specific skills gaps that exist within the system and how this compares nationally.

Work Stream 2 focuses on qualitative research to identify the things that will make a difference and the opportunities to do things differently across the local health and social care economy.

The Work Streams are inter-related, and Work Stream 1 will help to identify specific areas where any piloting work could be undertaken to achieve some 'quick wins' and the biggest impact.

Key activities to be undertaken in each Work Stream are set out below:

Work Stream 1: Baseline Assessment

- Identify the gaps (in both numbers and skills) in the clinical and social care workforce that exist currently (using statistical analysis) broken down by permanent, agency and contracted (fixed-term) staff
- Identify the types of posts and skills that we have difficulty recruiting to and in retaining suitably experienced and skilled clinicians and social care staff (using a combination of qualitative and qualitative analysis)
- Distinguish gaps arising from a failure to recruit and those arising from a lack of succession planning and supply of the skills needed.

- Undertake an analysis of how our area compares to others nationally in relation to the skills gap (using statistical analysis)

Work Stream 2: Qualitative Research

- Where available, review existing qualitative research undertaken within partner organisations to identify the challenges to addressing workforce gaps
- Explore with newly qualified doctors, social workers and other clinical staff the things that would interest them in considering a career within our area (quantitative and qualitative research)
- Explore with the existing clinical and social care workforce the things that would prevent them from seeking employment elsewhere
- Explore with the existing clinical and social care workforce the role they could play / would like to play in the future by moving their roles into an '*in and out of hospital'* job plan
- Work with the existing clinical and social care workforce to consider how '*portfolio*' job plans / job descriptions and training and personal development arrangements which span across acute, community, primary and social care settings would impact on recruitment and retention rates
- Consider opportunities for joint working and employment across sectors and the barriers to operationalising this
- Identify Best Practice nationally in improving recruitment and retention rates to key clinical and social care roles (qualitative research)
- Develop a suite of portfolio job plans / job descriptions and development programmes across health and social care settings
- Consider the legal and HR implications of developing alternative employment contracts for joint appointments and develop solutions to these

Success Criteria

Success in the longer-term will be measured by increased recruitment and retention rates across the health economy clinical workforce and the social care workforce, a reduction in clinical and social care vacancies, and an increase in staff and patient satisfaction across the local health and social care economy. Baselines will be established from the research undertaken and used to develop a Clinical and Social Care Workforce Performance Dashboard to monitor these key indicators over time, once the findings of the research have been published and, where appropriate, piloted.

Achievement of key project milestones will be monitored by the Core Project Team (see below) and reported to Health Education North West (who is funding the project).

Project Resources

HENW has provided £400,000 of funding to support this project.

The project will be led by a Project Manager employed by the CCGs, working closely with a lead clinician and HR specialist.

Lancashire County Council (LCC), LTHFT and LCFT will also provide support by providing access to clinical and social care workforce data, including existing

qualitative research and access to clinical and social care staff for qualitative research purposes.

Other resources required include access to newly qualified clinicians and social workers through the North West Deanery, students via local universities / Medical Schools and 6th Form Colleges, and policy and data analysis support and employment law advice.

Project Team

The Project Team will consist of the following people

Name	Organisation	Role
Joanne Platt	NHS Chorley and South Ribble and NHS Greater Preston CCG	Project Manager
Dr Mohan Kumar	GP Associate Director, North West Deanery	Clinical Lead for Work Stream 2
Tracy Boustead	Independent Consultant	HR Advisor and Lead for Work Stream 1
Karen Swindley	LTHFT	Partner
Damian Gallagher	LCFT	Partner
Social Care Lead TBC	LCC	Partner
Kirstie Baxter	Head of Workforce Transformation (HENW)	Regional Advice / links to other projects
Mike Burgess	Associate Head of Workforce Planning (HENW)	Regional Advice / links to other projects
Practice Nurse Lead TBC	-	Practice Nurse input

Name	Organisation	Role
TBC	University of Central Lancashire (UCLAN)	Advisor
Ann Garden	Lancaster University	Advisor
Dawn Clarke	NHS Chorley and South Ribble and NHS Greater Preston CCG	Equality & Diversity Lead
TBC	Private Sector Provider	Private Sector input to Project

Stakeholder Engagement

The following people / organisations will be engaged with the project but will not be a part of the Core Project Team.

Key Stakeholder	How are they involved
Dr Ann Bowman (Project Sponsor)	1-1 briefings, Project Status Reports, Project Newsletter
Clinical Senate (local)	Project Status reports
Greater Manchester, Lancashire and South Cumbria Clinical Senate	Project Status reports
Primary Care	Surveys / qualitative research / Project Newsletter
CCG Membership Councils	Advised of project and sought engagement / comments
Private Sector / Third Sector	Surveys / qualitative research / Project Newsletter
Mental Health Trust	Surveys / qualitative research / Project Newsletter

Key Stakeholder	How are they involved
HENW: WRAPT Project Lead / Performance Leads	Meetings / advice sought as and when needed
Local clinicians at LTHFT and LCFT and social care staff at LCC	Surveys / qualitative research
LETB	Via Stakeholder Forum
NHS Employers	Advice sought as and when needed / Project Newsletter / Sharing Learning
Relevant Trade Unions	Advised of project and sought engagement / comments
Education establishments, including colleges of Further Education and 6th Form Colleges	Via Project Team / Project Team members

Members of the Core Project Team will be expected to feedback / update and / or to identify and involve other relevant staff and / or stakeholders they deem to be relevant to the project as and when necessary.

Communication

The Project Manager will produce a bi-monthly newsletter (the first in October 2014) providing details and updates about the project, for circulation within stakeholder organisations.

Spending Plans

The funding will be allocated and used as follows:

Details	**Budget Allocation £**
Project Management and administrative support	45,000
Clinical Lead and Project Manager for Work Stream 2	40,000
Back-filling for clinicians and social care staff involved in qualitative research (if required)	25,000
Research costs: Researcher and survey costs	75,000
Legal Advice	20,000
HR Advice and Project Manager for Work Stream 2	25,000
Data Analytical Support	15,000
Final Report design / printing / publication costs	8,000
Communications	8,000
Stakeholder / Learning Event	15,000
Contingency	124,000
Total	**400,000**

Project Plans

Tasks	Responsibility	Milestones	Target
Work stream 1: Baseline Assessment Lead Officer: Tracy Boustead			
Collection of Primary Care clinical workforce data	Tracy Boustead	➢ Workforce survey issued to General Practice ➢ Deadline for completion of survey ➢ Reminders issued ➢ Survey completed	➢ 08/08/14 ➢ 30/09/14 ➢ 13/10/14 ➢ 28/11/14
Analysis of LCFT Clinical workforce data (from WRAPT)	Emma Forsyth (HENW)	➢ Posts to be included in analysis to be identified ➢ Criteria for inclusion in analysis to be identified ➢ Analysis started ➢ Analysis completed	➢ 31/10/14 ➢ 31/10/14 ➢ 31/10/14 ➢ 10/11/14
Analysis of LTHFT Clinical workforce data (from last statistical return)	Karen Swindley	➢ Posts to be included in analysis to be identified ➢ Criteria for inclusion in analysis to be identified ➢ Analysis started ➢ Analysis completed	➢ 31/10/14 ➢ 31/10/14 ➢ 31/10/14 ➢ 10/11/14

Tasks	Responsibility	Milestones	Target
Collection of Ramsey Healthcare clinical workforce data	Tracy Boustead	➢ Posts to be included in analysis to be identified ➢ Criteria for inclusion in analysis to be identified ➢ Analysis started ➢ Analysis completed	➢ 31/10/14 ➢ 31/10/14 ➢ 31/10/14 ➢ 10/11/14
Identification of posts to be included in data collection of social care workforce	Terry Mears (LCC)	➢ Posts identified ➢ Criteria for inclusion in analysis to be identified	➢ 31/10/14 ➢ 31/10/14
Collection of social care data	Terry Mears (LCC)	➢ Analysis started ➢ Analysis completed	➢ 31/10/14 ➢ 10/11/14
Data analysis, comparison and national benchmarking	Tracy Boustead	➢ Overall analysis started ➢ Overall analysis completed ➢ Comparison with national providers completed ➢ Summary of findings completed	➢ 17/11/14 ➢ 28/11/14 ➢ 05/12/14 ➢ 12/12/14
Draft report on findings of Baseline Assessment	Tracy Boustead	➢ Report completed and passed to project Manager	➢ 31/12/14

Tasks	Responsibility	Milestones	Target
Work stream 2: Qualitative Research Lead Officer: Dr Mohan Kumar			
Identify existing clinicians and social care staff willing to take part in qualitative research	Karen Swift/Damian Gallagher / Terry Mears / TBC by JP for Ramsey Healthcare	➢ Research groups established ➢ Engage with Junior Doctor Advisory Team	➢ 31/10/14 ➢ End Nov 14
Identify potential researchers and develop research brief	Mohan Kumar	➢ Research Brief developed for consideration by Project Team ➢ Researchers approved by Project Team ➢ Researchers appointed	➢ 31/10/14 ➢ 10/11/14 ➢ 17/11/14
Identify cohort of newly qualified clinical and social care staff willing to take part in the research	Mohan Kumar with Organisational leads	➢ Identify types of students to be involved ➢ Establish cohort	➢ 31/10/14 ➢ Mid Nov 14
Research into the development of portfolio careers / job plans across sectors	Project Team to identify Task & Finish Group to do this work	➢ Task and Finish Group established ➢ Legal advice sought ➢ Research into HR issues completed ➢ Draft report on HR and legal implications to Project Manager for inclusion in final report	➢ 30/11/14 ➢ End Dec 14 ➢ End Dec 14 ➢ End January 15 ➢

Tasks	Responsibility	Milestones	Target
Develop measures of success for the project	HENW (Callum / Neil?)	➢ Identify KPIs ➢ Establish baseline ➢ Agree future targets based on baseline assessment from Work Stream 1 ➢ Performance Dashboard agreed by Project Team	➢ End November 14 ➢ End December 14 ➢ End December 14
Qualitative research to identify best practice in recruitment and retention of best candidates	Mohan Kumar with Tracy Boustead	➢ Report produced for discussion with Project Manager	➢ End Jan 15
Undertake qualitative research with identified groups	Researchers	➢ Programme of qualitative research developed ➢ Research started ➢ Interim Report passed to Work Stream Lead ➢ Research completed ➢ Report passed to Project Manager	➢ 24/11/14 ➢ End Nov 14 ➢ End December 14 ➢ Mid Jan 15 ➢ End Jan 15
Identify themes for piloting approaches (derived from the results of the quantitative and qualitative research)	Mohan Kumar / Joanne Platt / Tracy Boustead	➢ Report on proposed pilots to Project Manager	➢ Mid February 15

Tasks	Responsibility	Milestones	Target
Governance and Project Management Lead Officer: Joanne Platt			
Establish Project Team	Joanne Platt	➢ Team in place ➢ Monthly meeting schedule established ➢ Monthly meetings taking place	➢ 20/10/14 ➢ 20/10/14 ➢ On-going to end March 2015
Develop communication and engagement plan	Joanne Platt	➢ Draft plan to Project Team for approval ➢ Implement plan	➢ November meeting of Project Team ➢ On-going from November 14
Project Management	Joanne Platt	➢ Monthly meetings (agendas / papers / notes) ➢ Project Status Reports ➢ Bi-monthly briefings ➢ Financial monitoring and reporting	➢ Monthly between October 14 and March 15 ➢ Monthly ➢ Oct and Dec 14 and Feb and April 15 ➢ Monthly

Tasks	Responsibility	Milestones	Target
Prepare Final Report	Joanne Platt	➢ Reports on outcomes of qualitative and qualitative analysis reviewed with Work Stream Leads ➢ Draft Report to Project Team ➢ Revisions / revised draft ➢ Final Report to Project Team for approval ➢ Submission of final report to HENW ➢ Publication	➢ Mid Feb 15 ➢ March meeting of Project Team ➢ Mid-March 15 ➢ 23rd March ➢ End March 15 ➢ April 15
Showcase event to share results of the research / learning	Joanne Platt	➢ Identify scale (sub-regional, regional or national) ➢ Develop programme and identify speakers ➢ Arrange venue / catering ➢ Publicity and invitees list agreed by Project Team ➢ Publicise event ➢ Event takes place	➢ Dec 14 ➢ Jan 15 ➢ Jan 15 ➢ Jan 15 meeting ➢ Feb 15 ➢ April 15

Responsibilities Project Approach

Monitoring and reporting arrangements

Recipients	Method	Frequency	Responsibility
Project Team	Project status report	Monthly*	Project Manager
HENW	Project status report	Monthly	Project Manager

* The Project Teams may need to meet more frequently at the beginning and end of the project

Approvals

The Core Project Team will sign off the monthly project status report prior to its submission to HENW.

Health & Safety

Risk Assessments: see below Health & Safety Plan: N/A

Environmental Plan

N/A

Security

Data Sharing Protocols that already exist across the local health and social care economy will ensure the security of clinical and social care workforce data shared for the purpose of this project.

Procurement

N/A

Options Appraisal

None

Risk Assessment

The key risk is the unavailability of key members of staff within partner organisations to provide and analyse the data to progress Work Stream 1 of the Project and lack of access to clinicians and social workers to undertake qualitative research. The Core Project Team will keep this under review and address any concerns on an ongoing basis.

Handover Strategy

The output of the project is a Research Report that will be written by the Project Manager and shared with all stakeholders by the end of March 2015.

Depending on the research findings, a number of pilots may be developed to test out the theories emerging from the research.

A Stakeholder event will be arranged to take place in April 2015 to present the research findings and details of any pilots to be undertaken. This will initially be targeted at the local health and social care economy but could be widened (or repeated) on a regional or national basis as deemed appropriate.

Project Documentation Log

Document	Person responsible	Location	Method of storage
PID	Joanne Platt	Chorley House, Leyland	Electronic
Terms of Reference for Project Team	Joanne Platt	Chorley House, Leyland	Electronic 16
Project Update for Clinical Senate	Joanne Platt	Chorley House, Leyland	Electronic

Version control

Version	**Updated**	**Author**
PID V0.1	5th August 2014	Joanne Platt
PID V0.2	8th August 2014	Joanne Platt
PID V0.3	18th August 2014	Joanne Platt
PID V0.4	20th August 2014	Joanne Platt
PID V0.5	25th September 2014	Joanne Platt
PID V0.6	20th October 2014	Joanne Platt
PID V1.0	12th November 2014	Joanne Platt

FF61 Health Education North West

Stakeholder briefing: Issue 2

Workforce for the future:

Portfolio careers to address workforce gaps

January 2015

Inside this issue

Overview of the project
Update on the work streams
Overview of the qualitative research
Key Contacts
How you can get involved

We want to encourage people to positively choose this area to work in

18

NHS Partners:

NHS Greater Preston CCG

NHS Chorley & South Ribble CCG

Lancashire Teaching Hospitals Foundation Trust

Lancashire Care Foundation Trust

Project overview

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

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

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

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

We want to encourage people to positively choose this area to work in, offer interesting and imaginative opportunities for staff and to provide the support needed to retain skills and capability locally. This research will help us to understand the things that we can do to encourage clinicians to want to work in our area and to stay in our area.

Work Stream 1 Update: Quantitative Research

We have now completed the collection of the data that will help us to identify where gaps exist in the local clinical workforce across provider organisations.

We are looking at data collected from GP practices in Central Lancashire, and data from Lancashire Teaching Hospitals Foundation Trust and Lancashire Care Foundation Trust.

This data is being analysed and has been shared with Ipsos MORI (the organisation we have commissioned to undertake the qualitative research). This analysis will help us to understand the critical areas where we need to act to make the biggest impact. Following completion of the qualitative research (see below), we will pull the key findings from both work streams together to help us to identify some pilot schemes to run in 2015-16 to tackle the workforce challenges we face.

Work Stream 2 Update: Qualitative Research

We have commissioned **Ipsos MORI** to undertake the qualitative research with clinicians (including students, trainees, newly qualified and established doctors and nursing staff).

Ipsos MORI is the second largest market research organisation in the United Kingdom, formed by a merger of **Ipsos UK** and **MORI**, two of Britain's leading survey companies in October 2005.

Ipsos MORI conducts surveys for a wide range of major organisations as well as other market research agencies. Its Social Research Institute works extensively for the Government of the United Kingdom, looking at public attitudes to key public services, and so informing social policy.

Issues such as identity, social cohesion, physical capital and the impact of place on attitudes are all key themes of the Institute's work.

Pilot schemes will run in 2015-16 to tackle the workforce challenges we face.

Overview of the qualitative research

The face of medical careers is changing and traditional boundaries of primary and secondary care are blurring. Health Education England is keen to explore how to shape the clinical workforce for the future and how to build portfolio careers that meet the needs of patients in the modern NHS. There is also the need to find out from our frontline workforce the factors that influence recruitment and retention of clinicians and to seek their opinions on what would be a sustainable model of change.

We have therefore commissioned Ipsos MORI to explore issues around the recruitment and retention of consultants, GPs and hospital and practice nurses outside of large city conurbations, specifically within Lancashire.

Ipsos MORI will be running a series of discussion groups this month, with foundation trainee doctors and student nurses who have yet to choose their specialty, various specialty trainees, consultants, GPs and hospital & community nurses, so that we can get a better understanding of what will influence future medical careers that may straddle the traditional boundaries of primary and secondary care.

In addition to discussions with existing and potential staff, Ipsos MORI will also be making contact with consultants, GPs and nurses who have left the area to gather information on why people chose not to stay.

Discussion groups will take place at **Education Centre 1, Preston Hospital** on the following dates and a number of people have already been specifically invited to attend one of these sessions.

Thursday 22nd January – *EC1, Seminar 2, 11.00 am – 12.30 pm* ***Friday 23rd January –*** *EC1, Seminar 2, 10.30 am – 12.00 noon* ***Monday 26th January –*** *EC1 Seminar 10, 10.00 am – 11.30 am*

Discussions will take around 90 minutes and will be moderated by a member of the Ipsos MORI team. If you have not already been invited to attend and would like to be involved, please contact one of the team (details below). If you have been invited to attend, please do your upmost to make one of the sessions. Your employers are supporting this project and are encouraging as many people as possible to take part in this research that will help to shape the future of the local health economy.

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This project is the first of its kind in the country. It has the support of Health Education North West, NHS Chorley and South Ribble and NHS Greater Preston Clinical Commissioning Groups, Lancashire Teaching Hospitals Foundation Trust and Lancashire Care Foundation Trust.

If you would like any further information about the qualitative research, please contact mohan.kumar@nw.hee.nhs.uk or Alison Messer at Ipsos MORI on 0161 240 2401 (Alison.messer@ipsos.com)

FF62 Health Education North West

Stakeholder briefing: Issue 1

Workforce for the future:

Portfolio careers to address workforce gaps

October 2014

Inside this issue

What the project is about
Strategic context
Project scope and work streams
Meet the project team
How you can get involved

We want to encourage people to positively choose this area to work in

NHS Partners:

NHS Greater Preston CCG
NHS Chorley & South Ribble CCG
Lancashire Teaching Hospitals Foundation Trust
Lancashire Care Foundation Trust
Health Education North West

What is the project about?

Welcome to this first edition of the stakeholder briefing for this project. This edition will introduce the project and the project team, and will be followed bi-monthly with an update on progress.

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

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

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

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

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

Strategic context

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

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

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

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

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

Project scope

The project is funded by Health Education North West. Working together, we will undertake a piece of research across the local health and social care economy. The research will consist of two key Work Streams.

Work Stream 1

Largely focuses on a quantitative analysis to identify the specific skills gaps that exist within the system and how this compares nationally.

Work Stream 2

Largely focuses on a ***qualitative*** analysis to identify the specific skills gaps that exist within the system and how this compares nationally.

The Work Streams are inter-related. Work Stream 1 will help to identify specific areas where any piloting work could be undertaken to achieve some 'quick wins' and the biggest impact.

We need to 'future proof' our clinical workforce across the local health and social care economy

Meet the project team

This Project is a partnership across the Lancashire health and social care economy. Key contacts are shown below:

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How you can get involved

This is a really exciting research project that will help us to understand how we can address the workforce challenges facing us now and in the future.

If you would like to get involved in the qualitative research, please contact mohan.kumar@nw.hee.nhs.uk.

In partnership with

FF63 Health Education North Central and East London

HE NCEL Community Education Provider Networks Update Report

1.0 Background

1.1 This paper is to outline the progress to date being made to establish Community Education Provider Networks (CEPN) across North Central East London, demonstrate the added value this whole-system approach has to support multi-professional primary and community-oriented education and to share some of the lessons learned that have been captured so far.

1.2 CEPNs may be broadly defined as 'groups of primary and community care organisations that come together to form partnership groups of like-minded organisations to collaborate with regard to workforce, education and training.'[1]

1.4 The purpose of CEPNs is to support "team-working across professional and organisational boundaries" to prevent fragmentation and duplication of care.

2.0 NCEL CEPN Programme Work Streams

Barnet CEPN	Tower Hamlets CEPN	Newham CEPN
• Workforce Development Strategy • Establishing CEPN Infrastructure • Practice Nurse Recruitment & Training • Multi-professional CPPD Programme • HCSW Development Programme • MPLO Single Assessment Appraisal Process • Medical Student Placements • Multi-	• Multi-agency Frontline Workers 'Health Inspires' Training Programme • MPLO Integrated Care Education Plan Programme • Bowel Cancer Screening Project • Coordination of Mandatory Training across Locality • Embedding Nurse & HCA Training in Primary Care	• Improve understanding and awareness of the service user experience on frontline workers • Understanding Wider Aspects of care/Nurses & HCAs programmes/Nurse Super Hub • Develop joint workforce planning programme • MPLO Self Care in the Community Programme

[1] HE NCEL Primary Care Workforce Project, 2013

Islington CEPN	Waltham Forest CEPN
• Workforce Modelling Programme • Cavendish Care Certificate • Nurse & HCSW Super Hub	• Increase General Practice student Nurse placements • Workforce Scoping Programme • Develop Self-care pharmacy programme

3.0 Lessons learned

3.1 Project Successes to date

Lesson No	Project Success	Lesson No	Project Success
1.	All Existing CEPNs take part in shared learning and developmental sessions	**2.**	New CEPN Areas to go live from November 2014
3.	Pan-NCEL CEPN Workforce Modelling Programme developed in partnership with Skills for Health	**4.**	Good relationships formed amongst CEPN multi-professional stakeholders across the respective localities
5.	Locality Fund - CCGs and CEPNs actively engaged in the process and were keen to be involved. Each of the 12 CCG Locality areas chose to bid for Locality funding.	**6.**	Each Locality area was awarded Locality Funding and has begun implementing successful projects. CEPN feedback stated the funding provided a real sense of purpose to the network.

4.0 Wave 2 CEPNs

4.1 Plans for next round of CEPN Bids: ONEL (Barking & Dagenham, Redbridge & Havering), Camden, City & Hackney, Enfield and Haringey.

- Conversations have been ongoing with new locality areas since Spring 2014.
- Representatives of potential CEPN areas invited to attend a CEPN Developmental session on 19th September. There was full representation from all areas and engagement and shared learning from all 12 Locality areas during the session.
- Invitation to Proposals sent out to each locality on Friday, 3rd October.
- The submission due date for all proposals is scheduled for Thursday, 23rd October and the evaluation panel will review all bids on Friday, 24th October. Each locality will be notified of the outcome of the bids shortly thereafter.
- All successful localities will be invited to an induction session and join the existing CEPNs at the next CEPN Developmental Day on Tuesday, 4th November 2014.
- The new CEPN areas scheduled to go live from November 2014. A buddy system has been established for each new CEPN locality to be paired with an existing one. The purpose of this is to provide an infrastructure of support very early in the new CEPN's development.
- To promote sustainability there will be a developmental programme designed as follows: establishing an effective governance infrastructure, leadership development and partnership working, measuring success through a robust evaluation framework, capability building in integrated care, workforce planning, and educational programme coordination, embedding educational quality and faculty development.
- Based on discussion at the Workforce Development Advisory Group CEPNs be invited to provide input into the use and allocation of future CPPD resources for primary and community care.

5.1 Actions to be considered

- The board are requested to receive this paper and offer suggestions and comments for on-going development of the CEPN programme.

Sanjiv Ahluwalia Chris Caldwell

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Community-based education providers network: an opportunity to unleash the potential for innovation in primary care education

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Keywords: community education, education network, federated model, provider-led education

INTRODUCTION

The last decade has seen a significant reconfiguration of secondary care services with fewer acute units providing more sophisticated care. At the same time, primary care has seen rising demand for services fuelled by greater numbers of people living longer, shifting work from secondary to primary care, higher expectations of healthcare from better-informed patients, and higher levels of multi-morbidity. It is also being recognised that the trend towards higher workloads and demand is unsustainable especially in the context of a tight fiscal settlement for the NHS in the coming years. The current primary care workforce is under significant strain with GPs reporting high levels of emotional exhaustion.[1] The need for better workforce planning (for the future) and development (for the current primary care workforce) is acknowledged in policy by the emergence of employer-led Local Education and Training Boards (LETBs).[2]

These pressures have generated a number of policies that have sought to influence the provision of services in primary care. Lord Darzi[3] first highlighted the need for GP and other community-oriented services to be co-located in polyclinics; so as to capitalise on the potential for collaborative practice afforded through proximity. The Royal College of General Practitioners[4] offered the federated or networked model of clinical service delivery in primary care whereby practices in geographically contiguous areas could work collaboratively (sharing resources and best practice) in the development of new services. Networks and federations of practices are beginning to form across the UK landscape. Internationally, federations or networks of community providers have thrived in New Zealand[5] and Canada. However, clinical primary care networks can be seen as a response to the needs of service and clinical commissioners, and are not primarily directed at responding to the workforce needs of local populations.

The 2012 Health and Social Care Act[2] places a strong emphasis upon the need to develop the healthcare workforce of the future. The challenge is to ensure that those in training are able to experience high-quality educational placements where healthcare is delivered.[6] This is especially pressing for integrated care delivered by community-oriented professional groups such as nursing, pharmacy and social care. Also important is the national recognition that GP training needs to train greater numbers for a longer duration. Thus, the current and future community educational infrastructure has to cope with rising demand for more placements in general practice and in the community despite the current workload and demand pressures faced by community organisations.[7]

Existing arrangements for service delivery act against the development of integrated models of care capable of spanning traditional organisational and sector-related boundaries for the betterment of patients

and local populations. The need to improve population health-related outcomes (a persistent failure of established health policy to date) requires an approach to care delivery that promotes integration between different parts of the health system and incorporates primary, community, and social care.[8] It also requires an emphasis on the values of local populations and their influence in the ways services are provided. The current education and training system is not designed to produce professionals skilled in the messy art of working across traditional boundaries, nor does current education equip healthcare workers to consider the needs of populations as well as individuals. There is an urgent need to enhance the generalist, collaborative, and population-based skills of our healthcare workforce in primary and secondary care.[9]

The three London and KSS LETBs have three internationally renowned academic health science centres (AHSCs) within their geography charged with the remit of speeding the time taken to translate laboratory- and research-based discoveries to patient benefit which can take up to 20 years.[10] A key missing partner in this mission is primary care. There is therefore an urgent need for researchers to partner more effectively with service and education providers for testing innovation in relation to key elements of healthcare delivery transformation such as self-management, system redesign, clinical decision support systems, evaluating new roles and delivering integrated care models. In London, the previous Strategic Health Authority initiated a programme of educational commissioning designed to enhance the role of educational provider organisations through greater autonomy in programme design and innovation, and alignment with AHSCs whilst maintaining learner safety and standards for recruitment, assessment, and doctors in difficulty through a shared service arrangement.

Thus the combination of greater pressures on clinical and educational workload and need for more local and responsive workforce planning and development; the policy context for the redesign of primary care and clinical services with the need to incorporate education and training provision; the need to improve population health outcomes through integrated working and learning; and changes to the local environment for the commissioning of educational services with greater alignment with AHSCs has led us to propose the development of community-based educational provider networks (CEPNs). We will describe the nature of these networks; their potential benefits and challenges, and describe the early work undertaken in the development of CEPNs in London and Kent, Surrey and Sussex geographic areas.

WHAT ARE COMMUNITY EDUCATION PROVIDER NETWORKS (CEPNs)?

CEPNs are envisioned as collectives or networks of primary and community organisations working collaboratively to enhance educational delivery in local geographic contexts. There is no pre-defined size for CEPNs though experience from clinical networks (e.g. Waltham Forest) suggests that a patient population size less than 25 000 or greater than 75 000 may prove challenging. Figure 1 illustrates the key components of CEPNs.

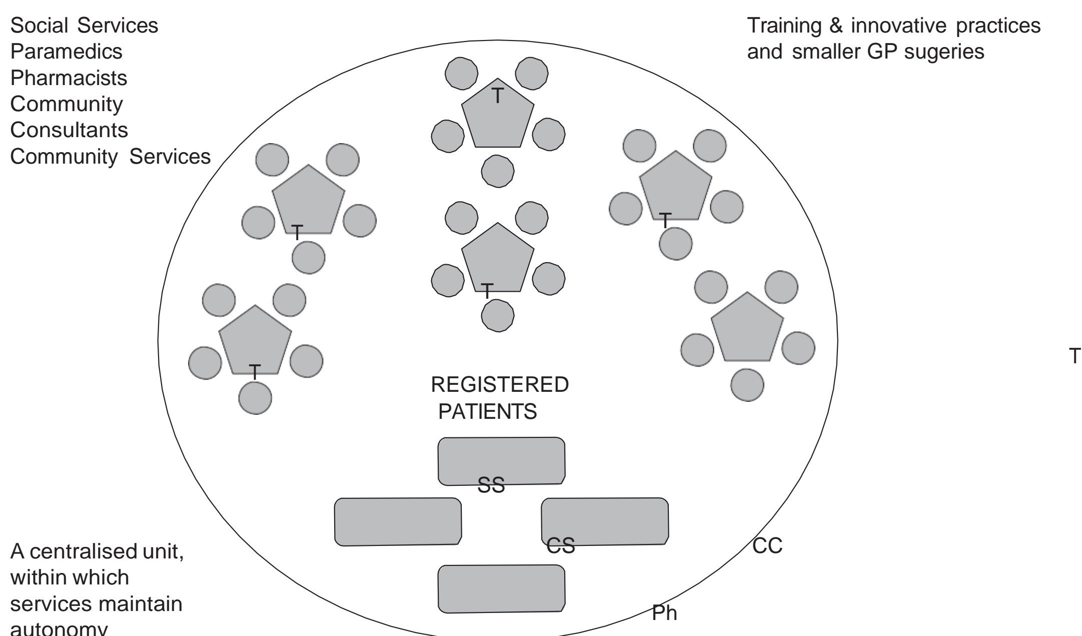

Figure 1 Components of a CEPN: CS, community services; T, Training practices; Ph, pharmacy; CC, community consultants; SS, social services

THE JOURNEY THUS FAR

All three London and Kent, Surrey and Sussex (KSS) LETBs have agreed that development of the primary care workforce and the promotion of community-based multiprofessional education and training are high priorities. The four LETBs are in various stages of developing plans for the design, piloting, and evaluation of CEPNs with input and support from their respective primary care educational teams. In Box 1 we share a case study to test the conceptual framework of CEPNs and offer insights on the benefits, challenges and sustainability of CEPNs.

Common to all potential CEPNs GP training practices will act as the orchestrating unit for community-based education provision, in varying degrees, encouraging local organisations to work collectively and develop ownership of local educational provision; extend the benefits of teaching to non-teaching organisations in the community; encourage innovation in educational delivery and diffusion of best practice; provide training and educational experiences to professional groups that are a priority for local workforce development; broaden the types and range of organisations involved in the delivery of community-based education; and encourage organisations unused to working together to collaborate around education and training.

Box 1 A CEPN case study

The local health community in Bromley faces a significant workforce crisis with 17 declared vacancies for practice nurses out of 46 local practices remaining vacant. At the same time it has been recognised that the local secondary care trust (South London Healthcare Trust) will be losing staff through reconfiguration.

A community educational provider network (CEPN) is being formed through a collaborative effort between local training and non-training practices, local community providers, London South Bank University (LSBU) and Greenwich University. The primary purpose of this CEPN is to look at the potential for collaborative working and development of professionals across traditional provider boundaries starting with development of locally based nurse training, enabling nurses wanting transition from South London Health Trust (local secondary care trust) to primary care; as well as developing more consistent skills in nurses already employed in primary care. These actions are designed to tackle recruitment difficulties faced by local GP practices as well as encourage closer working and learning between primary and secondary care in partnership with the local Higher Education Institute (local university offering courses for healthcare professionals).

A steering group involving all local provider groups, with clear terms of reference, has been set up to deliver the programme. They will design and oversee delivery of the training programme, in collaboration with London South Bank and Greenwich Universities with appropriate accreditation for acquired competencies. Community nurse mentors are being trained to support nurse placements in a federated model, linking training and non-training practices.

ISSUES FACING THE FUTURE DEVELOPMENT OF CEPNs

With the pressure experienced by primary and community care organisations, it will be essential to ensure that the emergent CEPNs have time to consider their development, and the resources (both human and financial) needed to build their capacity and relationships. The LETBs, in partnership with local primary care educational leaders, have a critical role to play in supporting their development with adequate seed funding and project management support.

Healthcare professional regulators (e.g. the General Medical Council, Nursing and Midwifery Council, and others) have an expectation of educational providers (both practitioners and venues for delivering education) to meet exacting standards. There is a need to work with the regulators to ensure an approach to educational governance that meets the requirements of the regulators whilst preventing the nascent CEPNs from becoming stifled by established regulatory regimes. There is an opportunity for co-production and innovation in doing so. The Royal Colleges will also need to collaborate to ensure that competencies related to interprofessional and collaborative practice are reflected in curricula.

Critical to the success of CEPNs as vehicles for improving workforce planning and development is a key role for Clinical Commissioning Groups as service commissioners to support the identification of local clinical service priorities and workforce needs. The LETBs and local educational leaders have a key role in facilitating the relationship between service and educational commissioning and educational provision in this regard.

Perhaps more significantly, however, true population-level transformation will require that CEPNs recognise the need for partnership with AHSCs to speed the transition of innovation for better population and patient

care. We anticipate that this will emerge through the development of Academic Health Science Networks (AHSNs) seeking to develop membership arrangements over geographic areas that involve primary, secondary and community care as well as spanning education, research, and service providers.[11]

CONCLUSIONS

It is our view that CEPNs offer a model for developing better workforce planning and development, tackle the challenge of improving population health outcomes, and speeding innovation in primary and community care. Their development will require partnership that spans clinical and educational commissioners, as well as education and service providers. The AHSNs are likely to be critical facilitators in supporting their development. We firmly believe that GP education has a central and critical role to play in this emerging landscape.

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Appendix: Nuffield Trust Submission to the Primary Care Workforce Commission

GP Learning Network: Site profiles

This document contains short profiles for each of the twelve organisations that are members of the Nuffield Trust's GP learning network.

The profiles are intended to give a snapshot of each organisation for the use of other members. Permission will be sought from members before any of this information is used in any other way.

List of profiles:

1) Shropshire Doctors Cooperative Ltd
2) Whitstable
3) One Medical
4) Hurley
5) GP Care
6) Invicta
7) Vitality
8) The Practice
9) AT Medics
10) Tower Hamlets
11) First4Health
12) Harness

Organisation name	Shropshire Doctors Cooperative Ltd
Location	Shropshire
Website	www.shropdoc.org.uk
Organisation type	Network
Organisation size	Practices: 54 Registered population: 450,000
Evolution of organisation:	Established in1996 as an out-of-hours Cooperative, Shropshire Doctors now deliver care 24/7 over multiple sites and services. In 2013, we helped set up 2 local GP Federations across a population of 500,000 and provided infrastructure and admin support to both. The cooperative represents the two federations on the Nuffield Trust network.
Main purpose of organisation & priorities	Shropdoc has a cooperative ethos based on quality service provision and extension of local General Practice. Shropdoc supported the formation of two federations to provide expertise to mitigate financial and infrastructure risks.
Services provided beyond core GMS	Out of hours contracts and SPA
Highlighted areas of innovation	**Technology**: Investigating the use of EMISWeb as the common, shared clinical system to enable to service development and delivery. Already involved in 'Simple Telehealth' project for COPD and looking to expand this area of work. We have two main workstreams at present; a) development of an Urgent Care strategy which blends current provision with Practice needs - bidding for several innovative Winter Monies projects b) moving secondary care services into community at scale, developing integrated teams

Organisation name	Whitstable Medical Practice
Location	South East
Website	www.whitstablemedicalpractice.co.uk
Organisation type	Super-partnership
Organisation size	Practices: 1, operating from 3 purpose built medical centres each with a personally registered list of 11,000+ patients. Registered population: 34,600. WMP in federation with Northgate Medical Practice, Canterbury, population 15,500. Combined list of 50,000+. Many Community Integrated Healthcare services provided to E. Kent via GP referral. Population of E Kent is 700,000. MIU serves a population of approx 110,000.
Evolution of organisation:	3 small Whitstable practices united in the early 1970s and moved into the (then new) Whitstable Health Centre. WMP has grown in line with the local population. We have designed and built 2 additional medical centres - the Chestfield Medical Centre, and Estuary View Medical Centre. We now operate all 3 of these medical centres. Each provides full PMS services, and Estuary View is the main provider site for our integrated healthcare services.
Main purpose of organisation& priorities	The purpose of WMP is to provide high quality NHS General Practice alongside a range of health care services normally associated with a visit to a hospital. Alongside general practice, our workstreams are: 1) Long term condition management 2) Urgent Care 3) Community Elective Services which include diagnostics, OPD clinics, GPSI clinics, day surgery, screening services, therapies 4) Intermediate care.
Services provided beyond core GMS	Multiple community contracts including: 1) MIU with xray, fracture clinic and DVT service. 2) Cataract day surgery service. 3) Multiple Consultant and GPSI led OPD services. 4) Therapies.

	5) Hearing Aid clinic. 6) Screening services, inc retinal photography, AAA screening. 7) Diagnostics inc X-ray, USS, echocardiography, mobile MRI.
Highlighted areas of innovation	**Integration**: 1) We have integrated a large list based General Practice with many secondary and community care services. 2) We are now working to create a Health and Social care Hub/Village with other stakeholders including a hospital trust, community trust, social services, PPG and others. One main feature is to redesign care pathways, and end the current urgent and elective care default position of hospital attendance. 30 We have federated with a large adjacent practice, and jointly are now in discussion with further practices. **Savings.** We have been able to demonstrate a £1.6m saving against hospital tariff for GP based secondary care services at EVMC over a 2 year study period.

Organisation name	OneMedicalGroup
Location	Leeds and London
Website	www.onemedicalgroup.co.uk
Organisation type	Limited company, multi-site operations
Organisation size	Practices: 8 plus three walk-in centres and one urgent care centre. Registered population: 40,000 plus 142,000 patients pa attend walk-in centres/urgent care centres
Evolution of organisation:	OneMedicalGroup (formerly One Medicare) was launched in 2004 by premises investor and development company One Medical and a group of entrepreneurial GPs. As a newly formed service delivery provider we were immediately successful in winning contracts to run 2 GP practices in Leeds and the Safe Haven service for patients excluded from mainstream primary care. In September 2013 the two sides of the business joined together in a more structured way to create the OneMedicalGroup in recognition of the opportunity to deliver integrated holistic healthcare solutions which cover all aspects of the patient's journey. The Group now includes OneMedicalCare, OneMedicalProperty and a new division, OneMedicalCommunity which delivers patient focussed community based healthcare.
Main purpose of organisation & priorities	OneMedicalGroup's purpose is to transform the UK healthcare landscape by delivering high quality patient focussed services & premises solutions, maximising the use of innovative technologies and methodologies that enhance patient experience as well as support well managed, efficient & effective services and share learning and best practice with colleagues and other health professionals. OneMedicalGroup has a fresh and unique approach to the delivery of GP services such as our focus on patient education which helps people to confidently manage their own conditions. We invest in developing the clinical and managerial skills of all our staff and are working within and alongside the NHS and with Local Government and the Third Sector to ensure that patients can access great primary and community care services when they are most needed.
Services provided beyond core GMS	AQP – Community Vasectomy, Sheffield AQP – Community Dermatology, Leeds LES – PVP (Safe Haven) Service, Leeds LES – Medical Support to Community Beds, Derby Nurse-Led Walk-In: Sheffield, Derby, Grimsby Nurse-Led Urgent Care: Bracknell
Highlighted areas of innovation	**Patient experience**: In November 2012 OneMedicalGroup introduced Patient Feedback Boards across all their sites. Designed to assist practices in gathering more frequent feedback from patients and as a tool to promote health and well-being within the community, the feedback boards quickly became a focal point for patients when attending the

	surgery. The feedback boards are divided into 3 sections. A large proportion is dedicated to obtaining patient feedback through a model which takes inspiration from Net Promoter Score methodology. Fixed to the bottom of the board are 5 token boxes. To promote participation from diverse patient demographics across the group, the token boxes are numbered 1 to 5 or with a range of emotions. Each month a question is selected and displayed in the middle of the feedback board. For six months of the year the Patient Participation Group (PPG) select the question, ensuring that appropriate topics pertinent to the local community are covered. The remaining six questions are set by the OneMedicalGroup Integrated Governance Committee. The results are discussed with the PPG who support the local management team in understanding the drivers behind the result. The practice team work together to form an action plan which is displayed in the 'We said, You did' section of the board for our patients to see. The 'In the Community' section of the board is designed to promote upcoming outreach or educational presentations the practice may be facilitating. Success: Since the introduction of the feedback boards many changes have been implemented and shared across the group which can be directly attributed to the feedback provided by our patients, such as: *New cleaning contractors to improve infection prevention and control. *Lunchtime cytology and sexual health advice clinics introduced in our city centre based practices, to provide convenient access for young professionals. *Restructured appointment availability to support improved patient access. *Additional receptionists to support in managing the increased volume of calls during peak hours.

Organisation name	Hurley
Location	London (mostly south & east)
Website	http://hurleygroup.co.uk/
Organisation type	Multi-practice organisation
Organisation size	• 17 practices in 10 London Boroughs covering 100,000 registered patients • Urgent care from 10 locations caring for 350,000 patients per annum • Focus on deprived communities • 4 partners, 22 lead GPs, board of directors, 400 staff • GP Partnership structure.
Evolution of organisation:	NHS GP Partnership format unchanged. Grew from single practice in 2007 largely through care-taking struggling practices initially. Majority of growth through procurement wins. Limited M&A activity. Growth in urgent care initially in Walk in Centres, MIUs and more recently UCCs in London A&Es.
Main purpose of organisation & priorities	Initially created to spread best practice to deprived communities. Started with a programme to help local single-handers, moved into care-taking failing practices and finally to setting up new services through winning procurements. The organisation's focus remains on dealing with London's most deprived communities. In addition, significant focus on staff opportunities and development. Most recently, developing telehealth solutions to frontline clinical issues to improve access, outcomes and efficiency.
Services provided beyond core GMS	Urgent Care (300,000 cases pa), Practitioner Health Programme, Substance Misuse, Nursing Homes, Refugee Care
Highlighted areas of innovation	**Technology to enhance access**: We are in the process of scaling up our WebGP platform to other practices around the country. There are 5 online services accessible to patients through their own practice website (Symptom checkers; Self-help guides and videos about common conditions; Sign-posting to alternate offers e.g. pharmacies; 24/7 phone advice within 1 hour (via 111); E-consults in which patients use their practice website to submit condition-based questionnaires to their own GP for response within 1 working day. Pilot (133,000 patients) showed better access for patients; high uptake by patients; improved health outcomes; efficiency savings for practices; commissioner savings through reducing urgent care attendances.

Organisation name	GP Care
Location	Bristol
Website	www.gpcare.org.uk
Organisation type	Network
Organisation size	Practices:100 Registered population: 850,000
Evolution of organisation:	We set up in 2006. Started as an LLP but now changed to a limited company. We started with contributions from the local practices and are still 'owned' by them. We have focused on community delivery of services that could not have been successfully bid for by individual practices. Our wider remit of support for and development of primary care itself is delivered through our partner organisation, One Care Consortium which was set up after our successful bid (jointly sponsored with our local GP OOH provider company) for some of the PMCF monies. We are using OCC to rework the patient access and IT functionality of practices.
Main purpose of organisation & priorities	All providers are effectively in a market place and bidding for contracts with the NHS as the commissioner. GPs recognised they were too small to independently bid for and win work in this environment. We now try to: develop & operate services in the community; reduce the NHS' dependence on hospital care; give commissioners a quality assured alternative to hospital delivery; improve patient experiences; reduce costs to the taxpayer / NHS; support remodelling of primary care and make it more fit for its future roles.
Services provided beyond core GMS	DVT services, ultrasound, community urology, MSK, hand surgery, Consultant Link (Advise & Guidance)
Highlighted areas of innovation	1. GP Care’s 'Consultant Link' service - which directly connects GPs and Consultants and is effective in reducing avoidable referrals to hospital. 2. Placing diagnostics within prisons to save the inmates having to be transported to acute sites but delivering care to them in that environment. 3. Community based DVT & anticoagulation services. 4. Community based primary diagnostics in urology including assessment of possible

Organisation name	Invicta Health
Location	Canterbury
Website	www.invictahealth.co.uk
Organisation type	Federation
Organisation size	Practices: 45 Registered population: 379,528
Evolution of organisation:	Founded in 2008 to provide GP in urgent care and to develop joint working to provide enhanced services - specifically anticoagulation. At this point we had 16 member practices each owning shares based on their list size. We added 4 more practices when CCG boundaries changed. Then in 2013 we added a further CCG membership of 24 practices who were keen to work together on joint provision of services. With then we successfully bid for funds from the Prime Minister's Challenge.
Main purpose of organisation & priorities	Local GPs wanted to collaborate to provide more complex services than were possible at practice level and to share the costs of setting up services/bidding etc. It also allows GPs to have provider representation within the overall health system that can work with secondary and community care and allow us to negotiate joint projects and develop integrated working. GPs had a number of concerns about capacity, sustainability and the threat of third party providers that were part of the drive to set up a joint organisation. We chose a CIC as we did not intend to make a profit for shareholders. Any profit is reinvested but the aim is to provide services that support member practices.
Services provided beyond core GMS	GP in Urgent Care, Community Diabetes, GP Management Community Beds, Primary Care Mental Health Pilot
Highlighted areas of innovation	**Integration**: We are developing primary care hubs in two towns based around the local hospitals which will act as a common branch surgery for all of the surrounding practices. This involves shared clinical systems and protocols, a common telephone network, the introduction of urgent visiting by paramedics. the ability of GP's to use step up beds in the community, mental health assessments in primary care by CPN's, developing nursing roles that are both practice and community based. We are collaborating with the CCG, MIU, secondary and community trusts, ambulance trust and 111. In the long term we are looking to develop this as a training hub for all clinical staff. We are developing alternative career structures for GP's allowing them to work

	in more than one practice, in urgent care and to offer the flexibility of locum work within the structure of a supportive organisation. The project will also work with local system wide plans to develop integration in the provision of urgent care.

Organisation name	Vitality
Location	Birmingham
Website	www.vitalitypartnership.nhs.uk
Organisation type	Super-partnership
Organisation size	Practices: 11 Registered population: 68,000
Evolution of organisation:	The Partners of Handsworth Wood Medical Centre and Laurie Pike Health Centre established the Vitality Partnership in June 2009. Since the inaugural partnership was established they have expanded further and now cover thirteen sites and are in active discussions with many other practices across the region. Vitality is now entering its sixth year as an organisation and aspires to be the primary care provider of choice within the Midlands. The Vitality Partnership also provides specialist NHS medical services and has continued to grow via mergers and opening other related healthcare services.
Main purpose of organisation & priorities	The overall partnership vision is one of building a larger, stronger and resilient provider organisation that maximises the potential of a large registered patient list size of approximately 100,000 patients to create an integrated network of health and social care services across Birmingham and Sandwell. The Vitality Partnership operates within a set of core values which emphasises its ethos and approach to developing and managing its business. These underpin organisational decision-making and shape business development and service delivery. The core values of the Vitality Partnership are: Delivering exceptional patient care; Providing patients with greater access to care through a choice of centres; Developing and sustaining a learning environment; Recognised as an employer of excellence; Demonstrating excellence in all business practices; Providing and seizing opportunities for additional services; Maximising use of technology to facilitate healthcare delivery The Vitality Partnership is creating a consistency in quality of services which includes: High quality of care for patients; Good access to care; Patients able to manage their own health better; Exceptional customer care; Working with specialist care partners; Training and developing exceptional health professionals of the future; Multi-agency working to protect vulnerable patients
Services provided beyond core GMS	Range of contracts PMS+; NHS specialist services; student health services.
Highlighted area of innovation	**Access**: We are currently focussing on enhancing patient access, service availability, experience and choice – enabling access to extended and integrated primary care

	services through both physical and virtual channels - whilst also reducing demand on Acute and Emergency services, within a simplified access model. The project focusses on the patient, enabling them to access coordinated clinical services via mobile, web, telephone and physical channels. Whilst we place clear emphasis on local practice delivery, the specific changes we expect patients to experience are: • - Extended access to the service (8-til-8) within a robust, clinically-led model; - Increased capacity to deliver consultations at the times when patients require them; - Clearer routing from NHS 111 services to local access; - Clear scheduling, navigation and prioritisation; - On-demand access to specialist services from within extended hours centres; - The ability to access services from home and whilst mobile; - Access to clinicians via new services such as instant messaging, live chat and video consultation; - Access to on-line supported self-management services; - Improved care coordination; - A noticeable reduction in our reliance on secondary care; - A focus on reducing referrals to acute services; - Greater involvement through real-time feedback and patient participation; - Significantly improved access for house-bound patients.

Organisation name	The Practice PLC
Location	Buckinghamshire
Website	thepracticeplc.com
Organisation type	Multi-practice organisation
Organisation size	Practices: 38 Registered population: 135,000
Evolution of organisation:	Established in 2005 by two GPs, this was a response to both the threats and opportunities of the 2004 GP contract. We have grown through winning NHS tenders in GP surgery contracts and community based services. We have 54 NHS contracts operating surgeries, walk in centres and outpatient services in the community. We contract with nearly a quarter of all CCGs and deliver over 1 million NHS contracts per year.
Main purpose of organisation & priorities	The aim of the original organisation was to develop primary care by liberating clinicians from the shackles of administration and provide an infrastructure that offered quality, expertise and scale. We believe in the NHS but also understand that it requires transformation with a focus on illness prevention and health promotion particularly in elderly care and areas of socio-economic deprivation. We believe that with empowerment and resourcing, primary care will develop and deliver innovative solutions to the current pressures on the NHS. This includes moving services nearer to the patient and nearer to where the patient is understood and involved in health care, leading to better health care outcomes and better value for money.
Services provided beyond core GMS	Community based Ophthalmology, ENT, Dermatology and referral management
Highlighted areas of innovation	**Integrated care**: In 2013 we completed an integrated service for a care homes project in Thames Valley, in partnership with Thames Valley Health Innovation and Education Cluster (HEIC). The aim of the project was to deliver high quality GP care and medicines management services. The process took into account the wishes of care home residents and addressed the issues of inappropriate hospital admissions. 450 residents across 7 care homes were registered with The Practice for primary care services. The Practice provided each patient with a named GP, routine visits, specialist medicines management support, urgent care, management of end of life pathways and OOH telephone advice. The project demonstrated that providing a dedicated stand-alone service for a population of care home residents can become the focal point for delivering high quality care. We demonstrated a cost effective approach through a centralised model operating at scale.

Organisation name	AT Medics
Location	London
Website	www.atmedics.co.uk
Organisation type	Multi-practice organisation
Organisation size	Organisation covers: 19 practices Registered population: 100,000
Evolution of organisation:	In 2004, 6 GP Directors, originating from the same medical school, set up a limited company some as GP Registrars. They initially took over 1500 list on a locum contract and built from there based on track record of delivery
Main purpose of organisation & priorities	Driven by a motivation to scale high quality primary care across London. Also a desire of 6 friends to work together in a way that would not have been possible to all join an existing partnership. Set up coincided with the development of APMS
Services provided beyond core GMS	Walk in centres and Minor Injuries units
Highlighted areas of innovation	**IM and T**: use of pan-AT Medics dashboard to share data and optimise clinical performance, web based clinical and practice meetings, online clinical advice forums. **Education**: largest GP training organisation in London. We encourage our salaried GPs to become F2 supervisors and GP trainers. Monthly pan-AT Medics educational meetings in Streatham. Weekly clinical meetings embedded in the practices. Over 100 medical students a year pass through the organisation - collaborations with at least 5 London medical schools
Focus of quality work	**Clinical effectiveness/Patient experience:** During the last 2 years, nine of our practices have participated in the RCGP Quality Practice Award. Eight of the practices have now achieved this award with the last practice waiting for assessment. **Professional satisfaction/experience:** Building on achieving Investors in People, AT Medics recognises that professional satisfaction/experience is key in motivating,

	retaining (and recruiting) staff and we have developed and implemented a career structure to enable career progression and role enhancement for both clinical and non-clinical staff within the organisation **Sustainability of services:** We have appointed a Management of Change Adviser to support us in reviewing some of our working practices (clinical and non-clinical) to rationalise expenditure and increase productivity.

Organisation name	Tower Hamlets GP Care Group CIC
Location	London
Website	
Organisation type	CIC
Organisation size	Practices:36 Registered population: 254,000
Evolution of organisation:	Eight Tower Hamlets networks were formed in 2009. Tower Hamlets GP Care Group consists of all eight networks is now a CIC
Main purpose of organisation & priorities	The formation of a borough-level GP Care Group in Tower Hamlets builds on many years of local GPs successfully working together and collaborating to improve services for patients. We already have eight GP provider networks and we agreed in January 2014 the time was right to move to the next level and form a new organisation that includes all of the GP practices in Tower Hamlets. We are a GP-led and run organisation and our reason for being is to deliver high quality responsive and accessible services to the people of Tower Hamlets as well as developing partnerships with other providers to support the delivery of the Tower Hamlets CCG Integrated Care strategy.
Services provided beyond core GMS	Healthy lifestyle trainers (LA), Phlebotomy (CCG), Educational training CEPN (LETB),
Highlighted areas of innovation	**System redesign**: the real innovation has been the way that networks in Tower Hamlets have formed and contributed to a system redesign in the delivery of care and in particular the delivery of network care packages with the subsequent improvement in outcomes.

Organisation name	First4Health
Location	London
Website	
Organisation type	Network
Organisation size	Practices: 29 Registered population: 190,000
Evolution of organisation:	In 2008, the original founding members (from 8 practices) formed a limited company. The focus of the work at this time was on succession planning for retiring GPs and increased recruitment opportunities to attract Gps to work in Newham. This group has subsequently formed into a Super-Partnership model known as First4Health Group. The role of these practices has been to 'pilot' a quality assurance central management structure which enabled practices to work towards full-merger over a 3 year period. Practices within the First4Health Federation are working together in a collaborative network type model. The over-arching F4H Federation umbrella organisation provides support for practices in three key areas: commissioning, shared service provision and core primary care service delivery.
Main purpose of organisation & priorities	The Vision for F4H Federation is that an Innovative, collaborative model will deliver the following benefits: - Improvement in quality of service delivery - Reduction in variation and deliver local quality standards - Development of new model for education and recruitment of clinical staff - Improving access and choice for patients - Robust succession planning ensuring managed transition in planned retirements - Deliver services from fit for purpose premises - More effective use of resources – maintain and maximise income for practices Underpinning the vision is the desire to preserve GP practices as the basic unit of NHS provision under contract to NHS England. Working collaboratively, through a range of federated and network models will support practices to cope with reduced income streams. Member practices will share and learn together as they create a robust central/back office function to work at scale across practices
Services provided beyond core GMS	PMS Contract. Public Health Contract for delivery of Vascular Health Checks

Highlighted areas of innovation	**Technology**: First4Health has a strong focus on IM & T development and the creation of a single Dashboard, which can be viewed by all practices (RAG style) and which includes all the quality and performance data about the practice are easily available. Member practices will support each other to ensure that every practice is 'green'. This Dashboard work (being taken forward in partnership with UCL Partners & CEG) will also provide a 'flag' system to ensure claims for financial payment are submitted on time and in line with appropriate guidance.

Organisation name	Harness
Location	North West London
Website	www.harnesscare.co.uk
Organisation type	Network
Organisation size	Practices: 21 Registered population: 107,000
Evolution of organisation:	Harness GP Cooperative Ltd was established in 2006 with founding members covering 50000 patients as a membership organisation for like-minded practices. Harness Care Cooperative Ltd was established as the provider arm and won various NHS contracts. Both organisations operate on a not for profit basis with a strong value base.
Main purpose of organisation & priorities	Harness is underpinned by 1. A commitment to collaborative and partnership working 2. A recognition of the value of every patient and the importance of continuity of care 3. A commitment to learning and personal and professional growth 4. An understanding of the importance of relationships with each other, the local community, local stakeholders and other health and social care partners 5. A commitment to providing support to members and to sharing information and learning together to transform primary care 6. A commitment to social responsibility
Services provided beyond core GMS	APMS contracts held for 3 general practices; primary care contract for 8-8 GP service; SLA for operation of referral service; SLAs held to manage general practices for partners
Highlighted areas of innovation	**Population health**: As a not for profit organisation, Harness engages with the communities in which they work to help improve the key detriments of health. We work in partnership with our colleagues in housing, voluntary sector and community groups. Current projects are: UNEMPOLYMENT - working with Skill Centre 20 unemployed young people have been bought into employment as apprentices in Harness practices. We are now working with public health on tackling long term unemployment through potential work placements and training. WINTER PRESSURE - we have partnered with Age UK Brent and Energy Solutions to bid for SIB funding to set up a community hub training

	volunteers to work across organisations and support the practices in keeping older people well and at home this winter **Education**: we are delivering an innovative programme with HEE funding to redesign the general practice workforce to work at scale - the project covers GP training, PM redesign of career pathway and nursing / HCA pathway. We are awaiting agreement of further funding for a project with Age UK Brent to develop volunteers into health and care support workers focussed on over 75s with named GP.

South London Collaboration for Applied Research in Health Care (CLARHC) , Centre for Implementation Science

Brief report

Evaluation of the South London Community Education Provider Networks (CEPNs) October 2014

Vari Drennan & Peter Littlejohn October 2014

1. Introduction

This brief report provides a summary of the key findings to date. At this stage this is a formative assessment rather than summative. It draws on analysis of documents and reports, observation at meetings and development events as well as discussions with individuals in CEPNs, HEIs and HESL. It is intended as an internal document to the South London Community Education Provider Network steering group and HESL rather than for wider distribution at this stage. The back ground to the South London CEPNs is provided in Appendix 1.

2. The CEPN development and wave 2

It should be noted that this is a three year development programme . The first year (13-14) was the pilot phase which identified the need to attend to key design principles of attention to leadership, infrastructure and processes. The second wave of CEPNS were agreed between March and May 2014. Only 2 of the 6 second wave CEPNs had been part of the pilot phase.

3. The start-up phase

The initial months of wave 2 CEPNS have been start up periods for most of the CEPNS have (see Table 1). Start up phases are essential and the complexity should not be underestimated of initiating a network such as this across multiple independent general practices together with the wider health and social care providers. CEPN 3 which was in phase 1 is furthest along in the achieving and surpassing the milestones set out by HESL. Appendix 2 also demonstrates this greater progress by CEPN 3 towards fulfilling the six core roles of the CEPN.

The CEPNS all have different plans and strategies as reflect the local history and landscape and priorities in general practice in the first instance . Three of the CEPNS have focused on the practice nurse issue – primarily as a starting point but also in response to what is acknowledged across London and beyond as difficulties in filling practice nurse vacancies. Those CEPNs starting with a broader perspective have included projects on practice nursing following their training needs assessments and planning processes.

As acknowledged in phase 1, having dedicated project management time to CEPNs is essential. Those CEPNs that have taken longer to recruit are also those slower in their progress to milestones. Although it is reassuring to see that CEPNs with focused project management time are delivering to their timescales.

It is evident in the last 4 months that the attention paid by the CEPN steering group to providing key infrastructure is valued and critical in the establishment phase of the second wave of CEPNs. This infrastructure includes guidance, development days, and templates for such things as reports . The development days have enabled shared learning of processes and tactics. This provision has also helped some key players within the CEPNs to begin to see beyond their own immediate start-up priorities and build momentum towards the HESL aspirations of CEPNs

Table 1 HESL set milestones by end of first six months

	CEPN					
	1	**2**	**3**	**4**	**5**	**6**
Legal entity/structure in place to administer funds	In progress	In progress	Yes	Discussions starting	Discussions starting	Discussions starting
Hire or allocate project management capacity	From month 4	From month 5	From month 1	From month 3	From month 5	From month 3
Clear objectives, activities and programme timeline in place	yes	Yes	Yes	yes	yes	yes
Evaluation strategy and tools finalised	In progress	In progress	In progress	In progress	In progress	In progress
Meetings with key stakeholders to introduce and promote concept	In progress	In progress	Yes	In progress	In progress	Yes
Local training needs assessment completed	Started	Started	Yes	Focused on practice nurses so	Focused on nurses to date	Focused on nurses to date
CCG and HEIs contacted about training budgets available	Yes	Yes	Yes	Yes	yes	Yes

4. Learning for the next phase

While the enthusiasm and appetite for CEPNS is evident in the HESL development days for CEPNs, there are also some issues that continue to percolate through the discussions. Often these are a reflection of CEPN steering group and board discussions but sometimes also with those of wider stakeholders.

The first of these is the concern regarding sustainability of the CEPN model and a weighing up of how far to invest in their development at the local level when the future is uncertain. Those in key roles in HESL have offered strong arguments about CEPNs having agency in the future. They have

offered one of the most compelling arguments in that HESL will contract for workforce development for primary care staff in 2015-16 through the entities of CEPNs. It is possible that some CEPNs and their constiuent stakeholders may need to see this modelled to grasp the implications. There may also need to be reassurances as to the implications of the reorganisation of Health Education England.

The second issue is the potential for conflict or duplication of effort between strategic networks funded by HESL (such as focused on sexual health) and the CEPNS. The potential for multiple training needs analysis and workforce planning surveys to be sent to general practices and others is high . The consequent risk is that the general practitioners and their staff will just ignore them all. There will need to be some more local attention paid as to how to share information for workforce development planning purposes.

The governance mechanisms and project planning set up by HESL mean that there is continued learning , re-iteration of the key aims and development between HESL , HEIs and the CEPNs. There is responsiveness within the HESL project planning that is likely to strengthen the ability of those CEPNs that have to date been slower in start up . Examples include gaining advice on appropriate legal entities for workforce development commissioning.

5. Conclusion

At this point the CEPNs are gathering momentum in their individual areas. In part this is a result of moving through the start-up phase but it is also supported by other organisational and policy developments. This includes a re-emphasis on delivery of primary care services across 'networks' of organisations and the further consolidation of GP confederations (in different forms).

Appendix 1

Background

South London Health Education South (HESL) London[1] has commissioned the development of Community Education Provider Networks (CEPNs) as a key delivery mechanism for supporting the development of the established and future workforce (HESL 2013a, 2014). Particular emphasis is given to a workforce that is trained and educated in an inter-professional way and has a more community, population and public health orientation than currently .

CEPNs are envisioned as "*a federated system of community providers built around GP training practices, which: offers all students, staff and the public a new exposure to population based healthcare, multi-professional education and training and inter-professional learning*". HESL 2013a p26.

CEPNs have been developed in two waves . The first wave was advertised in March 2013 and 4 were funded from May 2013 to March 2014 as 'prototypes' (HESL 2013b). A review of the first four months indicated positive beginnings (HESL 2013c) and suggested some design features needed to be emphasised such as 'clarity of function,….project management capacity ,….. infrastructure, …..processes for partner engagement ,……and undertaking needs assessment" HESL 2013b p2 . Two of the prototype CEPNs have gone forward into the second wave and been joined by four others. These have agreed funding in NHS financial years 2014-5 and 2015-16. Further areas have expressed interest (HESL CEPN development day June 2014). Each of the CEPNS has a collaborating University (3 in total), who also hold the funds for the CEPNS as they are not legal entities.

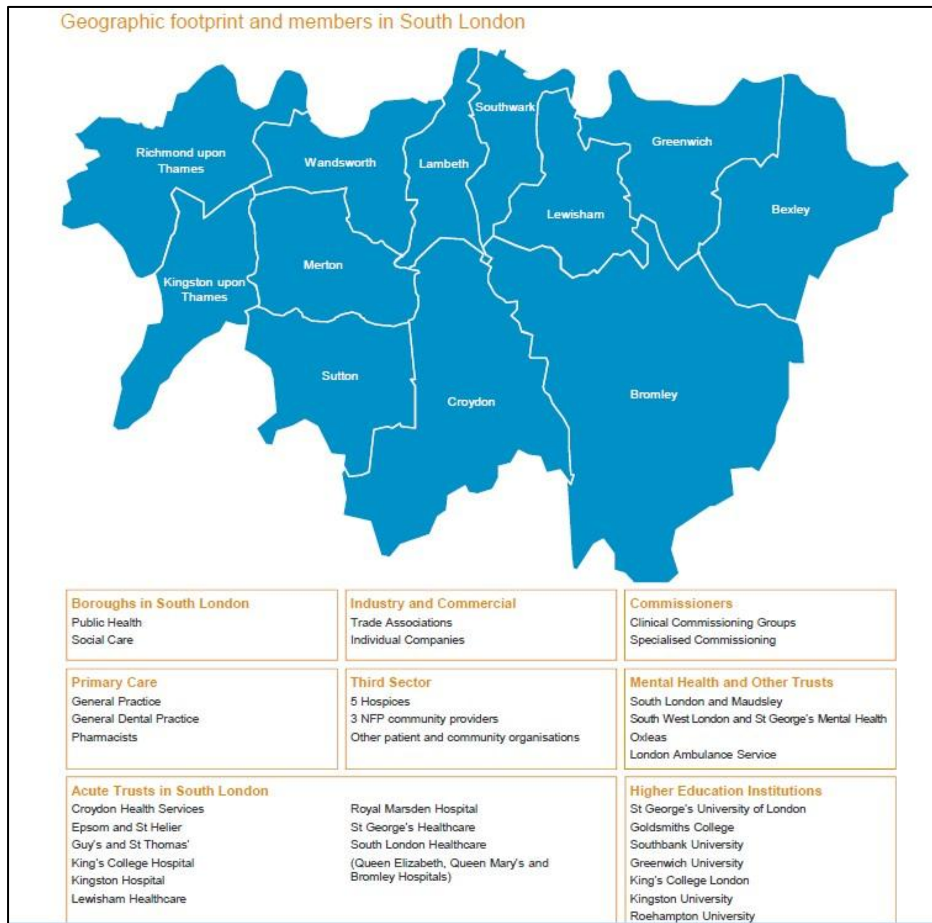
In addition HESL has taken the learning from the two prototype CEPNs, plus suggestions at a December 2013 CEPN development day to fund strategic networks to support CEPNS addressing issues across the whole of South London e.g. training needs analysis on primary care and community care services to support the delivery of sexual health and HIV service provision. The expectation is that these strategic networks will work to support CEPNs.

HESL have invested £1.2 million in the development of CPNs (source: Dr Chana introduction to CEPN development day June 2014). In addition there a HESL governance structure to monitor the progress. Key milestones have been identified for the CEPNS (appendix 2) including undertaking training needs assessments by October 2014 and by April 2015 being responsible for the continuing professional and practice development (CPPD) for primary care staff in their area. Some overall outcome measures have also been developed including increasing community placements for medical and non-medical students on professionally qualifying courses, increasing CPPD funding and activity for primary care staff (see appendix 3).

CEPNs in their conceptualisation draw implicitly on both network theory (6 P et al 2006) and also communities of practice (CoP) theory (Wenger 1998). Other evaluations of NHS networks have drawn on these as framing theories (see for example Abbott & Kilcorran 2005, Addicott et al 2006,) . As an educational innovation CEPNs are designed to both deliver on specific outcomes and also

[1] Health Education South London is the Local Education and Training Board of Health Education England The HESL covers the geographical area of the twelve Greater London Boroughs south of the river Thames and has a wide range of membership organisations (see appendix 1).

change educational culture. This evaluation aims to identify the outcomes of the CEPNs against the objectives, as well as provide the evidence of the contexts and mechanisms which promote or hinder the CEPN achievements.



Reproduced from page 11 of Health Education South London (2013a) Workforce Skills and Development Strategy 2013 – 2018. Accessed at http://southlondon.hee.nhs.uk/documents/hesl-strategic-documents/

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Table 2 Progress by the CEPNs towards the core roles .

CEPN roles	Progress to date					
	1	**2**	**3**	**4**	**5**	**6**
Increasing Community Placements	We will be testing current placement capacity and appetite for future growth as part of our engagement in the autumn.	We are developing a TNA to understand "placement readiness" ie. mentorship qualifications and capacity to receive trainees..	Practice approached and surveyed. Widespread interest in becoming training practices	Plan established for practice nurses	Plan to identify potential mentors	Increased practice nurse mentors
Supporting workforce development (Readiness to receive CPPD funding)	Workforce development priorities will be set as part of our engagement and a strategy drafted in the new year, it is anticipated that the CCG will host CPPD funding this year until a target operating model is agreed upon.	Focussed on setting up the network. Target set-up date 31st October, following company articles of association	Structure in place – governance, finance, board oversight, skilled staff and management. Strong on-going working relationship with CCG established. Continued strong relationship with GP practices.	Preliminary discussions held with potential entities.	Examining practicalities of potential local company	Initial work underway
Workforce development initiatives		Planned for general practices : -Primary Care Training Day x 2 (ear care, imms update, dementia awareness training).: -Customer Care training for non-medical training staff. -2x multi-professional admissions avoidance LES sessions: Planning also with strategic education networks e.g	Customer Service and Conflict Resolution training provided in conjunction with CCG - Practice Nurse training backfill project initiated - Supervisor training (3-day) course completed for 17 MDM staff - Practice nurse recruitment and training project	discussions being held around implementation of revalidation tool for Nurses and HCA's		Nurse training and development programmes HCA development programmes

CEPN roles	Progress to date					
			currently being negotiated with HESL - Two (Arthritis and musculo-skeletal) training initiatives currently being negotiated with HIN - Sexual Health training initiatives currently being negotiated with SWAGNET - Pharmacy training with Pharmacy HESL reps currently being investigated. - Investigating training for this year in dementia and minor illnesses - Provide supervision training for nurses to increase training capacity.			
Scope of network (breadth/depth)	We are currently testing the form & function questions with key project sponsors and forming the steering group in order to be able to answer this question.	To support workforce development through the allocation of CPPD currently held at the CCG. To (eventually) manage and co-ordinate courses within the NMET portal. To be in a position to support co-ordination of "pre-cert" nursing practice placements. To be in a position to support nurses to become qualified practice nurses.	Currently includes Practices (via GP's and practice managers) and CCG input. By end of year, will have included mental health (contacted), public health (contacted), 3rd sector (contacted), HEI's, pharmacy (contacted) and hospices Working with others	To be determined	Beginning relationship building	Nurse training as starting point Recruiting new potential community and practice nurses Drawing the steering group form a wide provider network

CEPN roles	Progress to date					
		Development and delivery of training courses (local and uni) Apprenticeships Working with others CEPN's to share resources	CEPN's to share resources in admin,			
Workforce planning/Future workforce	We hope to collect workforce data this month and next to inform 2015 commissioning intentions.	Training needs analysis (TNA) being sent out to practices September 2014 Working on "placement readiness".	TNA completed Othter planning included public health priorities	Ongoing discussions around what is actually achievable and timescales.	Designing training needs analysis	Developing core competency frameworks for practice nurses and HCAs in primary care.
Inter-professional learning	None to date	Some planned .Joint training discussions with social services, public health , planning the delivery of inter-professional learning, developing course portfolio and planning delivery thereof.	All our plans are aimed, where appropriate, at multi-disciplinary workforces. These include our past and planned programmes in supervisor skills, arthritis and musculo-skeletal and sexual health.	Beginning discussions		Within the steering group which has a wide membership from a wide provider network beginning to gain an understanding of each other's perspectives and how best to develop working relationships, joint training and shared learning.

FF67 Health Education South London

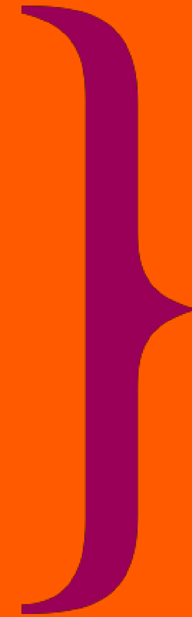
Next page

Brie

Developing people for health and healthcare

Community Education Provider Networks

The Case for CEPNs



NHS

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The Case for CEPNs

NHS
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Current state of education

- We commission education for (amongst others)
  - GPs
  - Practice Nurses
  - Physician Associates
  - District Nurses
- To do this we need reliable forecasts of what service will look like, what types of roles we will need, and in what numbers (demand)
- We also need to know where the supply will come from – commissions plus also factors like attrition from courses, turnover, where students end up working, etc
- We also provide CPPD funding for healthcare staff, and allocations are based on accurate numbers

NHS

Health Education South London

Current state of education (Cont'd)

- Majority of training traditionally takes place in secondary care settings
- Strong alignment between medical schools and acute providers
- Single disciplinary focus within training pathways
- Separate delivery of training for health vs social care
- Limited number of community training placements
- Limited capacity for delivery of community training
- Devolved budgetary arrangements through statutory bodies subject to a changing political landscape
- Lack of attractiveness of community based careers influencing training choices

Current state of community based care

- Multiple providers leading to:
  - Limited scope to develop proactive care
  - Variation in baseline skills for clinical and non clinical roles and unstructured career pathways and pay
  - Dispersed services limiting scope for effective communication

- Workload rarely stratified; the most skilled staff are as likely to see simple cases as the least skilled staff
- Limited use of substitution roles and new roles like care navigators and physician associates are rare
- Perceived lack of status of generalist professions

Education – drivers for change

Political & Economic

- Changing commissioning landscapes for health and education
- Health & social care- provider integration
- Evolving LETBs structure
- Squeezed education budgets
- Squeezed health budgets
- Unsustainable acute care landscape

Local strategies

- Shift of service provision- more care closer to home
- Move to inter-professional learning
- Clinical leadership development in primary care
- Embedding education in primary care service provision
- Compatible with HESL 5 year strategy

Workforce issues

- Cultural differences between health & social care
- Need to develop existing staff to work in different settings
- Shortage of GPs practice nurses and other community professionals
- Lack of workforce information in primary care

Population Health Needs

- Rising demand
- Growing burden of multiple chronic diseases
- Aging population
- Increasing complexity of specialist care
- Integration of health and mental health and social care
- Increasing health inequalities

The CEPN Vision

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- Separate entity, working within either an NHS body or partner organisation
- A vehicle to deliver a fit for purpose workforce to meet the needs of the population it serves
- A network connecting training and non training practices, community services, others services and education providers
- Developed, owned and delivered in the community
- Local co-ordination/ management of training and workforce development- across professional groups
- Building sustainability and stability through local collaboration
- Expanding community training placements
- Implements new roles as required; care navigators and physician associates
- Supports close working with social services and public health to better address the need of the population

Opportunities

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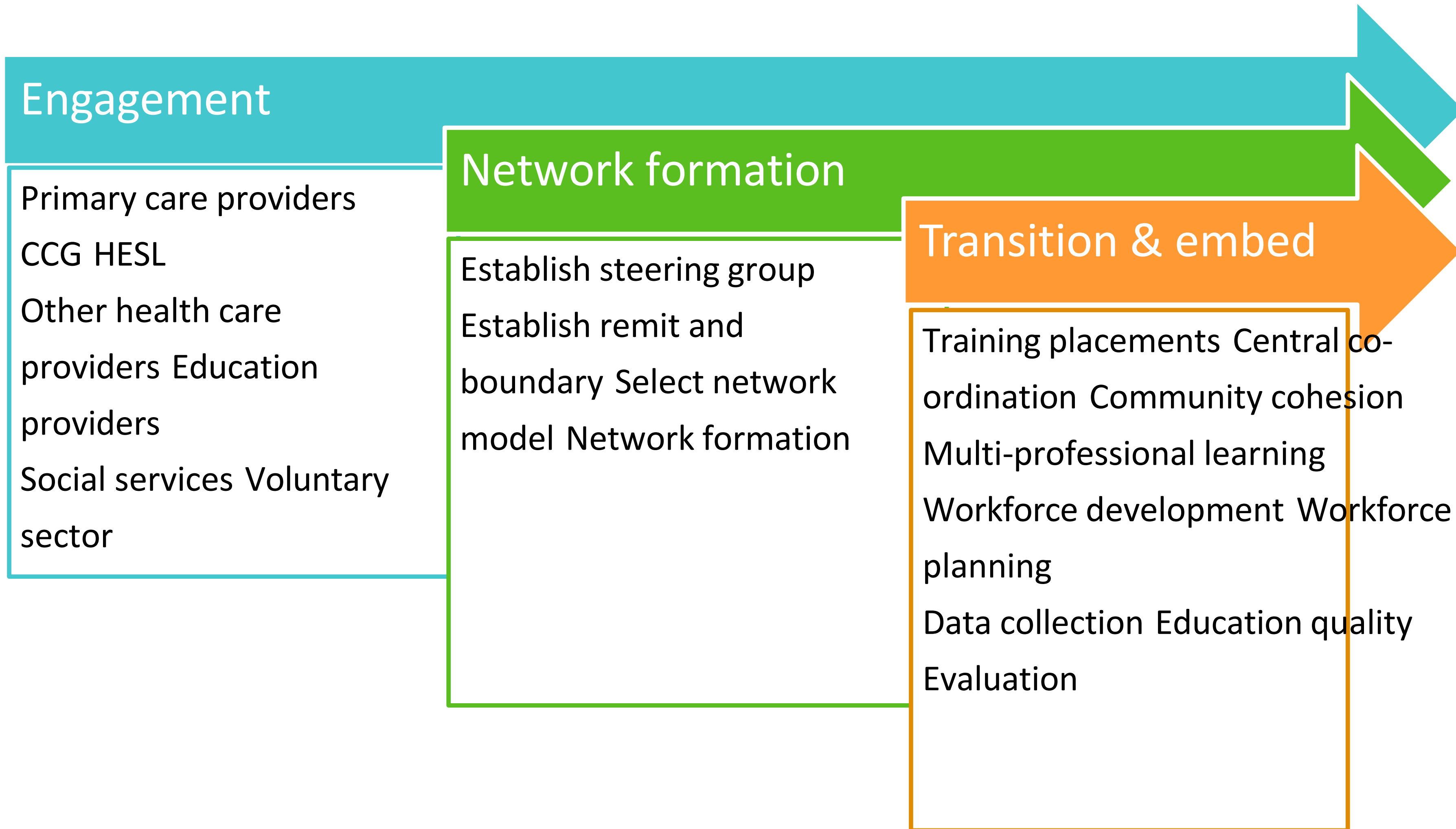
- Encourage and enhance local delivery of training within the community
- Change and innovation
- Community based health and care education based on local population need
- Support Organisational Development needs within health & social care
- Enabler to workforce development and transformation
- Funding to follow increased education capacity
- Aligning education to future service provision to transform services
- Increases capacity within the community to support 7 day services
- Sustainable education through a network of hub and spoke practices

CEPN Trajectory



Challenges

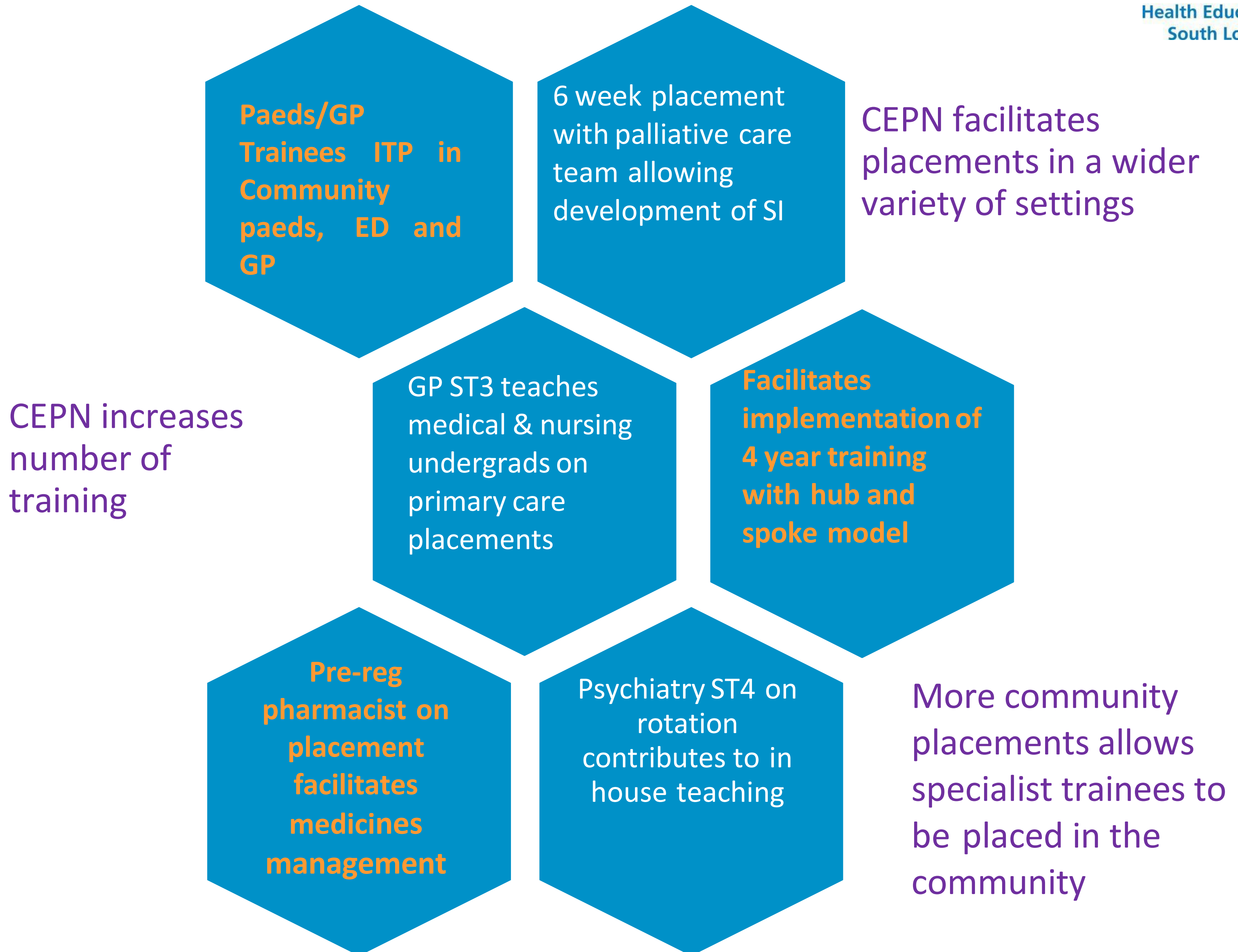
- Breadth and depth of engagement
- Communicating a complex concept
- Tailoring the CEPN model to local priorities
- Achieving sustainability
- Opposition to change and perceived threat
- Estates
- Time commitment required

Case study example
Wandsworth CEPN

- Existing GP federation (30 practices), expanded portfolio to include CEPN
- Year 1 (2013/14) focussed on:
  - network formation, increasing #s of GP supervisors and nurse mentors, development of hub & spoke arrangements for training
- Year 2 (2014/15) aims:
  - expand network to include public health, mental health, pharmacy, HEI's, charities and hospices
  - Roll-out and co-ordinate training
  - Increase physician associate placements
- Year 3 aims:
  - Network maturation, enabling data collection and shared training resources
  - Students placed with CEPN, CEPN designs placements- using

practices,
pharmacies, community services, etc.

GP Vision: 2025



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Community Education Provider Networks

Developing people for health and healthcare

Guide to Community Education Provider Networks

Introduction to CEPNs

THE NHS CONSTITUTION
the NHS belongs to us all

Contents

Subject	Page
Introduction | Community Education Provider Networks	Page 3
What are Community Education Provider Networks?	Page 3
• Prototype phase 4	2013/14 Page 3-
• Pilot Phase	2014/15 Page 4
• review of prototype CEPNs	Early Page 5
• Principles	Design Page 6
• and Challenges of CEPNs	Benefits Page 7
• state and building sustainability 8	End Page 7-
• ng CEPN development	Supporti Page 8

Community Education Provider Networks

Introduction

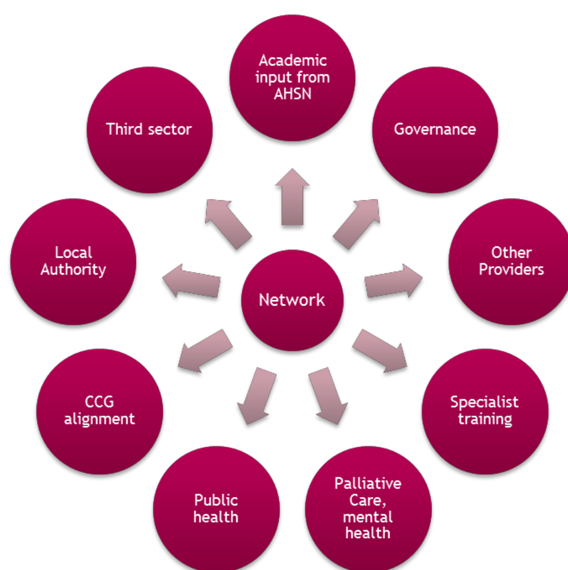
In April 2013 HESL issued a call for proposals to develop Community Education Provider Networks (CEPNs) which are based on the theory of Collaborative Networks defined as:

'*A collection of organisations that possess the capabilities and resources needed to achieve a specific outcome'.*

CEPNs are being developed to deliver our strategic aspiration of improving population health through the development of the current and future primary and community care workforce.

What are Community Education Provider Networks?

CEPNs are networked arrangements of providers within a specified geography. Their purpose is to understand and develop the community-based workforce, in order to meet the health needs of their local population. They are designed to improve the quality and localisation of education for health professionals. They aim to empower community organisations to work with higher educational institutions to assess workforce training needs, expand capacity for training in the community, innovate in the field of training and deliver multi-professional training.



- Defined geography
- Workforce development around population need
- Networked arrangement of education and service providers

2013/14 Prototype phase

Four prototype CEPNs were given seed funding to test different models of delivery. An early review was conducted in October 2013 from which a set of design principles and functions of CEPNs emerged. Functions include:

- Workforce Planning: Developing robust local workforce planning data to inform decisions on how education and training funding should best be invested

Community Education Provider Networks

- Education Quality: Supporting improvements in the quality of education programmes delivered in primary and community care, for example, through peer review
- Faculty Development: Developing local educational capacity and capability (for example, an ability to accommodate greater numbers of nursing placements or the development of multi-professional educators in community settings)
- Responding to Local Workforce Needs: Collaborating to meet local workforce requirements (such as specific skills shortages), including the development of new bespoke programmes to meet specific local needs
- Workforce Development: Developing, commissioning and delivering continuing professional development for all staff groups
- Education Programme Coordination: Local coordination of education programmes to ensure improved economy of scale, reduced administration costs and improved educational governance
- CCG engagement: ensuring effective spend of CPPD funding for primary care

2014/15 Pilot Phase

Based on very positive feedback from the initial review, phase two of the programme has started and additional pilots have been created.

CEPN second phase pilot sites are currently located in Bromley, Bexley, Greenwich, Lambeth, Croydon, Richmond and Wandsworth and we are aiming to develop CEPNs in every south London borough.

Three of the Higher Education Institutions in south London have been brought into the programme to support CEPNs with their development including advising on educational provision, running action learning sets, working with CEPNs to evaluate their activities and promoting the concept of CEPNs locally. As well as developing themselves as entities, our CEPNs have been working on the functions mentioned above and some early achievements include:

- Development of multi-disciplinary training in community paediatrics
- Conducting a GP workforce survey to identify practice staffing shortages, training priorities and willingness to work jointly
- Identifying the local training stakeholders in primary care
- Developing relationships across the key providers in the geography covered by the CEPN
- Identifying core skills required for practice and community nurses and Healthcare assistants
- Developing a programme of local training for secondary care nurses transferring to Practice nurse roles

Community Education Provider Networks

Community Education Provider Networks in South London

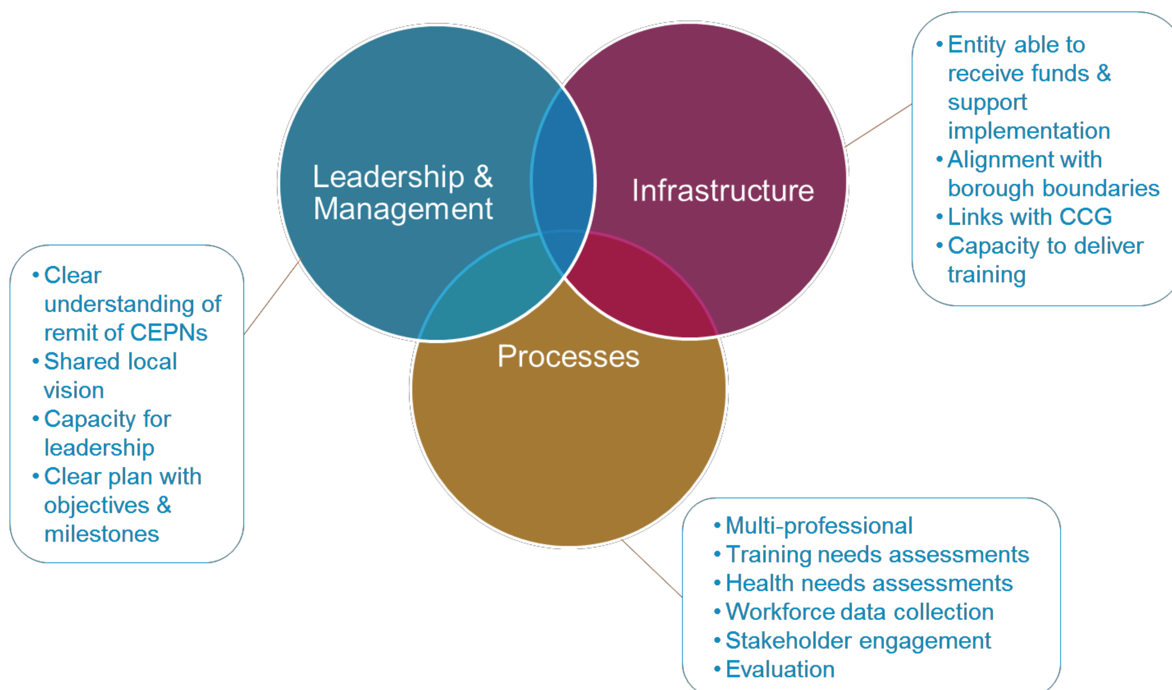
Early review of prototype CEPNs

In Autumn 2013 HESL commissioned the Evidence Centre to undertake an early review of the prototype CEPNs.

The review looked at the activities and progress of the prototype CEPNs in their first four months and what they believed to be the benefits and challenges with this approach. The aim was not to evaluate the CEPNs, but rather the focus was on collecting preliminary information to help Health Education South London consider whether the pilots could be continued and expanded in 2014. The external review comprised examination of 30+ programme documents and discussions with 29 stakeholders, 18 of whom were involved in CEPN implementation and 11 of whom were representatives of broader stakeholders such as higher educational institutions or local GPs.

The early review identified some key benefits and challenges, as well as design principles and building blocks that may help CEPNs to develop promptly.

Community Education Provider Networks



Design Principles

In April 2013 Health Education South London issued a call for proposals to develop Community Education Provider Networks. Four prototype CEPNs were funded to test different models of delivery.

An early independent review took place in October that has helped Health Education South London to develop some core CEPN design principles. These building blocks will help CEPN's to reach the potential milestones that one might expect if a CEPN is developed over a two year period.

- The key function of a CEPN is to support the delivery of a workforce capable of meeting the needs of a local population's health and improving clinical outcomes.
- CEPNs are 'groups of primary and community care organisations that come together with partners as a group of like-minded organisations to collaborate with regard to workforce, education and training'.
- CEPNs work at borough level to design, shape and deliver educational programmes for workforce development.
- CEPNs need the support of established educational and service networks to discharge their functions.
- Key levers for the development of CEPNs include management, financial and legal, and educational governance arrangements.
- Higher Education Institutes (HEIs) and Academic Health Science Networks (AHSNs) are key partners in facilitating the development of CEPNs. In South London, the AHSN is the Health Innovation Network.

Community Education Provider Networks

Benefits and Challenges of CEPNs

The membership of CEPNs can include, although is not limited to, GP surgeries, community pharmacies, community dentists, community optometry, community service providers, acute providers and HEIs. Some of the key benefits of CEPNs include:

- multi-professional education;
- streamlining educational governance and commissioning arrangements;
- real-time primary and community workforce data; and
- enhanced clinical and educational outcomes through the use of peer review.

Most importantly, education and training is more closely tailored to the needs of local communities and more likely to be aligned to service commissioners.

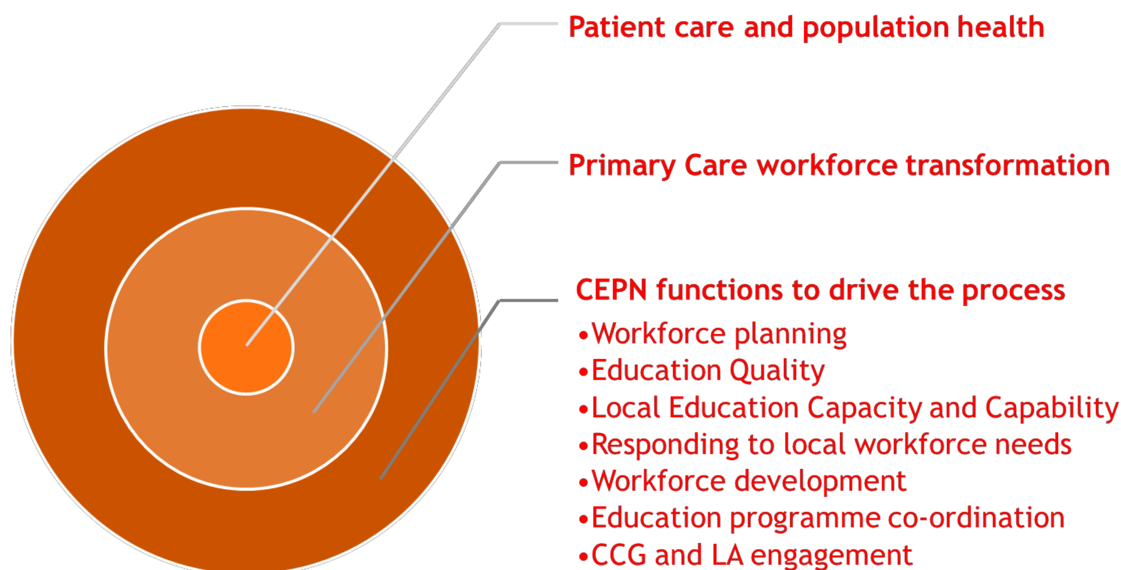
We know that one of the greatest challenges to developing the local healthcare workforce is the need to ensure appropriate provision for groups that have traditionally received less training once they have qualified. Community nurses, community pharmacists and emergent practitioner groups (such as healthcare navigators and health champions) are among these groups. CEPNs offer an opportunity to support the development of these groups whilst seeking to expand capacity and capability for more established professional groups.

End state and building sustainability

At end state it is envisioned that CEPNs will be able to discharge the following functions:

- Workforce Planning: Developing robust local workforce planning data to inform decisions over how education and training funding should best be invested.
- Education Quality: Supporting improvements in the quality of education programmes delivered in primary and community care, for example, through peer review.
- Developing local educational capacity and capability: (for example, an ability to accommodate greater numbers of nursing placements or the development of multi- professional educators in community settings).
- Responding to Local Workforce Needs: Collaborating to meet local workforce requirements (such as specific skills shortages), including the development of new bespoke programmes to meet specific local needs.
- Workforce Development: Developing, commissioning and delivering continuing professional development for all staff groups.
- Education Programme Coordination: Local coordination of education programmes to ensure improved economy of scale, reduced administration costs and improved educational governance.
- Alignment with local commissioners: ensuring that education and training is aligned to changes in service

Community Education Provider Networks



Supporting CEPN development

There is evidence that for CEPNs to do well, they need strong leadership that works across systems. They need support from leaders within local health economies who can bring together professional groups – some of them with limited experience of joint-working.

Financial and legal mechanisms need to be clear so that CEPNs can work within an environment that supports them and which facilitates long-term planning and assistance from Health Education South London.

Good educational governance is a critical component for the functioning of a CEPN. This ensures that educational experience meets the requirements of licensing by Royal Colleges and regulatory authorities. The development of these processes also provides the LETB with quality assurance.

Developing community education provider networks in South London

Lessons learnt in the first four months

October 2013

Key messages

What are CEPNs?

Community education provider networks are a federated model of partnerships developed to improve the quality and localisation of education for health professionals. The aim is to empower community organisations to work with higher educational institutions to assess workforce training needs, expand capacity for training in the community, innovate in the field of training and deliver multi-professional training.

In South London, four CEPN pilots are being funded from May 2013 – March 2014 to test the feasibility and potential benefits of this model. Each CEPN took a slightly different approach.

After four months of operation, a rapid external review was conducted to examine progress to date and what stakeholders believed to be the benefits and challenges with this approach. The aim was not to evaluate the CEPNs, because it is not possible to assess outcomes after only four months. Instead the focus was on collecting preliminary information to help Health Education South London consider whether the pilots could be continued and expanded in 2014.

The external review comprised examination of 30+ programme documents and discussions with 29 stakeholders, 18 of whom were involved in CEPN implementation and 11 of whom were representatives of broader stakeholders such as higher educational institutions or local GPs.

Perceived benefits

Stakeholders were positive about the potential for CEPN models. Although the four CEPN pilots each have a different focus and structure, the perceived benefits of community based networks were common and included a more localised approach to training needs assessment and education provision and shifting the focus from acute to community-based education and care.

Some CEPNs reported early successes, including:

- undertaking educational **needs assessments** using surveys or discussions with local health professionals;
- running **engagement events** attending by many different professions to consider local priorities or engaging with GP practices at primary care fora or practice meetings;
- setting up **training courses** for specific cohorts, identified as being in high need locally (such as healthcare assistants or practice nurses);
- encouraging a small number of nurses working in secondary care to **transfer** to primary care;
- making **links** with other organisations to fund training or to deliver training.

Perceived challenges

As with all initiatives, there have been some challenges setting up CEPNs. The three most commonly mentioned included:

- not being **clear** what constitutes a CEPN;
- difficulties setting up promptly or **engaging people** (especially over the summer period);
- concerns about **sustainability** and where CEPNs fit in with other educational models.

Those leading the CEPNs generally did not feel able to comment about further development needs at this stage and felt this would become clearer as implementation progressed. However if further pilots are set up, Health Education South London might usefully consider providing:

- more support to **promote** the concept of CEPNs locally;
- more visibility of a **senior champion** from Health Education South London to give status to the initiative locally;
- basic training or templates about **project management**, timetabling and planning how to ensure that activities will achieve objectives;
- basic training or templates to support **evaluation** design, including how to ensure a wide range of outcomes are measured;
- more opportunities for **support** / communities of practice.

Key design principles

The differing nature and focus of each CEPN, variation in progress and the short timescale in which they have been operating mean it is not possible to identify key success factors. To do so would require information about the relative success of each initiative.
However, it is possible to suggest design factors that may speed the process of set up and implementation. Three important top level factors are:

- **Vision and management**: such as clarity about function; visible leaders; and project management capacity;

- **Infrastructure**: such as established relationships and close links with the CCG, but not necessarily (co)dependent on the CCG;

- **Processes**: such as including secondary care and higher educational institutions as partners; taking time to engage; and undertaking needs assessments.

The lack of some of these characteristics should not be used as a reason against funding future potential CEPNs. They merely reflect factors that have been found beneficial for prompt set up.

Overall, the external review suggests that CEPNs are beginning to gather momentum and that there is positivity about the potential of this concept.
Health Education South London's planned evaluation of outcomes in 2014 will help to understand whether these benefits are realised and whether CEPNs could be a feasible model for the future.

Contents

1. Background 4

1.1 Context 4
1.2 Review scope 5
1.3 Review approach 6

2. Current happenings 7

2.1 Models being tested 7
2.2 Progress to date 10
2.3 Perceived benefits 10
2.4 Perceived challenges 13

3. Thinking about the future 19

3.1 Developmental needs 19
3.2 Key design principles 24
3.3 Evaluation principles 28

4. Summary 29

References 34

1.Background

1.1 Context

NHS workforce planning and development must be more local and responsive to account for increasing pressures on clinical and educational workloads, a challenging fiscal landscape, changes to how education is commissioned and the desire to improve population health outcomes through integrated working.[1,2] There are many potential models for training health professionals. In 2013, Health Education South London began testing an innovative approach to managing training for primary and community care professionals, known as community-based educational provider networks (CEPNs).

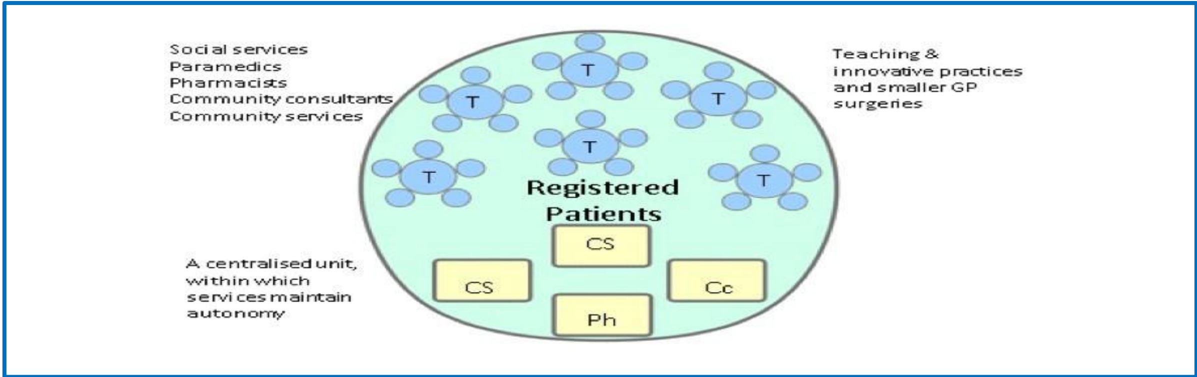
CEPNs are collectives or **networks of primary care and community organisations working collaboratively to enhance educational delivery** in local geographic areas. Such networks may take a multitude of different forms.
Figure 1 illustrates one model, to emphasise the wide variety of organisations that may be involved.

In South London, four CEPNs were funded from May 2013 to test the feasibility of this concept. Each of the CEPNs is taking a slightly different approach, but the guiding remit was to act as the orchestrating unit for community-based education and encourage local organisations to work collectively and develop ownership of educational provision.

> *"In short, the CEPNs were set up to support innovation in educational delivery and the diffusion of best practise and to provide training to professional groups that are a priority for local workforce development."* (stakeholder)

This model is also an attempt to broaden the types and range of organisations involved in the delivery of community-based education with the hope that organisations unused to working together will collaborate around the provision of training.

Figure 1: Potential components of a CEPN[3]



Legend: CS- Community services; T- Teaching practices; Ph- Pharmacy; Cc- Community consultants

1.2 Review scope

Health Education South London is planning an evaluation of the outcomes from CEPNs, beginning in the first quarter of 2014. This will draw on material collected by each CEPN as well as independently compiled material. The evaluation may examine the benefits and challenges of this model for trainees, trainers, patients, practices, community organisations and other stakeholders. In advance of this detailed evaluation it was important to gain some feedback about how CEPNs are developing in order to feed into decisions about next steps. Health Education South London therefore commissioned a rapid external review to draw together feedback from stakeholders about the first few months of operation.

The external review was conducted over a three week period in September and October 2013.

Within just four months of the CEPNs being awarded funding, it was not appropriate to objectively assess outcomes. Instead the review aimed to:

- describe the **progress** CEPNs have made during the first four months based on feedback from those involved in setting up and running the networks and associated stakeholders. This involved comparing what has actually happened during initial implementation against what was anticipated in the original invitation to bid;

- identify perceptions of the **benefits** of this approach and potential challenges moving forward according to the key stakeholders most closely involved in implementation;

- draw out important **building blocks** of CEPNs to assist in planning the potential rollout of this approach. The focus was on identifying what has worked well and not so well to date in order to propose key success factors that could be considered when implementing CEPNs in future;

- begin to consider key components that may be needed in a detailed **evaluation** of CEPNs.

1.3 Review approach

To achieve these aims, Health Education South London commissioned an independent organisation, The Evidence Centre, to review CEPN progress using the following activities:

- reviewing documents about aims and progress provided by each of the CEPNs and other background materials;

- speaking with clinical and operational leads from each of the CEPNs to gain information about progress, perceived benefits and challenges with the CEPN model and potential key success factors;

- speaking with key team members from Health Education South London, the London School of General Practice and other organisations to gain feedback about perceived benefits and challenges;

- informal discussions with a convenience sample of broader stakeholders from the CEPN regions, such as frontline staff who may benefit from the training and higher educational institutions and secondary care organisations that may be called upon to partner or support training;

- group meetings to discuss findings and next steps.

In total, **more than 30 documents were reviewed and 29 people provided feedback**, 18 of whom were directly involved in CEPN implementation from a provider or a commissioner perspective.

To safeguard anonymity, throughout this compilation of key themes, any quotes are identified only as being sourced from a ‘CEPN’ or from a stakeholder (meaning those from Health Education South London or stakeholders in local areas such as higher educational institutions or frontline staff).

There was no attempt made to compare between individual CEPNs or to judge progress in any way. Instead, the focus was on compiling perceived learning points at an early stage.

It is important to emphasise that the focus was on helping Health Education South London think about what could be **done in future**, rather than considering what might have been done in setting up these four pilots.
The review is not suggesting that Health Education South London should have done anything differently
– but rather focuses on considering what might be useful when considering the next phase.

2. Current happenings

2.1 Models being tested

Four CEPNs are being funded between May 2013 and March 2014. Each is testing a different model, which is described in simplistic terms below.

Bromley CEPN

The Bromley model is built on a strong relationship with the CCG (in fact the **CCG is the host organisation**).

This CEPN is focusing on developing **nurse capacity** in the community, as this has been identified as a particular shortage in this area.

The work programme covers two broad components:

- retraining fully qualified nurses who may have been working in secondary care and who are now considering working within general practice or community care;
- training for healthcare assistants (originally this was to facilitate entry to nurse training, but is now focusing on a broader programme).

These activities are closely tied to the CCG's existing work plans.

SLOVTS CEPN

SLOVTS is the South London Organisation of Vocational Training Schemes, which is a combination of several of GP postgraduate training schemes. The SLOVTS CEPN model is focused around an established GP training provider network.

This CEPN is targeting improved **GP training**, including exploring the possibility of joint training with other primary and community care teams and secondary care specialists to increase both the quality and quantity of training programmes and thus attract high quality candidates.

The topic focus is paediatrics, which has been identified as a priority by local stakeholders.

St Georges CEPN

The St Georges model involves situating the management of the CEPN within a **higher educational institution**. This approach is a partnership between St George's University of London and the GP training network around the St Helier area (VTS scheme).

This CEPN is using a **disease pathway** approach. Dementia is being used as a case study topic around which a multidisciplinary educational programme will be developed for trainee doctors and nurses.

Wandsworth CEPN

The Wandsworth model involves a **network of primary care providers** coming together to form a community interest company (CIC). Most general practices in the area are now engaged with the CIC, which was set up well before the CEPN pilot and took significant time and effort to develop.

Wandsworth Healthcare CIC's shareholders are local GP practices throughout the Wandsworth Borough (excluding Putney and Roehampton). Thirty-one of Wandsworth's 42 practices are shareholders in the CIC. For the CEPN, to date 39 of the 42 practices have engaged by completing the practice questionnaire. Thus this model focuses both on a local area and on a federated model of GP practices working together.

Over the period between May 2013 and March 2014, the Wandsworth CEPN is focusing on:

- mapping all training provided or supported in local GP practices and collecting basic staff demographic information from practices to help identify training needs
- engaging non-training practices to offer continuing professional development and other training
- expanding the training offered in current training practices

The overall aim is to learn more about training needs and to use **GP practices as the base** for providing more training.

Model characteristics

There are differences in the extent to which these four approaches include the characteristics inherent in Health Education South London's vision of CEPNs (see Table 1).

Comparing current progress against Health Education South London's original specification, it could be argued that some models appear to fit most closely with the initial vision of CEPNs – but every one of the models being tested has positive points. It is important to emphasise that there may be changes in functions over time as the CEPNs are at an early stage of development, but initially it appears that some approaches are not so much operating as a 'network as much as setting up 'projects' where different organisations can take part in training. In these cases, the 'network' and multiprofessional aspect thus comes in at the point of receiving training (or via trainers), but not through the planning and organisation of the training itself.

Exploring the extent of alignment with the original specification is not a criticism of individual CEPNs. Instead it merely highlights that a variety of strategies are being trialled and some of them more closely fit Health Education South London's original vision of what a CEPN might comprise. Testing a range of model variations arguably strengthens the process, because with careful evaluation it will be possible to draw out the components of the models that have worked well and less well. It is also true that Health Education South London's original conceptualisation is not necessarily 'correct' and may be further developed to include, exclude or differently prioritise some of these components in future.

Table 1: Extent to which each model currently contains characteristics of CEPNs

Characteristics	Bromley	SLOVTS	St	Wandsworth
Acting as the orchestrating unit for all community-based education	✓			✓
Encouraging local organisations to work collectively, including primary and secondary care and HEIs	✓	✓	✓	✓
Encouraging local organisations to develop ownership of educational provision	✓	✓		✓
Broadening the range of organisations involved in education (including non-training practices)		✓		✓
Organisations unused to working together are collaborating to deliver training			✓	✓
Broadening CEPN membership to providers such as optometry, dentistry, and pharmacy				
Supporting innovation in educational delivery				✓
Supporting diffusion of best practice			✓	✓
Undertaking training needs assessment and workforce planning	✓			✓
Engage patients to ensure patients are driving the new ways of working				
Providing training to professional groups that are high priority locally	✓			✓
Multidisciplinary teams are running training		✓	✓	
Multidisciplinary learners are involved in training		✓	✓	
Including undergraduate and postgraduate needs	✓	✓	✓	✓
Providing educational placements	✓	✓		
Support transformation of the workforce from secondary to primary care	✓			
Helping design a local workforce to support sustainable improvements in population health	✓		✓	
Facilitating integrated working with the aim of improving productivity and value for money				✓
Complying with regulatory and governance requirements	✓	✓		✓

Note: The CEPN characteristics are drawn from documents outlining Health Education South London's vision for CEPNs. This is not the only characterisation of CEPNs possible. CEPNs have been assessed as fulfilling each criteria based on programme documents and feedback from implementation teams and stakeholders. This reflects achievements at an early stage, not potential.

2.2 Progress to date

Just as each CEPN is taking a different broad approach, so too the degree of progress is varied. Table 2 provides a brief summary of progress as of September 2013.

All of the CEPNs have varied from the timeframes or focus areas specified in their original bids, and Health Education South London has accommodated this flexibility.

It is important to re-emphasise that the purpose of tabulating progress is not to judge or criticise individual CEPNs, but rather to learn about what has been working well to date. It is also important to highlight that CEPNs have several more months left in the initial pilot period and all believe they will have made significant progress in that period.

2.3 Perceived benefits

There was solid support for the CEPN concept. Current models for educating health professionals were perceived to be unsustainable both financially and politically. It was felt that the trend towards **relocating service provision** from acute care into the community needed to be mirrored by similar changes to the provision of education for health professionals in the community.

> *"This is a great model. It is about supporting one another in small peer support groups. It fits into theory of change models and it is so applicable and appropriate to education models. Other models don't work for community education."* (CEPN)

> *"Changing people's behaviour starts at grass roots level."* (CEPN)

Furthermore, people thought there was more scope to **share training** and resources in small groups (such as across GP practices).

> *"To run training properly you need to have groups that are smaller than CCGs. Small groups are better for collaborating and peer support and getting things done. Larger groups can be too formal. A tight knit smaller group is needed to make this model work that is a large enough organisation to be viable but that can be more local and responsive than CCGs can be."* (CEPN)

Table 2: CEPN progress over the first four months

Feature	Bromley	SLOVTS	St Georges	Wandsworth
Co-ordinating organisation	CCG	GP training scheme network	University	GP provider network
Broad purpose (during pilot)	Improve community nursing capacity and increase patient satisfaction with nursing care	Improve quality and quantity of GP postgraduate education, focused on paediatrics	Use dementia as a case study to develop a multidisciplinary education programme in the community	Develop into a recognised CEPN organisation in order to assess needs and provide training to fill gaps
Target group	Nurses	GP trainees	GP and nurse trainees	GPs as a first step
Activities already completed	Diabetes training for HCAs and nurses running, with all 77 places filled 8 nurse mentors completed update training and 8 new potential mentors	Two engagement events held to undertake needs assessment		Needs assessment / training scoping / stakeholder map Promoted CEPN at GP forum, practice manager forum and practice nurse forum
Activities scheduled / underway	Provide training for secondary care nurses ready to relocate to primary care (4 nurses have relocated) Cardiology training for HCAs / nurses being developed One GP identified for leadership training for sustainability of programme	Workplan being finalised based on event feedback. Likely to focus on training in paediatrics	Engage GP practice(s) as host venue Develop multidisciplinary educational programme and trial sessions with group of GP undergraduate and postgraduate trainees and nursing students (also others invited)	Running engagement events on a larger scale Define training gaps across multiple professions Co-ordinate with other organisations to run training to fill gaps Identify funding from other sources for training
Other plans		Analysis of existing capacity for GP trainees in practices Development of new trainers and supervisors Proposals for paediatric registrar outpatient training		
Evaluation planned	Before and after training impacts	Approach not yet finalised	Approach not yet finalised	Before and after training impacts

> *"It is very important to deliver training in the community. It allows you to set up a type of bartering system between GP practices. You can share capacity for training across practices so courses are always full and you can exchange services, like venues or admin help, rather than paying for training. This will be more cost- effective in the long-term."* (CEPN)

There was positivity about putting '**control**' of education into the community.

> *"We are trying to create a network of all stakeholders in primary care education to allow it to be bottom up so primary care organisations themselves are in charge of what education is needed."* (CEPN)

Thus there was support for the concept of CEPNs in principle, and no sign of 'burnout' relating to the initiatives, although questions remained about sustainability, funding and security within a constantly changing NHS landscape.

In addition to thinking about the potential of the CEPN concept as a whole, the implementation teams were asked about the perceived benefits of the individual CEPN initiatives. It is important to note that these benefits are the perceptions of senior stakeholders rather than objectively assessed benefits, or the perceptions of those who may not be so closely involved in implementation.

Bearing this caveat in mind, perceived benefits of local implementation of the CEPN model(s) included:

- increased **engagement** with local GP practices and social services (for example Bromley sees working with social services in nursing homes as a key success factor, Wandsworth reports regular engagement with the majority of local practices and SLOVTS has held specific engagement events);

- an increase in knowledge about the **training needs** of professionals (for instance SLOVTs and Wandsworth are compiling needs assessment data, based on surveys and feedback from practices and professionals);

- an increase in the **number of professionals** who have taken part in or will be given the opportunity to take part in training that would not otherwise have been available to them (for instance Bromley has training for nurses and HCAs underway);

- four nurses **moved** from working in secondary care to primary care in Bromley

There were plans to forge new links, perhaps set up e-learning resources and undertake many other activities that could have benefits throughout the pilot period.

Everyone spoken to thought that this approach was worth testing further, and it was acknowledged that it may take some time for benefits to accrue.

2.4 Perceived challenges

As with perceived benefits, the teams setting up CEPNs and representatives from Health Education South London were asked about potential challenges with the CEPN model(s) to date. The most commonly mentioned challenges are outlined here.

Unclear scope

The scope of the CEPN model in South London remains unclear, to both providers and commissioners to some extent. It is not clear whether the network model is being organised around specific pathways of care, around geographic areas or around a population focus (or all of the above).

> *"The team was not clear what CEPNs were so it is hard to create one and assess it. It is hard to promote this idea and conceptualise it. As a result the original specification was not clear."* (stakeholder)

The CEPNs each have a different focus, and whilst this diversity would be useful if detailed comparisons of processes and outcomes were being undertaken, this is not currently the case. Thus much of the learning from the diversity may be lost, leaving only a feeling that the purpose and scope of CEPNs is unclear.

In planning any future rollout of CEPNs in South London, it may be important to **clarify exactly what model should be tested**. For example, is the main focus on giving GP practices or other community organisations a leading role in co-ordinating a larger group of organisations to provide training or is the focus on bringing together any group of organisations to jointly offer training (about a specific topic area or for certain groups of professionals)?
Clarity of scope would help potential provider networks better understand what was required and would also help Health Education South London better assess the extent to which those objectives are being met.

This is not to suggest that multiple models are not possible or desirable, but the learning from the first four months suggests that a lack of clarity about scope and purpose has been inhibiting for some groups and may have hindered prompt rollout and broader buy-in. In the short-term it may be useful for Health Education South London to **concentrate on more clearly specifying the functions that CEPNs should fulfil**, and then test in detail whether this model is feasible and sustainable compared to more traditional approaches.

Another suggestion is to spend more time **engaging with groups that may consider putting in a bid** for CEPN funding, so that the intricacies of the concept can be explained and people have an opportunity to test their ideas, perhaps by writing a short one or two page expression of interest and getting feedback on that before progressing further. This may help to promote a shared vision of the concept.

Wider promotion and support

Whilst members of Health Education South London and those implementing CEPNs were supportive of the broader ideas behind CEPNs, the extent to which this is true of other stakeholders remains unclear. Only 11 stakeholders not heavily involved in CEPN implementation were spoken to during the review so conclusions cannot be drawn from this small sample, however there was a trend towards some frontline professionals and higher educational institution representatives being unclear about the role of CEPNs and where they fit in with other structures. This may be due to a lack of clarity about purpose due to the developmental nature of CEPNs or signal the **need for greater promotion** and engagement of a wider range of stakeholders than has currently been the case.

CEPN representatives suggested that a key challenge had been gaining buy- in to the concept of CEPNs because this is such a new idea. Other organisations may feel anxious about their own future or unclear of the CEPN remit, and this can lead to 'push back.' Health Education South London may like to consider ways to address this, perhaps through **wider promotion and support of the concept** if CEPNs are going to be tested further.

> *"This is a huge opportunity. Getting people around the table in the community is the way forward. There is support for this concept but it needs more advertising through GP magazines and so on to get the terminology out there. CCGs need to know more about it and do more to promote it."* (CEPN)

CEPNs also need to be mindful that their initiatives may appear threatening to other stakeholders, particularly as much training has traditionally been centred in secondary care.

> *"A challenge is that people have their own empires to defend. Maybe hospitals wants to bring things into the hospital rather than in GP practices and this could be worse if the hospital is under threat of closure."* (CEPN)

Some suggested that there may even be attitudinal barriers to multiprofessional learning, for instance if doctors do not think it is relevant to learn with and from social workers or vice versa.

Once CEPNs have their infrastructure set up, they may need **support to build partnerships** and generate projects to work on. In the short-term most of the CEPNs have a defined topic area or project plan, but in the longer term promotion of the existence and capabilities of these networks will be key to facilitating their integration as a 'mainstream' part of educational provision. Health Education South London and the primary care forum may have a role to play here in **making links between networks and projects that they could conceivably partner with others to complete**. For example, even within the current set of four pilots, it might be possible for two to partner up – with one having the infrastructure and networks to roll out training and another having an innovative model of multidisciplinary training to test (as in the Wandsworth and St Georges models, for example).

Funding

Interestingly, a lack of funding was not described as a major barrier to progress. Nor did CEPNs talk about wanting more upfront funding to pump prime their activities. Of course, further resources are always welcomed, but this was not seen a key limiting factor, except in one case.

Some CEPNs did say that the **funding provided was not enough to run training** itself, just to build a structure and start engaging people in a network to take the next steps. Thus some CEPNs were applying for other funding streams or seeking partnerships with the CCG to provide training. However this is not a limit in itself, and in fact could be argued to be a good way forward: using funds to set up a structure that is ready to take on training work. The lack of funding available to provide funding though was a frustration, once the groundwork had been put in to developing the network and partnership ready to do this.

Another funding issue is that there were some **technical or process bottlenecks**, such as Health Education South London's finance department reportedly being slow to process payments, which means that funding was not available when needed to finance activities.

Personnel

The main practical barrier was having enough **time and capacity** from senior and visionary personnel to devote to developing and maintaining the CEPN.

Having a **programme manager** in place on at least a part-time basis was essential to ensure the smooth running of activities and CEPNs that had existing programme management personnel or could readily appoint someone seem to have moved forward more quickly because they did not have the delay of recruitment.

> *"You can't underestimate the time it takes to do all the liaison and admin work and also the thinking through and planning. Having good management and day to day admin support is crucial. If these things get bigger and roll out, adequate admin time will be much more needed."* (CEPN)

Some of the CEPNs said they were not well placed to collect workforce and training needs data because they did not have capacity to do the work needed and they did not have the links with necessary organisations throughout the community.

Timing

The CEPNs began their work over the summer period when there is traditionally a loss of momentum as many people away on leave and it can be difficult to set up meetings or events or encourage people to send back needs assessment surveys.
This even further reinforces the caution expressed earlier about progress.
Progress to date should not be used as an early indicator of success throughout the entire pilot period.

CEPNs who were undertaking **training needs assessments** said that it took a great deal of time to get feedback from organisations and teams, perhaps more time that they had built into their project plans. This is a lesson for the future: when Health Education South London reviews any future funding applications for CEPNs, it may be important to **help applicants revise their schedules** to do needs assessments over the first quarter rather expecting these to be completed within the first month.

It also takes **significant time to meet with stakeholders** and explain the role of the CEPN. This reportedly has been most effective when done face to face in small groups, so time and capacity needs to be allocated to this, done by a person who is passionate and knowledgeable about the CEPN rather than seeing it as 'just another project.'

"The pace of change is a challenge. It is difficult to keep the momentum going due to having to hurry to fit everything into the pilot period. It takes time to develop relationships across organisations." (CEPN)

Terminology

Early on, Health Education South London used the term 'community hubs' to describe the CEPN model but this was altered to 'networks' as it was felt that people perceived that a hub would be associated with a building.
This illustrates the importance of terminology in shaping the way that CEPNs are viewed. It could be argued that using the term 'education networks' would be even more appropriate so as to simplify the terminology and to not implicitly exclude providers that may be based outside community organisations from the partnerships. Indeed if partnerships with secondary care organisations are thought to be key, then the term '**education networks**' or 'multiprofessional education networks' may more readily incorporate this concept, as well as allow for a broad range of functions and foci, depending on local needs.

Other practicalities

Another challenge for some CEPNs has been locating **community venues** in which to run training that are of sufficient size to account for multidisciplinary learners. When a wider range of professionals are involved in training the number of people taking part may be larger than can be accommodated in a GP practice, for instance.

"The minute you go multidisciplinary, the number of participants for training skyrockets. The practicalities of finding rooms to fit people are difficult." (CEPN)

Positioning of CEPNs

Most people involved with implementing CEPNs as well as external stakeholders **saw CEPNs as an addition to current structures** of education for health and care professionals, rather than as entities that may one day take on a 'lead provider' role. Again, this may be due to the phase of development, whereby CEPNs are just being set up.
However, it may be a cause for concern if Health Education South London's vision is for these networks to take on a central role in local education planning and provision in future.

Furthermore there was some concern that CEPNs could become a branch of CCGs or that there would be an inappropriate amount of crossover in funding and roles, thus negating the potential benefits of separating training from service provision and commissioning.

Others were concerned about **negotiating the relationship between CEPNs and CCGs**, so that CCGs 'relinquished the reins' but did not feel unduly challenged.

"The CCG is an important stakeholder because they have held the budget for training. But we need to work together now and they need to realise that practices will only buy-in if they see a benefit for themselves.
Over time we hope to change what training money is spent on." (CEPN)

"At first there might have been a little bit of push back from the
CCG, because they didn't really understand what was happening and maybe they felt threatened for their own security. It take a lot of time to have meetings and to build collaborative relationships so people can see we are developing a network, rather than trying to take over." (CEPN)

Health Education South London may **consider ways to smooth this process** in future, perhaps by inviting CCGs to introductory meetings, providing letters to explain the purpose of CEPNs and providing reassurance that CEPNs are not an attempt to destabilise CCGs.

Sustainability

Linked to this, an important issue is how CEPNs can be set up in a sustainable manner that does not rely on 'project'-type funding from Health Education South London. Whilst CEPNs may be funded from core costs in the short-term, in the longer term there is a desire to ensure that they become **self-sustaining entities**, perhaps linked to CCGs or higher educational institutions. Learning during the first four months of the pilot period does not allow conclusions to be drawn about sustainability because set up and implementation has just got underway.

The **legal form of organisations** is important from a procurement point of view because networks need to be able to hold funds and operate as a 'business.'

CEPNs that begin from an established structure (such as a community interest company) or with strong links to CCGs may have more longevity than those where a team has been set up to fulfil a specific 'project brief' such as delivering training about a certain topic. The process of setting up a community interest company is long and potentially arduous, and has not been done within the pilot timeframe. It may be that CEPNs are encouraged to consider this route in future, as they begin to demonstrate success, but it would be unreasonable to rule out potential networks from receiving pilot funding because they do not already hold this status.

Providing regular feedback

There is a perception that CEPNs have not been good at reporting back their progress to Health Education South London. Whilst the CEPNs have had a few short months to set up and there may not be a great deal to report, some CEPNs have not kept in contact to notify Health Education South London of this.

This may be a function of how the **relationships between the organisations** were set up from the outset. As this is a developmental pilot, Health Education South London has taken a supportive role rather than a 'top down' or authoritarian role, but is heavily reliant on CEPNs to report back progress, identify any support needs and evaluate their processes and successes robustly in order to help with decisions about further rollout of the CEPN concept. In contrast, it appears that some of the CEPNs have treated the funding a little like a 'development grant' where they are given funds to go away and try new things, perhaps reporting back on activities at the end of the grant period, and feeling free to change the scope of what they're doing as they go along rather than seeking permission from the funder.

The lack of clarity about the importance of regular contact is something that could be remedied by including a reporting schedule in the invitation to bid, ensuring the funding award letter requires attendance at meetings or telephone progress updates, making payment instalments dependent upon the receipt of a satisfactorily detailed progress report and using a reporting template more tailored to generate the information Health Education South London needs.

3. Thinking about the future

3.1 Developmental needs

In addition to asking CEPNs about current progress, the review also considered issues for future development – both the development of the four individual CEPNs and the model more generally. Once again it is important to note that this is not suggesting that these things should have been done in the initial pilot period – but rather considers what the next steps might usefully be.

Support during set up

If Health Education South London is considering piloting further CEPNs, there have been some lessons learnt about the clarity and support needed from the outset.

Stakeholders from both Health Education South London and the CEPNs suggested that it may have been useful to have more guidance about what constituted a CEPN and what was expected. The initial commissioning brief was purposefully broad to allow innovation and so that various different types of models could be tested. It also reflected Health Education South London's own developmental phase in terms of understanding what a CEPN may look like. However for future iterations, learning from these pilots can be applied about what helps speed development and these broad principles could be built into **commissioning specifications** (see the section on 'key design principles' and Box 1 overleaf).

Another opportunity for supporting future CEPNs may be to provide learning sets, written templates or podcasts to help strengthen project planning, management and evaluation skills. Those running CEPNs are doing so in addition to many other activities and for some, planning and managing large scale initiatives such as this may be new. Even experienced project managers could benefit from sharing ideas with others and learning how concepts may need to be adapted locally.

Ideally a one or two day **workshop** could be offered early on in CEPN development, to cover topics such as:

- expectations for CEPNs
- how to come together as a network
- how to work as a 'business'
- how to clarify objectives and activities
- how to plan project timelines
- how to build in evaluation from the outset
- how to engage with local stakeholders and practitioners
- how to undertake a training needs assessment

It is important to note that each CEPN is unique and thus not all would want or need support in all of these areas. However, workshop(s) like this would help to ensure that all CEPNs are starting from a common framework as well as building camaraderie.

This initial workshop or series of learning sets in quick succession could then be followed up in about one month with another session to:

- encourage CEPNs to report back on progress and receive support with any challenges encountered
- go into more detail about how to make links with local organisations
- describe how to work with established lead providers and higher educational institutions
- cover how to develop appropriate communication tools such as email newsletters and leaflets to promote the CEPN and the training offered
- begin planning for sustainability

Health Education South London was seen to be a useful resource for providing contacts and making introductions, so any learning sets could include this activity.

Following initial learning sets, progress update sessions could be held quarterly, with selected **CEPNs perhaps taking the lead in presenting a 'how to guide' on an aspect of their work** – such as how to analyse training needs or how to encourage practices to allow staff time away from clinical work for training, for example. In this way, a community of practice would begin to be built, with CEPNs taking the lead on sharing learning about how to progress this model rather than merely reporting on their activities.

"There needs to be more peer support and more clarity about what is needed. CEPNs need to be able to articulate what is the benefit for practices and get the good news stories out." (stakeholder)

Some suggested that group teleconferences between CEPNs and Health Education South London every six weeks or so during the first few months may help people keep engaged and keep prioritising the process.

Templates could also be provided from the outset to help CEPNs with various activities. This would provide a structure for the work in the initial stages. Providing completed templates could be built in as milestones as part of the requirements of receiving funding. Templates may include, amongst others:

- project plan
- training needs assessment
- evaluation plan
- interim and final reports

The Health Education South London team acknowledged that during this initial development phase they focused their energy on getting funds out into the community, but in future could perhaps hold some of the funding in- house to provide ongoing development support.

Support during implementation

In terms of ongoing development for existing CEPNs, most stakeholders did not identify significant support needs at this stage although they noted that these may become apparent as implementation progressed.

Suggestions for support over the next few months were largely related to promotion, communication and evaluation.

In terms of **promotion**, CEPNs suggested that they would like more visibility to help increase understanding among local health professionals and others about what a CEPN is and how it can benefit professionals and patients. To support this, suggestions included:

- a champion from Health Education South London writing a **letter** or memorandum that could be circulated to all local professionals and other stakeholders outlining what a CEPN is, why it is an important opportunity for primary and community care, and why it is important for people to come together to engage and support the concept rapidly whilst funds are available;
- members of the Health Education South London team **attending CEPN meetings** or stakeholder events to show there is support at senior level for this concept and to address any queries;
- help to find specific training **projects** (with associated funding) to work on, now that network infrastructures had been set up.

With regard to ongoing **communication**, CEPNs valued the opportunity to get together with others piloting the concept to learn different approaches and spark new ideas.

Some thought it would be useful to have more regular contact with Health Education South London, including visits to the locality rather than only centralised meetings at Health Education South London's offices.

Stakeholders from Health Education South London raised questions about whether there was a good balance in their commissioning relationship with the CEPNs. As previously noted, in the development phase, Health Education South London has taken a somewhat informal and supportive role in recognition of the developmental nature of these providers. However some wondered about whether a more authoritative role would be useful to prompt progress and to ensure regular reporting and appropriate evaluation.

Support measuring success

All of the CEPNs are required to evaluate their progress and successes during the pilot period. Plans for this have been developed to a varying extent and this is an area where further support may be warranted.

Half of the CEPNs have yet to think through fully how they will evaluate what they are doing, but recognise that this needs to be done. The other half have thought through their evaluation strategies, but these tend to focus on descriptive mechanisms and outputs, rather than an evaluation of the CEPN model itself.

All CEPNs are keeping records of their tangible outputs, such as the number of training programmes run.

CEPNs are also planning to measure any gains in knowledge and skills resulting from training, using before and after surveys with participants. In one case there are plans to follow up after training is complete to see whether new skills are embedded in the workplace.

There was a call for **support with planning what to measure and how to measure it,** recognising the short timeframe of the pilot period. For any future pilots, this may be something that Health Education South London wishes to build in from the outset, such that CEPNs are encouraged to think through simple templates with logic models and structured questions itemising their objectives, how they will achieve them and how success will be measured (see Figures 2 and 3 for basic examples).

For the existing pilot sites, Health Education South London may wish to consider providing a template so that CEPNs have a clear idea of the information that is expected in a **final evaluation report**. The template could include a table detailing outputs such as the number of engagement events run, the number of training activities run and the number of professionals of different types trained. It could also include space to report on the extent to which new types of training are being commissioned, whether professionals that would not usually have attended training are doing so, and the extent of multidisciplinary learning. Added to this, there would be space to provide information about outcomes for learners, practices / organisations and patients, if applicable. Finally, Health Education South London may expect a detailed summary of lessons learnt.
Providing such a reporting template as early as possible would make it clear that details about processes, outputs, outcomes and learning is required and would give the CEPN sites time to collect this information if they are not already doing so.

Whilst measuring knowledge gains or other immediate impacts from training is useful, it will perhaps not inform Health Education South London about whether the CEPN model itself is beneficial. To do this would require further documentation of what CEPNs do and how they do it and comparisons between areas using this approach and others that are not.

Figure 2: Basic example of a logic model template

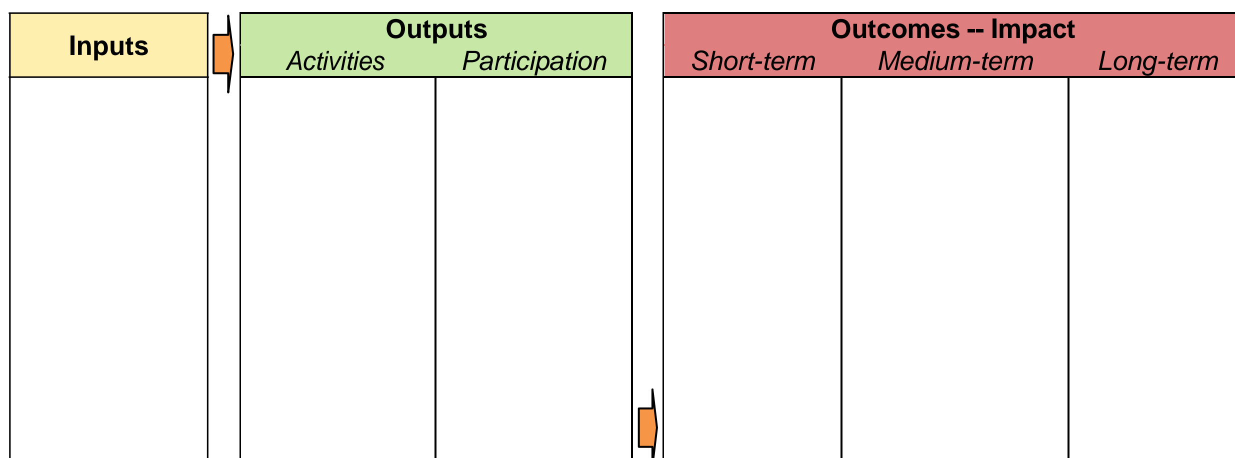


Figure 3: Basic example of a template to clarify measurement

What do we want to achieve?	How will we do it? (activities / outputs)	How will we know we succeeded? (indicators)	What tools will we use to measure?

Thus there are two issues regarding evaluation of CEPNs:

1. Some CEPNs may have ongoing development needs in terms of **learning simple and effective ways to evaluate** the impact of the activities they are undertaking. These could be addressed via providing templates and perhaps a short workshop or evaluation expertise.

2. However, even if each CEPN evaluates their activities well this will not provide evidence that the **CEPN model itself** is more beneficial than alternatives. To do this would require comparisons between areas and a more detailed focus on processes and success factors, as well as merely impacts from activities. This may be addressed in Health Education South London's planned evaluation of this approach.

3.2 Key design principles

From the information available to date, it is not appropriate to suggest a 'best model' of CEPNs going forward. Not only is no comparative information available, but it would be unfair and unwise to compare progress given the disparate populations and topics of focus. In other words, there are too many confounding factors to be able to say that prompt progress is a function of the model itself versus other issues.

However, it is possible to elucidate factors that have helped or hindered each CEPN to progress which may be considered key design principles for moving forward.

The top three helpful factors for implementing CEPNs rapidly can be divided into the areas of leadership and management, infrastructure and processes. Each of these areas has multiple subcomponents, and all interact with each other like the cogs of a wheel (see Figure 4).

Figure 4: Potential key design principles in prompt set up of CEPNs

Leadership and management

Wider research suggests that having strong leadership, good change management and clear shared goals is important when organisations are working together to innovate and support change.[4,5,6,7,8] This seems to apply to the development of CEPNs too.

The CEPNs that have progressed most promptly have a **defined leadership and management structure, with administrative resources**. It is difficult to say whether progress to date can be attributed to various models as opposed to the individuals involved in championing them, but in assessing the potential of additional CEPNs, Health Education South London might usefully examine whether both appropriate structures and leadership and management capacity are in place. This ensures that success isn't 'project orientated' and does not rely heavily on one or two particular individuals.

Having a clear vision of what they want to achieve, why and how has helped some CEPNs progress promptly because they have been able to articulate this vision and share it widely with others. This requires both good leadership, but also communication and networking skills. It is an example of how the key design principles interact – combining elements of leadership and processes.

Agreeing on common goals and having strong visionary leadership are essential, but research suggests that this is not enough. Instead it is important to have structured management processes, with due regard to communication strategies, project management and meetings and communication.[9,10,11]

Some CEPNs suggested that these may not be skills that frontline practitioners held, so using specialist management expertise was recommended.

> *"You need management support, rather than just being practitioner-led. This gives different expertise. To do this properly you need business skills, experience in governance for holding money and how to run things day to day. GPs might not have those skills or want to develop them so getting in a proper project manager helps."* (CEPN)

As well as leadership and management within the CEPNs, during the pilot period this vision and management may also be crucial at the level of the Local Education and Training Board (LETB). Having **champions** to promote the concept and 'sell' it to the wider community may be useful, particularly given the wide range of initiatives ongoing in primary care. To get the buy-in needed by a wide range of stakeholders, Health Education South London champions could usefully articulate that buy-in to the model could lead to a beneficial change in how training is funded, arranged and managed.

Gaining the balance between a supportive and a managerial commissioning relationship may also be worthwhile. The existing pilot has perhaps erred on the side of friendly support, whereas stricter adherence to reporting deadlines and provision of templates and learning sets may all have a place in future iterations.

Infrastructure

Published research suggests that organisational and educational change requires shared processes, solid infrastructure and clear resource allocations.[12,13,14,15,16,17,18]

In the case of CEPNs in South London, the components of infrastructure that have been found to speed implementation progress include:

- an existing structure or network of organisations working together
- close links with the CCG or other local commissioning stakeholders
- close links between primary and secondary care

CEPNs may be based around CCG areas, but this is not necessarily a pre-requisite. It does seem important however for close links to be made with CCGs, so that educational planning and delivery goes hand in hand with service commissioning and provision. In the Wandsworth CEPN pilot, there were established links with the CCG and this has been further strengthened by regular meetings and communication and by branding forthcoming training as being jointly hosted by the CCG and CEPN. This gives the CCG a sense of input and a degree of ownership around the training of health professionals and also benefits the CEPN by linking to an established organisation with funds, infrastructure and status.

However CEPN implementers and other stakeholders also warned against linking future CEPNs too closely CCGs, as these organisations may not themselves have a sustainable future.

> *"It doesn't have to be so closely linked with CCGs because we don't know if CCGs will last and we don't know what their role or pressures might be. Education might not always be a priority for CCGs. Having a separate organisation is therefore important."* (CEPN)

The CEPN model requires **partnerships between primary and secondary care**. Whilst the focus is on training in the community, good training of primary and community care professionals cannot be divorced from the role of secondary care. It is also important that training providers based in secondary care do not see CEPNs as 'competition', so building close links from the outset and drawing on the skills of secondary care providers appears beneficial.

It is not possible to say whether a particular legal entity or structural form is a key design element at this stage, though networks with an established structure have applied the model more quickly than networks being set up from scratch.

The population size being targeted, both in terms of professionals and patients, may ultimately have a bearing on success but no comparative information is available about this at this stage. This may be something that Health Education South London wishes to collect information about in future.

Interestingly, having a central support organisation, such as Health Education South London, was seen as an important part of the infrastructure when setting up CEPNs to help develop communities of practice and provide practical advice.

> *"Having a supportive central organisation is good to help share ideas with other pilots, facilitate networking with others in our area and help with setting up legal structures."* (CEPN)

Processes

The things that CEPNs do and the relative priority awarded to different processes may have a bearing on progress. The broader research literature emphasises that gaining buy- in, using change champions appropriately and taking time to build relationships can be significant predictors of success in change initiatives.[19,20,21,22,23]

In the case of these CEPN pilots, a key design element appears to be the amount of time and planning (and the speed at which) organisations and professionals have been engaged in the process. It can be time-consuming to promote a new concept, but in future it may need to be acknowledged that **a core facet of the CEPN role involves promotion and engagement**. There is no 'best' mechanism to achieve this. Some of the CEPNs have used existing primary care fora or practice meetings, some have set up specific engagement events and others have used face to face meetings with individual practices or small groups of practices. Regular telephone and email communication has also been found to be worthwhile.

> *"Networking is important. Get people around the table. Don't procrastinate. Keep the momentum going. Set regular meetings."* (CEPN)

Health Education South London helped prepare short promotional leaflets, but these did not seem to have been an immediate support, so it appears that more interactive promotional methods may be an important first step.

In terms of who to target, CEPNs were generally focusing on those that may be most motivated and easily accessible first, with a view to demonstrating success and then expanding to a greater range of professionals.

> *“The workforce have esteem and burnout issues so we need to make things better for them. We are starting with those who have capacity now first. So for example, we might target receptionists, then HCAs then nurses then eventually that will release capacity for GPs to attend training. You have to start with the groups that are most enthusiastic first.”* (CEPN)

Another important design element involves assessing the **training needs of the workforce**. Some CEPNs have begun this, and found that more time needs to be devoted to it. In future it may also be important to support CEPNs to draw on **health needs assessment data for the population**, because a key aim is for CEPNs to improve the quality and capacity of the workforce in order to impact population health and wellbeing. This perhaps requires a better understanding of the needs of the population itself.

It takes time for new things to embed so a key design principle is to **allow enough time for initiatives to take shape** and for relationships to be built, rather than expecting immediate successes. Health Education South London has been keen to understand early lessons learnt, but it is also important to be realistic and not pressure networks for outcomes at an early stage.

3.3 Evaluation principles

The section about developmental needs highlighted that CEPNs may benefit from some support to plan their own evaluations and self-assessments. Health Education South London is also considering a broader evaluation of the CEPN concept, either drawing on these four pilots, or based on future CEPNs that may be funded.

In thinking about the principles to include in such an evaluation, to really understand the benefits of the CEPN model(s) it will be important to **compare** with another approach to planning and providing community education. This could involve a combined quasi experimental and before and after design. Outcomes from CEPN pilots could b compared to areas not using the CEPN model, as well as examining outcomes before and after setting up CEPNs – but on area-wide basis, rather than solely for learners in individual training programmes.

The **‘outcomes’ to be measured**, and thus the exact methods to be used, would depend on Health Education South London’s and the CEPNs’ objectives, but in broad terms could cover the extent to which CEPNs achieve the ‘vision’ (such as bringing organisations together and multiprofessional education); learner outcomes, including perceptions of multidisciplinary learning / working; increased knowledge; increased confidence in multidisciplinary working; and perceptions of stakeholders about benefits and challenges of this model.

It would be spurious to provide further overarching evaluation ideas at this stage without an idea of the likely timeframe and budget available.

4. Summary

The key points from the review can be summarised as follows:

Progress to date

After just four months it is important to be realistic about the progress that CEPNs could make. At this stage:

- all four CEPNs have **planned** what they want to do and why;
- two CEPNs have undertaken a **needs assessment** regarding education in their coverage area and are compiling the findings for use when planning training delivery;
- one CEPN has run **engagement** events for local stakeholder organisations and another CEPN already met regularly with general practices and has used this meeting as a forum for discussion. Another CEPN has engaged via various primary care fora;
- one CEPN has begun running **training courses**. Quantitative information about outcomes for learners is not yet available. Others are in the process of scheduling training or attempting to find funding to offer training.

Benefits and challenges

The main perceived benefits of the CEPN model include giving more control and autonomy to community professionals, greater ability to respond to local needs and capacity issues and fostering communities of practice that have the potential to improve multidisciplinary learning and working.

The main perceived challenges in the development and implementation process have been: gaining clarity about what a CEPN is and where it fits within broader NHS structures; considering the sustainability of CEPNs in terms of how they will continue to operate and what legal entities may best be suited to take up this role; promoting the concept and engaging frontline staff and stakeholder organisations; developing links across organisations to plan and deliver training; and having enough time and capacity for managing the CEPN.

Key design elements

Based on information available to date, Box 1 provides a 'checklist' of factors that may be considered when assessing the potential of organisations wishing to build a community education provider network. It is important to note that without information about the success of the CEPNs, it is not possible to say that these factors are important for success, only for helping CEPNs set up and get underway promptly.

Box 1: Checklist of building blocks that may help CEPNs to develop promptly

Leadership and management

- Is there a clear understanding of the remit of CEPNs?
- Do senior leaders and champions locally have a shared vision?
- Is there a clear plan with objectives and milestones?
- Is capacity available for broad leadership, day to day management, regular liaison and administration?

Infrastructure

- Is there an established structure or entity to receive funds and support implementation?
- Does the network align with CCG boundaries (but not necessarily depend on them for sustainability)?
- Are there close links with the CCG or plans in place to build a strong relationship rapidly through face to face contact and ongoing dialogue?
- Does the network include primary and secondary care organisations? Are there plans to involve higher educational institutions?
- Is there capacity to deliver training, rather than just be an organising network?

Processes

- Is the network truly multiprofessional in nature or is there a narrower focus? (for example are or could disciplines such as pharmacy, optometry and dentistry be included in educational plans?)
- Is training needs assessment built into the plan? Is there capacity to think about workforce needs and skill mix over the longer-term?
- Is health needs assessment built into the plan (to account for training to improve population health outcomes)?
- Are plans in place to promptly and regularly engage with stakeholders from many organisations and disciplines or is the focus mainly on GPs?
- Are there plans in place to approach CCGs and other organisations to share training funds? (CCGs received funding for CPD in primary care)
- Has evaluation been planned from the outset?
- Does evaluation focus on more than learning outcomes for training participants?

It is important to stress that other design elements may be useful and that models that do not contain the elements above could still be feasible and worthwhile. It is too early to say that the above factors support the success of CEPNs, but they do appear to support prompter implementation.

Health Education South London was interested to know what factors may support CEPNs to link with established lead providers such as higher educational institutions and where CEPNs may best fit within the broader educational landscape. At this stage in development it is not possible to draw conclusions about this.

Nor is it feasible to specify timeframes for achieving key milestones, such as building collaborative relationships or offering specific training. This is because milestones will depend on the starting point from which networks begin, their focus and the things that they are setting out to achieve. However, in broad terms, Box 2 lists potential milestones if a new CEPN was trialled for a two year period.

Evaluation components

In order to fully understand the potential of the CEPN model, an evaluation will be required. Important components of an evaluation of current and future CEPNs may include:

- a clear specification of objectives of the CEPN model so that evaluation can assess the extent to which these objectives are achieved. Having a smaller number of well defined objectives may be preferable to a large number of lofty aims in the first instance;

- a comparison between areas implementing and not implementing a CEPN model;

- a comparison of relevant outcomes before and after implementation of the CEPN. The exact outcomes to be measured and the methods used to do so are dependent on the final objectives, but might usefully include descriptive information about the number and type of training programmes, learners and relationships / organisations involved; before and after assessments of improvements in learner outcomes such as perceived knowledge and confidence; system-level outcomes such as increased interprofessional working and documentation about CEPN processes, success factors and challenges. Over a short period, it would not appear appropriate to expect changes in patient outcomes.

Box 2: Milestones that may be expected if a new CEPN was set up over two years

By end of first six months

- Legal entity / structure in place to administer funds
- Hire or allocate project management capacity
- Clear objectives, activities and programme timeline in place
- Evaluation strategy and tools finalised
- Meetings with key stakeholders to introduce and promote concept
- Data for health needs assessment compiled (so aware of population health needs)
- Local training needs assessment completed
- CCG and HEIs contacted about training budgets available

By end of year one

- Working collaboratively across organisations
- Training programmes scheduled and being run collaboratively
- Evaluation of outcomes data being compiled regularly and monitored to promote change
- Six weekly or quarterly email newsletters being sent out to stakeholders or other proactive communication underway

By end of 18 months

- Ongoing promotion of the value of multiprofessional education to local organisations and health professionals
- Sustainability plans considered and discussed widely
- Taking part in learning sets or workshops to support other CEPNs

By end of year two

- Implementation of sustainability plans
- Evaluation analysis of outcomes and learning points completed
- Reporting back on outcomes to stakeholders
- Promotion of successes via local newsletters and trade press

Potential LETB actions

This rapid external review suggests that Health Education South London's pilot of the CEPN concept is progressing well. There are varying models being tested and each CEPN is at different stages of implementation, which has the potential to provide a rich source of learning for Health Education South London and others wishing to implement networks to support community education provision.

The review does not answer the question of whether the CEPN model(s) are worthwhile as it is too early to draw conclusions, but it does suggest that among some stakeholders the concept has been welcomed and that people feel there is potential.

Health Education South London is considering whether to fund further CEPN pilots in future. Box 3 summarises some of the potential action points that could be taken to further strengthen future rollout.

Box 3: Summary of potential supportive actions for Health Education South London

- Allocate time to **clarify the remit** and scope of CEPNs so that a more specific and clear invitation to bid document can be developed.
- Spend time **speaking with potential CEPNs** and helping them write bids to ensure that the group is clear about the scope and so that the bids are tailored both to meet localised needs but also LETB priorities.
- Consider using a simple **checklist** to assess the extent to which potential networks meet the criteria and may be able to flourish during the pilot period.
- Consider providing templates and/or **learning sets** to offer developmental support for CEPNs, including support with project management / planning, training needs assessment and evaluation.
- Think about what support can be provided to foster **communities of practice** and peer support, whereby CEPN pilots take the lead on sharing ideas and teaching each other about strategies that are working well.
- Think about how the concept of CEPNs can be promoted locally and nationally, so that pilot sites feel they are operating in a more supportive environment. This may include visibility at meetings by **LETB change champions**, letters of support / introduction from the LETB that can be widely circulated, direct contact with CCGs and articles in the trade press and journals.
- Consider taking a slightly 'harder line' with networks to ensure clear **accountability** and so regular meetings and timely reporting are a requirement of further funding instalments.
- Develop a detailed **template for final reports** so CEPNs are clear early on.
- Build in **evaluation** from the outset, including comparative evaluation methods.

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FF70 Health Education South London

Next page

Commitment
Education
Development

Pharmacy - the heart of the community

Community Pharmacies South London

Health Champions List

December 2014

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: @SouthLndnPharma
: Community Pharmacies South London

Bexley and Greenwich

Borough	Named health champion	Pharmacy name	Pharmacy address
Bexley Kent	A Banerjee	7Day Chemist	175 Bellegrove Rd, Welling, DA16 3QS
Bexley Welling,	Julie Craggs	B R Lewis	62 Upper Wickham Lane, Kent, DA16
Bexley	Ropa Mhlanga	Belvedere Pharmacy	11 Picardy Street, DA17 5QQ
Bexley	Kelly Wells	Boots Bexleyheath	31-33 The Mall, Bexleyheath, Kent DA6 7JJ
Bexley	Jean Crawley	Broadway Pharmacy	172 Broadway, Bexleyheath, Kent DA6 7BN
Bexley	Martina Lincoln	Broadway Pharmacy	DA6 7BN
Bexley	Medinat Ajoke Musa	Compact Pharmacy	137-139 Blendon Road, Kent, DA5 1BT
Bexley	Lesley Douthty	Davidinsons	5 Midfield Parade, Kent, DA7 6NA
Bexley	Krupa Patel	Davidinsons	5 Midfield Parade, Kent, DA7 6NA
Bexley	Dawn Purvis	Hollytree Pharmacy	2 Hollytree Parade, Sidcup DA14 6JR
Bexley	Corrina Birch	Hollytree Pharmacy	2 Hollytree Parade, Hill, Sidcup DA14 6JR
Bexley	Samantha Fayaz	Knightons Pharmacy	36 Nuxley Road, Kent DA17 5JG
Bexley	Elaine Ridgwell	Knightons Pharmacy	36 Nuxley Road, Kent DA17 5JG
Bexley	Sheik Allybocus	Lloyds Pharmacy	32 Pickford Lane, Bexleyheath, Kent DA7 4QW
Bexley	Clare Woodbridge	Lloyds Pharmacy	89 Barnehurst Ave, Barnehurst, Bexleyheath, DA7 6HD
Bexley	Rachel Balogun	Lloyds Pharmacy	32 Pickford Lane, Bexleyheath, Kent DA7 4QW
Bexley	Paula Pace	Lloyds Pharmacy	89 Barnehurst Ave, Barnehurst, Bexleyheath, DA7 6HD
Bexley	Nicola Higgs	Olins Pharmacy	9ER
Bexley	Esinam Sedudzi	Osbon Pharmacy	

Borough	Named health champion	Pharmacy name	Pharmacy address
Bexley	Janice Smith	Praise Pharmacy	146 Longlane, Bexleyheath, Kent DA7 5AH
Bexley	Linda Deadman	Roadnight Pharmacy	88 Station Rd, Sidcup, Kent DA15 7DU
Bexley	Elise White	Roadnight Pharmacy	88 Station Rd, Sidcup, Kent DA15 7DU
Bexley	Lilian Webster	Soka Blackmore	2 Pembroke Parade, Pembroke Rd, Erith DA8 1DB
Bexley	Gemma Hughes	The Co-Operative Pharmacy	41 Forest Rd, Slade Green, Kent DA8 2NU
Bexley	Manuela Shah	The Pharmacy Hut	286 Erith Rd, Bexleyheath, Kent DA7 6HN
Greenwic	Hunish Sembhi	Asda Pharmacy	Bugsby Way, Charlton, London SE7 7ST
Greenwic h	Ms Gabija Sadauskaite	Blackheath Late Night Pharmacy	47 Vanbrugh Park, Blackheath, London SE3 7JQ
Greenwic h	Lauren Hubbard	Blackheath Late Night Pharmacy	47 Vanbrugh Park, Blackheath, London SE3 7JQ
Greenwic h	Zaki Mustaq	Blackheath Standard Pharmacy	182 Westcombe Hill, Blackheath, London SE3 7DH
Greenwic h	Louisa O'Doherty-Ambridge	Boots Charlton	Unit 7, Charlton Retail Park, Bugsby Way, Charlton, London SE7 7SR
	Sue Gale	Boots Charlton	Unit 7, Charlton Retail Park, Bugsby Way, Charlton, London SE7 7SR
Greenwic	Manjit Ghai	Boots The Chemists	156 High Street, Plumstead, London SE18 1JQ
Greenwic	Sarah Towslson	Boots The Chemists	12-16 Hare Street, Woolwich, London, SE18 6NB
Greenwic	Adenike Bamisaye	Boots The Chemists	12-16 Hare Street, Woolwich, London, SE18 6NB
Greenwic	Julie Dempster	Burrage Pharmacy	57 Burrage Place, Plumstead, London SE18 7BE
Greenwic	Kathleen Collins	Central Chemist	3 Brewery Rd, Plumstead SE18
	Alison Smedmore	Central Chemist	3 Brewery Rd, Plumstead SE18
Greenwic	Sue Barham	Chemcare Pharmacy	1 Elford Close, Kidbrooke Village, London SE3 9FA
Greenwic	Jeanette Kempster	Co-Op Pharmacy	20 The Mound, William Barefoot Drive, Mottingham SE9 3AZ

DA5 3HP

Bexley	Keeley Willis-Barrett	Praise Pharmacy	146 Longlane, Bexleyheath DA7 5AH , Kent	Greenwic h	Dawn Aargent	Co-Op Pharmacy	20 The Mound, William Barefoot Drive, Mottingham SE9 3AZ

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Greenwic	Radka Borisova	Duncans Pharmacy	193-195 Greenwich High Rd, Greenwich SE10 8JA
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Greenwic	Sajida Saggu	Geepharm Chemist	1-3 Blackheath Hill, Greenwich, London SE10 8PB
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Greenwic h	Neerja Rai	Geepharm Chemist	36 Plumstead Common Rd, Woolwich, Greenwich, London SE18 3TN
Greenwic	Bhagawati Adhikary	Geepharm Chemists	36 Plumstead Common Rd
Greenwic h	Darren Asobie-Owoghiri	Grove Pharmacy	No. 17 The Village, Charlton, London
Greenwic	Fay Rix	H N Dickinson Pharmacy	192 Bexley Road, Eltham, London SE9 2PH
		Greenwich Tina McCarthy H N Dickinson Pharmacy	192 Bexley Road, London SE9 2PH 71-73 Mottingham Road, London, SE9 4QZ
Greenwich Dixon	Vanessa O'Brien	Jarman &	71-73 Mottingham Road, London, SE9 4QZ
Chemists Greenwich		Allison	
Brookes	Jarman & Dixon	Chemists	
Greenwich Kidbrooke,	Tracey Gartell	Kidbrooke Pharmacy	134 Rochester Way,
Blackheath, London SE3 8AR Greenwich			Leah Pittom Kidbrooke
Pharmacy	134 Rochester Way, Kidbrooke,		Blackheath, London SE3 8AR
Greenwich Woolwich	Adedapo Akinlabj	Lloyds Pharmacy	45 Woolwich New Rd, SE18 6EW
Greenwich SE3	Archana Patel	Masters Pharmacy	176 Shooters Hill Rd, London, 8RP
Greenwich	Justyna Rapita	Meridian Pharmacy	271 Greenwich High Rd, London SE10 8NB
Greenwich	Kelly O'Donnell	Morrisons Pharmacy	2 Twin Tumps Way, Thamesmead, London SE28 8RD
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Greenwich	Vera Tindall	N S Warwick Ltd	12 Kingsman Parade, Woolwich SE18 5QE

Borough	Named health champion	Pharmacy name	Pharmacy address
Greenwic	Hadi Barakat	Neem Tree Pharmacy	110 Mcleod Rd, Abbey Wood, 0BS
Greenwic	Daniella Fitzmaurice	Roopson Pharmacy	422 Well Hall Rd, Eltham, London SE9 6UD
Greenwic	Georgina Powell	Rose Pharmacy	24 Creek Rd, London SE8 3BN
Greenwic	Stevie Vanstone	Royal Arsenal Pharmacy	23 Arsenal Way, Woolwich, London SE18 6TE
Greenwic	Leah Roberts	Sainsburys Pharmacy	1A Philipot Path, Eltham, London SE9 5DL
Greenwic h	Natalie Bull	Sainsburys Pharmacy	1A Philipot Path, Eltham, London SE9 5DL
Greenwic h	Devanshi Patel	St James Pharmacy	52 Powis Street, Woolwich, London SE18 6LQ
Greenwic h	Bhavna Hirani	St James Pharmacy	52 Powis Street, Woolwich, London SE18 6LQ
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Greenwic	Diane Boston	Totty Pharmacy	44 Charlton Church Lane,
Greenwic	Aarti Patel	Totty Pharmacy	44 Charlton Church Lane,
Greenwich	Kulwinder Johal	Village Pharmacy	9 The Village, Charlton, London SE7 8UG
Greenwich	Baljinder Sangar	Village Pharmacy	9 The Village, Charlton, London SE7 8UG
Greenwich	Cheryl Margetson	Whinchat Pharmacy	1 Whinchat Rd, Thamesmead, London SE28 0DZ
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Pharmacy Greenwich	Woolwich Late Night	Rathnakar Raju Pharmacy	10 Woolwich New Road, London SE18 6AB
Greenwich	Adebayo Oduduwa	Worthcare Pharmacy	Gallions Reach Health Centre, Bentham Road, Thamesmead, London SE28 8BE
	Pam Morris	Boots The Chemists	800 Petts Wood Karne Gulten
		Boots The Chemists	800 Petts Wood Monsurat Hamzat
		Boots The Chemists	

Bromley

Borough	Named health champion	Pharmacy name	Pharmacy address
Bromley	Georgina Gilchrist	Alliance Pharmacy	C/O Waitrose
Bromley	Micheal Hallam	Boots the Chemist	15 Station Approach
Bromley	Phillipa Fantie	Boots the Chemist	182 High Street
Bromley	Alison Martin	Boots the Chemist	90 Station Road
Bromley	Jonathan Amugi	Boots the Chemist	4-5 Coleman House
Bromley	Precious C Nwogu	Boots the Chemist	125 Burnt Ash Lane
Bromley	Kirsty Pullen	Boots the Chemist	15 Station Approach
Bromley	Bonnie Jenkins	Boots the Chemist	234 The Glades Shopping Centre
Bromley	Sharon Shooman	Boots the Chemist	234 The Glades Shopping Centre
Bromley	Simon Bull	Boots the Chemist	Unit B
Bromley	Karen Gulten	Boots the Chemist	77 Queensway
Bromley	Jeffrey Courtenay	Boots the Chemist	216 High Street
Bromley	Jenest Oswald	Boots the Chemist	Unit B
Bromley	Mohanraj Sithambaram	Brownes Chemist	481-483 Bromley Road
Bromley	Sandra Monaghan	Chislehurst Pharmacy	59 Chislehurst Road
Bromley	Hannah Coldspring	Chislehurst Pharmacy	59 Chislehurst Road
Bromley	Deborah Bryant	Coney Hall Pharmacy	5 Kingsway
Bromley	Denise Harris	Coney Hall Pharmacy	5 Kingsway
Bromley	Maria Buxton	Cray Hill Chemist	88 Cotmandene Crescent
Bromley	Tameila Brown	Cray Hill Chemist	88 Cotmandene Crescent
Bromley	Jayne Willis	Crofton Pharmacy	1 Place Farm Avenue
Bromley	Alison Seare	Crofton Pharmacy	1 Place Farm Avenue
Bromley	Israel Shotayo	Day Lewis Bromley	443 Downham Way
Bromley	Samina Faulcher	Day Lewis Bromley	443 Downham Way
Bromley	Yvonne McDowall	Day Lewis Pharmacy	5 Station Approach
Bromley	Michelle Calthorpe	Day Lewis Pharmacy	136 Main Road
Bromley	Michelle Harrison	Day Lewis Pharmacy	136 Main Road
Bromley	Kelly Newbound	Day Lewis Pharmacy	195 Widmore Road
Bromley	Donna Baylis	Eldred Drive Pharmacy	25 Eldred Drive
Bromley	Donna Norton	Eldred Drive Pharmacy	25 Eldred Drive
Bromley	Kellie Murphy	Elmers Pharmacy	172 Upper Elmers End Road
Bromley	Anne Cox	Elmers Pharmacy	172 Upper Elmers End Road
Bromley	Amber Richardson	Farrants (Excel Pharmacies)	13 Station Square
Bromley	Priya Patel	Farrants (Excel Pharmacies)	13 Station Square
Bromley	Karen Tardivel	Hamlet Pharmacy	45 Anerley Road
Bromley	Aradhana Raguri	Hamlet Pharmacy	45 Anerley Road
Bromley	Sharon Biggs	Kamsons Pharmacy	121 Anerley Road
Bromley	Gina Cox	Lloyds Pharmacy	59 High Street
Bromley	Pam Cook	Lloyds Pharmacy	108 High Street
Bromley	Kelly Fitzsimons	Lloyds Pharmacy	59 High Street
Bromley	Gemma Oldfield	Lloyds Pharmacy	3 Roundway
Bromley	Pamela Price	Lloyds Pharmacy	3 Roundway
Bromley	Janice Tomlin	Lotus Pharmacy	119 Croydon Road
Bromley	Sophie Stennett	Lotus Pharmacy	Kelly Ashmore
Bromley	Tina Stevenson	Macks Pharmacy	2 Eden Park Avenue
Bromley	Jacqueline Anderson	Macks Pharmacy	165 High Street
Bromley	Carole Salcedo	Macks Pharmacy	2 Eden Park Avenue
Bromley	Lauren Harington	Macks Pharmacy	165 High Street
Bromley	Faisal Sabih	Osbon Pharmacy	55 High Street
Bromley	Nicky Clark	Park Langley Pharmacy	90 Wickham Road
Bromley	Maureen Burch	Paydens Pharmacy	399-401 Croydon Road
Bromley	Christine Lewis	Paydens Pharmacy	399-401 Croydon Road
Bromley	Stella Schwartz	Peters Chemist	15 Bromley Road
Bromley	Lynn Wilkinson	Petts Wood Pharmacy	83 Queensway
Bromley	Melaine Young	Petts Wood Pharmacy	83 Queensway
Bromley	Nicola Till	Rowlands Pharmacy	10 Crescent Way
Bromley	Tracy Bamford	Rowlands Pharmacy	10 Crescent Way
Bromley	Tina Jones	Rowlands Pharmacy	121 Westmoreland Road
Bromley	Karen O Driscoll	Rowlands Pharmacy	121 Westmoreland Road
Bromley	Tracey Hardy	Scotts Pharmacy	7 High Street
Bromley	Kerry Moss	Silversands Ltd	Anglesea Healthy Living Centre, 1 Kent Rd
Bromley	Kayley Hall	Silversands Ltd	Anglesea Healthy Living Centre, 1 Kent Rd
Bromley	Dee Thorn	Stevens Chemist	5 High Street
Bromley	Aimee Saunders	Stevens Chemist	5 High Street
Bromley	Chloe Smith	Superdrug Stores	190-192 High Street
Bromley	Georgia Dartnell	Tesco Pharmacy	Edgington Way
Bromley	Claire Alfred	Tesco Pharmacy	Edgington Way
Bromley	Teresa Stow	United Pharmacy	5 The Parade
Bromley	Michelle Johnson	Village Pharmacy	131 High Street
Bromley	Sarah Amura	Village Pharmacy	131 High Street
Bromley	Simone Tallis	Wallace Prring & Co.	40 Chatterton Road
Bromley	Amanda Craymer	Wallace Prring & Co.	40 Chatterton Road

Lambeth, southwark and Lewisham

Borough	Named health champion	Pharmacy name	Pharmacy address
Lambeth	Hina Mansha	Adarshi Pharmacy	
Lambeth	Charles Amesikeiu	Baba Chemist	7 Tulse Hill, Brixton, London SW2 2TH
Lambeth	Tareq Uddin	Baba Chemist	7 Tulse Hill, Brixton, London SW2 2TH
Lambeth	Jiabul Hoque	Boots (Brixton Road)	
Lambeth	Rebecca Farr	Boots (Brixton)	449 Brixton Road, Brixton, London SW9 8HH
Lambeth	Christian Sackey	Boots (Clapham)	
Lambeth	Sona Pradhan	Boots (Lower Marsh)	
Lambeth	Susana Moreira	Boots (Streatham)	
Lambeth	Shakil Muntasir	Boots (Waterloo Station)	
Lambeth	Olayinka Teniola	Boss	
Lambeth	Geraldine Banahene	Boss Chemist	
Lambeth	Tracey Gibson	Cam Pharmacy	
Lambeth	T Gibson	Cam Pharmacy	44 Kennington Road, London SE1 7BL
Lambeth	Maryan Noor	Copes	570 Streatham High Road, Streatham, London SW16 3QQ
Lambeth	Justina Navickaite	Copes Pharmacy	
Lambeth	Denean Jeffrey	Copes Pharmacy	
Lambeth	Edomitutu Lawal	Day Lewis Brixton Hill	110 Brixton Hill, Brixton, London SW2 1AH
Lambeth	Mark Mills	Day Lewis Foxley Square	
Lambeth	Dean Ingleton	Day Lewis Gipsy Road	
Lambeth	Elaine Harre	Day Lewis Gipsy Road	
Lambeth	Ann Marie Campbell	Day Lewis Gracefield	
Lambeth	Christine Loba	Day Lewis Mokwell	
Lambeth	Sarah Mills	Day Lewis Stockwell	
Lambeth	Uma Patel	Day Lewis Stockwell	
Lambeth	Lasha Kikvadze	Deejay	154 Norwood Road, West Norwood, London SE27 9AZ
Lambeth	Nelson Cuneapen	Deejay Chemists	

Borough	Named health champion	Pharmacy name	Pharmacy address
Lambeth	Amit Chappoa	Elmcourt Pharmacy	Unit 4, 220 Norwood Road, London SE27 9AQ

Lambeth Leanne Kelly Hatcher Fairlee Pharmacy Lambeth Sandhya Kaira Fairlee Pharmacy

Lambeth Agnieszka Kostrycka Hills 99 Kennington Lane, Kennington, London SE11 4HQ

Borough	Named health champion	Pharmacy name	Pharmacy address
Lambeth	Jairo Alexander	Hills Pharmacy	99 Kennington Lane SE11 4HQ
Lambeth	Agnieszka Kostrycka	Hills Pharmacy	

Lambeth Kartazyna Palka Jackson Chemist Lambeth Olga Jankauskaite Jackson Chemist Lambeth Aleli Jay Santos Junction Pharmacy Lambeth Mrs. Renuka Patel Junction Pharmacy Lambeth Rajan Khakural Junction Pharmacy Lambeth Hiten Patel Kingshield Pharmacy LambethJune Mcloughlin Lloyds Pharmacy

Borough	Named health champion	Pharmacy name	Pharmacy address
Lambeth	Florence Mirindo	Lloyds Pharmacy	76 Kennington Road, London SE11 6NL
Lambeth	June Mcloughlin	Lloyds Pharmacy	76 Kennington Road, London SE11 6NL
Lambeth	Catia Martins	Medimex Uk Ltd	
Lambeth	Mr Luis Ibanez	Medirex	28-29 Wilcox Close, South

Lambethbeth, London SW8 2UD Lambeth Ola Shobande Medirex 28-29 Wilcox Close, South Lambeth, London SW8 2UD

Lambeth Ermias Lakee Millenium Pharmacy (Lotian)

Lambeth Jm Mercera Millenium Pharmacy (Lotian)

Lambeth Georgia Dolan Millenium Pharmacy (Ramsey)

Lambeth Frank Onyugo Millennium Pharmacy Lambeth Rebeka O Lewofe Millennium Pharmacy (Bx)

Lambeth Solomon Tekle Millennium Pharmacy (Bx)

Lambeth Raushan Shah Millennium Pharmacy (Lg)

		lennium Pharmacy (Lothian)	81A Lothian Road SW9 6TS 81A
Lambeth	Kashif Rafiq Siddique	New Park Pharmacy	Lothian Road SW9 6TS
Lambeth	Shilpa Jain	New Park Pharmacy	
Lambeth	Mustansirbillah Damani	Orbis Pharmacy	83 Ramsey House, Vassal Road, London SW9 6NB

Borough	Named health champion	Pharmacy name	Pharmacy address
Lambeth	Agnieszka Siemieniako	Orbis Pharmacy	
Lambeth	Amina Malik	Pascoe Pharmacy	
Lambeth	Salima Bhatia	Pascoe Pharmacy	
Lambeth	Miss Marzena Sieczak	Paterson Health	
Lambeth	Adam Earl	Paterson Heath & Co. Ltd	
Lambeth	Nori Atiamu	Pavilion Pharmacy	
Lambeth	Victoria Murphy	Pavilion Pharmacy	
Lambeth	Nirav Patel	Paxton Pharmacy	127 Gipsy Hill, Norwood, London SE19 1QS
Lambeth	Sara Tuccu	Peace Pharmacy	
Lambeth	Ms Sara Tuccu	Peace Pharmacy	Unit 2, Woolford Court, 100 Coldharbour Lane, London SE5 9PU
Lambeth	Romoke Onyugo	Peace Pharmacy	Unit 2, Woolford Court, 100 Coldharbour Lane, London SE5 9PU
Lambeth	Sean Earl	Pearl Pharmacy	
Lambeth	Seetal Patel	Pearl Pharmacy	
Lambeth	Sasidhar Singirikonda	Phillips Pharmacy	
Lambeth	Vimal Patel	Phillips Pharmacy	46 Poynders Road, London SW4 8PN
Lambeth	Jignasa Shah	Prentis	62 Sydenham Road, Sydenham SE26 5QE
Lambeth	Bina Thakor	Prentis Pharmacy	
Lambeth	Andra Samarghitan	Prentis Pharmacy	
Lambeth	Ron Damani	Pulse Pharmacy	
Lambeth	Godfrey Oweng	Pulse Pharmacy	
Lambeth	Simon Earl	Pulse Pharmacy	
Lambeth	Samia Belkacem	Pulse Pharmacy	
Lambeth	Anis Sultan	Queens Chemist	
Lambeth	Sandra Maria	Reena'S Pharmacy	
Lambeth	Arwa Rajabali	Rosendale Pharmacy	
Lambeth Pharmacy	Jinal Pandya	Rosendale	
Lambeth	Susan Guy	S.G. Manning	
Lambeth Aguado-	Adolfo Lorenzo	Sainsburys Pharmacy	480 Streatham High Road, Streatham, London SW16 3PY
Lambeth	Nemalavadee Umanee Sefgrove Chemist	Sefgrove Chemist Lambeth	Wendy Freeman SE19 1TQ
Lambeth	Wendy Freeman	Sefgrove Pharmacy	3-5 Westow Hill, London
Lambeth	Karina Patel	Sg Manning	294 Brixton Hill, Brixton, London SW2 1HT
Lambeth	Jessica Gonzales	Springfield Pharmacy	
Lambeth	Luciano Oruci	Streatham Pharmacy	95 Streatham Hill, Streatham, London SW2 4UD
Lambeth	Bair Serry	Superdrug Norwood	
Lambeth	Sanjali Manani	Superdrug Pharmacy	202-204 Streatham High Road, Streatham, London SW16 1BB
Lambeth	Ruby Asante	Superdrug Pharmacy (Brixton)	
Lambeth	Sebele Sahle	Superdrug Pharmacy (Clapham)	
Lambeth	Abdul Rahman	Unipharm	
Lambeth	Yusuf Rahman	Unipharm Pharmacy	
Lambeth	Shiju Thomas	Vitelow	
Lambeth	Gita Patel	Watts Pharmacy	
Lambeth	Mihir Kateria	Westbury Chemist	84-92 Streatham High Road, Streatham, London SW16 1BS
Lambeth	Wasim Habib	Westbury Chemist	84-92 Streatham High Road, Streatham, London SW16 1BS
Lewisham	Victoria Buckingham	Abc Pharmacy	56-60 Loampit Hill, Lewisham SE13 7SZ
Lewisham	Lynne Thorpe	Amin Pharmacy	285-287 Brockley Road, London SE4 2SA
Lewisham	Carmela Ticknell-Smith	Baum Pharmacy	10-12 Manor Park Parade, Lee High Road SE13 5PB
Lewisham	Mandy Smith	Baum Pharmacy	10-12 Manor Park Parade, Lee High Road SE13 5PB
Lewisham	Brianna Mcadam	Beechcroft Pharmacy	30 Tranquil Vale, Blackheath SE3 0AX
Lewisham	Michelle Crouchman	Beechcroft Pharmacy	30 Tranquil Vale, Blackheath SE3 0AX
Lewisham	Charlotte Melvin.	Beechcroft Pharmacy	30 Tranquil Vale, Blackheath SE3 0AX
Lewisham	Korila Patel	Bentley Chemist	374 Brockley Road, Brockley SE4 2BY
Lewisham	Anne Jones	Boots Uk Ltd	104-106 Rushey Green, Catford SE6 4HW

Lewisham	Charles Aseervatham	Boots Uk Ltd	72-78 Lewisham High St, Lewisham SE13 5JN
Lewisham Forest Hill	Jill Gidman	Boots Uk Ltd	21-23 Dartmouth Road, SE23 3HN

Borough	Named health champion	Pharmacy name	Pharmacy address	Borough	Named health champion	Pharmacy name	Pharmacy address
Lewisha	Anish Sood	Brook Pharmacy	109 Chinbrook Road, Lee SE12 9QL	Lewisha	Tracey Bitmerd	Lords Chemist	11 Burnt Ash Road, Lee Green, London SE12 8RG
Lewisha	Sunita Sood	Brook Pharmacy	109 Chinbrook Road, Lee SE12 9QL	Lewisha	Julie Hatch	Lords Pharmacy	11 Burnt Ash Road, Lee Green SE12 8RG
Lewisha	Carol Gibb	Brownes Chemist	481-483 Bromley Road, BR1 4PQ	Lewisha	Monika Kosmider	Makepeace	264 Kirkdale, Sydenham SE26
				Lewisha	Susan Smith	Makepeace	264 Kirkdale, Sydenham SE26
Lewisha m	James Amarteifio	Cambelle Chemist	83 Boundfield Road, Catford SE6 1PH	Lewisha m	Delena Sappleton	New Cross Pharmacy	Waldron Health Centre, Amersham Vale, New Cross SE14
Lewisha m	Devina Kwok	Crofton Park Pharmacy	435 Brockley Road, London SE4 2PJ	Lewisha m	Kamran Khan	New Cross Pharmacy	Waldron Health Centre, Amersham Vale, New Cross SE14
Lewisha m	Geraldine Norman	Day Lewis	443 Downham Way, Downham BR1 5HS	Lewisha m	Vaishalee Chawla	Nightingale Pharmacy	134 Deptford High Street, Deptford SE8 3PQ
Lewisha m	Susan Burgin	Day Lewis	443 Downham Way, Downham BR1 5HS	Lewisha m	Ibrahim Kargbo	Pepys Pharmacy	2 Golden Hind Place, Grove Street SE8 3QG
Lewisha m	Susan Newman	Day Lewis	467 Bromley Road, Downham BR1 4PH	Lewisha m	Ismet Ahmet	Pepys Pharmacy	2 Golden Hind Place, Grove Street SE8 3QG
Lewisha	Ian Cinco	Duncans Chemist	24 Bromley Hill, Downham BR1 4JX	Lewisha	Miss Ying Voang	Perfucare	136 Kirkdale, Sydenham SE26
Lewisha	Sivadeepa Satkunarajah	Gokul Chemists	53 Baring Road, Lee SE12 0JS	Lewisha m	Kymberley Monaghan	Perry Vale Pharmacy	193I Perry Vale, Forest Hill SE23 2JF
Lewisha	James Punyer	Grove Park Pharmacy	344 Baring Road, Grove Park 0DU	Lewisha m	Dhaval Bhavsar	Perry Vale Pharmacy	Shop 193 I Perry Vale, Forest Hill, London SE23 2JF
Lewisha	Nikunj Shah	Grove Park Pharmacy	344 Baring Road, Grove Park 0DU	Lewisha m	Casmo Allen	Qrp Pharmacy	389 Queens Road, New Cross SE14 5HD
Lewisha	Hema Patel	Krisons Chemist	506 New Cross Road, New Cross SE14 6TJ	Lewisha m	Ronak Patel	Qrp Pharmacy	389 Queens Road, New Cross SE14 5HD
Lewisha	Gurbans Guram	Lee Pharmacy	19 Burnt Ash Hill, London SE12 0AA	Lewisha m	Palma Leke	Qrp Pharmacy	389 Queens Road, New Cross SE14 5HD
Lewisha	Teresa Gayson	Lee Pharmacy	19 Burnt Ash Hill, London SE12 0AA	Lewisha m	Sangita Patel	Rickman Chemists	197 Stanstead Road, Forest Hill SE23 1HU
Lewisha	Naresh Kumar	Leegate Pharmacy	18 Leegate, Lee SE12 8SS	Lewisha m	Sula Smith Blake	Rickman Chemists	197 Stanstead Road, Forest Hill SE23 1HU
Lewisha	Wayne Kistensamy	Leegate Pharmacy	18 Leegate, Lee SE12 8SS				
Lewisha	Azmina	Lewis Grove	1 Lewis Grove, Lewisham SE13 6BG	Lewisha	Dipesh Patel	Ruprai Chemist	296-298 Lewisham High Street, Lewisham SE13 6JZ
Lewisha	Jolana Bullingham	Lewis Grove	1 Lewis Grove, Lewisham SE13 6BG	Lewisha	Lindsey Smith	Rushey Green Pharmacy	The Primary Care Centre, Hawstead Road, Catford SE6
Lewisha	Catalena Facciano	Lloyds Pharmacy	401 Queens Road, New Cross SE14 5HD	Lewisha	Wikdy Shiburt	Rushey Green Pharmacy	The Primary Care Centre, Hawstead Road, Catford SE6
Lewisha	Charlene Stone	Lloyds Pharmacy	314 Sangley Road, Catford SE6	Lewisha	Hiral Patel	Sheel Pharmacy	312-314 Lewisham Road, Lewisham SE13 7PA
Lewisha	Rizwan Shuja	Lloyds Pharmacy	401 Queens Road, New Cross SE14 5HD	Lewisha	Richard Agbabkwuru	Sheel Pharmacy	312-314 Lewisham Road, Lewisham SE13 7PA
Lewisha	Simon Schlazer	Lockyers Pharmacy	252 Evelyn Street, Deptford SE8 5BZ	Lewisha	Vishal Prakash Khade	Sheel Pharmacy	312-314 Lewisham Road, Lewisham SE13 7PA

Borough	Named health champion	Pharmacy name	Pharmacy address
Lewisham	Elizabeth Baker	Sparkes Pharmacy	9B St Georges Parade, Perry Hill, London SE6 4DT
Lewisham	Jodie Evans	Sparkes Pharmacy	9B St Georges Parade Perry Hill, SE6 4DT
Lewisham	Abdur Rouf	Station Pharmacy	2 Amersham Vale, New Cross SE14 6LD
Lewisham	Afnan Al-Issa	Superdrug Pharmacy	73-77 Sydenham Road, London SE26 5UR
Lewisham	Shorif	Superdrug Pharmacy	73-77 Sydenham Road, London SE26 5UR
Lewisham	Naomi Steadman	Superdrug Pharmacy	73-77 Sydenham Road, London SE26 5UR
Lewisham	Orawan Chuangvicheam	Superdrug Stores	138-140 Rushey Green, Catford SE6 4HQ
Lewisham	Joanna Korzeniewska	Touchwood	
Lewisham	Carol Perrett	Vantage Pharmacy	237 Bromley Road, London SE6 2RA
Lewisham	Guna Riske	Vantage Pharmacy	237 Bromley Road, London SE6 2RA
Lewisham	Sagda Manan	Widdicombe Chemist	220 Hither Green Lane, Lewisham SE13 6RT
Lewisham	Emma Salih	Wise Chemist	363 Sydenham Road, Sydenham SE26 5SL
Lewisham	Zoe Vassel	Wise Chemist	363 Sydenham Road, Sydenham SE26 5SL
Lewisham	Justina Okolo	Woolstone Pharmacy	7 St Georges Parade Perry Hill, 4DT
Southwar	Karim Lalljee	A.R Chemists	176-178 Old Kent Road SE1 5TY
Southwar	Sandra Pires	Ar Chemists	176-178 Old Kent Road SE1 5TY
Southwar	Damilola Belety	Asda Pharmacy	Old Kent Road, Ossory, London SE1 5AG
Southwar	Beletu Lemma	Asda Pharmacy	Old Kent Road, Ossory, London SE1 5AG
Southwark	Samuel Ollenwu	Bonamy Pharmacy	355 Rotherhithe New Road, Bonamy Estate, London SE16 3HF
Southwark	Pallavi Patel	Bonamy Pharmacy	355 Rotherhithe New Road, Bonamy Estate, London SE16 3HF
Southwark	Louisa Lambethptey	Boots	Unit 333, Elephant & Castle Shopping Centre, London SE1 6
Southwark	Millie Oduro	Boots The Chemist	Unit 11-13, Surrey Quays Shopping Centre, Redriff Road, Rotherhithe SE16 7LL
Southwar	Lorna Legister	Boots Uk Ltd	20 Rye Lane Peckham, London SE15 5BS
Southwar	Dorothy Danquah	Boots Uk Ltd	Unit 333 Elephant & Castle Shopping Centre SE1 6 TB
Southwar	Tanya Yakar	Boots Uk Ltd	Unit 8-11 Hays Galleria, Counter Street, London SE12HD
Southwar	Falguni Patel	Camberwell	10 Crosswaith Avenue Sunray Avenue, Camberwell SE5 8ET
Southwar	Jody Fisher	Campion & Co Chemist	38 Albion Street, Rotherhithe, London SE16 7JQ
Southwar	Elena Ingrid Solomon	City Pharmacy	39-41 Borough High Street, London SE1 1LZ
Southwar	Akash Patel	Classic Pharmacy	55 St.Georges Road, Elephant & Castle, London SE1 6ER
Southwar	Pauline Laxten	Davis Chemist	10 Crossthwaite Avenue, London SE5 8ET
Southwar	Abigail Rochester	Day Lewis	1-3 Melbourne Terrace, London SE22 8RG
Southwar	Rockson Longmatey	Day Lewis Pharmacy	103 Peckham Road, Peckham SE15 5LJ
Southwar	Anusha	Day Lewis Pharmacy	103 Peckham Road, Peckham SE15 5LJ
Southwar	Jamseena Para	East Street Pharmacy	18 East Street, London SE17 2DN
Southwar	Farida Kadari	East Street Pharmacy	18 East Street, London SE17 2DN
Southwar	Andy Still	Fourway Pharmacy	12 Half Moon Lane, London SE24 9HU
Southwar	Rupal M Padhiar	Fourways Chemist	36 Denmark Hill, London SE5 8RZ
Southwar	Kalpesh Patel	Herne Hill Pharmacy	
Southwar	Miss Thuy Quan	Jamaica Road Pharmacy	182 Jamaica Road, North Southwark, London SE16 4RT
Southwar	Ms Doreen Singleton	Kalmak Chemists Ltd	1 Milroy Walk, Kings Reach, Stamford Street SE1 9LW
Southwar	Ms Ozen Salih	Kalmak Chemists Ltd	9 Upper Ground SE1 9LP
Southwark	Betty Wicks	Kristal Pharmacy	127-129 Evelina Road, Nunhead, London SE5 7AF
Southwark	Dipesh Daya	Kristal Pharmacy	127-129 Evelina Road, Nunhead, London SE15 3HB
Southwark	Theresa Ling	Lings Chemist	269 Old Kent Road, London SE15 3HB
Southwark	Danielle Bailey (Dispenser)	Lloyds Pharmacy	18 Harper Road, Rockingham Estate, London SE17 2SX

Borough	Named health champion	Pharmacy name	Pharmacy address
Southwark	Teresa Malley	Lloyds Pharmacy	18 Harper Road, Rockingham Estate, London SE17 2SX
Southwark	Hameed Saddiqui	Lloyds Pharmacy	147-149 Peckham Hill Street, London SE15 5JZ
Southwark	Vila Johnson	Lloyds Pharmacy	43-45 North Cross Road, London SE22 9ET
Southwark	Gladys Asafo-Adejei	Maddock Pharmacy	5 Maddock Way, North Southwark, London SE15 5JZ
Southwar	Alan Kwizera Loyla	Maddock Pharmacy	Maddock Way Pharmacy
k	Akhtar	Medicx Pharmacy	Eyot House, 50 Old Jamaica Road, London SE22 9ET
Southwar k	Safia Rahman	Medicx Pharmacy	Spa Medical Centre, Eyot House, 50 Jamaica Road, Bermondsey, London SE16 4TE
Southwar Southwar k	Parbati Baral	Medicx Pharmacy	Spa Medical Centre, Eyot House, 50 Jamaica Road, Bermondsey, London SE16 4TE
Southwark	Sowmya Arepally	Morrisons Pharmacy	Aylesham Centre, Rye Lane, Peckham SE17 3NH
Southwark	Sandra Mole	Morrisons Pharmacy	Aylesham Centre, Rye Lane, Peckham SE15 5EW
Southwark	Jacqueline Fretwell	Pyramid Pharmacy	193-221 Southwark Park Road, Bermondsey, London SE16 3TS
Southwark	Mitchelle Carpenter	Pyramid Pharmacy	193-221 Southwark Park Road, Bermondsey, London SE16 4TE
Southwark	Yasmin Hafeez	Qrystal Pharmacy	7 Newington Causeway, London SE15 5EW
Southwark	Amit Patel	Ridgway Pharmacy	251 Walworth Road, London SE17 1RL
Southwark	Mary Edwards	Ridgway Pharmacy	251 Walworth Road, London SE17 1RL
Southwark	Paulina Podgorska	Rumsey Chemist	47 Dulwich Village, London SE21 7BN
Southwark	Kevin Forrester	Sainsburys Pharmacy	80 Dog Kennel Hill, East Dulwich, London SE5 8ER
Southwark	Josephine Williams	Sainsburys Pharmacy	80 Dog Kennel Hill, East Dulwich, London SE5 8ER
Southwark	Loretta Thompson-Quartey	Sogim Pharmacy	115 Lordship Lane, London SE22 8HU
Southwark	Gulzar Rashid	Southwark Tesco Pharmacy	Old Kent Road, London SE1 5HG
Southwark	Jadwiga Nuzski	Southwark Tesco Pharmacy	Old Kent Road, London SE1 5HG
Southwark	Leanne O Brein	Superdrug	Unit 4 Butterfly Walk Camberwell Green, London SE5 8RW
Southwark	Tanya Reynolds	Superdrug	371/375 Walworth Road, London SE17 2AL
Southwark	Miss Afnan Al-Issa	Superdrug Pharmacy	73-77 Sydenham Road, London SE26 5UR
Southwark	Shorif Omorr	Superdrug Pharmacy	73-77 Sydenham Road, London SE26 5UR
Southwar	Farjana Kabir Irma	Superdrug Pharmacy	Unit 339, Elephant & Castle Shopping Centre, London SE1 6TB
k	Reyes Kwaku Antwi	Surdock Chemist	162-164 Lower Road, London SE16 2UN
Southwar		V.E Lettsom Chemist	84 Vestry Road, London SE5 8PQ

Croydon

Boroug h	Named health champion	Pharmacy name	Pharmacy address
Croydon	Fungisai Parerenyatwa	Addiscombe Pharmacy (Ampharm	331 Lower Addiscombe Road, Croydon, Surrey CRO 6RF
Croydon	Lucy Bell	Addiscombe Pharmacy (Ampharm	302 Lower Addiscombe Road, Croydon
Croydon	Anjali Price	Allcorn Chemist	
Croydon	Fran Lindsay	Aumex Pharmacy	43-44 Central Parade, New Addington CRO 0JD
Croydon	Jenny Roe	Aumex Pharmacy (Medimpo Ltd)	43-44 Central Parade, New Addington CRO 0JD
Croydon	Suba Sagayanathan	A-Z Pharmacy	20 London Road, Croydon CRO 2TA
Croydon	Radhika Patel	A-Z Pharmacy (O & AO Sotubo)	20 London Road, Croydon, Surrey
Croydon	Jessica Ady	Bids Chemist	495 London Road, London SW16 4AE
Croydon	Kiran Kagadada	Bids Chemist	495 London Road, London SW16 4AE
Croydon	Julie West	Boots the Chemist	Centrale Shopping Centre, Unit 66, 21 North End, Croydon, Surrey CRO 1TY
Croydon	Maqsuda Chaudhuri.	Boots the Chemist	118/120 Brighton Road, Coulsdon, Surrey CR5 2ND
Croydon	Hellen Sollie	Boots the Chemist	
Croydon	Jane Wilmer	Boots the Chemist Ltd	77 George Street
Croydon	Bhumin Shah	Brigstock Pharmacy	141 Brigstock Rd, Thornton Heath, Surrey CR7 7JN
Croydon	Alkesh Amin	Brigstock Pharmacy (Brigstock Ltd)	141 Brigstock Rd, Thornton Heath, Surrey CR7 7JN
Croydon	Karey Holmes	Coulsdon Road	
Croydon	Raj Phull	Croychem Ltd	38 Lower Addiscombe Road, Croydon CRO 6AA
Croydon	Nasrin Eelch	Croydon Pharmacy	44 South End, Croydon, Surrey CRO 1DP
Croydon	Gabi Ciocan	Croydon Pharmacy (PAMC Ltd)	44 South End, Croydon, Surrey CRO 1DP
Croydon	Munaf Khan	Day Lewis Pharmacy	150 Addington Road
Croydon	Chloe Piner	Dougans Chemist (Medimpo Ltd)	114 Headley Drive
Croydon	Mahendra Patel	Dougans Pharmacy	

Borough	Named health champion	Pharmacy name	Pharmacy address
Croydon	Mo Rahman	Fieldway Pharmacy	3 Wayside Fieldway, New Addington CRO 9DX
Croydon	Stacey Seymour	Fieldway Pharmacy (Capsaris (UK) Ltd)	3 Wayside Fieldway, New Addington CRO 9DX
Croydon	Jackie Allen	Fishers Chemist (AM Kurtz)	1 Enmore Road
Croydon	Vanessa Williams	Fishers Pharmacy	1 Enmore Road
Croydon	Charlene Reynolds	Goldmantle Pharmacy (S Khosla)	2 Forestdale Centre
Croydon	Maria Luiza Gabara	Kents Chemist	66 Church Street, Croydon, Surrey CRO 1RB
Croydon	Anita Patel	Klub Pharmacy Ltd (K Patel)	10 Crown Point Parade
Croydon	Teodor Petrov	Klub Pharmacy Ltd (K Patel)	11 Crown Point Parade
Croydon	Navdeep K Kalsi	Larchwood Pharmacy	215 Lower Addiscombe Rd, Croydon, Surrey CRO 6RB
Croydon	Mitesh Patel	Lloyd George Pharmacy	63-65 Whitehorse Road, Croydon, Surrey CRO 2JG
Croydon	Hazel Fernandes	Lloyd George Pharmacy (Ampharm Ltd)	Parchmore Road, Thornton Health, Croydon, Surrey
Croydon	Reshma Ravindran	Lloyds	
Croydon	Sharon Marsh	Lloyds Pharmacy	123 Addington Road, Selsdon, South Croydon, Surrey CR2 8LH
Croydon	Dishna Sudars Wickramasingh	Lloyds Pharmacy Ltd	337 Limpsfield Road
Croydon	Irene Owusu-Ansah	Lloyds Pharmacy Ltd	130 Church Road, London SE19 2NT
Croydon	Janet Courtman	Lloyds Pharmacy Ltd	123 Addington Road
Croydon	Nelima Begum	Lloyds Pharmacy Ltd	97 Addington Road
Croydon	Jessica Gardiole	Lloyds Pharmacy Uppernorwood	
Croydon	Janice Pearce	Makepeace & Jackson Pharmacy (Dejure Ltd)	7 Station Parade, Sanderstead, Croydon, Surrey CR2 0PH
Croydon	Jeanette Seddon	Makepeace & Jackson Pharmacy (Dejure Ltd)	7 Station Parade, Sanderstead, Croydon, Surrey CR2 0PH
Croydon	Riddhi Mahida	Mayday Community Pharmacy	512-514 London Road, Croydon, Surrey CR7 7HQ
Croydon	Tejas Khamar	Mayday Community Pharmacy (VU Chem Ltd)	514 London Road

Borough	Named health champion	Pharmacy name	Pharmacy address
Croydon	Renu Sharma	McCoig Pharmacy (Dejure Ltd)	367 Brighton Road
Croydon	Carly Wood	McGoig Pharmacy (MediPharmacy Ltd)	143 Wickham Road
Croydon	Sharon Edwards	Medipharm Chemist (Dejure Ltd)	37 Limpsfield Road
Croydon	Payal Patel	Medipharm Pharmacy	37 Limpsfield Road, Sanderstead, South Croydon, CR2 9LA
Croydon	Gill Harris	Mona Pharmacy	246 Wickham Road, Croydon, Surrey CRO 8BJ
Croydon	Jackie Gibbons	Orion Pharmacy	939 Brighton Road Purley Surrey CR8 2BP
Croydon	Martina Mary Dominique	Parade	299a Thornton Road, Croydon, Surrey CRO 3EW
Croydon	June Hall	Sainsburys Pharmacy - Purley Way	2 Trafalgar Way, Croydon, Surrey CRO 4XT
Croydon	Kirsty Green	Sainsburys Pharmacy - Purley Way	3 Trafalgar Way, Croydon, Surrey CRO 4XT
Croydon	Miss Louise Tucker	Shirley Pharmacy	175 Shirley Road, Croydon, Shirley CRO 8SS
Croydon	Mrs Daksha J Patel	Shivas Pharmacy Ltd	300 London Road, Croydon, Surrey CRO 2TG
Croydon	Mrs Larraine Willis	Shivas Pharmacy Ltd	301 London Road, Croydon, Surrey CRO 2TG
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Learning Together: local integrated child health

A model for Paediatric and GP Registrars learning together in jointly run integrated child health clinics in a primary care setting

Dr Chloe Macaulay Wendy Riches

Dr John Spicer

Professor Monica Lakhanpaul **July 2014**

UCLPartners
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In particular, we wish to thank the GP and paediatric registrars, for their enthusiastic help and inspiration. Many have or are about to move onto new jobs and we hope that you will take Learning Together with you.

The Evidence Centre lead part of the evaluation and we are grateful for all their help and advice. Finally our thanks to the many colleagues who have been involved at the edges, supported stakeholder meetings or helped shape the development and thinking behind Learning Together. It has been such a pleasure to work with all of you to create a sustainable educational model that can make a difference.

Lessons learnt: joint reflection from a GP and Paediatric Registrar

"A six-year old girl had booked into the clinic with a three-month history of repeated episodes of vomiting. There had been an initial gastroenteritis illness, but her symptoms had waxed and waned over time. This resulted in six visits to the GP with episodic vomiting, and bouts of severe abdo pain which prompted mum to call an ambulance on one occasion. All examinations, stool and urine cultures were normal, and there were no other alarming 'red flag' features to the medical history. Latterly the symptoms had been noticed to come on during school days, especially Sunday evening, and be better at weekends and school holidays. Bloods tests had been requested to investigate medical causes of vomiting and were yet to be done.

When we saw her in clinic she was a quiet, shy, worried looking child who took some considerable time to engage with the consultation, preferring to look at mum to answer questions for her. Mum was attentive and encouraged her daughter to talk to us. The six-year old was not able to tell us what she thought was causing the pain, nor if there was anything she was worried about. Mum volunteered information about the divorce, but said that process had been occurring for the last year or so and was stable. She liked school, had friends, and there were no concerns from the teachers. Asking about her siblings was the most revealing part of the history; she was extremely close to her older brother and followed him everywhere. At which point mum mentioned that this brother had been having some difficulties at school.

He was being severely bullied, which had been witnessed by his sister who attends the same school. The bullying was so severe that he was removed from and reintroduced after some weeks off. She had been the one who reported the bullying both to mum and the school. Upon review of the story, the abdo pain and vomiting had coincided almost exactly with this period of time. The brother had just been reintroduced back into the school, which had been a big focus for the family, and had gone well.

It was only when we were talking about the effects of this bullying episode on her and linking it with the vomiting that the six-year old smiled and engaged with the consultation. Mum was tearful; the child was visibly relieved and relaxed that the issue had been aired. It seemed to open a dialogue between mother and daughter.

In the absence of other medical features we have attributed this presentation to somatisation of emotional pain. I made a follow-up phone call with the family a few days later to see whether they had any further comments or questions and to confirm that I had cancelled their blood tests; they said they were *"delighted"* and that it *"made sense"* to all of them."

Learning points we identified:

- Think outside the medical box: Focus on the whole child not just the medical model
- Context: trying to find out who are the important people in the child's life, from the child's perspective
- Talk to the child: Persist in trying to engage the child in the consultation throughout –we noted her enthusiasm when talking about her brother, and gave her the opportunity to tell her own story in her own words. It took time.

Contents page

Project group 2

Project expert advisors 2

Acknowledgements 2

Lessons learnt: joint reflection from a GP and Paediatric Registrar 3

Contents page 4

Executive summary 6

1 Background 9

1.1 The need to improve care and services for children 9

1.2 Current training arrangements for Paediatricians and GPs 10

1.3 Integrated child health training clinics offer a potential training solution 10

1.4 Development of the Pilot Model 2012-13 11

1.5 Pre-pilot work March-July 2012 11

2 UCLPartners evaluation pilot programme 13

2.1 Recruitment of sites 13

2.2 Matching up registrars 13

2.3 Booking clinics 14

2.4 Clinic day 14

3 Evaluation strategy 17

3.1 Aim 17

3.2 'What do people think?': Aim and methods 17

3.3 CAFE pilot audit: Aim and methods 19

Lessons Learnt : GP Registrar 23

4 Results 24

4.1 Participation 24

4.1.1........ Participation in the intervention: Learning Together clinics 24

4.1.2........ Population of children and young people seen in the intervention 26

Lessons Learnt: Paediatric Registrar 27

4.1.3........ Participation in the "What do people think' evaluation 28

4.1.4........ Participation in the CAFE pilot audit 28

4.2 .... Results 29

4.2.1........ Results 'What do people think?' 29

4.2.2........ Limitations 29

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4.2.3........ Results of CAFE pilot audit..30

4.2.4........ Limitations 33

5 Drawing out the lessons 35

5.1 Background: child health 35

5.2 Working hypothesis 35

5.3 Learning themes 35

Learning - clinical knowledge and skills 35

Confidence 36

Inter speciality learning: working with a Registrar from another speciality 36

Guidance Adherence: CAFE pilot audit 37

Summary of learning themes 37

Some educational process issues 37

5.4 Patient confidence and experience 42

5.5 Working with the wider practice team 43

5.6 Service outcomes 43

5.7 Health economics 44

5.8 Feasibility of the educational model 46

6 Key conclusions 49

References 52

Appendix A: Economic evaluation of the Learning Together Project 53

1. Background 53

2. Aim 53

3. Methods 53

4. Results 58

5. ....Conclusion 64

Executive summary

What happened

Learning Together is an educational intervention: a Paediatric Registrar and a GP Registrar see children or young people in a joint clinic based in a GP Surgery, sitting in the same consultation seeing patients together. The intervention is inter-disciplinary and aims to provide participants with experiential learning. The ultimate aim is to improve outcomes for children and young people.

The project was funded by Health Education North Central and East London and hosted by UCLPartners. Learning Together clinics started in December 2013, following a first phase of recruitment in September 2013. A second recruitment wave was undertaken in January 2014 and included an extension of the project beyond the UCLPartners area into South London and North West London. Data collection covered the period from December 2013 to May 2014.

Over the six-month period:

- 848 children were seen in 145 Learning Together clinics
  - 44 learning pairs made up of:
    - 37 individual paediatric ST5-8 registrars
    - 40 individual GP ST3-4 registrars
    - The majority of pairs ran a series of four or more clinics together
  - 40 GP practices hosted clinics
- 12 NHS Trusts released paediatric registrars In the evaluation:
  - 608 learning logs were completed by the registrars
  - 351 families took part in a survey
  - 125 families took part in follow up interviews

In a 'CAFE' pilot audit of four common childhood conditions: twenty-two GP practices audited notes of consultations for their registrars, before, after and during the Learning Together clinics.

What we found out

In 99% of the 351 forms, parents said they had a good experience of care at the joint clinics which suggests that they are doing something right for children. In 87% of the 351 feedback forms completed immediately after the clinics, parents reported increased confidence to manage their child's health. Almost all thought that it was useful seeing a GP and Specialist together (99%) and would recommend this type of clinic to friends or family (99%). They thought the doctors worked together well (97%) and they liked the 'one stop' approach.

Learning Together clinics are a viable educational training model for GP ST 3-4 and paediatric ST5-8 registrars, to improve their clinical knowledge and skills and professional working relationships. It is not a simple model. It builds on the primacy of experiential learning as a method to best approach acquisition of knowledge and skills, but also to become familiar with inter-professional practice. The best way to make it work is just to start doing it. It requires development and adjusting as you go along in terms of who to book and how you work together. Many lessons were learnt in the project and we have translated them into a guide of 'pull out' adaptable resources that will help future implementation and roll out.

We also found out a lot about what registrars learnt in a dynamic learning experience:

- Learning themes for both GP and paediatric registrars included:
    - New knowledge
    - Clinical skills
    - Communication skills (with children and families)
- Inter-speciality learning themes:
    - Ongoing collaboration
    - Satisfaction with team working [defined narrowly as Learning Together pairs or their partners team]
    - Attitudes

We found that it takes a series of clinics for the 'penny to drop' about each other's roles. Inter speciality learning themes are more difficult to achieve than the clinical ones, but are necessary if we want to integrate child health, improve outcomes and keep children unnecessarily out of hospital.

Something positive happened in this timeframe of Learning Together that moved practice for GP registrars taking part in Learning Together from a baseline of 57% before to 72% during (p value < 0.01) and increased to 76% after, (p value < 0.05 compared to before). It shows Learning Together can be a positive lever that changes practice.

To support local implementation we modelled resource use and health gain for children and young people.

- We consider that Learning Together would be cost neutral to the system if there are: two fewer unnecessary outpatient department referrals a month; or three fewer A&E attendances a month.
- If resources were not saved (i.e. if the clinics did not make any difference to referral or A&E attendance rates) we estimate that Learning Together would be cost effective if three more children every year with conditions such as asthma or constipation are successfully treated (regaining good health) compared with usual primary care before the joint clinics were introduced.

We can imagine that a combination of these goals are achievable as a result of Learning Together clinics and we are pleased to put health gain for children alongside the debate on resource use. To illustrate the possibilities, we can show that 55% of Learning Together appointments resulted in an avoided referral or A&E visit as reported by the registrars. Also 98% of the 125 parents and carers

interviewed said that they had not had an unplanned visit to hospital for the child's condition within the one to two months since their clinic appointment because they had learnt how to manage their child's condition more effectively. Value is complex, but we conclude that the local 'bang' is achievable and the system 'buck' small.

The UCLPartners Learning Together project generated a lot of good will and put people in touch to improve local education. Locally the model became infectious – registrars loved the experience and promoted it. The flexibility of the model was a key factor that enabled enthusiastic local implementation at a high and maybe unsustainable level. As a guide we recommend each trust aims to release at least one SpR 5-8, once a month for six months, to a local GP training practice, to support joint education in local integrated child health. We think the commitment to learn together is worth the results.

Who else is doing it?

- A South London 'extension' is already in hand at two centres and will be rolled out further over the next few months .We have had national and a lot of local interest in the model
- In order to improve availability of paediatric trainees, access to Learning Together and/or other community experience should be written into statements of requirements for the commissioning of higher paediatric programmes and we aim to support that
- The National Director of Curriculum Renewal for the RCGP has expressed interest in the Learning Together project and will use its findings to inform development of the four year GP training programme – child health and mental health are key domains for improvement
- See www.pich.org.uk – Learning Together is part of the PICH programme run by the London School of Paediatrics.

In the national context of suboptimal outcomes in child health, models that change practice are of real value and this is a model that shows a lot of potential. The programme was largely a positive experience for participants and has been welcomed by trainers and supervisors. We know that changing doctors' practice and implementing high quality guidance is difficult. We commend Learning Together to educational commissioners, local trainers and educational supervisors as a way of doing this and making a difference for children and young people locally.

1 Background

1.1 The need to improve care and services for children

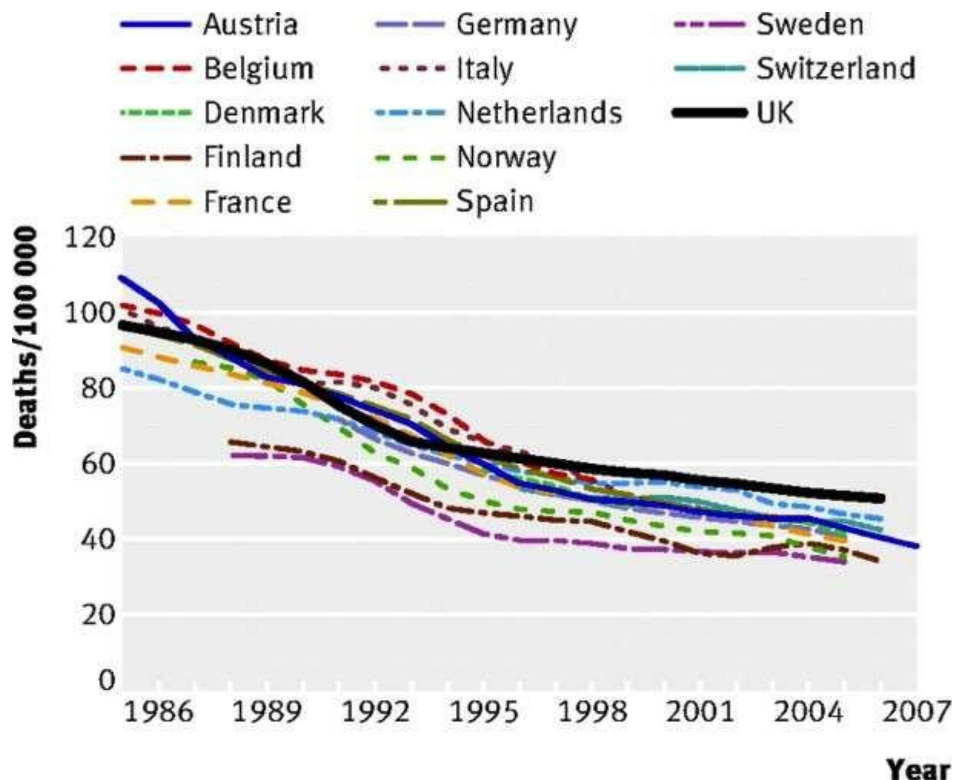
"The care provided by UK children's health services is inferior in many regards to that in comparable European countries. Although there are many examples of good practice, health services too often provide poor outcomes and are seemingly planned around the needs of organisations rather than those of children, young people, and families." (Wolfe 2011).

We need to improve the care that we provide for children. There is increasing data that child health in the UK is not as good as many of its European counterparts and we should be addressing this:

- Emergency attendances and hospital admission rates (HES data) continue to increase
- Death from asthma in children is higher than other European countries
- A significant number of the children and young people seen within secondary care, both in emergency departments, and also in out-patients, could be seen within a primary care setting (Saxena 2009, Milne 2010)
- Likewise children with chronic problems too often have to make do with disjointed care fitted in around acute services (Healthcare Commission 2007).

The reasons for this are multifactorial and often relate to the structures of the NHS, but one potential area for improvement is the training of our child health professionals.

Figure 1: All cause mortality in children 0-4yrs [1]



1.2 Current training arrangements for Paediatricians and GPs

Our current general paediatric postgraduate training curricula and programmes are focused on training paediatricians almost exclusively in and for today's predominantly hospital-based system. Most paediatric trainees spend a maximum of six months out of hospital during their eight year run- through training progamme. This is in a community child health placement, which may be very specialised in neurodisability and behavioral paediatrics, and not reflect this in its title.

Looking more widely at the Government's health reforms and the future direction of healthcare, in the medium and long-term many general paediatricians are likely to be spending at least some of their time working within a primary care 'out-of-hospital' setting (RCPCH 2011). A recent survey at the London School of Paediatrics suggested that more than 50% of trainees would value more out- of-hospital training. So the direction of travel is moving away from the hospital-based care. In addition, surveys suggest that paediatric trainees lack confidence in managing long-term conditions and they would welcome more opportunities of clinic based training or long term condition training (London School of Paediatrics data).

"Despite the high number of children coming into their surgeries, many GPs have little or no experience of paediatrics as part of their professional training. This means that, technical competence notwithstanding, many GPs lack the confidence to assess and treat children effectively, something that comes from specialist training and experience." (Kennedy 2010).

General practitioners currently have a three-year model of training. RCPCH data *(*RCPCH 2007) suggests that only 50-60% of GPs, in many parts of the country, have had any formal paediatric / child health training outside their GP posts. The training/exposure that trainees get during VTS GP posts can be fantastic, if their Trainer is confident in managing children, but equally it can be less so. In a recent study 92% (*n*=46) of GP trainees who had done a Paediatric placement felt either confident or very confident in acute asthma management in children, compared to 71% of GP trainees who had not done a placement. An accepted curricular change to a four- year GP programme is in hand, with particular reference to child health and mental health. For financial reasons there is no timescale yet agreed, and the Learning Together project will help build the background case for its promotion. [2]

More fundamentally, given the organisational separation between the Specialist Paediatrician working in secondary care and the generalist Medical Practitioner working in primary care, it would be of value to consider their professional relationships more carefully. Trainees in each discipline are used to working together in hospital departments, but not in the arguably more risk-laden environment of a GP practice. It is not inconceivable that, by each discipline working more closely together, delivery of appropriate child health care can be advanced. Key arguments about the principles of inter-professional learning hardly need restating here.

1.3 Integrated child health training clinics offer a potential training solution

In 2012 we came up with a vision:

- All general paediatric trainees who complete training should have done some of their postgraduate training within a primary care setting

- All GP trainees should have had some dedicated paediatric training within a primary care setting prior to completing their GP registrar year.

1.4 Development of the Pilot Model 2012-13

Our aim was to create a series of child health training clinics within GP practices that provide training. These clinics would be jointly run by the GP Registrar, placed within the practice, and a Senior General Paediatric Trainee (ST5-8) visiting from the local secondary care provider: the registrars would sit in the same room together seeing patients together. The clinics would be based around a series of patient appointments, but could also include 'virtual MDTs' (discussion about the patient without them physically being in the clinic) and other educational activities. The GP Registrar would provide continuity throughout the year, and would offer the know-how to access the GP record, GP prescriptions and to request investigations.

The focus of the clinics would be around a sharing of ideas and education with learning in both directions. We also realised that there was potential that these clinics may reduce some referrals into the local secondary care provider, and hence have a positive financial impact for clinical commissioning groups looking to reduce OPD referrals. *It is worth stating that these clinics would be 'primary care run and administered' and therefore would not be operated on a 'Payment by Results' (PbR) basis, as per normal referrals into secondary care.*

There would also be the opportunity for the SpRs to support other child health related CPD learning for other members of the practice (GPs, practice nurses, health visitors), as well as developing their experience in taking a more preventative, 'public health' perspective on their child health work.

Supervision and senior support for these clinics would come jointly from the GP Trainer (who has responsibility for the GP Registrar's training) and the Consultant Paediatrician (who has responsibility for the SpRs' training). Ideally a debrief/feedback should take place shortly after each clinic (within a few days). They will also have a training agreement.

Governance arrangements were formalised through the two Schools – those of General Practice and the School of Paediatrics.

1.5 Pre-pilot work March-July 2012

Clinics were initially set up in three sites, with slightly different models/focuses: one clinic at a Haringey practice, with one constant Paediatric Registrar and GP ST3 pairing (the same two individuals doing the clinics for the whole period), one clinic in a Camden practice, with a constant Registrar and alternating GP ST3/2/return to clinical practice trainee; and one clinic in Brent, with an experienced GP ST3 who had done several years of paediatric training, and a rotating group of Paediatric registrars. Individual governance arrangements were made for each site, with honorary contracts, and supervision for each Trainee from their own Supervisor.

Patient feedback was collected and a focus group of trainees' feedback and learning was carried out. Feedback from both was positive and on the back of that a larger pilot was carried out in five sites with GP ST4 trainees, who were doing a year-long Innovative Training Programme (ITP) in Paediatrics. This meant they were spending half their week doing only child health related activities. As part of their year, all GP ST4s took part in a Learning Together clinic every two to four weeks, with a Paediatric Trainee, or trainees, from the local hospital. A more formal qualitative analysis was done on trainees' experiences, which shaped this year's larger pilot. It became clear that two elements were important to improve learning and impact of the clinics: a constant pairing between the two trainees and debrief in a Practice meeting/MDT after the clinics, both for personal learning and for wider impact - clinical continuity and cascading of learning to the wider GP team.

2 UCLPartners evaluation pilot programme

In July 2013 UCLP put a bid into HEE NCEL for money to support a much larger pilot of Learning Together clinics in North Central and East London. The aim was to establish fifty pairs, doing Learning Together clinics over a six-month period with an evaluation of learning and clinical outcomes. A description of the process follows.

2.1 Recruitment of sites **Roadshows/Stakeholder events**

Contact was made with all Paediatric Departments and GP trainers during August 2013. All were invited to one of two Roadshow/Stakeholder events where the project was showcased.
Unfortunately, despite more interest, only about twenty individuals attended the two events.

Direct contact with each area

Further personalised contact was then made with paediatric departments and community trusts to explain the rationale and remit of clinics. All paediatric training programme directors (TPDs) or clinical leads were identified and approached either by email or in person by members of the project team. CM visited most paediatric sites and had meetings or discussions with members of the local team. She presented the project in consultant meetings and departmental teaching sessions.

Recruitment and project design proceeded concurrently. In January a second wave of recruitment was launched. The UCLP website was used in the second wave of recruitment to allow registrars to download information and registration forms.

Once the number of available paediatric registrars (PRs) in each area was determined, GPs (usually via VTS leads) were approached individually and the scheme was discussed in more detail. In most areas one member of the project team went out to a 'VTS afternoon' and discussed how the clinics worked. Interested GP trainees (GPTs) were encouraged to get agreement from their GP trainers and put themselves forward to be part of the scheme.

2.2 Matching up registrars

Once PRs and GPTs were identified in each area, the project leads went through a process of pairing them up. GPTs were paired with PRs who worked at (or did their on-calls at) the hospital that would usually be the referral site for that practice. Each practice also had to put forward one or two preferred days for the clinics, which were ideally on a morning when there was a lunchtime meeting that the pair could go on to after the clinic and feed back about the patients seen.

The project team recommended that one GPT was paired with one PR in each practice, but this model was flexed in several sites due to logistical reasons (PRs moving sites, so no longer being able to participate), and the fact that often two GPTs wanted to be involved. As a result in some sites one PR did clinics with alternating GPTs, or consecutively with two GPTs. In another site, one PR did clinics with two GPTs at the same time (i.e. there were three in the consultation, with the GPTs taking turns to be the lead).

2.3 Booking clinics

A member of the Project Team spoke to at least one of the pair or his/her Trainer about how the clinics work: The GPT has the responsibility to "advertise" the clinics amongst his/her practice team, and encourage colleagues to book patients into the clinic. In general four to six thirty-minute slots were recommended for "pre-booked" patients, although several practices did shorter time slots of twenty minutes.

Advice was given about whom to book in: children with difficult to manage common problems such as constipation, recurrent wheeze etc; children who would be referred to secondary care that do not need secondary input; "frequent flyers" to GP or urgent care; those discharged from secondary care and in need of follow up. In general, GPTs were encouraged to email PRs a few days before the clinic with the presenting complaints of the children booked in, allowing some pre-reading and thought about management (starting the learning cycle). In addition, practices were encouraged to have two 15-minute slots held for "book-on-the-day" patients. The idea was that these represent "unfiltered" primary care.

2.4 Clinic day

Trainees were encouraged to meet before the clinic and run through the list of patients, sharing knowledge, resources and ideas before seeing the patients. The Project Team suggested that trainees alternate who leads each consultation: in practice most trainees report that they alternate who starts the consultation, with the other "pitching in" at some point through the consultation.
Management plans are made jointly. Some children are followed up in the clinic, but most if follow- up is needed are followed up by the GPT.

At the end of the clinic, trainees are asked to fill in a learning log and reflect to maximise their learning. They then feed back to the wider MDT team at the practice meeting about the patients seen, both to allow for clinical continuity of patient care (sharing the management plans) and to cascade the learning. This is also an opportunity for supervision by the GP Trainer. The PR is then encouraged to return to their place of work and debrief with their Paediatric Supervisor, completing the learning cycle.

Pre-starting:

- Participating GP Registrar advertises clinic to rest of GP staff, explains rationale, appropriate patients, format, etc, and encourages referral and interest. A decision is made on the best day to hold the clinics
- Participating GP Registrar and Paediatric Registrar allocate clinic dates (ideally six clinics between November 2013 and March 2014)

Booking patients:

Patients booked by practice staff – triaged by the participating GP Registrar.

- Six thirty-minute slots
- Two ten-minute "emergency slots" booked on the day

Patients who could be seen in the clinic:

- "Walk in" for the "need to be seen today" slots of the clinic
- Child with problem 'x' seen before in primary care, but difficult to manage, i.e. second opinion
- "Frequent flyers" to GP or urgent care
- Discharged from secondary care and in need of follow up
- Secondary care-type problems that do not need specialist input

Patient who should not be referred to the clinic:

- Children in need of specialist paediatric input i.e. diabetes/neurology
- Emergency referrals - 'red flags' - seen by other professionals in the practice should not be delayed by being booked into this clinic (unless they are "walk in" for a "need to be seen today" slot)

Clinic preparation

Participating GP Registrar emails Paediatric Registrar with patients booked (problems not names) one to two days before clinic to allow preparation.

Ideally, the clinic should be on a day when there is a practice meeting/education meeting at lunchtime, so that GP/Paediatric registrars can feed back to wider team.

Ideally, a Practice Nurse/HV/other should also be present within consultation when appropriate e.g. Nurse for asthma.

Clinic day: example

- 20-30 minute pre-clinic discussion around patients to be seen
- 9.00am-12.00noon – six booked slots
- 12.00am-12.30pm – two emergency slots
- 12.30pm-1.00pm – debrief/discussion with GP Trainer/filling in learning log* etc
- 1.00pm-1.30pm – feedback of patients at practice meeting and dissemination/cascading of learning to wider GP team
- Virtual MDT: feedback/referral/advice of other GP patients
- Paediatric Registrar discusses patients with Paediatric Supervisor
- Ongoing email/telephone contact between GP and Paediatric Registrar about patient management

Learning and support outside clinics

During the year we also held two learning afternoons; the first was in March 2014 and the second in June 2014. The purpose of the afternoons was multipronged: the afternoons were a way of capturing experiences to inform evaluation, but also an opportunity to encourage reflection and learning from the cases seen. In addition, we used them for people to share their experiences of what was working well and less well for them in doing the clinics – exploring barriers and good practice, to share solutions and enable everyone to get the most out of their clinics.

All participants had contact details of members of the Project Team and made (often frequent) contact with questions and queries. Further information, for example learning logs, educational agreements, etc. was available, as mentioned on the UCLP website. The website was also a helpful tool and resource for discussion with other roll-on sites that were interested in up-scaling the model.

In addition to taking part in the clinics, participants were encouraged to take part in other activities:

Paediatric trainees were encouraged to sit in with a GP Trainer's regular clinic and attend an on-call with their GP Trainee "partner"; GP trainees were encouraged to attend a general paediatric clinic in the hospital and an on-call with the Paediatric Registrar.

3 Evaluation strategy

3.1 Aim

The Learning Together clinics were primarily designed as an educational intervention with the ultimate aim to improve care and outcomes for children, young people and their families.

Learning Together is a complex inter-professional intervention. Its core component involves two doctors, approaching the end of their postgraduate training, learning together with extended learning in the wider team. Being a complex intervention, it was not possible to evaluate each individual component of the intervention and to identify which led to the most effect on learning. The intervention was implemented into 'real life' NHS clinics and therefore the approach taken to the evaluation was pragmatic. It was not to define causality, but to gain an understanding as to whether joint clinics between two trainee doctors, from different professional backgrounds, had an effect on learning overall and to provide recommendations for the design of future similar interventions.

Working hypothesis

Health outcomes and service use could be improved if senior specialist registrars in general practice and paediatrics had a better understanding and experience for the application of child health knowledge and skills in the context of general practice i.e. for both specialisms to learn to work together to provide optimal care.

The approach to the evaluation was subdivided into three components:

- A quantitative and qualitative analysis using self-reported data from participants, including registrars, parents and the practice team, utilising surveys, interviews, questionnaires and a focus group to consider 'what do people think?' This was the main and primary component of the evaluation pilot project
- A retrospective locally led pilot audit of four common childhood illnesses: Constipation, Asthma, Fever and Eczema (CAFE)
- Health economics 'what if' models and threshold analysis, to inform the Project Group's consideration of resource use. This component was not designed to give results.

3.2 'What do people think?': Aim and methods **Aim**

An Independent Evaluator led and conducted this element of the project to help the Learning Together Project Team consider the potential impacts of the clinics for families and for the professionals taking part. Following a pilot stage, the brief was translated into an agreed evaluation design, which tested professionals' self-confidence in managing child health for the following outcomes:

- Improved knowledge and skills among professionals
- Improved recognition by GP trainees and registrars of each others' roles
- Increased awareness of child health issues among the wider GP practice team
- Carers satisfied with the care received
- More children managed in primary care and fewer children visiting hospital unscheduled

- Guideline adherent care

Methods

The methods used included:

- A survey of GP trainees' and paediatric registrars' perceived knowledge and confidence before taking part in clinics and again after four to six clinics. A comparison group of GP trainees and paediatric registrars who did not take part in the clinics
- A short focus group with GP and paediatric registrars
- Telephone interviews GP and paediatric registrars
- A feedback form for parents and carers after attending a clinic appointment immediately after the clinic
- Follow-up telephone interviews with parents and carers one to two months after their appointment
- Analysis of learning logs documenting the characteristics of children seen and their conditions
- Follow-up telephone interviews with parents and carers one to two months after their appointment
- Template of questions for GP trainees to collect feedback from other team members at two practices.
- Feedback from nurses via team questionnaires and interviews
- Feedback from stakeholders to inform barriers and enablers at meetings

An online survey was conducted in November 2013/December 2013, before the programme began and again in May 2014 towards the end of the programme. All ST3 GP trainees and ST7-9 paediatric registrars in London were invited to take part, regardless of their involvement in Learning Together clinics.

A short focus group of less than an hour was held with some participants midway through the programme and telephone interviews were made with some participants towards the end of the programme.

It was originally planned that case logs completed before, during and after the clinics would be assessed by an independent clinician to examine whether best practice was being followed (and compared with a control group), but insufficient information was provided on case logs to allow this. Similarly WBPA were also planned for both GP and paediatric registrars to assess guidance adherence, but this was also removed during the project due to low take up in a pilot phase.

The methods used to assess parents' and carers' experience of the clinics were: an anonymous survey completed immediately following the clinic and handed in at the practice reception; a telephone interview one or two months after attending the clinic for those who provided contact details and consent to be followed up. The same approach was used for carers' confidence to self- manage.

The methods used to assess impacts on referral rates for outpatient hospital care were: case logs where GP trainees and paediatric registrars estimated whether a clinic appointment resulted in an avoided hospital visit; follow-up interviews with parents and carers one to two months after their clinic appointment to see whether they had an unplanned hospital visit for the child's condition

In addition to examining the outcomes of the Learning Together approach, feedback about feasibility was collected using these methods: a focus group with GP trainees and paediatric registrars part way through the programme; telephone interviews with GP trainees and paediatric registrars as they complete the programme; feedback from other stakeholders towards the end of the programme

3.3 CAFE pilot audit: Aim and methods **Aim**

The CAFE pilot audit focused on four common childhood illnesses: Constipation, Asthma, Fever and Eczema (CAFE). A retrospective audit of notes was conducted by GP practices who hosted Learning Together clinics, with the aim of surveying guidance adherence and patient outcomes during the period of the Learning Together educational evaluation project.

As part of a broader evaluation strategy the CAFE pilot audit focused on guidance adherence and patient outcomes within primary care alone. CAFE aimed to:

- Give insight into the quality of care provided to children by measuring guidance adherence in four sentinel conditions within primary care:
  - Idiopathic **C**onstipation in under 18s
  - **A**sthma in under 18s
  - **F**ebrile illness without focus in under 5s
  - **A**topic Eczema in under 18s
- Pilot a methodology and a tool of binary metrics for both guidance adherence and patient outcomes in the four conditions to inform evaluation of future roll out of the joint clinics.

The CAFE pilot did not attempt to cover the pathways into hospital based care due to the time constraints in the project.

The pilot audit was agreed in April 2014, following a pilot phase of other methods. By April it was apparent that learning outcomes were being described and the pilot audit was agreed to support interpretation of them.

Methods

A retrospective audit of patient notes was conducted at the end of May 2014. Binary guidance adherence outcomes and binary health outcomes were chosen for this pilot audit. All outcomes were evidence or consensus based and considered to be surrogates for high quality care. The use of binary metrics enabled the aggregation of outcomes across different clinical conditions and types of outcome. In practice this meant that all the outcomes across all four conditions could be pooled to produce a guideline adherence score. This addressed the problem of having small population numbers seen in any one condition in the joint clinics. The power of this methodology was it provided an overall reflection of care with sufficient effect sizes in respect of the intervention.

Child health outcomes and binary metrics were agreed by informal consensus. Of particular interest to the project were health outcomes that relate to the health status of the childQuestions on outcomes were addressed to the child or parent or, as with fever, determined from the notes using a well establish proxy measure:

- **Constipation health outcome: "Are you better?"** Defined as relief from symptoms, may include normal bowel habits, no pain, taking reduced laxatives without symptoms getting worse
- **Asthma health outcome: "Are you satisfied with your child's breathing?"** Defined by the patient or parent, for example good asthma control, able to fully participate in normal routines
- **Fever proxy health outcome: 'Did the child return within 7 days to any setting?'** [3]
- **Eczema health outcome: "Is your eczema under control?"** Defined as minimal or no impact on quality of life, such as pain, impact on sleep, able to take part in everyday activities, psychosocial well-being.

NICE Clinical Guidelines and Quality Standards were primarily used for a few binary metrics in each condition – see Table 1 below. The NICE definition of terms was used throughout to support the metrics and the audit of notes.[4] [5] [6] [7] [8] [9] [10] [11] An audit proforma was developed and substantially revised after testing by the team in a GP site so that simple yes/no boxes could be ticked by a member of the practice management or clinical team.

Each metric was retrospectively collected for three time periods:

- **Before** the GP Registrar started Learning Together clinics, in their routine practice with normal consultation slots. An opportunistic sample that could easily be identified of up to three patient notes were requested and this could be any period from October 2013 onwards
- **During** the Learning Together clinics, as joint consultations took place with longer consultation slots than usual. Data on notes of all patients seen with the sentinel conditions was requested. The joint clinics took place from December 2013 to May 2014
- **After** the GP Registrar had taken part in Learning Together clinics and was back in their routine practice with normal consultation slots. An opportunistic sample that could easily be identified of three from any patients seen from January 2014 to May 2014 subject to the joint clinic schedule at each site.

The quality of note recording was not reported or requested due to time constraints for the 'Before' and date notes were selected conveniently, usually via an electronic systems report.

All participating GP sites were invited in mid May 2014 to take part in the audit of notes. The aim was to recruit six to ten participating sites. Payment of £350 was offered to cover time to complete the data for the sentinel conditions for each GP Registrar. Data was only requested on the four sentinel conditions if the Registrars had seen any child or young person with the condition in their joint clinics. Phone calls or patient follow-up for the outcome data took place in the two to three week period of the audit and outside of the clinics. Anonymous data was collected by the GP Registrar, Trainer or member of the GP team. A control group was invited to join in mid May 2014.

Data sheets were returned and analysed by the project team. Outcomes were aggregated by optimal and suboptimal totals. All 'yes' responses were categorised as optimal outcomes, with the exception of 3.4 in fever (see table 1). The change in outcomes during and after the clinics were compared to outcomes before the joint clinics using a chi-squared test for a two by two contingency table using a calculator at http://www.socscistatistics.com/tests/Default.aspx.

Table 1: Summary of questions asked in the audit of notes Metrics used in the CAFÉ pilot audit

		A. Before – sample max 3 patients		B. During - all patients seen		C. After [or May 14] - sample max 3 patients	
		Yes	No	Yes	No	Yes	No
1	**Constipation**						
1.1	Do the notes record that the child or young person with constipation received oral macrogols as first-line treatment?						
1.2	For a child or young person undergoing laxative treatment for DISIMPACTION, do the notes record they received a review of their treatment from a healthcare professional within 1 week of starting treatment?						
1.3	For a child or young person undergoing laxative treatment for MAINTENANCE therapy, do the notes record they received a review of their treatment from a healthcare professional within 6 weeks of starting treatment?						
1.4	For a child or young person undergoing laxative treatment for MAINTENANCE therapy, do the notes record they received a review of their treatment from a healthcare professional within 6 weeks of starting treatment?						
1.5	(Follow up) Ask the parent or patient: Are you better - yes or no?						
2	**Asthma**						
2.1	Do the notes record that the child or young person with asthma has a written personalised action plan?						
2.2	Do the notes record that the child or young person has had a structured annual review in the last 12 months and assessment of asthma is made using a recognised tool?						
2.3	(Follow up) Ask the parent/patient: Are you satisfied with your child's breathing?						
3	**Fever**						
3.1	Do the notes record that all of the following were measured: temperature; heart rate; respiratory rate; capillary refill time?						
3.2	Do the notes record the risk of serious illness, using the NICE traffic light table?						
3.3	If the child was sent home, to the notes record that the parent was given safety net information including when to seek further help						
3.4	Did the child return within 7 days to any setting?						
4	**Eczema**						
4.1	Do the notes record that psychological wellbeing and quality of life of the child, young person, family is discussed?						
4.2	Do the notes record that the child or young person is receiving treatment based on recorded severity using the stepped-care plan, supported by education?						
4.3	(Follow up) Ask the parent/patient: Is your child's eczema under control?						

Lessons Learnt : GP Registrar

"I have enjoyed the clinics and had a really good experience, since I have not done paediatrics as part of my training up until now. I learnt a lot about the approach that the paediatric registrar takes to history taking and doing the exam. It gave me more confidence to work with children in primary care. It helped me see that not everyone has to be referred to hospital. I am more confident about handling issues in primary care now.

This is a totally different way of learning. I would usually discuss cases with my Trainer then refer, but now I know what I could do differently. I am gaining more of an insight into how to approach cases.

We have had good feedback from parents. Some are really complex cases that would be referred to hospital anyway so we are not stopping every hospital visit, but the clinics are particularly good for in-between cases where you don't know whether to refer or not.

There have been challenges though. It has been hard to get everyone in the practice involved so it is as though it is just me as a trainee taking the lead. The multidisciplinary team meeting has not been happening after clinics. We just cannot get people to come along. No-one responds to emails when I try to arrange meetings and the other GPs referring aren't getting any feedback about what we did because they don't come to meetings. It also seems a bit one way with me learning a lot but the paediatric registrar is not getting a lot back.

Having quick access to a Paediatrician has been good for our practice, but we need a meeting or a way to give feedback to those who have referred in.

Sometimes clinics run over quite a bit. Even with 30-minute appointments, it is not enough time to deal with everything. The cases can be quite complex. In future we should have fewer appointments at each clinic so we can build in proper time to debrief afterwards with the Trainer and have a meeting with practice. It would be good to run clinics on the same day as a team meeting happens every week so we could go straight from the clinic into the team meeting and report back so everyone is learning. The Registrar could be there for first 15 minutes at the practice meeting. It would also be good to get the Trainer more involved from the start so they can introduce it to practice more and it would be a practice-wide thing.

Despite the challenges I think it [the Learning Together approach] is something that should definitely be made a regular part of training. Before I was not very confident but this has made me more confident. Children are a big part of general practice and for those who have not done paediatrics as part of their training this is really good for helping to differentiate the grey areas that you see every day."

4 Results

4.1 Participation

4.1.1 Participation in the intervention: Learning Together clinics

Learning together clinics started in December 2013 following a first phase of recruitment in September 2013. A second recruitment wave was undertaken in January 2014 and included an extension of the project beyond the UCLPartners area into South London and North West London. Data collection covered the period from December 2013 to May 2014.

Over the six month period:

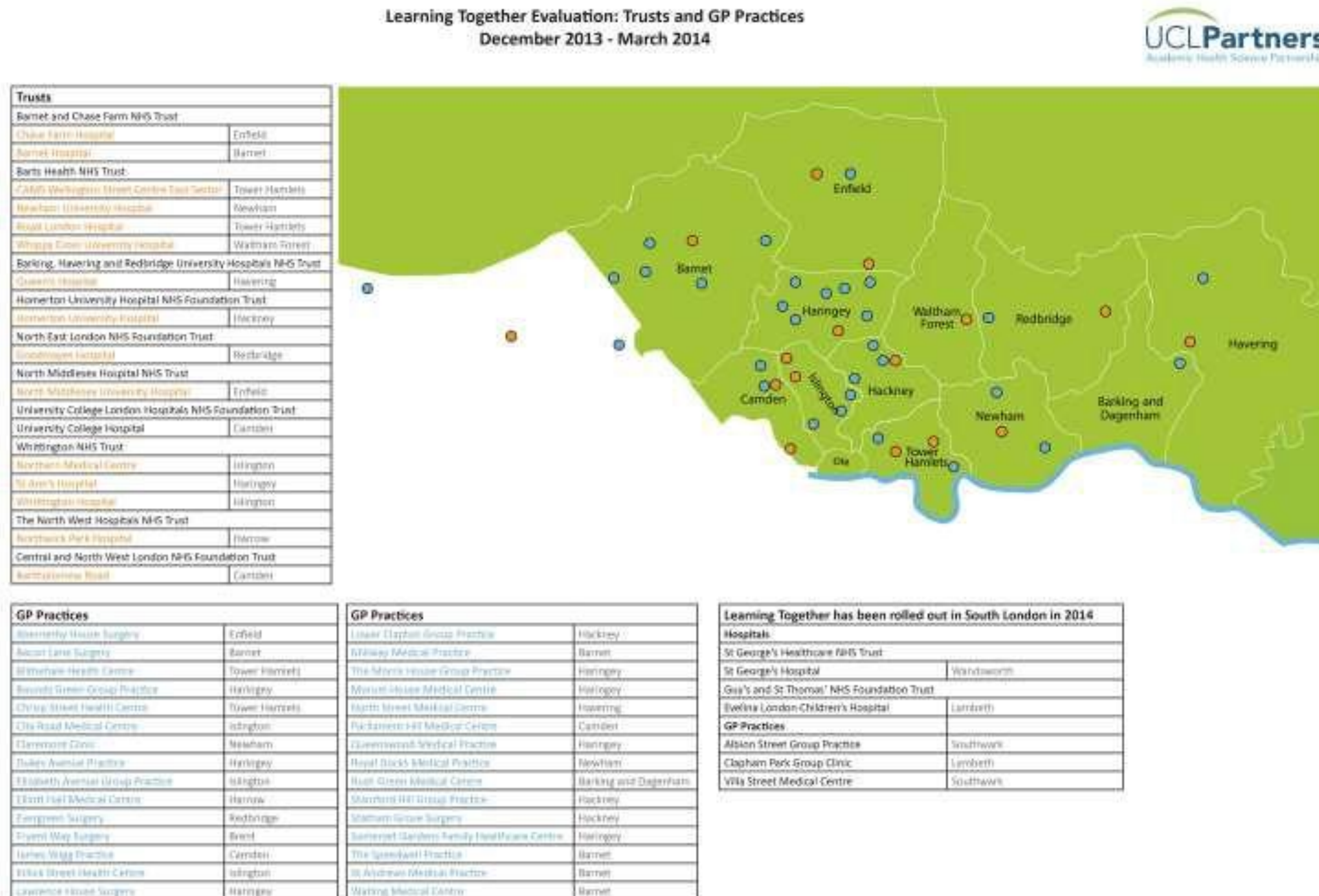
- 848 children were seen in 145 Learning Together clinics
- 44 learning pairs made up of
  - 37 individual paediatric ST5-8 registrars
  - 40 individual GP ST3-4 registrars
  - The majority of pairs ran a series of four or more clinics together
- 40 GP practices hosted clinics
- 12 NHS Trusts released paediatric registrars (see figure 1)

UCLPartners
Academic Health Science Partnership

NHS
Health Education
North Central and East London

NHS
Health Education
North Central and East London

Figure 1: Trust and GP practices who took part



4.1.2 Population of children and young people seen in the intervention

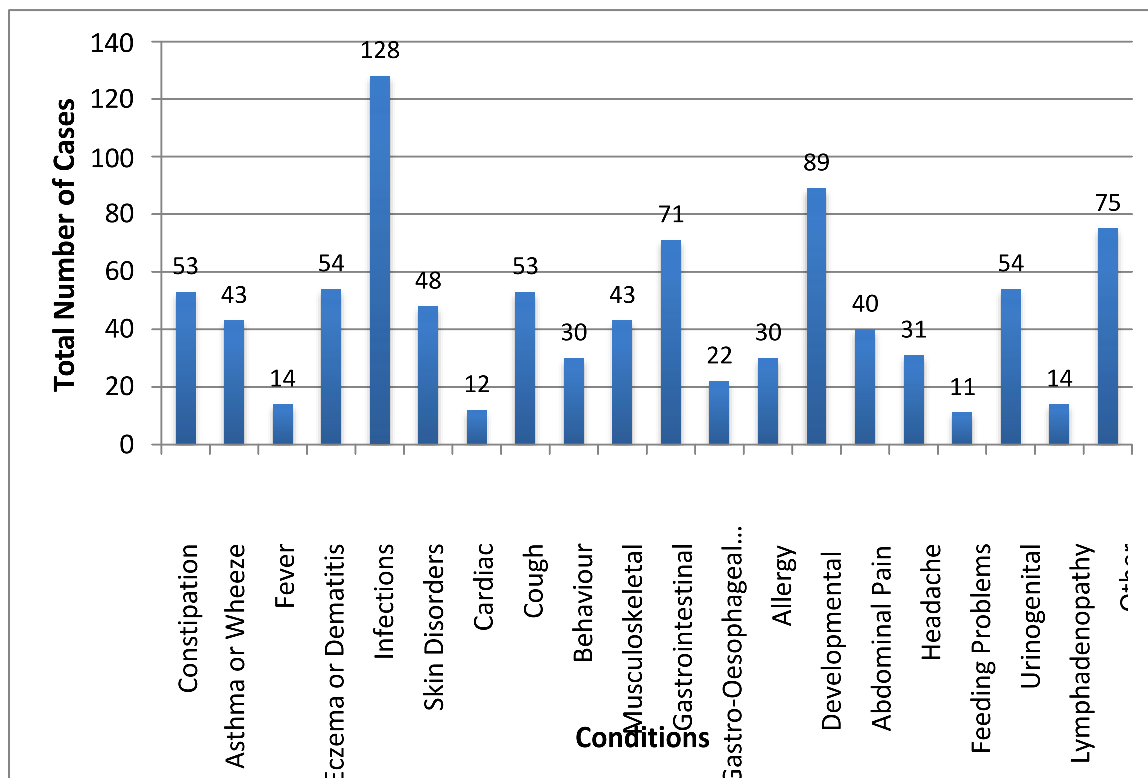
Data was collected directly from all 34 practices who participated in the intervention at the end of May 2014 and June 2014. Lists of all conditions seen in the joint clinics were returned from the Practices and this information was categorised into a group of conditions by the Clinical Lead for the project.

In the 848 children seen in the joint clinics, over 900 individual presentations of conditions or symptoms were documented. The four most commonly seen conditions or symptoms were:

- Infection [includes e.g. Upper Respiratory Tract Infections]
- Developmental [includes e.g. six-week baby checks]
- Gastrointestinal

How symptoms are described is likely to vary across sites. In the CAFE audit of 22 Practices the numbers of children with conditions or symptoms seen in the joint clinics were returned as: Constipation 43; Asthma 14; Fever 15; Eczema 32. It appears from this subset of data that Fever in particular may be described differently across sites.

Figure 2: Conditions seen in Learning Together



Lessons Learnt: Paediatric Registrar

"I have enjoyed Learning Together clinics. It is good to see what happens in the community. Both parties found it useful and it might be especially good for GPs if they have not done paediatrics before. But I do not think it was that useful from a learning point of view for me. It didn't give me new knowledge or skills and didn't make me more confident in my role.

I did learn how things work in primary care though, but that happened after the first one or two clinics. I didn't need so long. It did feel I bit like I was providing a service, which was fine and I enjoyed it, but it was definitely more about improving services and providing good care than learning anything new.

The things I found particularly useful were meetings with the whole team afterwards. It was good to share knowledge with the wider group of GPs, so not just one person benefited.

There needed to be management support in primary care to organise patient lists, provide a room, give out consent sheets and any other appointments or admin needed, so it was quite resource intensive. We were also concerned about the costs. Having two expensive doctors seeing things like six-week baby checks or routine primary care follow-ups just does not seem like a good use of time or money.

There was a lot of paperwork. I recognise this is needed because this was a pilot and we got into the swing of it. The main problem was we were not prepared for it in advance. We just thought we would turn up, we didn't know we had to fill in forms. If we got all the information at once and had a proper induction meeting, then that would have made everything clear. I liked the learning logs though. They helped to consolidate everything. We just didn't have time in clinics, so more time should have been allowed.

I might seem like I am being negative but I do not feel that way. I enjoyed it a lot. Being part of the primary care team was good. I felt part of the team. I learnt about referral pathways in the community and I learnt about seeing teenagers by themselves in the community because in hospital you would see them with their parents. I can see that GPs have a much closer relationship with whole family, not just the individual and episodic focus as in hospital. I didn't learn anything clinically and I don't feel like I am a better or more confident doctor now, but I was able to act as an interface between primary and secondary care and I think this cut referrals because we gave advice about where to go, not just to A&E. Families took this seriously because a Specialist as well as a GP was giving this advice.

Every one of our patients walked away happy. None wanted a referral to hospital for further reassurance. The verbal feedback was very positive by parents. They were happy from the outset since they were told in advance they were seeing a specialist, especially those who had already seen a GP. Parents are anxious so having reassurance from a Specialist helped. We could tell families what to look out for and when to go to hospital.

I think this should be part of regular training or regular service - not even training - because the paediatric registrar gets to work more independently. There is also lots of focus now on reducing A&E and hospital use. These clinics can help with that. It frees up time and decreases the load on A&E. It gives GPs more confidence and helps parents with reassurance and easy access. It is win-win all round."

4.1.3 Participation in the "What do people think' evaluation

Of the 44 learning pairs across 34 Practices, 23 pairs appear to have submitted information about their activities for evaluation purposes. The number of pairs who submitted may be greater than 23, but cannot be determined from the evaluation sheets, which identified sites rather than learning pairs.

Table 2: Response rates from data collection methods for the 'What do people think' evaluation

Method	Number invited	Number taking part	Response Rate
Online before and after survey with ST3 GP trainees and ST7-9 paediatric registrars	401	218 before, including 36 from Learning Together 82 after, including 7 from Learning Together	54% before (60% for Learning Together) 20% after (12% for Learning Together)
Follow-up calls with professionals	60	15	25%
Case logs	Unknown	608 Learning Together from 23 pairs 75 other from 22 practices and hospitals	-
Surveys with families immediately after clinics	848	351	41%
Follow-up calls with families	171	125	73%
GP trainees facilitating discussion at practice	30	2	7%

In addition to the information collected and summarised in Table 2 above, a focus group for under an hour was held with 19 participating registrars in March 2014.

4.1.4 Participation in the CAFE pilot audit

All GP sites were invited to return data for their participating registrars. The aim was to recruit at least six to ten participating sites and six to ten non-participating sites. Twenty-two participating sites returned data for their registrars. No GP sites were recruited to the control group and this was probably a combination of insufficient time to complete the audit and less motivation to assist in the project.

A total of 22 surveys were returned containing 778 data points. After data cleaning, which removed data where the education intervention had not taken place, 699 metrics remained. In other words, before and after data was removed if the GP Registrar had not seen any child with the condition in their Learning Together clinic. The volume of surveys returned from participating project sites exceeded our expectation.

4.2 Results

4.2.1 Results 'What do people think?'

Table 3: Summary of results: what do people think?

Evaluation question	Evidence
Impacts for families	
Did the parents and carers of children seen in clinics have a good experience of care?	99% of 351 surveyed, plus 125 follow-up interviews
Did parents and carers have increased confidence to manage their child's condition?	87% of 351 surveyed, plus 125 follow-up interviews
Impacts for professionals	
Did Learning Together clinics improve the self-reported knowledge and skills of GP trainees and paediatric registrars regarding child health issues?	No change in quantitative before and after surveys compared to control group, but interviews and focus group suggested benefits
Did Learning Together clinics improve how confident GP trainees and paediatric registrars feel about managing child health issues?	Interviews and focus group suggested benefits In the follow-up survey
Did Learning Together clinics improve GP trainees' and paediatric registrars' understanding of each others' roles and responsibilities?	Reports in interviews and focus group, plus some non-significant positive trends in survey
Impacts on the quality of care	
Did Learning Together clinics improve the extent to which GP trainees and paediatric registrars report working together?	Positive feedback from interviews and focus group; no significant change in before and after survey
Did Learning Together clinics improve the extent to which GP trainees and paediatric registrars provide guideline-adherent care?	Insufficient evidence collected
Impacts on the wider system	
Did the Learning Together model raise awareness about child health issues in the wider GP practice team?	Insufficient evidence collected
Did Learning Together clinics have a short-term impact on referrals to hospital or unplanned hospital visits?	Reports from professionals on case logs suggested a hospital visit was avoided for 55% of appointments

4.2.2 Limitations

Limitations of the main evaluation 'what do people think?' were acknowledged a priori. It was planned as pilot evaluation, which includes pilot of design and methods. The approach was to have a design which 'measures' a number of outcomes using various methods in order to try and get a 'picture' of what kinds of impacts the joint Learning Together clinics may be having. Power in the statistical sense was never part of the design consideration. This was partly pragmatically as the even 100% response had been achieved to every piece of data collection the study was still likely to be underpowered given the time available. Proving that the learning model 'worked' or 'did not work' based solely on any single piece of data was not considered achievable at the outset. In addition, there are known 'threats to validity' that were not 'controlled'. Characteristics of the learning pairs were not collected, such as prior experience or amount of training in child health.

So the importance of the before and after data collection, outside of the learning intervention, was to carry on learning about responses and to see what the nature of those responses are to inform future study designs.

The results of the quantitative online survey are difficult to interpret because of the limitations of the design and/or the very uneven or low response rates. Specifically the lack of 'after' responses (seven) from registrars who took part in the clinics is a limitation to the interpretation of the quantitative results.

Following an initial pilot phase 'after' case logs were not requested from registrars when they returned to usual. The decision was made in March 2014 not to collect this data, based on advice from the Independent Evaluator, because of the low response to 'before' data collection. Similarly, logs from a control group were not requested. Furthermore, the interpretation of the control data would have been difficult because the nature of care delivered outside of the clinic e.g. by a Paediatric Registrar working in neonates is very different in relation to care and patients in primary care.

4.2.3 Results of CAFE pilot audit

Results of the pilot audit are presented in Tables 4 and 5 below and are described as follows:

Data set 1 (Table 4): Inclusion criteria: to demonstrate that there was the possibility that shared learning may have occurred data 'during' was a prerequisite. In other words 'no intervention' before and after data was removed from the data submitted by the practice, if the GP Registrar had not seen any children with the sentinel condition in their Learning Together clinic.

Data set 2 (Table 5): Inclusion criteria: a patient outcome is reported for the consultation. This was derived post hoc from data set one.

The practical challenge of catching a parent who is able to take a follow-up call was a challenge in the audit. With more time more data sets would have been returned with patient outcomes.

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Table 4: Data set 1: All outcomes where the condition had been seen in the joint clinic

Data set for Intervention		A Outcomes before				B Outcomes during				C Outcomes after			
		Optim	Sub optim	Total	%	Optim	Sub opti	Total	%	Optim	Sub optim	Total	%
1	Constipation												
1.1	Do the notes record that the child or young person with constipation received oral macrogols as first-line treatment?	14	4	18		35	8	43		10	1	11	
1.2	For a child or young person undergoing laxative treatment for DISIMPACTION, do the notes record they received a review of their treatment from a healthcare professional within 1 week of starting treatment.	5	7	12		8	16	24		1	6	7	
1.3	For a child or young person undergoing laxative treatment for MAINTENANCE therapy, do the notes record they received a review of their treatment from a healthcare professional within 6 weeks of starting treatment.	7	9	16		21	10	31		4	4	8	
1.4	Ask the parent or patient: Are you better - yes or no?	10	6	16		27	7	34		3	6	9	
2	**Sub**	**36**	**26**	**62**	**58.0**	**91**	**41**	**132**	**68.9**	**18**	**17**	**35**	**51.4**
2	**Asthma**												
2.1	Do the notes record that the child or young person with asthma has a written personalised action plan?	1	10	11		9	5	14		4	2	6	
2.2	Do the notes record that the child or young person has had a structured annual review in the last 12 months and assessment of asthma is made using a recognised tool?	9	2	11		7	3	10		4	2	6	
2.3	Ask the parent/patient: Are you satisfied with your child's breathing?	8	2	10		7	3	10		4	0	4	
2	**Sub**	**18**	**14**	**32**	**56**	**23**	**11**	**34**	**67**	**12**	**4**	**16**	**75**
3	**Fever**												
3.1	Do the notes record that all of the following were measured: temperature; heart rate; respiratory rate; capillary refill time?	15	9	24		10	5	15		8	2	10	
3.2	Do the notes record the risk of serious illness, using the NICE traffic light table?	8	16	24		6	9	15		7	3	10	
3.3	If the child was sent home, to the notes record that the parent was given safety	23	1	24		15	0	15		9	1	10	
3.4	Did the child return within 7 days to any setting?	19	5	24		10	5	15		10	0	10	
3	**Sub**	**65**	**31**	**96**	**67**	**41**	**19**	**60**	**68**	**34**	**6**	**40**	**85**
4	**Eczema**												
4.1	Do the notes record that psychological wellbeing and quality of life of the child, young person, family is discussed?	7	17	24		20	12	32		8	6	14	
4.2	recorded severity using the stepped-care plan, supported by education?	12	12	24		28	4	32		10	3	13	
4.3	Ask the parent/patient: Is your child's eczema under control?	8	10	18		18	7	25		8	2	10	
4	**Sub**	**27**	**39**	**66**	**40.**	**66**	**23**	**89**	**74.15**	**26**	**11**	**37**	**70.27**
	Totals	**1**	**1**	**2**	**57.**	**2**	**9**	**3**	**70.**	**90**	**3**	**1**	**70.**
						p-value compared to A			***0.00***	*p-value compared to A*			***0.0***

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Table 5: Data set 2: Data groups that included a reported patient outcome

	Data set for Intervention where outcome reported	A Outcomes before				B Outcomes during				C Outcomes after			
		Optim	Sub optim	Total	%	Optim	Sub optim	Total	%	Optim	Sub optim	Total	%
1	Constipation												
1.1	Do the notes record that the child or young person with constipation received oral macrogols as first-line treatment?	12	4	16		27	6	33		9	0	9	
1.2	For a child or young person undergoing laxative treatment for DISIMPACTION, do the notes record they received a review of their treatment from a healthcare professional within 1 week of starting treatment.	5	7	12		7	11	18		1	5	6	
1.3	For a child or young person undergoing laxative treatment for MAINTENANCE therapy, do the notes record they received a review of their treatment from a healthcare professional within 6 weeks of starting treatment.	5	9	14		18	8	26		4	3	7	
1.4	Ask the parent or patient: Are you better - yes or no?	10	6	16		27	7	34		3	6	9	
2	**Sub**	**32**	**26**	**58**	**55.1**	**79**	**32**	**111**	**71.1**	**17**	**14**	**31**	**54.8**
2	**Asthma**												
2.1	Do the notes record that the child or young person with asthma has a written personalised action plan?	1	9	10		7	3	10		4	0	4	
2.2	Do the notes record that the child or young person has had a structured annual review in the last 12 months and assessment of asthma is made using a recognised tool?	8	2	10		7	2	9		4	0	4	
2.3	Ask the parent/patient: Are you satisfied with your child's breathing?	8	2	10		7	3	10		4	0	4	
2	**Sub**	**17**	**13**	**30**	**56.6**	**21**	**8**	**29**	**72.4**	**12**	**0**	**12**	**100.0**
3	**Fever**												
3.1	rate; respiratory rate; capillary refill time?	15	9	24		10	5	15		8	2	10	
3.2	Do the notes record the risk of serious illness, using the NICE traffic light table?	8	16	24		6	9	15		7	3	10	
3.3	If the child was sent home, to the notes record that the parent was given safety	23	1	24		15	0	15		9	1	10	
3.4	Did the child return within 7 days to any setting?	19	5	24		10	5	15		10	0	10	
3	**Sub**	**65**	**31**	**96**	**67.7**	**41**	**19**	**60**	**68.3**	**34**	**6**	**40**	**85.0**
4	**Eczema**												
4.1	Do the notes record that psychological wellbeing and quality of life of the child, young person, family is discussed?	7	11	18		18	7	25		7	3	10	
4.2	Do the notes record that the child or young person is receiving treatment based on recorded severity using the stepped-care plan, supported by education?	9	9	18		22	3	25		8	1	9	
4.3	Ask the parent/patient: Is your child's eczema under control?	8	10	18		18	7	25		8	2	10	
4	**Sub**	**24**	**30**	**54**	**44.4**	**58**	**17**	**75**	**77.3**	**23**	**6**	**29**	**79.3**
	Totals	**138**	**10**	**23**	**57.9**	**19**	**76**	**275**	**72.3**	**86**	**26**	**112**	**76.7**
						p-value compared to A			***0.000***	***p-value compared to A***			***0.000***

4.2.4 Limitations

The results show a statistically significant difference:

- **Data set 1** (Table 4): Aggregate of all process and health outcomes returned:
  - Before 57% before the intervention in solo GP training consultations
  - During the joint clinic 70% p-value 0.0011 ($p<0.01$) when compared to before
  - After 70%, p-value 0.011 ($p<0.05$) when the GP Registrar returns to solo GP training consultations, compared to before
- **Data set 2** (Table 5): Data groups that included an associated health outcome:
  - Before 57%
  - During 72% p-value 0.0090 (p-value 0.01) compared to before
  - After 76% p 0.0028 (p-value <0.05) compared to before

The lack of a control group of practices who did not host clinics makes interpretation problematic as results cannot be interpreted as being due to the impact of Learning Together alone. The extent to which the change is a result of usual training is unknown. However, we can be reasonably confident that we have avoided a Hawthorne effect in the data.

The timeline of the audit, at the very end of the project in May 2014, meant that the registrars were unaware of the audit metrics and conditions at the time they took part in the educational intervention or in the period that after data was mainly reported. Therefore, they were unable to tailor their consultations to meet requirements of the audit. The Hawthorne effect describes how behaviour changes simply as a result of being measured or studied. That this has largely been avoided in the CAFE audit is helpful as it allows the process of the audit itself to be discounted as the change agent in the results.

Methodologically there is a black box between the input of an educational intervention and the desired outcome of improved health status for patients and this is challenging. [12] . In this complex picture traditional evaluation methods may not be adequate. [13]

The ROMLA matrices as a tool in investigating guidance adherence and clinical outcome: are they useful in children with head injuries? [14]

Methodologically aggregating child health and process outcomes was a purposeful approach in the pilot. Outcomes were analysed separately by process and health outcomes alone, as one is expected to lead to the other. In a subset of dataset one the three health outcomes were excluded to show:

- Before 55%
- During 66% p-value 0.009006 (p-value < 0.01) compared to before
- After 67% p-value 0.0028841 (p-value <0.05) compared to before

The removal of health outcomes from data set 1 does not change the overall picture of the results. As anticipated, a subset of health outcomes alone or, indeed, of a single condition are too small to make any conclusions about and demonstrate why a priori the aggregate approach was adopted

The change in guidance adherence health outcomes for children reported and the relationship between them is complex and has not been analysed here. This complexity includes the self-limiting nature of some childhood conditions which can mask poor, even unsafe practice. For example, with febrile illness without focus in a child, the failure to exclude a serious illness or identify an acutely sick child is a sub optimal but rare outcome. Another complexity is that no adjustment was made for the clinical relevance of the health outcomes, for example, in constipation. It can take a few months to achieve a return to symptom-free health in this common condition and the data collected is known to have been too short to see the full effect of optimal outcomes developing, particularly in the 'after' data.

In summary, the relationship between health and process outcomes is complex: sometimes optimal health outcomes are not reflected in good process outcomes; sometimes good care takes time to manifest in optimal health outcomes and so on. One of the jobs of these metrics was to simply see if any overall change had taken place.

A second aim was to inform future projects. Where audit is considered in other evaluations consideration could be given to using a 'no intervention' comparison group from participating practices, to avoid recruitment of a separate control group of GP practices. A few sites misunderstood the 'no intervention' criteria (see dataset 1 above for a description) and incorrectly returned data for one of the four conditions when the condition had not been seen in their Learning Together clinics. The registrars in the practice had therefore not had a Learning Together 'experience' for that condition. As a result 79 data points were returned only to be excluded from data set 1. Of this removed data in the 'before' group 63.23% of care was optimal and in the after group 63.33% of care was optimal. With such small numbers this data cannot be interpreted, but it alludes to a practical approach for a control group in future projects. Had it been anticipated that it would not be possible to recruit control sites for CAFE we would have used this approach ourselves.

5 Drawing out the lessons

5.1 Background: child health

We know we have a problem in child health:

- The care of children and young people provided is inferior in the UK compared to Europe [Wolfe 2011]
- There is consensus that significant numbers of children could be seen in primary care rather than in hospital [Saxena 2009, Milne 2010]
- Care is disjointed for many with long term conditions

5.2 Working hypothesis

Learning Together sought to address this need though paired education.

The hypothesis is that health outcomes and service use could be improved if senior specialist registrars in general practice and paediatrics had a better understanding and experience for the application of child health knowledge and skills in the context of primary care i.e. for both specialisms to learn to work together to provide optimal care.

5.3 Learning themes

Outcomes for participants were purposefully not described at the beginning of the evaluation project so that they could be self-directed by the learners and considered at the end of the project to inform a final model.

Learning - clinical knowledge and skills

In the learning logs both paediatric and GP registrars reported increased knowledge of conditions. This was identified in the qualitative analysis as a common theme and a few examples from the registrars are given below:

> *"I never felt that confident about managing long term asthma. We looked it up together and I discussed with my Supervisor. Now I am very confident to make asthma plans!" [Paediatric Registrar]*

> *"On a practical level, the thing that helped me learn was all the resources that the Paediatric Registrar told me about. Things I had no idea about before. Not just guidelines, but useful websites, things to give out to families, the nuts and bolts stuff."* (GP Registrar)

> *"Seeing how the Paediatric Registrar talked to children and got them engaged was good. I tended to just focus on the parents. Seeing how to talk to children and the types of questions to ask and the words to use was good." (GP Registrar)*

Both groups of registrars also identified future learning needs as a result of the joint clinics and this included reading guidance about specific topics and management of specific conditions to complement reflective learning. A key example is safeguarding which was highlighted as a learning need by both groups.

Confidence

Quantitative data from the online surveys suggests that Learning Together clinics were associated with a significant improvement in self-reported confidence. The qualitative data gives some insight as to why confidence may have increased**:** GPs report increased confidence because of new knowledge and skills; paediatricians via more autonomy outside of the hospital setting:

> *"Despite the challenges I think this [the Learning Together approach] is something that should definitely be made a regular part of training. Before I wasn't very confident but this has made me more confident. Children are a big part of general practice and for those who have not done paediatrics as part of their training this is really good for helping to differentiate the grey areas that you see every day." (GP Registrar)*

Participants also noted that changes in their confidence may have improved their communication style overall:

> *"There is much that I have learnt during these clinics, which may not be knowledge-based but certainly important for my professional development, including gaining confidence in clinics, leadership skills by role modelling and teaching skills, which in turn has improved my consultation style and examination since I am role-modelling/demonstrating/teaching during the clinic. It is two-way and I am learning a lot." (Paediatric Registrar)*

Confidence is difficult to interpret as it relies on self-awareness and needs considering alongside other themes such as guidance adherence.

Inter speciality learning: working with a Registrar from another speciality

A greater understanding of each others' roles and responsibilities was reported by the registrars in case studies, in learning logs and at the workshops. Follow-up of patients via email was also commonly reported to the Project Team. Improved recognition by GP trainees and registrars of each others' roles and willingness to work together was identified as a driver that appeared to result in more appropriate referrals being made and more children supported within primary care:

> *"I have found working on the Learning Together programme has been beneficial in ways I had not expected prior to starting clinics: I had expected that from an educational point of view I would probably have less to gain than my GP colleague, however, while preparing for clinics and in running the multidisciplinary team meeting lunchtime teaching sessions, the depth and breadth of my knowledge about conditions which are infrequently seen in acute hospital settings (e.g. food allergy, chronic eczema) has increased hugely. I have a renewed appreciation for the work of GP colleagues, and am particularly envious of the way in which they practice holistic and family centred care - one example would be when I was fairly puzzled by a rather bizarre consultation where a mother brought her child (who had been missing a lot of school with minor complaints) to the walk in emergency clinic slot with a sore throat - examination completely normal, child completely well. The mother burst in to tears during the consultation and it emerged that there were a lot of family issues going on - several family members were depressed, her daughter had anorexia, all the children had school refusal etc. The GP Trainee and I discussed the case at lunch time teaching with GPs who knew the family really well and had developed relationships over the last 20 years with*

them and their insights were really revelatory - we just do not get the chance to practice like that in A&E!"[Paediatric Registrar]

"It helps to improve relationships between primary and secondary care. Face to face communication is so much better than phone or email and you get to see first-hand how each other works and the different roles people have." [GP registrar)

Guidance Adherence: CAFE pilot audit

Adherence to NICE guidance is recognised as a good proxy measure for high quality care that will improve patient outcomes. As detailed in Section 3.3 above, CAFE included measures about the health status of the child or young person: how concerned or satisfied the parent was with their child's breathing; are you better?; is your eczema under control? We only have small numbers for health outcomes, but the approach to include them is an important step that promotes thinking about the child or young person's health alongside learning.

The CAFE pilot also allows comparison of changes in practice before and after the joint clinics. The avoidance of the Hawthorne effect means the significant changes in guidance adherence are not a result of the audit. The results hint at an interesting association between improved guidance adherence in Learning Together clinics, and for a period after the clinics when GP registrars return to usual solo ten-minute appointment slots. Something positive is happening in this timeframe that has moved practice for GP Registrars within primary care from a baseline of 57% before to 72% during (p value < 0.01) and increased to 76% after, (p value < 0.05 compared to before). This a very encouraging message for child health.

The CAFE pilot suggests that Learning Together can be a positive lever for change. The educational model shows real promise in terms of improving practice in common childhood conditions within primary care.

Summary of learning themes

Table 6 below illustrates broad learning themes. These are suggestions taken from the evaluation and cases discussed at workshops. The themes are intended to provide a useful summary for future projects. Learning was both clinical and inter-speciality.

Some educational process issues

What was immediately apparent, not unexpectedly, was the affirmation of experiential learning as a powerful education method: the value of learning from the clinical interaction and the reflective discussion that happened at the time or thereafter. GP trainees particularly referenced an improvement in clinical knowledge and skills and was proven to extend to patient care by the CAFE element above. We further suggest learning can be immediate in a joint clinic and rendered more powerful by the dyadic nature of the experience.

Paediatric registrars spoke about how it often took time to settle into their new role and environment and suggested that having a series of six clinics facilitated this. They were working in a new environment and out of their 'comfort zone'. In addition they were unused to working under direct observation [of the GP trainee] whereas GP trainees are very used to joint clinics with their trainers. GP trainees are also used to videoing their consultations for later analysis and it emerged that paediatric trainees are not [perhaps, yet!]:

> *"Overall it was a positive experience. It takes quite a while to settle in as a hospital doctor to go into GP practice. You do not have the consultant next door to ask. You need time to get used to everything."*
> (Paediatric Registrar)

One of the elements of generalist practice is a 'different' view of risk management and safety netting and it may be more difficult for a specialist to see the generalist perspective: one Paediatrician reported a case where there was a discussion about a teenage girl with abdominal pain. The Paediatrician wanted to immediately refer for investigations and the GP did not because the patient was otherwise well, and there were no 'red flags'. After discussion they agreed to follow up the patient in primary care. The learning here was clearly about working in an environment without rapid access to investigation and the differing interpretations of watchful waiting and common presentations in primary care.

Some young doctors reported feeling rather competitive and wanted to read up on guidelines the night before a joint clinic. This seemed to be related to certain nervousness in advance, or a need to be seen to be 'doing the job right'. Nonetheless the far commoner reports talked of it being great fun working with a new colleague and a refreshing learning experience. Such sentiments should not be underestimated as being of value in the learning journey.

What Learning Together clinics demonstrated quite evidently was a novel way of working, which operationalised integrated care between specialities. Strictly speaking, this does not fit the classical definitions of inter-professional education, but there are elements that could be so described. Our doctors were learning about one another's working contexts, roles and responsibilities (this was more described by the paediatricians than GPs) for example.

Facilitation and Supervisor support both during clinics and after was a key need reported, both from the point of view of patient safety, but also to interpret, consolidate and reflect on the learning that had taken place. Supervisors could have helped more occasionally with organisational issues such as:

> *"Having a better selection of cases would be better – so registrars learn for example about recent discharges. More thought needs to be put into which cases to book in and the GP Trainee shouldn't do this all alone."*
> (Paediatric Registrar)

However, for the most part, the generic issues described above were reflected in commentary from GPs and paediatricians alike. Learning for paediatricians and GPs alike is driven by the content of the case mix available in clinics and there may be ways of constructing clinics that serve individual

learning needs as well as addressing patients' presenting issues.

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Table 6: Summary of learning themes

Theme	What was learnt	What they said	What prompted the learning
1. Learning for Registrars			
New knowledge	Resources: guidelines and websites Information to give to families	*"On a practical level, the thing that helped me learn was all the resources that the paediatric registrar told me about. Things I had no idea about before. Not just guidelines, but useful websites, things to give out to families, the nuts and bolts stuff."* (GP Registrar)	Knowledge transferred from learning partner
New knowledge	Earlier identification and treatment of constipation	*"The Paediatric Registrar immediately got to the point of the diagnosis, which I had been hesitant about previously. She worked out very quickly that the trouble was constipation despite the patient denying any straining at stool and, while reassuring both father and child, suggested a trial of movicol. It was useful to see how this was done."* (GP Registrar)	Knowledge transferred from learning partner
New knowledge	Asthma standards and guidelines Confidence to make an asthma plan	*"I never felt that confident about managing long term asthma. We looked it up together and I discussed with my supervisor. Now I am very confident to make asthma plans!"*[Paediatric Registrar]	Knowledge transferred from learning partner translated into a new skill Supervision
Clinical Skills	Feeling faecal impaction in a child	"*The Paediatric Trainee showed me a really good way of doing toscopy in a child…I now have much more success*" [GP Registrar]	Observation of learning partner and putting it into practice
Clinical skills	Clinical judgement	*Children are a big part of general practice and for those who have not done paediatrics as part of their training this is really good for helping to differentiate the grey areas that you see every day.*"[GP Registrar]	Experience of Learning Together clinics

Clinical skills	Consultation style	*There is much that I have learnt during these clinics, which may not be knowledge-based but certainly important for my professional development including gaining confidence in clinics, leadership skills by role modelling, teaching skills which in turn has improved my consultation style and examination since I am role-modelling/ demonstrating/teaching during the clinic. It is two-way and I am learning a lot."* [Paediatric Registrar]	Role modelling to a partner in the clinic

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Theme	What was learnt	What they said	What prompted the learning
Communication skills	Focusing on the child	*"Seeing how the Paediatric Registrar talked to children and got them engaged was good. I tended to just focus on the parents. Seeing how to talk to children and the types of questions to ask and the words to use was good."* [GP Registrar]	Observation of learning partner
Communication skills	Tips when speaking to a parent	"we love slippery children" when treating with emollients for eczema [Paediatric Registrar]	Knowledge transferred from learning partner
Communication skills	Using ICE (ideas, concerns, expectations) approach	"the GP approach of exploring parents' concerns is firmly embedded in GP training…it was an eye-opener" [Paediatric Registrar]	Observation of learning partner
Inter speciality learning: working with a Registrar from another speciality			
Ongoing collaboration	Who to speak to	" I am pleased when I see a child on the ward is from my Learning Together practice. I will usually call [the GP] up and speak to someone I know when they are discharged …to do a verbal handover rather than relying on a discharge letter which may or may not get there" [Paediatric Registrar]	Learning Together clinics
Satisfaction with team working [defined narrowly as Learning Together pairs or their partners 'home' team]	How each other practice	*"It helps to improve relationships between primary and secondary care. Face to face communication is so much better than phone or email and you get to see first-hand how each other works and the different roles people have."* [GP Registrar]	Learning Together clinics

Attitudes	Understanding one another's' working conditions and pressures	*"I have found working on the Learning Together programme has been beneficial in ways I had not expected prior to starting clinics: I had expected that from an educational point of view I would probably have less to gain than my GP colleague, however while preparing for clinics and in running the multidisciplinary team meeting lunch time teaching*	Learning Together clinics

Theme	What was learnt	What they said	What prompted the learning
		sessions, the depth and breadth of my knowledge about conditions which are infrequently seen in acute hospital settings (e.g. food allergy, chronic eczema) has increased hugely. I have a renewed appreciation for the work of GP colleagues, and am particularly envious of the way in which they practice holistic and family centred care - one example would be when I was fairly puzzled by a rather bizarre consultation where a mother brought her child (who had been missing a lot of school with minor complaints) to the walk in emergency clinic slot with a sore throat - examination completely normal, child completely well. The mother burst in to tears during the consultation and it emerged that there were a lot of family issues going on - several family members were depressed, her daughter had anorexia, all the children had school refusal etc. The GP trainee and I discussed the case at lunch time teaching with GPs who knew the family really well and had developed relationships over the last 20 years with them and their insights were really revelatory - we just don't get the chance to practice like that in A&E!" [Paediatric Registrar]	
Attitudes	Understanding of each other roles	*"The tendency when you receive a referral in hospital is to assume that there is a diagnosis to be made that the GP has referred because there is something serious going on. From my discussion at the practice meeting and subsequently [at the joint clinic] it was clear that in primary care the approach is different and sometimes reassurance is all the family are looking for".* [Paediatric Registrar]	Learning Together clinics
Attitudes	Understanding of each other roles	*"I feel like I have more of a handle now on what happens in primary care. I see the pressures that my GP colleague is under, especially the time pressures and not knowing what is going to walk in. It has opened my eyes up a lot to what happens and why many things might be referred on. It also helped me see where we could work together more and provide more streamlined care."* [Paediatric Registrar]	Learning Together clinics

5.4 Patient confidence and experience

In 87% of the 351 feedback forms completed immediately after the clinics, parents reported increased confidence to manage their child health. In 99% of the 351 forms parents said they had a good experience of care at the joint clinics which suggests that they are doing something right for patients. Almost all thought that it was useful seeing a GP and Specialist together (99%) and would recommend this type of clinic to friends or family (99%). They thought the doctors worked together well (97%).

Directly comparable patient satisfaction figures for primary care encounters for children are not available, but a recent Ipsos Mori poll (2014) of over 900,000 patients reported that 93% of those responding have overall trust and confidence in their GP, and 83% feel they are treated with care and compassion.

One hundred and seventy-one families gave permission to be contacted again to ask about their experience. Of these, 125 were interviewed (73%). Interviews were stopped after reaching saturation point. Feedback from the interviews mirrored that from survey forms.

> Parents and carers noted that they were happy with their experience of Learning Together clinics:
>
> *"I found this helpful beyond words. I understand things more and found both doctors so professional and human."* [Mother]
>
> *"It was good and we didn't go to hospital. The doctors were friendly and told us what to do at home."* [Child]

A key theme was reducing the time needed to go to multiple hospitals for various appointments and tests. Patients liked the 'one stop' approach:

> *"The whole thing was good. Having two doctors worked well because one knew us and the other was a special children's doctor. It meant we didn't have to go to A&E and was reassuring. We had to wait a bit, but much less than if we went to hospital."* [Family member]
>
> *"It was great for my child as hospital can sometimes be a bit overwhelming."* [Mother]

A small number of parents and carers said that there had been too many people in the room, such as when a supervising doctor or a Nurse was present in addition to the GP trainee and paediatric registrar. This highlights the importance of gaining a balance between joint working and learning and 'overcrowding.'

5.5 Working with the wider practice team

Information on the impact of Learning Together clinics on the wider practice team was only collected from two practices in the evaluation. As such, there was insufficient evidence collected to understand whether the Learning Together model raised awareness about child health issues in the wider GP practice team. However, we know from the workshops and conversations with the project team that the recommendation to feedback after clinics to the wider practice team, both to offer clinical continuity and to share learning, was done in most places. Arranging timetables around this activity was sometimes difficult. Where it was done, this seemed to increase learning for trainees and the team as a whole and is seen as a strength of the model by GP VTS leads.

> *"A child under two had been seen in the Learning Together clinic with a very anxious mother. In the follow up meeting the Health Visitor happened to bring the same case for discussion, and having visited the home was able to bring more insight to the case. A timetable for follow up was agreed" GP Trainee. The GP Trainer reflected "for the first time I had to go upstairs and knock on the Health Visitor's door and get their email address ….I know … it's embarrassing!"(GP Trainer)*

In the evaluation there were mixed views about involving nurses as key partners within clinics. Although some nurses thought it would be useful to be present, others reported a lack of capacity and it not being their role. GP and paediatric registrars tended to indicate that there were already too many people in the room during clinics (especially when a GP Trainer sat in). This mirrored the views of parents and carers who attended a clinic with three professionals. The overall feedback was that it may not be appropriate for a Nurse to attend as well as a GP Trainee and Paediatric Registrar – but a Nurse could potentially substitute for a GP Trainee to keep the number of people in the room low. Those providing feedback thought that nurses could be involved as part of multidisciplinary team meetings, especially if these were more structured to allow time for discussing cases and learning.

Involving nurses in a meaningful way for them has not been universally straight forward. It may be that a different strategy is required for this. The Leicester[15] model is a good resource and place to start to identify barriers to learning with expert facilitation.

5.6 Service outcomes

Given that the intervention is primarily an educational intervention, *learning* was the primary outcome for our evaluation. However, one of the aims is to up-skill professionals, and enable working together to reduce additional visits to hospital for example reducing the need for specialist review, or for further management due to suboptimal management of conditions. As a result, the onward "journey" of the child after being seen in the learning together clinic is important.

In learning logs completed about each child seen, professionals estimated that 55% of Learning Together appointments resulted in an avoided visit to hospital, either due to avoiding a referral for specialist opinions, tests or outpatient care, or avoiding a visit to the emergency department.
Practices used the clinics for different ways locally: to optimally manage patients *below* their referral threshold; to avoid a 'soft' referral; some to avoid a difficult referral; to support local learning goals etc. In other words the populations in the clinics varied in ways we can't plot in relation to the probability of referral and make this encouraging finding 55% difficult to interpret.

The potential impact on hospital visits was supported by feedback from parents and carers in follow- up interviews one to two months after a clinic appointment. Ninety-Eight percent of one hundred and twenty-five parents and carers interviewed said that they had not had an unplanned visit to hospital for the child's condition within the one to two months since their clinic appointment. They said this was because they had learnt how to manage their child's condition more effectively, had been told about warning signs to look out for and had been given other care pathways and primary care follow-up when needed.

Individual registrars reported increased knowledge about local systems, as noted above. This may in turn lead to service changes.

> *"I did not realise that all children from the practice I was working in routinely went to hospital A for Xrays, because Xrays could be requested electronically, but the usual path of referral was to hospital B. This makes no sense and I have discussed with management how we can address it" (Paediatric Registrar)*

5.7 Health economics

In the evaluation participants commented on the increase in resource use and we know that releasing paediatric registrars was a key barrier in early set up that was overcome as the reputation of the project grew. However, resource use is an important consideration for the project. Even if an intervention is believed to be doing no harm, or as good as something else, if it is consuming more resources this can be regarded as ineffective use of resources. The resource could be better spent on something less resource intensive and as effective.

Two 'what if' health economic models were developed for the project. They cannot be regarded as 'results' or evidence. The models give a conceptual framework in which scenarios can be considered in data poor areas and allow decision makers to test their beliefs about the benefit (anticipated health gain) of an intervention alongside resource use and prompts considerations and caveats to the model to be made explicit and discussed about health outcomes and resource use. Models can also identify key drivers that usefully inform future research.

The full report can be found in Appendix A.

Model 1: Resource use in the system overall

The model considered GP trainees only for simplicity and illustrates the circumstances under which Learning Together could be considered cost neutral. The number of clinics avoided also depends on whether these clinics were assumed to be replacing or in addition to usual primary care. The difference in the numbers reported below depended on the assumptions used when calculating costs. The model illustrates that Learning Together could be cost neutral to the NHS if:

- Between 11 and 32 'GP trainee appointments' could be avoided per month across the whole practice, or
- between 0.9 and 2.7 fewer unnecessary secondary care referrals per month, or
- Between 0.4 and 3.2 fewer unnecessary A&E attendances

Interpretation of model 1

This model shows that if Learning Together could prevent a number of unnecessary GP appointments by leading to more effective early recognition and management of children in primary care, th en it would not require more NHS resources to create Learning Together partnerships and could even save the NHS money. If it could prevent unnecessary use of secondary care and A&E attendance it could also be cost-saving. In reality, a consequence of the clinics could lead to a reduction in GP appointments, secondary referrals and A&E attendances saved. The team noted that this type of measure of activity was helpful in illustrating how the educational intervention can avoid resource use. GP trainees and paediatric registrars who participated in Learning Together estimated that **55% of Learning Together appointments they participated in resulted in an avoided visit to hospital**. We do not know from the reported data whether the children booked into Learning Together appointments would have otherwise been referred directly to hospital, seen by another GP, or if the Learning Together appointment was an additional intervention in the patient's clinical pathway. We therefore cannot interpret these views into resource savings. However, while we cannot assume a cost saving it illustrates how Learning Together is likely to be cost neutral if these views are reflective of wider practice in Learning Together clinics.

The model is also useful as a benchmark that can be tested locally, together across primary and secondary care, and used to shape patient selection alongside locally identified learning goals.

Model 2: Child health outcomes

As an alternative approach, a second model was developed and a threshold analysis was undertaken to consider the improvement in health outcomes that would be required for a monthly Learning Together clinic to be considered cost-effective under NICE decision rules for cost-effectiveness.
Under an assumption of no impact on follow-up health service use and cost, (i.e. the clinics did not make any difference to referral or A&E attendance rates) the Learning Together clinics would have to lead to a health improvement of between 0.10 and 0.29 quality adjusted life years per year to be considered cost-effective. This improvement would need to be sustained as long as Learning Together clinics were in place.

What does that mean?

- This is the equivalent of at least three more children every year with conditions such as asthma or constipation being successfully treated (regaining good health) compared with usual primary care before the joint clinics were introduced
- If the health gain were over a shorter period of time than a year, say for a self-limiting rather than a long-term condition, then more children would need to be successfully treated than before Learning Together, in order for the change in primary care to be considered cost- effective
- If health service use were also to fall as a result of improvements in health following a Learning Together consultation, then the threshold health gain required for cost- effectiveness for the intervention would also fall.

Interpretation of model 2

We wish to emphasise that Learning Together is designed as an educational not a service intervention.

We do not have a year's data on health outcomes from this pilot. However, the CAFE audit suggests that learning can be immediate and change practice in primary care swiftly implemented in Learning Together clinics and in the GP trainees' management of children following participation in Learning Together clinics. The statistically significant change in adherence to NICE guidance is a good early indicator that changes in the health of children can be made as a result of the joint clinics. Where the gain in child health outcomes is sustained over a year then a strong case for additional investment in Learning Together could be made.

Overall, using both health economics models as a framework for our considerations has been a helpful challenge and one that enables us to commend the Learning Together approach as an educational intervention

5.8 Feasibility of the educational model

As part of the evaluation at programme workshops and via stakeholders, information was received on barriers and enablers to inform the consideration of feasibility of the model by the clinical project lead.

The flexibility of the model enabled local implementation and this was a key success factor for roll out in primary care. Learning Together clinics were not centrally defined in terms of patient selection or outcomes and as a result all groups of stakeholders (consultants in trusts, GP trainers, parents and registrars) regarded Learning Together as a positive learning experience.

Organising clinics

The most important first step to get clinics going and ensure feasibility is to get clear buy-in from paediatric and GP leads. This can be done either bottom-up – by trainees' interest, taking the idea to their trainers/supervisors – or more centrally – by cascading of information from others such as UCLP. A clear understanding of what the clinics entail and the commitment required is important before clinics begin. Where practices have fully understood the commitment before clinics started, the clinics seem to have worked best.

Release of the Paediatric Registrar was the biggest barrier to the clinics, and the greatest difficulty to be overcome. However, most consider that planning for one or two registrars in a paediatric rota to get released for half a day once a month is achievable and are prepared to build this into hospital rotas. Having a champion in your trust to encourage/support Paediatric Registrar time is vital; liaising with the Rota Coordinator early to plan clinic times in advance helps.

A sustained period of time over which clinics were held was important and may vary across learning outcomes. The learning of new clinical knowledge and skills appears to be pretty immediate, as demonstrated by the audit. The understanding of one another's roles, the local landscape and working together takes more time to develop and may require external facilitation in a learning set or workshop. Those who completed more frequent clinics in shorter periods of time – one to two months – gained much less learning than those who did monthly clinics over a six-month period. As a result, we encourage monthly clinics over a six-month period, this would mean that potentially two Registrar pairs could participate in clinics each year (with a six-month cycle for each pair).

Clinic content

Booking the right type of patients is an important consideration: several clinics had patients that were too complex, or too many walk-ins. It is important to ensure that the wider practice team knows about the remit of the clinics – what patients to include, etc. – in order to get maximum learning. This is not prescriptive. Some trainees may be keen to see simple paediatric problems only, others may prefer some more complex cases. For example paediatric trainees in community posts may be keen to see behavioural problems whereas others may feel too out of their depth. This is something to be established between the pair and the practice team.

The length of appointments is also key: in one or two practices, clinic slots were shorter than the suggested 20-30 minutes. Feedback from participants in this pilot and in earlier pilots does suggest that in order to really address, reflect and learn from cases, the appointments need to be at least 20 minutes for more simple booked slots and 30 minutes for more complex cases. This was considered particularly important for cases where communication was central with both the parent and child, for example understanding the management of eczema.

Maximising learning outside clinics

The format and quality of supervision, both from the GP Trainer and the Paediatric Supervisor, greatly influences the amount of learning that trainees derive from the clinic. Where supervision and challenge is more rigorous, trainees are forced to reflect and follow on with their learning. It was apparent from the first workshop that some registrars were confused by the lack of prescribed learning outcomes. Table 6 above on learning themes may also help direct learning goals

Participants were encouraged to feedback at local practice meetings after every clinic. Sharing learning at multi-professional team meetings immediately following clinics was also seen to be beneficial both for the practice and for paediatric registrars

The evaluation does not throw light onto the likely effect of peer or paired learning within other professions and how it would be received by nurses for example. Little data was collected in the evaluation that usefully informs this. Some suggestion has been made that barriers include lack of capacity as a key issue.

6 Key conclusions

Key achievements of the project include:

- Establishing high patient satisfaction profiles with the educational model
- Setting up of 44 learning pairs over and beyond a large LETB geography
- Successfully examining a dyadic model of cross discipline working
- Reaffirming the primacy of experiential learning for child health
- Working successfully in an integrated style of care
- Piloting and improving guideline adherence and improved child health
- Building an economic case for shared specialist/generalist care

Feasibility of Learning Together clinics

We commend Learning Together as a viable and novel educational intervention that has experiential learning at its core. Forty-four learning pairs were established across twelve Trusts and forty GP practices in six months with one hundred and forty-five clinics and eight hundred and forty-eight children and young people, across and outside of the UCLPartners patch.

Locally the model became infectious – registrars loved the experience and promoted it. The flexibility of the model was a key factor that enabled enthusiastic local implementation at this high level. As a guide to sustainability, we recommend each Trust aims to release at least one SpR 5-8, once a month for six months to a local GP training practice, to support joint education in local integrated child health.

It is not a simple model. It builds on the primacy of experiential learning as a method to best approach acquisition of knowledge and skills, but also to become familiar with inter professional practice. The best way to make it work is just to start doing it. It requires development and adjusting as you go along in terms of who to book and how you work together.

Learning themes

We have identified the following learning themes from the pilot and in summary they break down as follows:

- Learning themes for both GP and paediatric registrars:
  - New knowledge
  - Clinical skills
  - Communication skills (with children and families)
- Inter-speciality learning: working with a Registrar from GP or paediatrics:
  - Ongoing collaboration
  - Satisfaction with team working [defined narrowly as Learning Together pairs or their partners 'home' team]
  - Attitudes

We found that it takes a series of clinics for the 'penny to drop' about each other's roles. Inter- speciality learning themes are more difficult to achieve than the clinical ones, but are necessary if we want to integrate child health, improve outcomes and keep children unnecessarily out of hospital.

Learning changed practice

Something positive happened in this timeframe of Learning Together that moved practice for GP Registrars taking part in Learning Together from a baseline of 57% before to 72% during (p value < 0.01) and increased to 76% after, (p value < 0.05 compared to before). It shows Learning Together can be a positive lever that changes practice.

Patient confidence and experience

In 87% of the 351 feedback forms completed immediately after the clinics, parents reported increased confidence to manage their child health. In 99% of the 351 forms parents said they had a good experience of care at the joint clinics, which suggests that they are doing something right for patients. Almost all thought that it was useful seeing a GP and Specialist together (99%) and would recommend this type of clinic to friends or family (99%). They thought the doctors worked together well (97%).

A key theme in feedback from parents was reducing the time needed to go to multiple hospitals for various appointments and tests. Patients liked the 'one stop' approach.

Working with the wider practice team

Feedback after clinics to the wider practice team, both to offer clinical continuity, discuss other children in the Practice, and to share learning, was done in most places. This seemed to increase learning for trainees and the team as a whole and is seen as a strength and requirement of the model by local GP VTS leads.

It may be that a different strategy is required for involving nurses. The Leicester[16] model is a good resource and place to start to identify barriers to learning with expert facilitation. More work needs to be done on this aspect. However it is consistent with the principles of Inter Professional Learning that GPNs and HVs, for example, could and should be incorporated into later iterations of the Learning Together model.

Service outcomes

Learning Together can make a small but positive contribution local to services. Professionals estimated that 55% of Learning Together appointments resulted in an avoided referral or A&E visit. Ninety-eight percent of the hundred and twenty-five parents and carers interviewed said that they had not had an unplanned visit to hospital for the child's condition within the one to two months since their clinic appointment because they had learnt how to manage their child's condition more effectively.

Health economics

We did some modelling to help inform thinking about the value of Learning Together in relation to both resource use and health gain for children and young people. We estimate that Learning Together is good value and an effective use of resources in the system if you :

- We consider that Learning Together would be cost neutral to the system if there are: two fewer unnecessary outpatient department referrals a month; or three fewer A&E attendances a month.

- If resources were not saved (ie if the clinics did not make any difference to referral or A&E attendance rates) we estimate that Learning Together would be cost effective if three more children every year with conditions such as asthma or constipation are successfully treated (regaining good health) compared with usual primary care before the joint clinics were introduced.

Value is complex but we can imagine that these are achievable as a result of Learning Together clinics and we are pleased to put health gain for children alongside resource use in the debate on resources. The 'bang' is achievable and the 'buck' small.

Next steps

- A South London 'extension' of Learning Together is already in hand at two centres and will be rolled out further over the next few months
- In order to improve availability of paediatric trainees, access to Learning Together and/or other community experience should be written in to Statements of Requirements for the commissioning of higher paediatric programmes
- The national director of curriculum renewal for the RCGP has expressed interest in the Learning Together project and will use its findings to inform development of the four year GP training programme – child health and mental health are key domains for improvement.
- See www.pich.org.uk Learning Together is part of the PICH programme run by the London school of Paediatrics.

Summary

Learning Together clinics are recommended as a viable educational training model for GP and paediatric registrars to improve their clinical knowledge and skills, and professional working relationships.

In the national context of suboptimal outcomes in child health, models that change practice are of real value and this is a model that shows a lot of potential. The programme was a positive experience for participants and has been welcomed by trainers and supervisors. We know that changing doctors' practice and implementing high quality guidance is difficult. We commend Learning Together to educational commissioners, local trainers and educational supervisors as a way of making a difference for children locally.

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Appendix A: Economic evaluation of the Learning Together Project By: Hannah Rose Douglas

July 2014

1. Background

Learning Together (Learning Together) is a complex educational intervention delivered by GP trainees and paediatric registrars once a month in a GP practice. The objective is to improve the quality and consistency of care for common childhood conditions across a GP practice. The intervention was designed so that the impact was not only for the children seen face-to-face in the joint clinics, but also in the medium to long term, through shared professional learning across the GP practice and through shared learning with colleagues in secondary care. Therefore, the intervention was designed to have both direct and indirect impacts on health care resources and health outcomes. The purpose of the economic evaluation was to understand the potential for a Learning Together intervention to impact on health care resource use and health outcomes within the NHS. However, the indirect and longer-term costs and consequences have not been captured in the economic analysis presented here, as the indirect impacts are very difficult to measure objectively in a small study. The economic analysis presented below is therefore only a partial economic analysis of Learning Together as it only measures those aspects of the intervention that could be quantified in a meaningful way.

2. Aim

To evaluate the costs and consequences of Learning Together clinics and to consider the impact on resource use of different models of Learning Together clinics across GP practices in the same locality.

3. Methods

Economic evaluation of health care is concerned with how changes in use of health care resources impact on health outcomes compared with the next best alternative, which can be either usual GP practice or another intervention. The cost-effectiveness of an intervention compared with usual GP practice is influenced by:

a. The difference in resources and cost of the intervention itself
b. The change in health service use following the intervention
c. The difference in health outcome as a result of the intervention, such as a difference in time to recover from symptoms of ill-health.

Description and cost of the intervention

Learning Together clinics are joint clinics run by a GP Trainee and a Paediatric Registrar (see section 2). Each clinic lasts a morning or afternoon clinical session and between six and eight children attend each clinic, either through an internal referral and booking system (around three quarters of the attendances) or as walk-in appointments (a quarter of attendances). They are usually followed by a team meeting to discuss the children seen that day. Clinician time is therefore the main cost of Learning Together clinics.

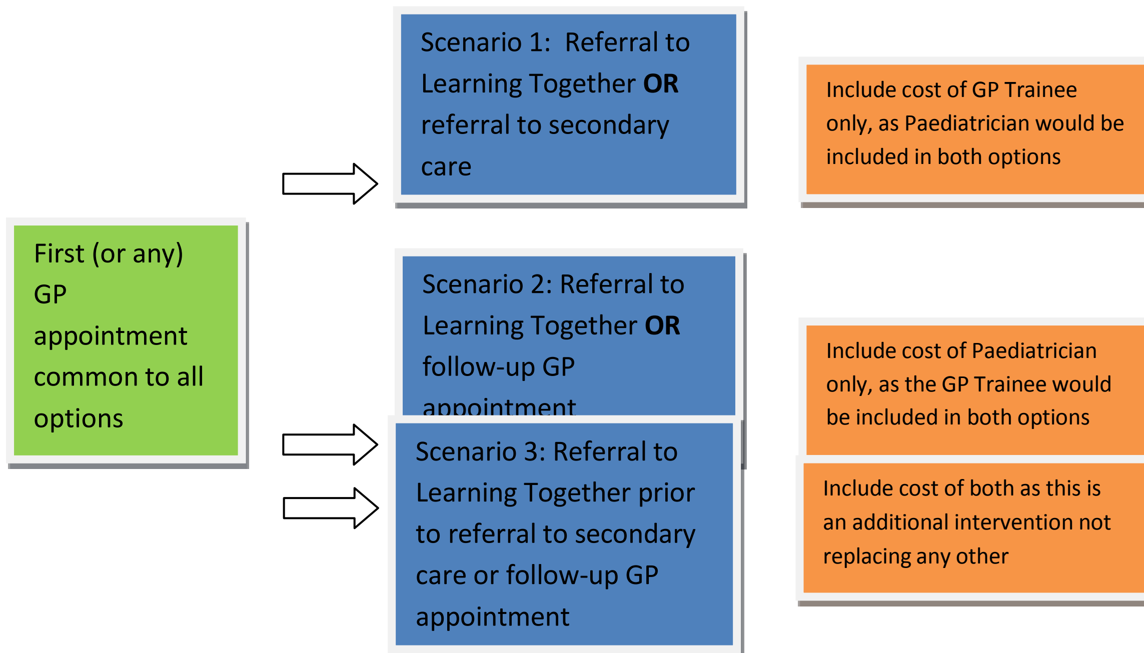
Economic evaluation usually adopts a societal perspective meaning that it takes into account the value of resources to the public purse; it does not usually take into account who the payer is within the health care system. A resource such as clinician time is measured in terms of the value to the NHS (salary and employers' on-costs) regardless of which part of the NHS pays that salary since this was a matter of local and national financing arrangements.

Three cost scenarios for Learning Together have been evaluated to reflect the different models of Learning Together clinics in the project, both between GP practices and over time within the same practice:

- In the first scenario it is assumed that the Learning Together clinics replaced referral to paediatric outpatients. The change in resource use from usual care (prior to Learning Together clinics) was therefore the presence of a GP Trainee in what would otherwise have been a routine paediatric outpatient appointment in hospital albeit in a different setting. The GP trainee's time was included, but the paediatric registrar's time was not, reflecting the fact that they would already have been seeing these children in a different setting prior to Learning Together. From the GP Trainee perspective Learning Together clinics are effectively a second face-to-face appointment with a child who would otherwise have been referred on to the hospital
- In the second scenario, it was assumed that Learning Together clinics were made up of children who have more complex clinical presentations, but who should still be managed in primary care. The Learning Together clinic was not a replacement for a referral to secondary care, but a follow-up GP appointment with the addition of a Paediatric Registrar in attendance. In this scenario, the Paediatric Registrar was the additional resource since the children would have been seen by a GP in a follow-up appointment, as part of usual GP practice.
- In the third scenario, Learning Together clinics represented an additional intervention in the clinical pathway that would not otherwise have taken place, that is, an intervention after an initial GP appointment and before either a follow-up appointment or a referral to secondary care. In this scenario, the cost of both the GP Trainee and the Paediatric Registrar were included to reflect that this was an additional intervention that would not otherwise have been offered as part of usual GP practice.

Figure 1 illustrates these different models for costing the Learning Together clinics.

Figure 1: Approaches to costing Learning Together under different modelling assumptions



In reality, children are seen in Learning Together clinics for a mixture of reasons and therefore the total cost reflects a combination of these scenario costs. The consequence for cost-effectiveness of using different costs in the economic model was explored in threshold sensitivity analysis (see the Results section below).

The cost of a Learning Together clinic does not take into account the face-to-face GP appointments that are displaced because Learning Together appointments are longer than routine GP appointments. The difference is likely to either increase costs (because of the need to create more appointments elsewhere in the Practice) or have an impact on health outcome (because of a delay in seeing a child in an appointment that has been displaced by Learning Together). This has not been factored into the analysis as its consequences are hard to trace without empirical data on what happened to the children booked in to see other GPs or whose appointment is delayed. However, the effects are likely to be marginal on health outcomes and costs if Learning Together clinics constitute a small part of the total GP time spent seeing children.

The Learning Together clinics also involve some GP Trainer time. In many GP practices there was a scheduled lunchtime meeting after each clinic to review the cases seen that day, with the primary care team. There are also differences in time spent travelling between hospital and GP practices and a decrease in the time required for written correspondence between secondary and primary care clinicians. However, these additional costs and savings have not been included as experience varied between GP practices and no routine data were collected for the evaluation. It was not considered that these costs would be sufficiently large to change the overall results of the analysis.

The change in health service use

Activity data on follow-up care after an initial Learning Together face-to-face consultation was collected by some practices as part of the project evaluation. Although the same data were not collected for the period prior to the intervention or for eligible patients not attending Learning Together clinics, these data were used in a threshold analysis to estimate the change in health service use that would be required for Learning Together to be cost neutral.

If an intervention is cost neutral (saving resources in other parts of the health service as a result of Learning Together), it implies that it is better than usual GP practice; this is only half of any economic evaluation which should also include changes in outcomes. However, Learning Together would be cost-effective if it reduced unnecessary health care use (which would not be expected to have an impact on health outcomes if it were unnecessary). Furthermore, if Learning Together were cost neutral or cost saving, then the magnitude of change in health outcome becomes a less crucial metric in the analysis; if an intervention is shown to result in superior health outcomes compared with the status quo by any order of magnitude and can be demonstrated to be cost neutral, then it should be the preferred option for decision-makers.

A complete set of follow-up resource use data were available from one participating GP practice, where 43 children were booked to be seen in Learning Together clinics over a five-month period from January 2014 to May 2014. Data were audited on the pathways for all children following an initial face-to-face consultation. This included the number of referrals to specialist secondary care, accident and emergency attendance, follow-up primary care appointments (Nurse, Physiotherapy, GP appointment, Learning Together clinics), and the number of children for whom no follow-up visits were scheduled. This dataset was the baseline data used in the analysis. Using this data, it was possible to run a threshold analysis to determine the reduction in health service use compared with usual GP care that would be required for Learning Together clinics in primary care to be cost neutral or cost-saving for the NHS.

Data on costs were obtained from the National Schedule of Reference Costs for 2012-13 outpatient attendances dataset (Department of Health, November 2013[1]). A weighted average cost for all specialist paediatric outpatient attendances was calculated. The cost of specialist paediatric referral was estimated from the weighted average reference cost for specialist paediatric services. None of the children in the practice audit were referred for a general paediatric outpatient assessment.

There was no NHS reference cost reported specifically for children's A&E attendances. Therefore a general population cost was used for an A&E attendance in the model. A weighted average cost for all A&E attendances (type 1, not admitted, with investigation 1-3 and treatment 1-3) was calculated. Since these data incorporated A&E attendances that included expensive investigations and treatment which would not normally be required for children with the types of conditions that could be managed within a Learning Together clinic in a primary care setting, this is likely to be an over- estimate of the true A&E attendance cost.

1 https://www.gov.uk/government/publications/nhs-reference-costs-2012-to-2013

A change in health outcome

Cost neutrality is not a sufficient goal in itself for a change in health care to be preferred over the next best alternative. If there is an improvement in health outcomes resulting from an intervention, then an increase in cost from introducing that intervention may also be considered cost-effective if there is sufficient health benefit to justify its cost. Ideally, to integrate health outcome metrics into an economic analysis requires data on the time spent in a state of ill-health and in a state of good health (no symptoms) over a given time period. From this, the additional time in good health resulting from the intervention could be estimated. This health gain can be converted into a Quality Adjusted Life Year (QALY) which is used routinely in health economic models to compare the difference in cost between interventions and the difference in effectiveness as measured in QALYs (the incremental cost-effectiveness ratio, or ICER).

Assessing the health status of children over time following a Learning Together face-to-face consultation was not a main outcome of the Learning Together evaluation. However, as reported in Section 3.3, data were obtained from parents on the child's well-being at an interval after the consultation. Data were also collected for some GP practices on a sub-group of children seen by the GP Trainee before Learning Together clinics were established. This and qualitative evidence indicated that that there may be an improvement in health outcome for children seen in joint Learning Together clinics.

Threshold analysis

Threshold analysis can be undertaken to evaluate the additional health gain that would be required for the Learning Together model of care to be cost-effective. Threshold analysis was undertaken to explore cost-effectiveness in the absence of data. This approach can be used to explore the threshold of cost-effectiveness under different assumptions about the quality of life impact of specific childhood conditions which is not empirically known. There is an accepted decision rule in the NHS that an intervention that leads to a gain of one healthy year for one individual as measured in QALYs is "worth" paying around £20,000 per year for[2]. It is therefore possible to calculate backwards from this decision rule to estimate the health gain that would have to be achieved in order for an increase in cost to be considered cost-effective

The impact of Learning Together on cost-effectiveness use was explored under different scenarios by altering the following parameters in the model:

- Health care resource use – to explore the change in referrals, A&E and GP appointments that would be required for Learning Together to be cost-neutral

[2] A QALY is a measure of health where perfect health is one and death is zero. A year of perfect health is one QALY and a year in less than perfect health is between zero and one QALYs depending on severity. The National Institute for Health and Care Excellence (NICE) uses this decision rule to guide its decisions on whether to recommend specific health care interventions and technologies. If a health care intervention can demonstrate that it leads to one additional QALY and costs less than an additional £20,000 per year compared with the next best alternative, then it is recommended for the NHS. One additional QALY might be achieved by extending perfect health by one year by preventing premature death for example, or by improving quality of life by ten percentage points for ten more people for a year (equivalent to one QALY) or for one person for ten more years (also worth one QALY).

- Children's health outcomes following a primary care face-to-face consultation - to explore the threshold at which Learning Together would be cost-effective. The baseline assumption explored in the threshold analysis was a change in health status of 10 percentage points, say from 0.7 QALYs to 0.8 QALYs or 0.8 to 0.9 QALYs over one year. The clinical interpretation of what this change would mean in a primary setting was also explored.

The results of the threshold analysis are presented in the Results section. The tables should not be interpreted as evidence of cost-effectiveness. This type of analysis is a means of exploring the impact of changes in resource use and health outcomes in the absence of suitable evidence; it does not conclude whether these impacts are more or less likely with Learning Together clinics compared with routine clinical care.

4. Results **Costs**

The source of data on clinical salaries was the NHS Pay and Conditions Circular (M&D) 2/2014 for hospital, medical and dental staff. A 30% uplift in salary has been included to reflect employer on- costs. The data was not adjusted for the ratio of indirect to direct (face-to-face) contact time, which is usual practice when calculating average costs of NHS staff time (PSSRU, Unit Costs of Health and Social Care 2012-13). A detailed survey of clinical work to produce comparable data was not possible within the time frame of this project. Furthermore, since the evaluation had to consider the marginal cost to the NHS of additional hours of GP trainees' and paediatric registrars' time, an average cost is a less useful measure of the human resource being displaced by the intervention.
Salary reflects the cost to the NHS of additional face-to-face patient contact, once all other costs (non-face to face activities such as clinical training and administration) have already been accounted and paid for from a specified budget line. The marginal cost does not take into account any difference in administrative costs (although correspondence is required for Learning Together clinics), travel time, time taken up with lunchtime meetings or any costs associated with GP trainers. All these are presumed to be common to all alternatives, although travel time to different GP practices will vary and is likely to be higher for some Learning Together clinics in practices further away from the hospital. Adopting a marginal approach to costing means that Learning Together costs reported here will be systematically lower than if an average cost were used.

Tables 1-3 report the unit costs used for the economic model. Table 1 shows the unit costs and calculation of the cost per Learning Together session for each scenario (described above). Learning Together

Table 1: Medical salaries and calculation of cost per Learning Together clinic for medical staff working in Learning Together clinics, 2013-14.

Clinical role	ST	Basic salary	Salary with top-up banding addition	Salary plus on-costs*	Notes
GP trainee	3	£35,952	£ 53,928	£70,106	Salary derived from the NHS Pay and Conditions Circular (M&D) 2/2014 for hospital, medical and dental staff
Paediatric registrar	7	£43,434	£ 65,151	£84,696	
Annual leave (wks)			6		Data from discussions with Learning Together project participants and the project team
Educational training (wks)			4		
Working weeks (a)			42		
Sessions per week (b)			8		
Clinical sessions per year (either Learning Together *or* GP trainee alone) (a x b)			336		
Cost per GP trainee session (c) scenario 1			£209		Calculated as salary plus on-costs divided by the number of clinical sessions per year
Cost per paediatric registrar session (d) scenario 2			£252		
Cost per Learning Together session (c+d) scenario 3			£461		

**includes 30% uplift as suggested by the project team*

The marginal cost per clinical session was £209 for a GP Trainee, £252 for a GP Registrar and £461 for a Learning Together clinic, assuming this represents an additional patient consultation and does not replace a referral to secondary care or a follow-up GP appointment (Table 1). These were the costs used to calculate the costs of Learning Together clinics under the different costing assumptions shown in Figure 1.

Tables 2 and 3 report the unit costs for primary and secondary care used in the model and their sources.

Table 2: Unit cost of follow-up primary health care intervention included in the health economic model

Resource	Unit cost	Source
GP trainee cost per patient	£15	Assuming 14 patients per usual GP session clinic and clinic costs of £206, see Table 1. This does not take into account non face-to-face patient time therefore this cost is likely to be higher in real life. No data were available to support a calculation of the ratio of direct to indirect contact for GP trainees.
Practice Nurse	£27	PSSRU Unit costs of Health and Social Care (2013) Average cost per face-to-face patient contact.
Health Visitor	£47	
Community physiotherapist	£47	

Table 3: Unit costs of secondary specialist health care intervention included in the health economic model.

Intervention	Unit	Source cost
Specialist paediatric referral to secondary care	£176	Average cost of all paediatric outpatient attendances weighted by activity (proportion of total reported activity). National Schedule of Reference Costs Year: 2012-13 – All NHS trusts and NHS foundation trusts – Outpatient Attendances.
A&E attendance – not admitted	£115	Weighted average of all non-admitted Accident and Emergency attendances including category 1-3 investigation and 1-3 treatment. Attendances for children and adults as no paediatric attendances were reported

Table 4 shows the cost of the intervention as well as the resource use and cost of follow-up health care as audited by one GP Practice. It does not present routine GP appointments in primary care with follow-up up health service use because these data were not available from the GP Practice.

In the base case scenario shown in Table 5, it was assumed that there is no difference in health service use after a Learning Together clinic, as no data were obtained for this comparison. The only difference that is assumed is that a child followed-up in a future Learning Together clinic would have otherwise been booked in for a routine GP appointment as part of usual care. The data below shows the resource use for 43 patients audited as part of the Learning Together evaluation under different assumptions about the cost of Learning Together (scenarios 1, 2 and 3).

Table 4: Cost of Learning Together clinics and associated resource use compared with GP trainees for one GP practice in the Learning Together project, 5 months (January–May 2014) under assumption of no change in follow-up resource use

	No. clinics in the audit	Children booked	Attend 1st consultation	No. referred to secondary care/private	Follow-up in Learning Together	Follow-up by GP trainee alone	Follow-up practice nurse	Follow-up practice physio	Follow-up	Follow up not scheduled	A&E attendance	Total
Resource use (Learning Together)	6	43	41	3	3	17	2	1	1	17	0	
Cost under scenario 1 *	£1,252			£528	£78	£365	£5	£4	£47	0	0	£2,370
Cost Under scenario 2	£1,512			£528	£95	£365	£5	£4	£47	0	0	£2,647
Cost under scenario 3	£2,764			£528	£173	£365	£5	£4	£47	0	0	£3,977
Resource use (usual care)	6	43	41	3	0	17	2	1	1	17	0	
Costs of GP trainee alone (no Learning Together clinics)**		£641		£528		£253	£5	£4	£47	0	0	£1,569

*Costs vary by assumptions about Learning Together clinics, see Figure 1 above * * Attendances x GP trainee cost per patient (see Table 2)

Table 5 shows the difference in cost of primary care and follow-up resource use immediately following Learning Together or usual GP practice under the most conservative assumption of no change in care pathway following initial consultation. The difference in cost under the different scenarios, presented in Table 5, is the data that will be used in the threshold analysis to calculate the change in resource use that would be required for Learning Together to be cost neutral (Table 6).

Table 5: The difference in cost of primary care consultations including follow-up health care resource use for 43 patients audited over 5 months in one GP practice, for the 3 scenarios for Learning Together.

Description	5-month Cost	Notes
Additional cost of Learning Together clinics over 5 months compared with usual GP trainee care:		
		Scenario 1 £801 Assuming GP trainee costs only are included in cost of Learning Together
		Scenario 2 £1,078 Assuming Paediatrician costs only are included in cost of Learning
		Scenario 3 £2,408 Assuming GP trainee and Paediatrician are included in costs of Learning Together clinics
Cost of usual GP trainee care incl. follow-up health care	£1,569	Not adjusting for indirect to direct patient contact time

Threshold analysis

Table 5 indicates that Learning Together clinics have higher costs upfront than routine GP appointments assuming no difference in clinical follow-up of the child. There is qualitative evidence and audit data to show that Learning Together may have a positive impact on health care resource use and health outcomes. This section explores the impact of putative changes in resource use and cost on the cost-effectiveness of the intervention. It also considers the change in health outcomes required for Learning Together to be considered cost-effective. These calculations are presented for illustrative purposes only and are not based on empirical data.

Impact of change in follow-up resource use:
In the absence of data to inform the model, the threshold analysis presented below explored the impact of a change in clinical pathway following a Learning Together clinic. Table 6 shows the change in health service use that would need to be achieved for Learning Together to be cost neutral compared with usual primary care. The cost of A&E reported in Table 3 includes relatively more expensive A&E attendances that lead to Category 3 investigation and treatment. These more intensive attendances are not likely to be “unnecessary” and therefore the cost of A&E attendance that could be avoided by a Learning Together intervention is likely to be lower than that reported in Table 6. The estimated increase in total health service cost per month for children who attend Learning Together clinics based on the assumptions set out above is around £160 and £480 per month.

Table 6: Threshold analysis showing the reduction in service use by a GP Practice required for Learning Together to be cost neutral under the three cost scenarios per month assuming a low GP cost per Trainee in the base case analysis

Change in resource use	Scenario 1	Scenario 2	Scenario 3
Monthly increase in Learning Together cost:*	£160	£ 216	£ 482
Per month reduction in GP trainee appointments across the GP practice	11	14	32
Per month reduction in referrals to secondary care across the GP practice	0.9	1.2	2.7
Per month reduction in A&E attendance in the practice population	0.4	0.9	3.2

*based on 5-month cost differences reported in Table 5 (rounded to nearest whole number)

Impact of change in health outcomes of the child:
Table 7 shows the impact of a change in children's health outcome under the different cost scenarios for the Learning Together project. An interpretation of what such a change would mean in practice for primary care is presented in the Table 7 below.

Table 7: Threshold analysis showing the change in health outcome required for Learning Together to be cost-effective at £20,000 per QALY, based on 5-month audit data from one GP practice.

Description	Scenario 1	Scenario 2	Scenario 3
Improvement in health outcomes			
Learning Together more expensive per year by:*	£1,923	£2,587	£5,779
QALY threshold for cost-effectiveness	0.10	0.13	0.29

*based on 5-month cost differences reported in Table 5 (rounded to the nearest whole number)

Clinical interpretation of a change in QALYs:
The numbers reported in Table 7 are not based on empirical evidence. They indicate the change in impact on health outcomes that would need to be achieved for the additional cost of Learning Together to be worthwhile for a predefined measure of "worth". It suggests that an additional one
0.10 to 0.29 of a QALY would need to be gained in health per year per GP Practice for one Learning Together clinic per month to be considered cost-effective[3]. However, the QALY is an abstract measure of health outcome. The kind of "what if" scenarios presented in Table 7 is only helpful if it can be translated back to real clinical practice in a way that is meaningful to clinicians and decision- makers.

[3] Assuming the NICE threshold for cost-effectiveness of £20,000 per additional QALY gained

The challenge is that the impact of a change in symptoms of common childhood conditions such as constipation, asthma and fever is difficult to quantify empirically[4]. A change health outcome of 0.10 QALY could be interpreted as an improvement in a person's health from experiencing "some symptoms" (but symptoms sufficiently worrisome to seek treatment) to "no symptoms". Table 7 reports that under the most costly assumptions for Learning Together (scenario 3), a GP Practice would have to see an improvement of 0.29 QALYs in one child for a year, or an improvement of 0.10 QALYs in around three children, with the improvement lasting for at least a year for the intervention to be cost-effective. In other words, every year at least three more children who present with conditions such as asthma or chronic constipation will need to be effectively managed in primary care, than would have been the case prior to the introduction of Learning Together. This health gain could be achieved in any children presenting in primary care, either directly through face-to-face consultations in Learning Together clinics or as a result of the GPs' enhanced knowledge, skills and experience from Learning Together applied in their management of children during routine GP appointments.

Clearly, the shorter the overall duration of health gain from an intervention, the more additional children would need to be successfully managed in primary care for Learning Together to be cost- effective compared with routine practice. Also, the more children who are successfully managed as a result of Learning Together, the lower the QALY health gain threshold required for Learning Together to be cost-effective. If Learning Together were to be only used as a short-term intervention, say six Learning Together clinics over six months, then half the QALYs would be required for it to be cost-effective (0.15 QALYs in one additional child, or one more child successfully treated). If Learning Together led to a sustained improvement of clinical care of children, then it would become increasingly more cost-effective

5. Conclusion

Under conservative assumptions of no difference in follow-up resource use, Learning Together is a more expensive option than routine GP practice. Depending on whether these clinics replace GP appointments, replace secondary care referrals, or represent an additional face-to-face contact in the clinical pathway, the cost per Learning Together session is between £209 and £461. No comparative data were available to evaluate the difference in total cost taking into account all follow-up health service use. Over a five-month period in one GP Practice, the total cost of primary care and initial follow-up health service use for 43 patients booked into a Learning Together clinic was between £2,370 and £4,000 depending on whether these clinics were assumed to be replacing or in addition to usual primary care. That is the equivalent of around £474 to £800 additional cost per month associated with primary care and initial follow-up health care use.

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[4] Studies in adults with asthma and COPD have suggested that the quality of life weighting for this condition is between 0.5-0.8 depending on the severity of the condition (Pickard, Wikle et al Use of a preference-based measure of health (EQ- 5D) in COPD and asthma, 2008). Assuming that a healthy year of life in a population is worth at least 0.9 QALYs, the study suggested that an improvement or cure of symptoms in one person for a year would represent an increase in QALYs of 0.1 to 0.4 QALYs depending on the severity of the condition.

The economic evaluation considered the threshold at which Learning Together would be cost neutral (that is, if it reduced unnecessary health care use further along the clinical pathway). Cost neutrality is not an endpoint in itself, but is a useful tool when considering scenarios in which unnecessary use of health care could be avoided (for example by reducing follow-up GP appointments because the child has got better or reducing A&E attendance by children who have a self-limiting illness or by increasing parents' confidence to manage their child's symptoms at home). The model estimated that Learning Together would be cost neutral if there were between 11 and 32 fewer GP trainee appointments per month across the whole practice. Similarly, Learning Together would be cost neutral if there were between 0.9 and 2.7 fewer unnecessary secondary care referrals per month, or between 0.4 and 3.2 fewer unnecessary A&E attendances. The unit cost of A&E used in the model included more costly investigation and treatment which would be unlikely to be required in "unnecessary" A&E attendances; therefore the cost of A&E is likely to be lower and, consequently, the threshold for cost neutrality also lower.

A threshold analysis was also undertaken to consider the improvement in health outcome that would be required for a monthly Learning Together clinic to be considered cost-effective under NICE decision rules for cost-effectiveness. Under an assumption of no impact on follow-up health service use and cost, the Learning Together clinics would have to lead to a health improvement of between
0.10 and 0.29 quality adjusted life years per year to be considered cost-effective. This improvement would need to be sustained as long as Learning Together clinics were in place. This is the equivalent of at least three more children every year with conditions such as asthma or constipation being successfully treated, compared with usual primary care before Learning Together clinics were introduced, if Learning Together clinics were to be provided once a month for a year. If the health gain were over a shorter period of time than a year, say for a self-limiting rather than a long-term condition, then more children would need to be successfully treated, in order for the change in primary care to be cost-effective. If health service use were also to fall as a result of improvements in health following a Learning Together consultation, then the threshold health gain required for cost-effectiveness for the intervention would also fall. If Learning Together clinics were offered for a shorter period with sustained improvement in practice then the cost would be lower and threshold improvement in health required would also be lower.

FF73 Health Education North West London

North West London Collaboration of Clinical Commissioning Groups

The Shape of Caring review – Lord Willis' visit to North West London

Tuesday 15th July 2014 10:45 - 13:00

The Hellenic Centre, 16-18 Paddington Street, Marylebone, W1U 5AS

In attendance:

Name	Role	Organisation
Lord Willis	Independent Chair	HEE Shape of Caring Review
Suzie Loader	Nurse Advisor	Health Education England
David Sines	Emeritus Professor	Buckinghamshire New University
Thirza Sawtell	Director	Strategy and Transformation, NHS North West London
Tim Spicer	Chair and GP	Hammersmith & Fulham CCG
Susan Sinclair	Director of Strategy	West Middlesex University Hospital
Louise Ashley	Chief Nurse, Director of Quality Governance	Central London Community Healthcare NHS Trust
Claire Gore	Director of People	The Hillingdon Hospitals Trust
Colin Stacey	Lay Partner	Lay Partner's Advisory Group
Angeliki Kollias-Pearson	Care Navigator	Central London Community Healthcare NHS Trust
Claire Robinson	Care Navigator	Central London Community Healthcare NHS Trust
Ben Doyle	Care Navigator	Central London Community Healthcare NHS Trust
Caroline Durack	Senior Clinical Transformation Lead	Central London Community Healthcare NHS Trust
Edgar Swart	Lead Nurse	STARRS
Louise Archer	Senior therapist	STARRS
Sally Armstrong	Practice Nurse and CCG Board Member	Cuckoo Lane Health Centre, Ealing CCG
Julie Belton	Nurse Practitioner, Director Nurse Led	Cuckoo Lane Health Centre
Shaun Hare	Deputy Director Psychological Medicine	Central and North West London NHS FT
Ursula Gallagher	Lead Nurse	Outer NWL CCG Federation (*Brent, Harrow, Hillingdon*)
Mary Mullix	Deputy Director of Nursing	Inner NWL CCG Collaboration (CWHHE)
Lis Paice	Medical Chair of NWL Integrated Care Pilot	Hillingdon NHS Foundation Trust
Theresa Murphy	Director of Patient Experience and Nursing	Hillingdon NHS Foundation Trust
Kathryn Jones	Deputy Director of Education and Quality	Health Education North West London (HENWL)
James Cuthbert	SRO for transformation in the Tri-borough	Tri-borough Adult Social Care
Jane Royes	Social Work CPD Lead	Tri-borough Adult Social Care
Natalie Oswald	Workforce and Primary Care Team	Strategy and Transformation, NHS North West London
Matthew Hannant	SaHF Programme Manager	Strategy and Transformation, NHS North West London
Sarah Longfield	Mental Health Team	Strategy and Transformation, NHS North West London

Key discussion points

1. Introduction

- Welcome and introductions
- Purpose and objectives

2. Session One: Context

Shape of Caring review: Thinking about the future

Lord Willis of Knaresborough

- Historically we have looked at the management of individual conditions but, as the population are ageing, most people tend to have a number of comorbidities and therefore care needs to focus on the individual person rather than the condition. Understanding the most effective way to encourage and support people to self-care is a real challenge.
- Spending on healthcare has increased each year by an average of 4.4% since the NHS was introduced, which is not sustainable therefore we need to deliver care more efficiently and effectively.
- There are approximately two million nurses and health care support workers in health and social care in England, who deliver most hands-on patient care, but whose access to training varies.
- In response to recommendations made in a number of national reviews, including the Francis report, the Shape of Caring review will focus on nurse and HCA training in England, to ensure there are common standards and competencies across the system in order to establish a high quality workforce and clear career paths. There are three key principles to the review – it is patient centred, evidence based and will deliver solutions.
- The review will comprise a literature review (led by Anne-Marie Rafferty), multiple engagement events across the country to collect evidence, surveys and questionnaires and publicity through social media. It will be completed by the end of February 2015 so it can be debated before the General Election.

The North West London Context

Tim Spicer, Chair of Hammersmith and Fulham CCG

- The eight CCGs of North West London are working in collaboration with a wide range of stakeholders to transform the whole health and care system for its two million people through a number of programmes, so care is more integrated, delivered closer to home and, where appropriate, provided in the best facilities.
- The majority of care is provided by relatives/ friends and part of the Whole Systems Integrated Care programme is to understand how to support this and encourage people to self-care.
- The other key area, is to understand the role of the acute sector in the delivery of care in an out-of-hospital setting because, unlike General Practice, this is something that many acute staff do not have experience in. For example, Hammersmith and Fulham CCG have commissioned home visits from a Geriatrician, who had never visited a patient's home before, but was able to get a better understanding of the needs of the particular patient by seeing their living situation, when compared to conducting a consultation in a clinic.
- As the Shaping a Healthier Future programme progresses, developing the workforce is recognised as the key enabler to support the change. One of the challenges to delivering integrated care is ensuring that education and

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Key discussion points

training are also integrated and that learning takes place in the environment in which staff will be working. North West London are therefore planning to develop Community Learning Networks (CLNs) which will provide the infrastructure for integrated education and training in an out-of hospital setting to support integrated care.

Session Two: Introduction to innovative staff in North West London

Care Navigator Role as part of 'Village Working'

Caroline Durack, Clinical Transformation Lead, Central London Community Healthcare NHS Trust

- The Care navigator is a non-clinical role to help patients navigate the complexity of community services to ensure that their care is joined-up. The services organised are based on the patient's wishes and are determined through a clinically led multi-disciplinary team meeting, which the Care Navigators then co-ordinate.
- This role is being piloted across North West London and there will be over 50 across the patch by the end of August, many of whom have a background in health and social care. As this is a new role, it is evolving based on feedback from the Care Navigators and their colleagues.
- **Further detail about the role can be found in the papers for the visit.**

Merging nursing and therapist roles

Edgar Swart, Lead Nurse, Short Term Assessment, Rehabilitation and Reablement Service Louise Archer, Senior Therapist, Short Term Assessment, Rehabilitation and Reablement Service

- The Short Term Assessment, Rehabilitation and Reablement Service (STARRS) is a unique team working in varied conditions therefore a key challenge is to identify the right staff with the right skills.
- The measures of success are being able to maintain patients in their own home (where appropriate), enabling them timely access to services required and ensuring long-term access to community services.
- STARRS supports and empowers families and carers through their interaction with them during home visits.
- There is a good skill mix in the team, co-ordinated by an effective management structure. The team includes senior nurses with a large amount of experience to share with the team and Band 1 – 4 support workers, who receive competency training as part of the team.
- This would therefore be a good apprenticeship route and there was general support for a robust set of competencies for Band 1 – 4 staff that are recognised by all organisations to ensure clear accountability structures for integrated working.
- **Further detail about the STARRS service can be found in the papers for the visit.**

Nursing leadership and innovation in Primary Care

Sally Armstrong, Practice Nurse and Nurse Member, Ealing CCG

Julie Belton, Nurse Practitioner & Director of a Nurse Led Alternative Provider Medical Services Practice

- As more care moves from an acute to community setting, one of the key challenges will be to train highly skilled

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Key discussion points

acute nurses to be skilled practice nurses. To support this, a 'bottom-up' mentorship and leadership programme for nurses is being developed where nurses will be able to train and sign-off competencies for their colleagues.

- One enterprising example of nursing leadership is Cuckoo Lane Health Centre in Ealing, a nurse practitioner-led practice, which has been running for nine years and covers a population of 4,500. It is a mutual participation model employing practice nurses, nurse practitioners and GPs. It is looking to take on HCAs and will put in the education and training to support this. The practice is comparable to other practices when using measures such as the Quality and Outcomes Framework, feedback from patient surveys and patient participation groups.

- There are other examples of practices in North West London with different innovative nursing models, for example, nursing triage at the front door of walk-in centres.

- **Further detail about nursing leadership and innovation in North West London can be found in the papers.**

Session Three: Integrated education and training

Patient-centred education for integrated care

Lis Paice, Medical Chair of North West London Integrated Care Pilot

- Pathway simulation exercises can provide an important way to shortcut and condense experience for staff to layer on to their existing skill base. Users play an important role in identifying key factors in delivering improved care, particularly from within support staff not directly involved in care provision.

- Developing integrated care pathways will require a different skill set than classical training therefore simulated pathways for multiple staff groups with a diversity of skills, along with patient input, ensures they develop this learning.

- Empowerment to do things differently needs to be felt at a local level, with a mind-set oriented to integrated care – how can we fill the gaps between patients and services – addressing membership and 'preceptorship'.

- Consolidation and accessibility improvements to patient records have been essential to achieving these developments. Technology and apps for education and training could better support this in the future.

- **Further detail about patient-centred education can be found in the papers.**

Integrated education and training from a social care context

James Cuthbert, Assistant to the Executive Director, Tri-borough Adult Social Care

Jane Royes, Social Work Continuous Professional Development Lead, Tri-borough Adult Social Care • It is important to look at people's needs in context – not just the state of the mind and the body.

- A new social work continuous professional development framework has just been put in place and we need to
ensure this supports integrated working.

- Social care is an essential central service to delivering integrated care. It is critical that we understand respective roles and responsibilities and establish a shared values base, through critical reflective practice and co-operative enquiry in MDTs comprising both health and social care workers. We need to align support, co-

DRAFT

Shaping a healthier future

Key discussion points
incentives to drive best quality integrated care. • The current home care workforce is currently too small to support the significant amount of work that is planned to move out-of-hospital and this is a potential role for Band 1 – 4 HCAs, but it needs to be commissioned to incentivise workforce development.
Summary and relevance for the Shape of Caring Review
• We are moving towards a population-based view of healthcare, served by a mobile workforce, which no longer precludes the social or voluntary sectors in the way it did when we referred to care 'wrapped around the GP'. • The focus is on 'proficiency', irrespective of titles, and how can we provide the necessary assurance whilst enabling patient-centred care. • Who will fill in the gaps between services and provide the necessary links to produce integrated care? North West London is building solutions, there is a passion for change and there are many opportunities: ○ Design of multi-agency mentor programmes ○ New learner placements, embedding whole systems in reality ○ Multi-agency supervision and assessment ○ Investment in technology and simulation to deliver work-based learning wrapped around the user
Close of meeting

DRAFT

Health Education North West London

The Education and Training Requirements of Practice Nurses and Support Staff in North West London

A Scoping Report to Health Education North West London

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Table of Contents

Section		Pag
i	Table of contents	1
ii	List of Tables and Figures	2
iii	Acknowledgements	3
	Executive Summary	4
1.0	Introduction	7
2.0	Background	7
2.1	Project objectives	8
3.0	Methods	8
3.1	Mapping Education and Training Opportunities	8
3.2	Scoping Survey	8
4.0	Results	11
4.1	Mapping of Educational Opportunities	11
4.2	Establishing the survey population	12
4.3	Survey Results	12
4.3.1	Respondents	12
4.3.2	Qualifications	12
4.3.3	Professional experience	17
4.3.4	Areas of specialist interest and practice	17
4.3.5	Professional support	18
4.3.6	Training in specialist areas	20
4.3.7	Training in non-specialist areas	21
5.0	Discussion	26
5.1	Gap 1- Training does not map to competencies	26
5.2	Education and training issues	26
5.3	Workforce issues	27
5.4	Gap 2 Learning opportunities are difficult to identify and of a wide variety	29
5.5	System issues	29
5.6	Strengths and limitations	30
6.0	Recommendations	32
6.1	Recommendation 1	32
6.2	Recommendation 2	32
6.3	Recommendation 3	32
7.0	References	33
	Appendix 1 – Steering Group	34
	Appendix 2 – Scoping survey tool (separate document)	35
	Appendix 3 – Scoping activity time-line	36
	Appendix 4 – Education mapping (separate document)	40

List of Tables and Figures

Table/ Figure	Title	Page
Table 1	Estimated Numbers of Practice Nurse, Health Care Assistant and Nurse Practitioner Respondents	12
Table 2	Areas of specialist interest and associated nurse-led clinic	17
Table 3	Level of academic training for specialist role	18
Table 4	Training attendance in past 12 months	19
Table 5	Future training needs	20
Figure 1	Survey Dissemination Flow Chart	10
Figure 2	Percentage of respondents	13
Figure 3	Current grade/ band	14
Figure 4	Academic qualifications	15
Figure 5	Years of experience	16
Figure 6	Percentage of respondents interested in training	21
Figure 7	Academic level of training in specialist area	25

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EXECUTIVE SUMMARY

Introduction

The scope of the nursing role in primary care has expanded over the past 30 years to deliver a range of specialist primary care services to support people with chronic disease. This expansion has led to the development of a number of titles and associated roles including advanced practitioner, practice nurse and most recently primary care nurse. The development needs of this sector of the healthcare workforce have not been explored in any depth.

This scoping project was commissioned by Health Education North West London (HENWL) and aimed to inform the Workforce Skills Development Strategy 2013-2018 to support the implementation of *Shaping a Healthier Future* (2013).

Project objectives

The objectives of the current project were to:

1. Extend the practice nurse education needs analysis survey to the outer CCGs in North West London;
2. Increase response rates to the survey through outreach and fieldwork activity;
3. Map the scope of the current education provision to the General Practice Nurse Competency Framework;
4. Provide an analysis of the barriers to accessing education and training for practice nurses and support staff, and
5. Suggest solutions for improving access to education and training and ensuring education provision is fit for purpose.

Methods

The scoping project comprised two concurrent phases. Phase one focused on mapping the education and training available to primary care nurses and support staff and phase two focused on identifying the number of practice nurses and support workers in outer NWL general practices together with their training and education needs.

Results

The survey response rate was 42% (142/337) of all the possible health care assistants, practice nurses and nurse practitioners estimated to be in the three localities.

The survey captured responses from Practice Nurses (64% [91/142]); Specialist/ Advanced Practitioners (22% [32/142]) had the job title of. Those working in band 6 and 7 roles comprised 51% (64/126) of respondents. A significant number 18% (22/126) were not in *Agenda for Change* (2004) banded roles and 13% (16/126) were support workers/ Health Care Assistants (HCA) in bands 1-4.

Three quarters of the respondents (78% [131/142]) indicated that they were registered nurses. A small number of respondents indicated that they were midwives 4% (6/142) district nurses 6% (9/142), school nurses 1% (2/142) and paediatric nurses 1% (2/142). The experience of respondents ranged from more than 25 years to less than 5 years, with 37% (45/123) of respondents having entered practice nursing between 1990 and 1999.

The following vocational/ academic qualifications were indicated by respondents, 8% (9/142) had an NVQ (level 1-3), 40% (59/142) of the respondents held a Dip HE, 24% (35/142) held a BSc. and 5% (7/142) had a MSc. Respondents may have indicated more than one qualification.

A third of respondents 34% (48/142) indicated they mentored or supervised others. Almost two thirds of respondents (64% [91/142]) indicated that they did not have a clinical mentor and 50% (71/142) said they did not receive or had no access to clinical supervision. Only 7% (11/142) respondents reported receiving training in mentoring.

The most common areas of specialist interest were asthma, COPD and diabetes with more than half of those with a special interest running a nurse led clinic. Other areas of specialist interest with associated nurse led clinics included heart disease, family planning and sexual health with around one third of respondents indicating that they ran a nurse led clinic. Respondents identified that they were responsible for other running other clinics although these were small in number.

Respondents had attended a wide range of training in the past 12 months with a greater emphasis on mandatory areas. Unsurprisingly there was some interest in all the areas of training identified in the survey. The data indicates that nurses working in specialty areas of practice have varied levels of education and training for providing care, especially in the areas of diabetes, heart disease, COPD, family planning, sexual health, travel health and asthma, with a small proportion of those responding indicating that they had been prepared at graduate or post-graduate level.

Discussion

The results of the survey suggest that there are two key gaps in the provision and infrastructure of education and training for practice nurses and support staff. Both gaps are linked to the need to establish levels of qualification for specialist clinical roles and mentorship support.

Gap 1 - There is no evidence in our results to indicate that practitioners or employers use an agreed competency framework to guide professional or service development and the appropriateness of education and training programmes. As a result, there is a wide range of content and training provision based on mandatory training requirements and perceived professional development needs in terms of higher education provision.

Issues contributing to this gap include academic attainment, variability in continuing education programmes, workforce issues including the age of the current workforce and the lack of a well-adopted competency framework. These also contribute to the apparent ad hoc nature of current uptake of training.

Gap 2 - Practice nurses and support staff indicate interest in developing a wide range of skills and knowledge to meet the needs of patients and the services they deliver. However, the ability to identify topics of interest at an appropriate skill and academic level for their role is complicated by a huge range of online, HEI, non-HEI,

and in-house sessions. There is no single portal of information that identifies where training is provided, its content, level and applicability to different roles and types of practitioner.

System issues contributing to this gap include a lack of coherent and easily accessible information about education and training, weak professional networking and nursing leadership that is not visible to practice nurses and support staff working across general practice setting within the localities.

Recommendations

Recommendation 1 - A whole systems review that leads to the development of coherent competency framework addressing the knowledge and skills of support and specialist practitioners would ensure consistency and comparability of learning outcomes and practice skills and provide a platform for its adoption across healthcare education. A core curriculum for nurses in primary care, and for support staff in primary care, may be one way of addressing these shortcomings enabling nurse educationalists, mentors and education facilitators to identify appropriate programmes for staff and assess levels of competence in the workforce consistently.

Recommendation 2 - Educational Facilitators working within a defined infrastructure might provide a hub for education, training and development. The role could encompass acting as career advisor and competency guide to both staff and employers and facilitate effective communication of training opportunities. Such training coordinators in primary care might be best positioned working in cross-locality positions to link staff to new and existing and educational networks. A larger educational network that can span organisational, sectoral and disciplinary boundaries would be well placed for developing the most adaptive workforce for the current complex world of primary care, and for the future.

Recommendation 3 - A clearly communicated infrastructure for education and training including a boundary spanning open portal that lists educational opportunities is essential. It would also be worth considering the provision of standardised competency documentation appropriate for practice in all roles to assist all those involved in the process of training, mentoring, assessing and appraising nurses and support staff in general practice settings.

1.0 INTRODUCTION

Primary Health Care is at the centre of the National Health Service (DH, 2012). The increased emphasis on preventing admission to and early discharge from secondary care requires a realignment of services and expertise across the healthcare economy. In North West London (NWL) Shaping a Healthier Future (2013) sets out the ways in which health services need to be shaped to meet the challenges of an aging population with complex needs and multiple co-morbidities. The shift of services requires a workforce that is able to work across the health and social care pathway to ensure seamless care for patients. Nurses working in primary care play a key role in delivering preventive and supportive interventions and assisting general practitioners (GP) in meeting the expanding primary care remit. The scope of the nursing role in primary care has expanded over the past 30 years to deliver a range of specialist primary care services to support people with chronic disease. This expansion has led to the development of a number of titles and associated roles including advanced practitioner, practice nurse and most recently primary care nurse. The development needs of this sector of the healthcare workforce have not been explored in any depth.

This scoping project was commissioned by Health Education North West London (HENWL) and aimed to inform the Workforce Skills Development Strategy 2013-2018 to support the implementation of *Shaping a Healthier Future* (2013).

2.1 BACKGROUND

General practices that employ a higher number of nurses have been shown to perform better in a number of clinical domains, as measured by the Quality Outcomes Framework (Griffiths, et al., 2010). However the number of general practice nurses and support staff employed with primary care in NWL is unclear and the qualifications, skills and education and training needs of the workforce are largely unknown. In 2012 the Royal College of General Practitioners General Practice Foundation updated and expanded the General Practice Nurse Competence Framework (GPNCF) published in 2009. The competencies build on previous iterations and take account of the general and specialist areas of care that Practice Nurses (PN) deliver and were the subject of consultation across England and the devolved administrations. There are few dedicated preparation programmes for nurses entering practice nursing as a specialism and it is unclear how widely the GPNCF is used to direct the development of nurses entering the field of primary care or the continuing development of those who are established practitioners to ensure a fit for purpose workforce.

Several complementary projects have been commissioned in NWL to facilitate a greater understanding of the size of the workforce and the education and training needs of nurses and support staff working in primary care generally and general practice settings specifically. An education needs analysis survey of practice nurses in inner NWL Central Commissioning Groups (CCG) was completed by Buckinghamshire New University (BNU) in December 2013 and extended to include the Ealing CCG in spring 2014. The London wide Local Medical Committees (LLMC) in conjunction with HENWL conducted an online survey of the general

practice workforce. Finally a resource documenting the current education and training programmes/days available to practice nurses and general practice support staff was collated and circulated to practice nurses in 2013. The data collected from these projects have provided some detail about the general practice workforce, but the response rates were modest and some gaps remain.

2.2 Project objectives

The objectives of the current project were to:

6. Extend the practice nurse education needs analysis survey to the outer CCGs in North West London;
7. Increase response rates to the survey through outreach and fieldwork activity;
8. Map the scope of the current education provision to the General Practice Nurse Competency Framework;
9. Provide an analysis of the barriers to accessing education and training for practice nurses and support staff, and
10. Suggest solutions for improving access to education and training and ensuring education provision is fit for purpose.

2.3 Project Steering group

A project steering group was formed to advise the project team on aspects of the project, including approaches to access and dissemination of the survey and the study methods (see Appendix 1). The group met regularly throughout the project to receive project reports and provide advice.

3.1 METHODS

The scoping project comprised two concurrent phases. Phase one focused on mapping the education and training available to primary care nurses and support staff and phase two focused on identifying the number of practice nurses and support workers in outer NWL general practices together with their training and education needs.

3.2 Mapping Education and Training Opportunities

Education and training opportunities were identified through:

- Stakeholder input, online searchesand telephone contact to identify providers;
- Extraction of data from publicly available training opportunity information, and
- Alignment of training opportunities with GPNCF.

3.3 Scoping Survey

3.2.1 Survey tool

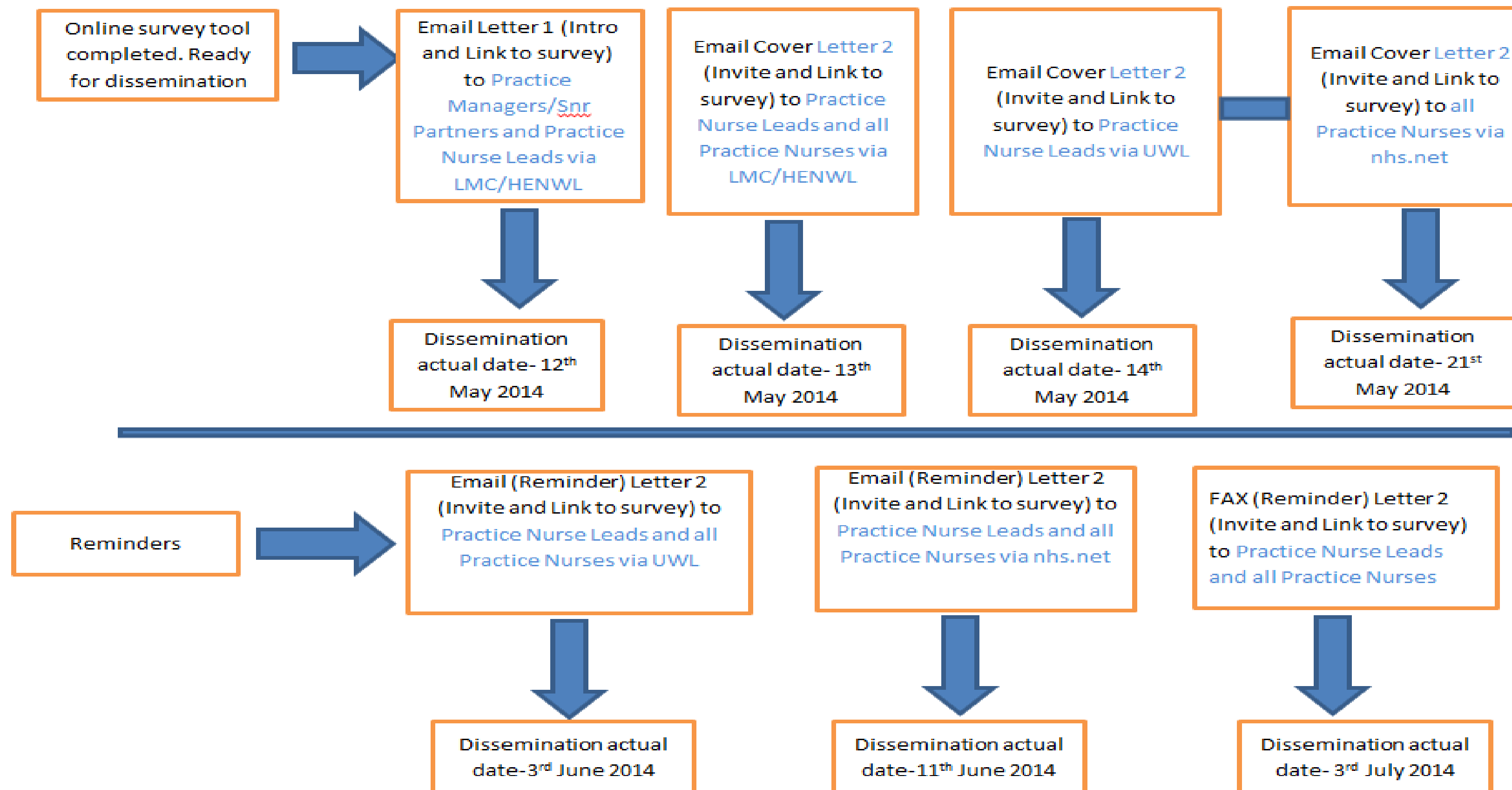
The survey tool used by BNU for inner NWL CCG consisted of 38 items that focused on a wide range of issues including education and training. To ensure consistency of data collected and to facilitate the comparison of the education and training data, between this project and the BNU reports, the survey tool was shortened to 22 items (Appendix 2) to focus wholly on education and training.

3.2.2 Survey dissemination

The survey was disseminated over a five-month period, between March and July 2014, using four different approaches in an attempt to increase the response rate (Figure 1 and Appendix 3). These included:

1. Email correspondence
2. Telephone correspondence
3. Attending Practice Nurse forums
4. Field visits to general practices, training events and network meetings

Figure 1. Survey Dissemination Flow Chart



4.1 RES

4.2 Mapping of Educational Opportunities

The GPNCF (2012) describes a framework for education and training that is fundamental to the professional responsibilities of the practice nurse. The document consists of a training matrix comprising 26 areas of knowledge, skill and competency (see Box 1).

Box 1: General Practice Nurse Competencies

o Communication with Patients	o Health Screening
o Communication with Teams	o Cervical Screening
o Personal and People Development	o Immunisation of children and adults
o	
o Health, Safety and Security	o Travel Health
o Quality and Service Improvement	o Mental Health
o Equality and Diversity	o Men's Health
o Health & Well-Being	o Women's Health
o Management of Emergency Situations	o Family Planning and Sexual Health
o Therapeutic Monitoring	o Health Promotion
o Wound Management	o Ear Care
o Care of Patients with Long Term Conditions: Diabetes	o Care of Patients with Long Term Conditions:
o Care of Patients with Long Term Conditions: Cardiovascular Disease	o Care of Patients with Long Term Conditions: Other Conditions
o Minor Surgery	o Care of Patients with Long Term Conditions: Chronic Obstructive Pulmonary Disease (COPD) and Asthma

We used the GPNCF to map the educational opportunities available to practice nurses and support staff working in primary care in NWL. We identified any available training that might fit the above areas included it if attendance was possible within a single day's travel or training involved online learning. Topics were included, regardless of length or accreditation of training (Appendix 4). This process identified a wide range of training of varying design, length, content and mode of delivery.

4.3 Establishing the survey population

A systematic exercise was undertaken to identify PN and support staff working in every general practice (GP) surgery in name Brent, Harrow and Hillingdon. Internet searches were useful to identify initial points of contact. Email requests for further contact information were sent to CCG leads, nurse leads, communication leads, and

general practice managers in the area. This process identified a total of 337 possible staff in the three localities (Table 1)

Table 1: Estimated Numbers of Practice Nurse, Health Care Assistant and Nurse Practitioner Respondents

'Outer' North West London CCG	Number of GP practices	Estimated number by staff type				
		Health Care Assistants	Practice Nurses	Nurse Practitioners	Othe	Total
Brent	73	40	85	15		14
Harrow	37	19	82	5		10
Hillingdon	48	10	67	14		9
Total	**158**	**69**	**23**	**34**		**33**
Survey respondents (% of estimated number)		17 (25%	9 (39%	32 (94%	2	142 (42%)

4.4 Survey results

4.4.1 Respondents

The survey was disseminated to outer NWL CCG including Brent, Harrow and Hillingdon from 8 May 2014 to 31 July 2014. The survey response rate was 42% (142/337) of all the possible health care assistants, practice nurses and nurse practitioners estimated to be in the three localities. Of the survey respondents, 64% (91/142) were practice nurses and 22% (32/142) had the job title of Specialist/ Advanced Practitioners (see Figure 2). Of those who answered the question on banding (126/142), 51% (64/126) worked in band 6 and 7 roles. A significant number 18% (22/126) were not in *Agenda for Change* (2004) banded roles and 13% (16/126) were support workers/ Health Care Assistants (HCA) in bands 1-4 (see Figure 3). Most of the respondents (59% [75/127]) work part-time; of these 60% (62/103) work more than 24 hours per week. A third (41/126) of respondents worked out-of-hours. Most respondents have been appraised within the last 1-3 years and two-thirds (67% [88/131]) were appraised by a GP.

4.4.2 Qualifications

Three quarters of the respondents (78% [131/142]) indicated that they were registered nurses this included respondents who identified that they were registered general or state registered nurses. A small number of respondents indicated that they were midwives 4% (6/142) district nurses 6% (9/142), school nurses 1% (2/142) and paediatric nurses 1% (2/142). None of the respondents were health visitors. Eighteen percent of the respondents were nurse prescribers 18% (25/142) with the V300 qualification for nurse independent and supplementary prescribers and 4% (5/142) with the V100 for community practitioner nurse prescribers.

Respondents indicated that they had the following vocational/ academic qualifications, 8% (9/142) had an NVQ (level 1-3), 40% (59/142) of the respondents held a Dip HE, 24% (35/142) held a BSc. and 5% (7/142) had a MSc. Respondents may have indicated more than one qualification (see Figure 4).

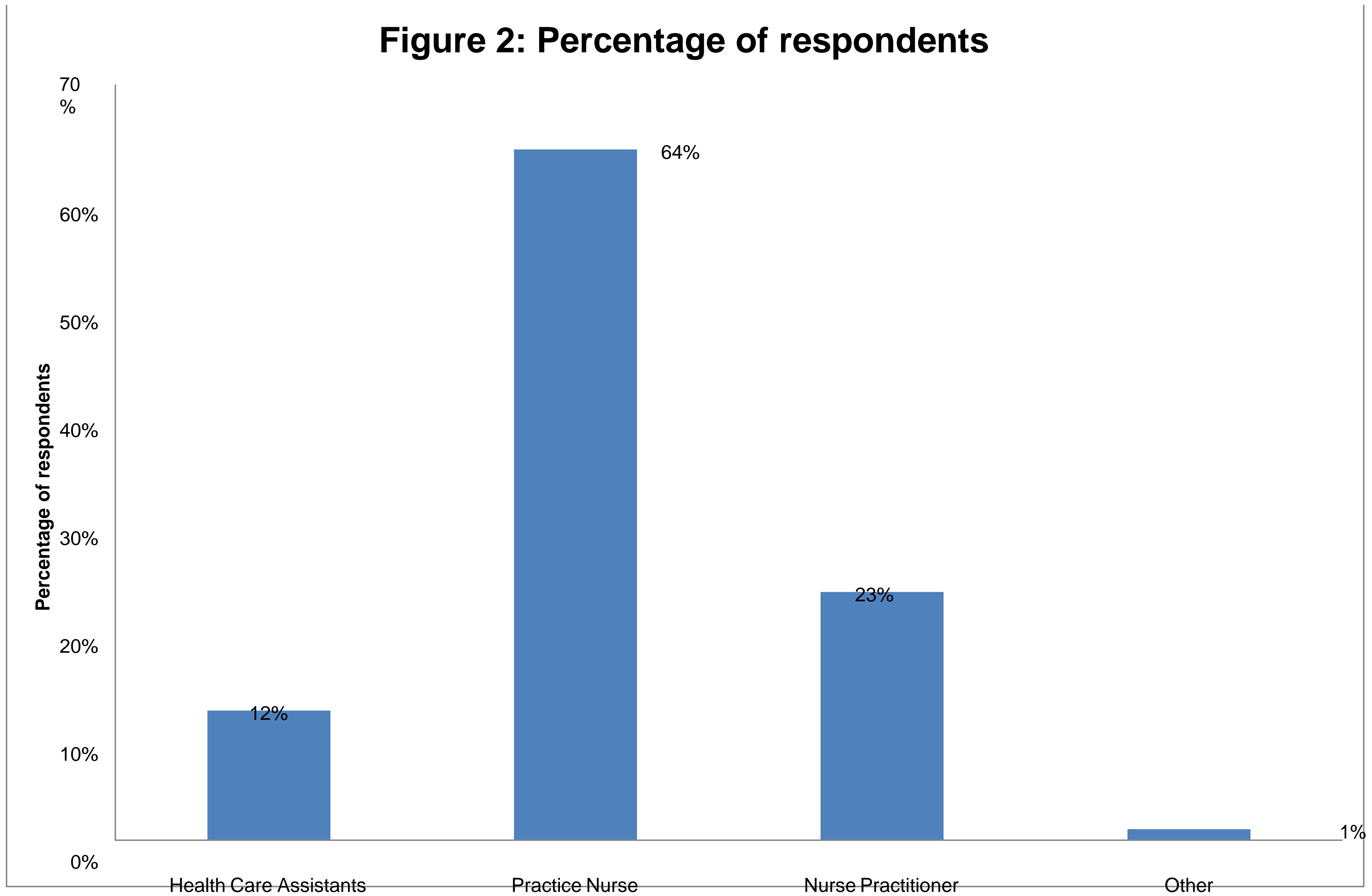


Figure 2: Percentage of respondents
Percentage of respondents
70
%
60%
50%
40%
30%
20%
10%
0%
64%
23%
12%
1%
Health Care Assistants
Practice Nurse
Nurse Practitioner
Other

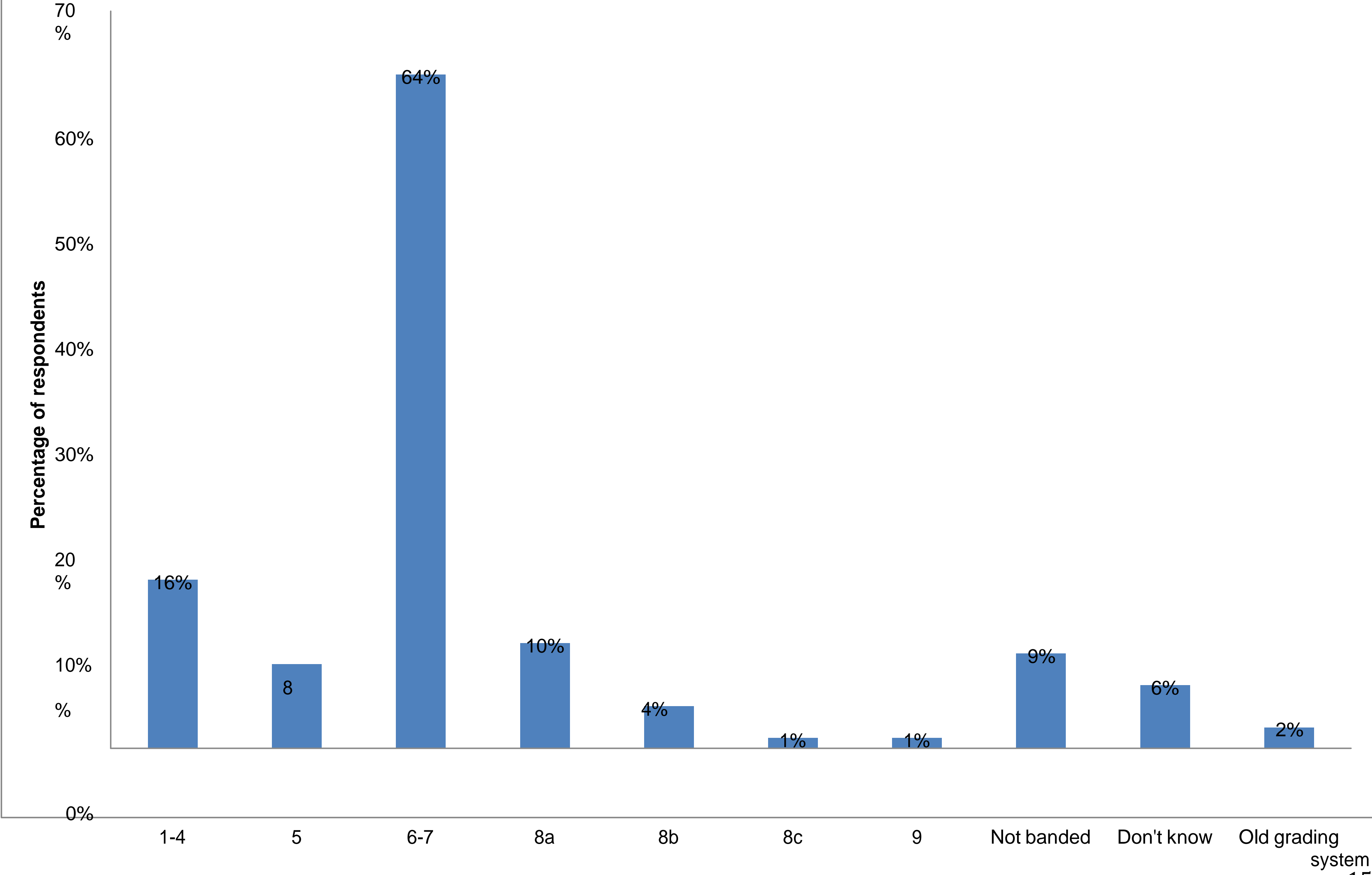
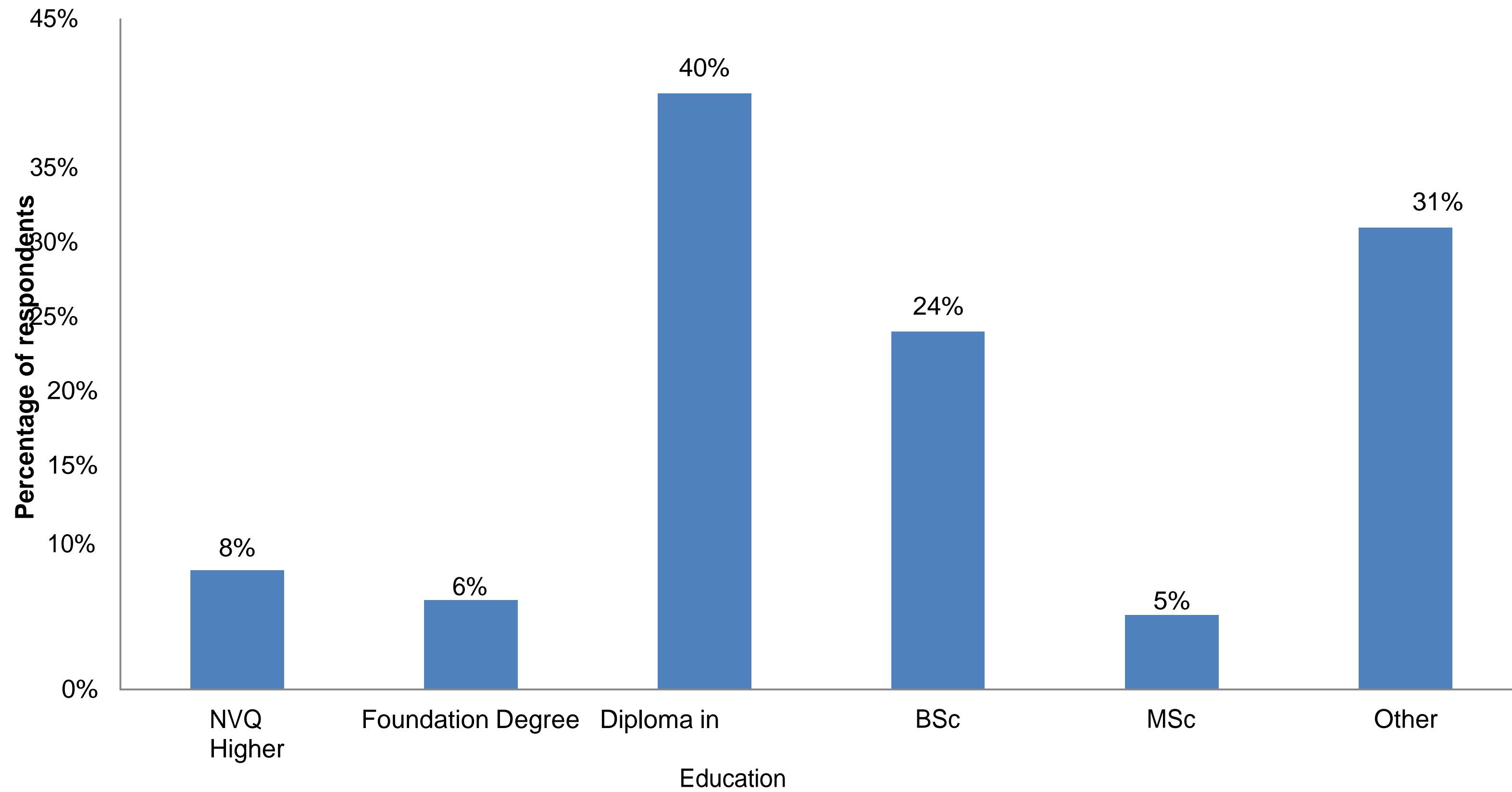


Figure 3: Current grade/band
Percentage of respondents
70
%
60%
50%
40%
30%
20
%
10%
%
0%
16%
8
64%
10%
4%
1%
1%
9%
6%
2%
1-4
5
6-7
8a
8b
8c
9
Not banded
Don't know
Old grading system



* respondents could provide more than one answer

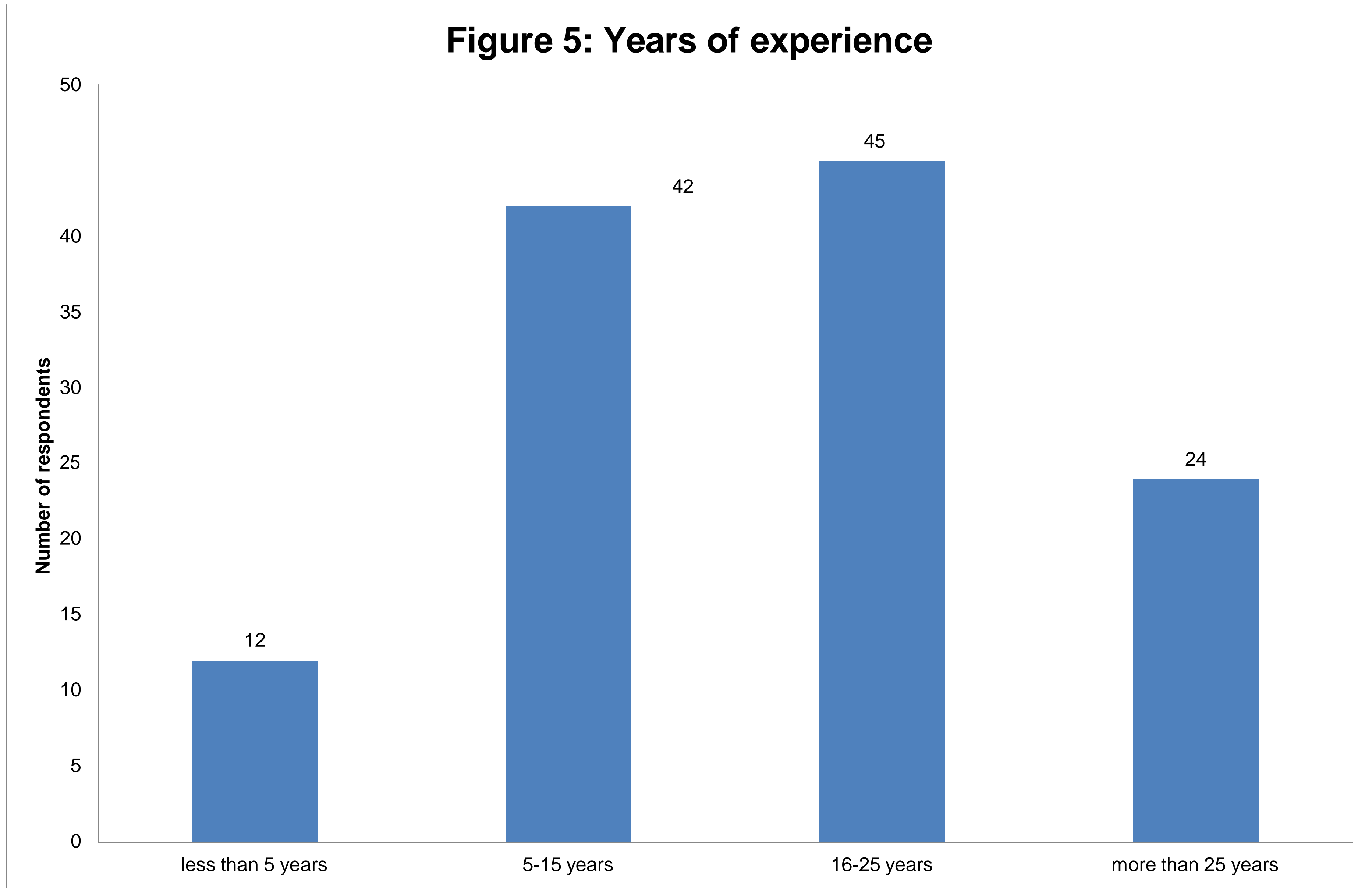


Figure 5: Years of experience
Number of respondents
50
40
35
30
25
20
15
10
5
0
12
42
45
24
less than 5 years
5-15 years
16-25 years
more than 25 years

4.4.3 Professional experience

Of the respondents who answered the question (123/142) about the year they entered primary or community care as a registered nurse 19% (24/123) have greater than 25 years experience, 36% (45/123) have 16-25 years experience, 34% (42/123) have between 5-15 years experience, 10% (12/123) have less than 5 years experience. Most of this group 36% (45/123) entered practice nursing between 1990 -1999 (Figure 5).

4.4.4 Areas of specialist interest and practice

The following data is based on questions that asked respondents to indicate if they had a specialist area of interest, ran a nurse-led clinic in the specialist area, (see Table 2) and their level of responsibility for the clinic (sole, shared or minimal). The most common areas of specialist interest were asthma, COPD and diabetes with more than half of those with a special interest running a nurse led clinic (Table 2). Other areas of specialist interest with associated nurse led clinics included heart disease, family planning and sexual health with around one third of respondents indicating that they ran a nurse led clinic (Table 2). Respondents identified that they were responsible for running other clinics although these were small in number (Table 2).

Table 2 Areas of specialist interest and associated nurse-led clinic

Area	Special interest	ic
	No. (%)	No. (%)
Asthma	80 (56)	49 (34)
Diabetes	79 (55)	43 (30)
COPD	70 (49)	42 (29)
Family planning	68 (48)	19 (13)
Sexual health	53 (37)	14 (10)
Heart disease	48 (34)	20 (14)
Other clinics:		
Anticoagulant	- -	*3 (2)*
Travel health	- -	*11 (8)*
Child immunisation	- -	*9 (6)*
Baby clinic	- -	*3 (2)*
Triage/minor illness	- -	*6 (4)*
Cytology	- -	*6 (4)*
Smoking cessation	- -	*7 (5)*
Wound care	- -	*5 (3)*
Other	- -	*15 (10)*

Respondents were also asked to indicate the level of academic training they had undertaken for the specialist role (see Table 3). Many respondents described having a specialist area of clinical interest, though their academic level of training for that area varied greatly from un-certificated to post- graduate level.

Table 3 Level of academic training for specialist role

Specialist Area	No. of response	Academic level of training							
		Not certificated		Certificate		Diploma		Degree or higher	
		No	(%)	No.	(%)	No.	(%)	No.	(%)
Asthma	10	28	(27	2	(21)	4	(47)	5	(5)
Diabetes	99	26	(26	3	(39)	2	(27)	7	(7)
COPD	85	41	(48	2	(28)	1	(20)	3	(4)
CHD	74	39	(53	2	(28)	1	(18)	1	(1)
Family Planning	97	21	(22	4	(49)	2	(25)	4	(4)
Triage/minor illness	64	24	(38	1	(23)	1	(20)	1	(19
Travel	98	39	(40	5	(56)	3	(3)	1	(1)

4.4.5 Professional support

A third of respondents 34% (48/142) indicated they mentored or supervised others. Almost two thirds of respondents (64% [91/142]) indicated that they did not have a clinical mentor and 50% (71/142) said they did not receive or had no access to clinical supervision. Only 7% (11/142) respondents reported receiving training in mentoring. Ten percent (15/142) of respondents described themselves as having an Assessor/ Mentor qualification.

In Brent, Harrow and Hillingdon, 53% (75/142) responded that they were part of a professional network, however this related to a range of professional, union/ indemnity, and regulatory bodies.

4.4.6 Training attendance in past the 12 months and future needs

Survey respondents were asked to indicate if they had received training in specified areas in the past 12 months (see Table 4) and to rate its effectiveness on a scale of 1-5. Respondents rated most topics and modes of delivery including online, surgery-based, PCT/GCG-based and HEI-based training as 5 (excellent) or 4 (good).

Table 4 Training attendance in the past 12 months

Training area	Received training in the last 12 months	
	No	(%)
CPR	11	(81)
Child safeguarding	9	(65)
Immunisation and anaphylaxis training	9	(64)
Cervical cytology training	8	(58)
Infection control	7	(56)
Adult safeguarding	7	(54)
Fire Safety	7	(51)
Flu update	6	(46)
Health and safety	4	(35)
Specialist diabetes training	3	(27)
Moving and handling	3	(25)
Health check training	3	(24)
Ear care	3	(23)
Specialist COPD training	2	(20)
Equipment training	2	(20)
Phlebotomy	2	(20)
CVD training	1	(11)
Independent non-medical prescribing training	1	(9)
Customer service training	1	(9)
Mentoring	1	(8)
Consultation skills training	1	(7)
Independent non-medical prescribing annual update	8	(6)
Leadership	6	(4)
Specialist LTC training	4	(3)

4.4.7 Future training needs

In addition, respondents were asked to indicate their future training needs (Table 5). The number of respondents answering these questions varied according to topic and most topics were considered to be of some interest (Figure 6).

Table 5 Future training needs

Training area	Percentage of respondents (n=142) interested in training	Interested in training (%) of those who answered question			
		Yes:	(%)	No:	(%)
Specialist COPD training	51	7	(87	4	(5)
Flu update	50	7	(93	2	(3)
Infection control	48	6	(89	6	(8)
Ear care	48	6	(81	1	(14)
Specialist diabetes training	45	6	(83	8	(10)
Immunisation and anaphylaxis training	44	6	(91	2	(3)
Adult safeguarding	42	5	(86	7	(10)
Child safeguarding	42	6	(85	5	(7)
Health and safety	42	5	(82	9	(13)
CVD training	42	6	(88	3	(4)
CPR	41	5	(79	1	(15)
Cervical cytology training	39	5	(86	5	(8)
Consultation skills training	39	5	(80	1	(14)
Health check training	37	5	(77	1	(14)
Independent non-medical prescribing training	35	5	(66	1	(13)
Mentoring	35	4	(74	1	(15)
Leadership	32	4	(67	1	(21)
Independent non-medical prescribing annual update	31	4	(70	9	(14)
Specialist LTC training	31	4	(77	5	(9)
Fire Safety	30	4	(63	1	(22)
Moving and handling	29	4	(61	1	(28)
Equipment training	27	3	(67	1	(23)
Customer service training	23	3	(56	1	(29)
Phlebotomy	22	3	(53	1	(27)

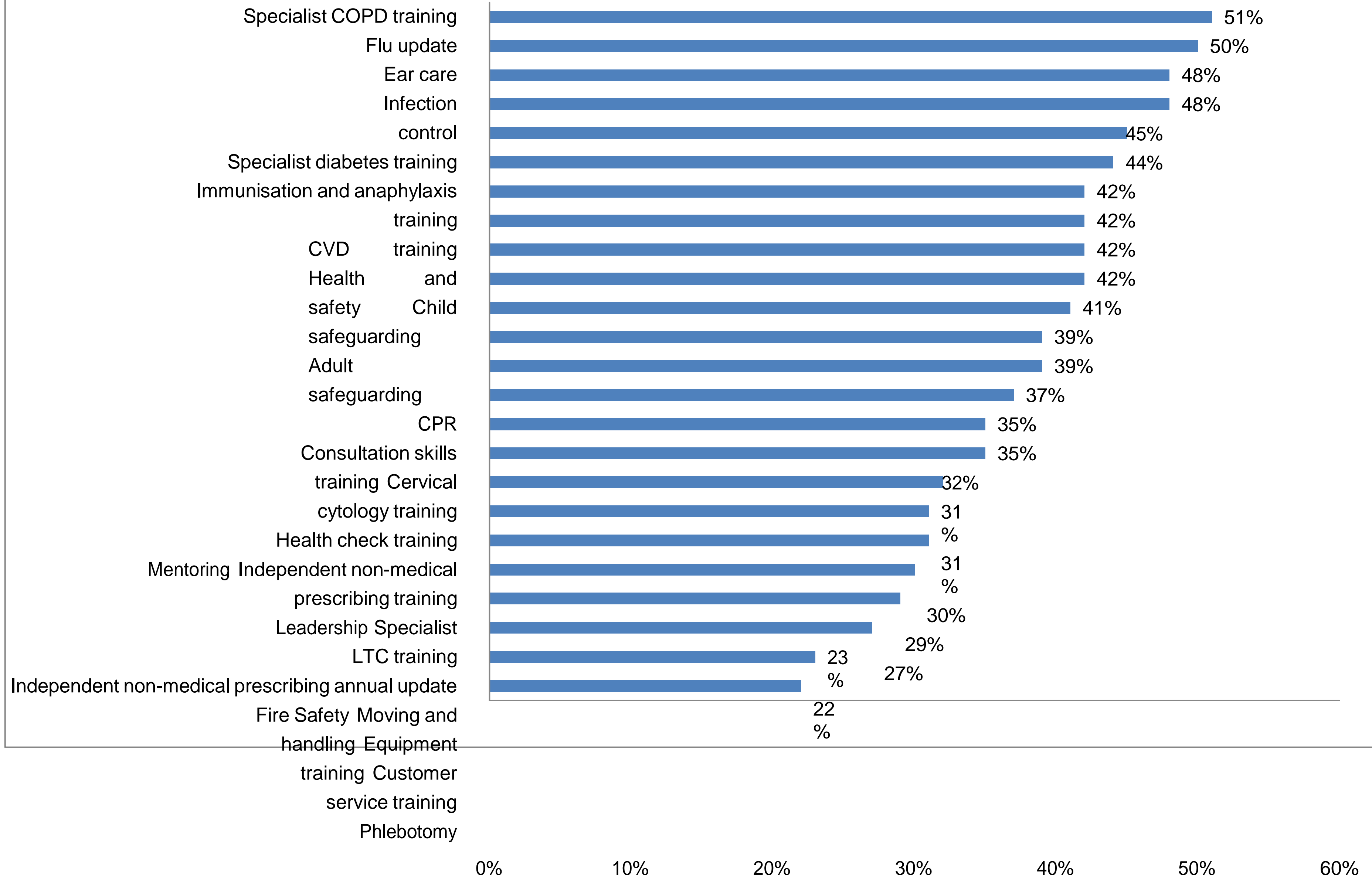


Figure 6: Percentage of respondents (n=142) interested in training
Specialist COPD training
Flu update
Ear care
Infection
control
Specialist diabetes training
Immunisation and anaphylaxis
training
CVD training
Health and
safety Child
safeguarding
Adult
safeguarding
CPR
Consultation skills
training Cervical
cytology training
Health check training
Mentoring Independent non-medical
prescribing training
Leadership Specialist
LTC training
Independent non-medical prescribing annual update
Fire Safety Moving and
handling Equipment
training Customer
service training
Phlebotomy
51%
50%
48%
48%
45%
44%
42%
42%
42%
42%
41%
39%
39%
37%
35%
35%
32%
31 %
31 %
30%
29%
27%
23 %
22 %
0%
10%
20%
30%
40%
50%
60%

When asked what other areas of education and training were needed respondents indicated that training in a range of assessment skills as well as health promotion, communication and management skills were of interest. These needs do align to areas of the GPNCF and are pertinent aspects of professional development, as shown in Box 2.

Box 2 – Additional areas of training

- Physical Assessment
- Leg ulcers and Doppler
- Spirometry
- Dermatology
- Menopause and HRT
  - Breast feeding, weaning
  - Weighing, monitoring babies
  - Smoking cessation
- Interpreting test results
- Communication Skills
- Conflict training skills
- Appraisal training
- Level 3 Safeguarding
- Decision making
- Computer training
- Revalidation training
- Clinical supervision
- Mentor for HCA

4.3.7 Training in Specialty Areas

The data indicates that nurses working in specialty areas of practice have varied levels of education and training for providing care, especially in the areas of diabetes, heart disease, COPD, family planning, sexual health, travel health and asthma (see Figure 7).

4.3.7.1 COPD

Half of respondents (49% [70/142]) indicated that COPD was an area of specialist interest and more than half of these said they ran a nurse-led clinic in this area (60% [42/70]). Of those who responded 45% (64/142) have some responsibility for services of these 59% (38/64) have shared responsibility and 16% (10/64) have sole responsibility. Four percent (3/85) of respondents indicated that they had degree level of training COPD, whilst 20% (17/85) diploma level training 28% (24/85) have certificate level training. Only 20% (28/142) reported having attended training within the last 12 months. Overall, 51% (72/142) of respondents reported an interest in receiving training in this area.

4.3.7.2 Diabetes

Just over half (53% [79/142]) of respondents indicated that diabetes was an area of specialist interest and of these 54% (43/79) said they ran a nurse-led clinic. Of those who responded 52% (74/1420 take some responsibility for these services of these 70% (52/74) have shared responsibility and 14% (10/74) have sole responsibility. Seven percent (7/99) of respondents had graduate level of training, 27% (27/99) had training at diploma level and 39% (39/99) had training at a certificate level. The type of training attended previously varied from study days, Diabetes UK, NIPS, in-practice sessions, or aspects of the Warwick course. Within the last 12 months, 27% (39/142) reported having had specialist diabetes training.

4.3.7.3 Asthma

Fifty-six percent (80/142), reported a specialty interest in asthma and of these 61% (49/80) ran a nurse-led clinic. Of those who responded 52% (74/142) had some responsibility for these services of these 65% (48/74) have shared responsibility, 18% (13/74) have sole responsibility for services. Five percent (5/104) of respondents had graduate level of training, 47% (49/104) had training at diploma level and 21% (22/104) are certificated. The survey did not ask about recent training in asthma, however many respondents did indicate in the narrative responses that they would like training in asthma and spirometry.

4.3.7.4 Family Planning

Forty eight percent (68/142), reported a specialty interest in asthma and of these 28% (19/68) ran a nurse-led clinic. Of those who responded 49% (70/142) had some responsibility for these services of these, 70% (52/74) take shared responsibility and 14% (10/74) take sole responsibility for services. Only 4% (4/97) had a graduate training in asthma, 25% (24/97) had training at diploma level and 49% (48/97) are certificated. The survey did not ask about recent training in family planning.

4.3.7.4 Travel Health

Eight percent (11/142) run nurse led clinics. Of those who responded 47% (67/142) had some responsibility for these services of these 55% (37/67) take shared responsibility and 36% (24/67) take sole responsibility for services. One percent (1) has post-graduate training in travel health, 3% (3/98) have diploma level training and 56% (55/98) have a certificate level of training. The survey did not ask about recent training in travel health, although respondents did indicate in the narrative responses that they would like updates in this area.

4.3.7.5 Heart Disease. CHD

Thirty four percent (48/142) of respondents indicated that CHD was an area of specialist interest of these 42% (20/48) ran a nurse led clinic. Of these 40% (57/142) have some responsibility for these services, 7% (4/57) have sole responsibility and 65% (37/57) had shared responsibility. Only 1% (1/74) of respondents have graduate level of training in CHD, 18% (13/74) had diploma level training and 28% (21/74) have certificate level of training. Of all the respondents, only 11% (16) had completed training within the last 12 months. When asked who provided training, answers included DOH, GP update, in-house, Kirk House and journals.

4.3.7.6 Triage/Minor Illness

These two areas were merged in the survey as a single question and there the two topics could not be separated. Four percent of respondents (6/142) indicated that they ran nurse-led minor illness/injuries clinics. A third of all respondents (45/142) had some responsibility for these services of these, 62% (28/45) reporting having a shared responsibility for this area and 18% (8/45) have sole responsibility. Nineteen percent (12/64) had graduate level of training in the area, 20% (13/64) had a diploma level of training on the topic and 13% (15/64) have certificated training on the topic. A small number of

those responding in the free text question (11) indicated that they would like minor illness training.

Respondents also identified specialist long-term care 31% (44/142) and independent non-medical prescribing training 35% (50/142) as areas of interest in specialist training.

4.3.8 Training in Non- Specialist Areas

Areas that may not be considered as specialist areas include communication, leadership and consultation skills were also of interest for further training.

4.3.8.1 Consultation skills

This training may be related to triage but was not defined in the survey question. Seven percent (10/142) respondents had attended consultation training within the last 12 months and 39% (56/142) wanted further training. Table

4.3.8.2 Health-Check Training

Of all respondents, 24% (34/142) had received health check training in the last 12 months, as provided by the CCG, GP or in-house. There was an interest in receiving this training by 37% (53/142) of respondents.

4.3.8.3 Customer-Service Training

Of all respondents, 9% (13/142) reported having had this training in the last 12 months, which was provided in-house, online or by the Blue Stream Academy. There was interest in receiving this training by 23% (33/142) of respondents of whom 70% (23/33) were practice nurses.

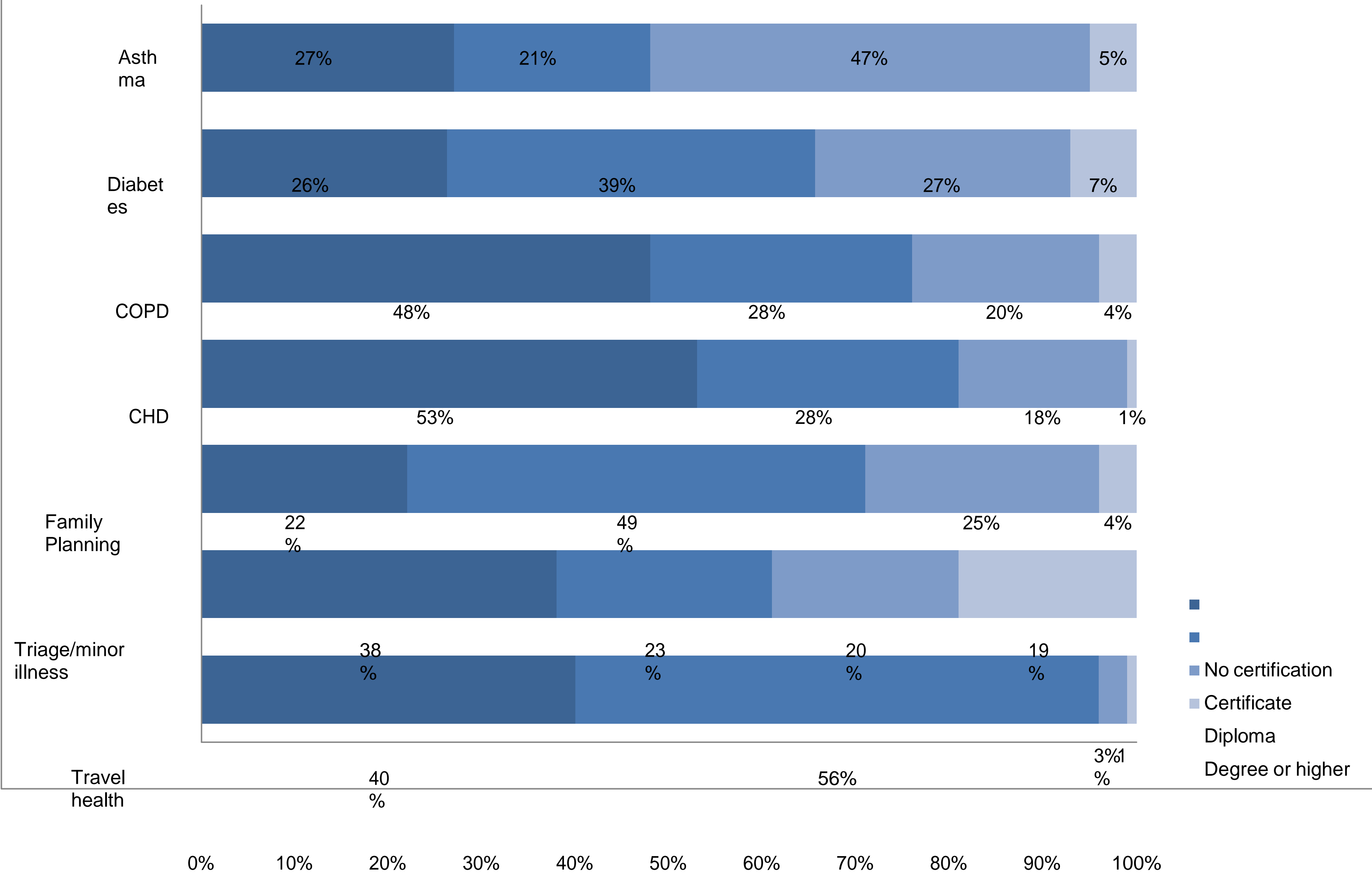


Figure 7: Academic level of training in specialist area
Asth
ma
27%
21%
47%
5%
Diabet
es
26%
39%
27%
7%
COPD
48%
28%
20%
4%
CHD
53%
28%
18%
1%
Family
Planning
22
%
49
%
25%
4%
Triage/minor
illness
38
%
23
%
20
%
19
%
Travel
health
40
%
56%
3%1
%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
No certification
Certificate
Diploma
Degree or higher

5.1 DISCUSSION

The discussion focuses on key gaps in the provision of education and training and the education, workforce and system issues that arise from these gaps.

5.2 Gap 1 - Training doesn't map to competencies

There is no evidence in our results to indicate that practitioners or employers use an agreed competency framework to guide professional or service development and the appropriateness of education and training programmes. As a result, there is a wide range of content and training provision based on mandatory training requirements and perceived professional development needs in terms of higher education provision.

Implications within this gap include problems associated with planning the development of nurses new the field of primary care and general practice settings. Inconsistency in learning outcomes, appropriate academic level and varying costs for preparatory and continuing knowledge and skills development. On-going competency and professional development to meet the needs of a changing healthcare system become difficult to plan.

5.3 Education and training issues

5.3.1 Academic attainment

The level of academic attainment within the respondents was variable with just over a quarter of the respondents having completed an undergraduate degree and only 5% with a postgraduate degree. Qualifications in the areas of declared specialist interest also varied from a short course to focused academic modules or diploma/degree programmes in specific areas such as, asthma, diabetes and nurse practitioner.

The trend towards keeping people with long-term conditions out of acute care requires the higher-level competency associated with increased monitoring and early intervention skills of the primary care workforce including PN and support staff. In addition, the preparation of pre-registration nursing students requires placements within primary care and general practice settings that are able to provide mentorship to facilitate the learning needs of undergraduate and postgraduate students.

As described in the results the current practice nurse workforce is highly experienced in terms of years working in general practice, and this may be one reason for the lack of academic qualifications within the discipline. Few staff (10%) indicated that they were currently studying for an academic award. There is also a need to establish levels of qualification for specialist clinical roles and mentorship support to drive appropriate levels of knowledge and skill within the workforce.

Commissioning of future provision needs to involve stakeholders to ensure programmes are responsive to clinical practice and workforce needs including, access programmes to prepare those who have not been involved

in formal education for some time, flexible scheduling, practice-based experience and consideration of costs to employer and employee.

5.3.2 Variability in continuing education programmes

Nurses working in primary care have a very broad range of responsibilities as described by the GPNCF. However, the content of training, assessment methods and exposure to practice required to reach and update the stated levels of competence are not addressed. The survey data showed that GPs undertake the majority of staff appraisals, but their familiarity with the GPNCF and role in personal and professional development planning is unclear. In conversations with practitioners and support staff, colleagues were unable to describe the competency documents that were used to guide continuing education and professional development. This suggests that the GPNCF have not been widely adopted.

The educational mapping described in this report suggests that available training is a broad mix of non-standardised programmes with a range of differing objectives. One example is that Public Health England suggests that mandatory immunisation updates should be undertaken annually and consist of one-day of content. Feedback from respondents suggests that content of these days appears to vary widely depending on the time available for release from practice and who is delivering the teaching programme. For assessment of skill based competencies such as cervical cytology, there also appears to be wide variation between how training is offered, e.g., online or ‘in-house’ and which competencies are assessed and how frequently.

There is a range of online, non-HEI and HEI educational opportunities but staff must seek out these options and as we found the learning outcomes and content of this training is not always available or transparent. Practice nurses and health care assistants report having to search online or call around to see what training is locally available, or to wait for in-house sessions to occur.

An agreed core curriculum, with defined outcomes linked to a competency framework that addresses support worker and nursing workforce requirements may be one way of addressing these shortcomings. This would enable educationalists, mentors and education facilitators to identify appropriate programmes for staff and assess levels of competence in the workforce consistently.

5.4 Workforce Issues

5.4.1 The practice nurse and support staff workforce

It has been difficult to establish the size of the practice nurse and support staff workforce and surveys have had varying success in terms of response rates. A systematic approach and multi-stage research design this project attempted to identify all non-medical staff working in every GP surgery in the three localities. As expected practice nurses represented the largest proportion of staff in general practice and despite the multiple approaches that

were used to access all nursing and support staff in primary care in this project the needs of support staff remain potentially under-represented.

The majority of staff have been working in general practice for 15-25 years. The implications of this factor reflect a balance between a strong experience base and the increasing risk of a workforce nearing retirement. This is clearly concerning given the pressures upon primary care and may be one reason for minimal uptake of higher professional training and other educational opportunities. On a positive note this will also provide the opportunity to refresh the general practice workforce from a population of practitioners who have been prepared at diploma/degree level and developed specialist expertise at undergraduate or post-graduate levels.

The professional background of nurses in the primary care workforce is varied, which seems appropriate given the range of skills necessary for use in primary care, but is predominantly from the branch of adult nursing. HENWL workforce data recently predicted a shortfall of nurses needed in primary care. Comments from practitioners during fieldwork indicated the lack of a clear professional and academic path into practice nursing. Practice nurses also commented that the Nursing and Midwifery Council does not have a primary care or practice nurse typology within its categories of practice. The move to a broader health and social care remit for healthcare workers that spans current care boundaries suggests that current delineations between branches of nursing in particular may need to integrate. Future recruitment to practice nursing may depend upon a deeper understanding of the broad competencies and types of specialist roles necessary to practice across primary and secondary care.

5.4.2 Mentorship

Respondents indicated that practice nurse and support staff access to mentors was limited and a number of different terms were used to describe this role e.g., mentors, sign-off mentors, and qualified clinical teachers. This is important because a lack of clinical mentors is an apparent problem for meeting both the needs of practitioners new to the field and pre-registration students gaining experience in primary care settings. During our field research a number of practice nurses told us that they would like to mentor, supervise or teach new practice nurses and pre-registration students but felt that they lacked the academic support needed to pursue mentorship programmes and that there was a lack of recognition (financial) on the part of employers regarding the importance of this role. A proportion of respondents identified that they had completed the ENB 998 Teaching and Assessing in Clinical Practice programme in the past but felt their knowledge and skills needed updating.

Further attention to the issue of mentoring might clarify what is needed at both a system and educational level to create mentorship models that best fit with primary care and delivering the Shaping a Healthier Future agenda.

5.4 Gap 2 – Learning opportunities are difficult to identify and of wide variety

Practice nurses and support staff appear to have an interest in developing a wide range of skills and knowledge to meet the needs of patients and the services they deliver. However, the ability to identify topics of interest at an appropriate skill and academic level for their role is complicated by a huge range of online, HEI, non-HEI, and in-house sessions. There is no single portal of information that identifies where training is provided, its content, level and applicability to different roles and types of practitioner.

5.5 System Issues

The results of this scoping project suggest that there are a number of issues that could be addressed by developing a more coherent system for supporting, informing and developing practice nurses and support workers. While the component parts of such a system do exist they do not always work in a way that promotes effective workforce development or use of resources. The three elements that emerge from the data focus on professional networks, nursing leadership and effective communication of educational opportunities.

5.5.1 Professional networks

During the planning and design stage of the scoping, monthly practice nurse forums were highlighted as a means of accessing practice nurses. However fieldwork revealed that regular, publicised meetings were not held in Brent, Harrow or Hillingdon. Feedback during fieldwork suggests that Ealing has a robust nursing network with a monthly practice nurse forum that provides 'in-house' training on a variety of topics during the meetings.

Respondents interpreted the meaning of professional networks in a range of ways with some referring to regulatory and union/ professional organisation such as the Royal College of Nursing, which has a Practice Nurse Forum and other groups that may be of use to practice nurses e.g., Wound Care Forum. Some respondents indicated that they participated in Nursing In Practice groups. Time to attend network events within the locality or externally was also an issue and given the difficulties in accessing accurate data about the number of practice nurse and support staff in primary care, it is not surprising that efforts to bring practitioners together to share information and best practice face barriers.

5.5.2 Nursing leadership

Nurse leaders in the roles of Advanced Practitioners and Practice Nurse Leads were present within Brent, Harrow and Hillingdon but were not easily identified on web pages or in other information sources. Survey respondents were unaware of who might be available to them to advise on education and training. Named Practice Nurse Leads were difficult to identify and in some cases those in one area would name a leader in another locality, and that person was no longer in post or denied that they held a leadership, education, or training role. A Communication Lead was a role identified in Brent but these individuals were also difficult to locate.

It is possible that the changes within CCGs have resulted in a disruption of professional leadership and communication networks but reliance on these

inconsistent and informal communication networks may be a weak method for communicating new evidence in practice, expectations for training or opportunities for educational development. The clear articulation of existing nursing leadership within primary care that is well signposted on web resources would be helpful. The role of those in leadership positions as Education Facilitators who act as a resource for advising staff, mentors, individual practitioners and employers about education and training needs or professional development planning needs to be examined further.

5.5.3 Awareness of educational opportunities

The survey suggests that current approaches to disseminating education and training opportunities are variable across local areas and rely on weak approaches to dissemination and loose or infrequent professional networks. This acts as a barrier to both access and uptake of available training. Without access to timely information about practice issues, it is unclear how protocols, evidence based guidelines, or current expectations for professional practice are disseminated.

In the course of the project, comments from respondents indicated that they were unaware of changes to the way in which education is commissioned locally and how workforce development is linked to strategic change in the NHS. Several practitioners told us that they did not know what HENWL or Health Education North West London was or how it impacted on education and training opportunities and some practice managers also failed to recognise HENWL as a local organisation. Given the disparate nature of general practice it may be worth considering the development of an educational portal to facilitate consistent and timely information about education and training. The existence of GPNCF also needs to be addressed and the value of a well-qualified and competent practice and support workforce explored with stakeholders.

5.6 Strengths and limitations of the project

The survey response rate was a positive outcome of this piece of work and resulted from using multiple methods of gaining access to PN and support staff. These methods are resource intensive and it was not possible to visit all 159 general practice surgeries during the project. Other issues prevented us from achieving a higher response rate, particularly from support staff in bands 1-4. The lack of IT access in some practices meant that hard copies of the survey needed to be provided and a small number of practices refused to cascade the survey to staff.

This project aimed to integrate the results from the project being undertaken by BNU (funded by CWLL) and used the same survey instrument to facilitate the merging of data. However, data from the main project of inner NWL CCG localities, which was completed in 2013 and extended to Ealing in 2014, was not made available to the project team. As a result we have not been able to merge the data sets.

Trying to match education and training opportunities to the GPNCF proved complex. The availability of publically available, clear and detailed information about programmes was poor and highlighted to the research team how difficult it was for practitioners to locate and make judgments about the applicability of the learning and content.

6.1 RECOMMENDATIONS

We are aware that there are other similar projects being undertaken across Health Education England. This offers the opportunity for the recommendations that follow to be discussed in the light of others findings and for subsequent developments to be connected across appropriate HEE boundaries, forming regional and national initiatives where indicated. Based upon the identified themes regarding the workforce in primary care, including practice nurses and support staff in Brent, Harrow and Hillingdon, there are a number of recommendations that are worth consideration. Three areas are highlighted in line with the discussion above:

6.2 Recommendation 1 – Agreed Competency Framework and associated curriculum

A whole systems review that leads to the development of coherent competency framework addressing the knowledge and skills of support and specialist practitioners would ensure consistency and comparability of learning outcomes and practice skills and provide a platform for its adoption across healthcare education. A core curriculum for nurses in primary care, and for support staff in primary care, may be one way of addressing these shortcomings enabling nurse educationalists, mentors and education facilitators to identify appropriate programmes for staff and assess levels of competence in the workforce consistently.

The commissioning of future provision needs to ensure that stakeholders are involved and perhaps consider a co-production approach to ensure programmes are responsive to clinical practice and workforce needs including, access programmes to prepare those who have not been involved in formal education for some time, flexible scheduling, practice-based experience and costs to employer and employee.

6.3 Recommendation 2 – Integrated Network of Educational Facilitators

Educational Facilitators working within a defined infrastructure might provide a hub for education, training and development. The role could encompass acting as career advisor and competency guide to both staff and employers and facilitate effective communication of training opportunities. Such training coordinators in primary care might be best positioned working in cross-locality positions to link staff to new and existing and educational networks. A larger educational network that can span organisational, sectoral and disciplinary boundaries would be well placed for developing the most adaptive workforce for the current complex world of primary care, and for the future.

6.4 Recommendation 3 –Integrated Educational Portal

A clearly communicated infrastructure for education and training including a boundary spanning open portal that lists educational opportunities is essential. It would also be worth considering the provision of standardised competency documentation appropriate for practice in all roles to assist all

those involved in the process of training, mentoring, assessing and appraising nurses and support staff in general practice settings.

7.1 REFERENCES

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APPENDIX 1 – STEERING GROUP MEMBERS

Members of the Primary Care Nursing Steering Committee (HENWL)

Therese Davis Deputy Director of Education and Quality (HENWL) Catherine

O'Keeffe, Shared Services

Tony Burch, General Practitioner (HENWL) Ursula Gallagher, Brent, Harrow

and Hillingdon

Sally Armstrong, Practice Nurse & Nurse Member Ealing CCG

Gil Rogers, Director of General Practice Nursing, London-wide Local Medical Committee

Lizzie Wallman, Assistant Director for Quality & Patient Safety, CWHH Clinical Commissioning Groups Collaborative

APPENDIX 2 – SCOPING SURVEY TOOL

Separate attachment

APPENDIX 3 – SCOPING ACTIVITY TIMELINE

22nd February 2014- 4th July 2014 Estimated Number of Nurses and Support Staff in North West London

- Created an excel spreadsheet with relevant information specific to all 8 CCG's in NWL- list of GP surgeries with contact details, surgery codes, names/emails of practice managers, names/emails of Practice Nurses (PN's), Health Care Assistants (HCA's) and Nurse practitioners (NP's). Information collated from online sources.
- From the information collected- devised a table of estimated numbers of PN's, HCA's and NP's in NWL.

5th March 2014- 2nd May 2014 Field Based Data Collection

- Accessing existing Data- Corresponded with Lizzie Wallman and Sue Proctor to access existing data concluded from Scoping project conducted by Bucks for Inner CCG's. Negotiations ongoing.

1st March 2014- July 2014- Outreach Efforts

1) Communication Leads Participants

Identified Brent, Harrow & Hillingdon CCG communication leads and locality support managers in Primary care (via Eileen Bryant -email of 28th March 2014) so that they could be emailed.

2) Practice Nurse Forums

Identified Survey Respondents by making efforts to seek dates for future Practice Nurse Forums in outer CCG's. Managed to secure date to attend PN forum in Brent (Harness locality taking place on 18th June 2014). A very productive event to attend as managed to get 11/13 surveys completed on the day. The other 2 were received via hardcopies in a self-addressed envelope which was provided by UWL.

3) Online Forum- RCN

Liaised with RCN on 9th June and agreed to have survey posted on RCN nurse Forum until 31st July. RCN also sent a mass email to members on their forum in Harrow, Hillingdon and Brent.

2nd April 2014- July 2014- MAPPING HEI Educational Offerings

- Composed a spreadsheet in Excel for the mapping exercise. Identified HEI training centres, non-HEI training centres and Online Modalities offering specific courses, in order to map against RCGP document.

22nd May 2014- 4th July 2014 Field Based Data Collection

- Prepped for Field based data collection. Converted the survey as a word document to have hardcopies of the survey with self- addressed envelopes.
- Analysed survey results (52) for week 2- 22nd May- 3oth May to determine which GP practices need to be targeted as a priority to visit
- Took hardcopies of survey to GP practices to be completed by nurses as well as an i-pad for surveys to be completed electronically. Started field based work on 10th June 2014 and visited 42 GP practices over 14 days (for 4 days out of 10 visited practices either in morning or afternoon. Not full days). On average visited 4-5 GP practices a day. **(Refer to Table of Response Rate via Field Based data collection)**

Response Rate via Field Based Data Collection

Date visited	Number of Practices visited	GP Practice Post code and CCG	Total Number of Surveys complete d on site	Total number of hardcopies of survey and self - addressed	Tracking Details	Total number of surveys received back
10/06/14	3	UB4-Hillingdon	3			
11/06/14	5	UB10/HA4- Hillingdon	6			
12/06/14	1	NW10- Brent	2			
13/06/14	2	UB3- Hillingdon	2	2	13/06/14 (1) 13/06/14 (2)	
16/06/14	4	HA1- Harrow	6	16	16/06/14 (1) 16/06/14 (2) 16/06/14 (3)	1
19/06/14	2	UB3- Hillingdon	1	4	19/06/14 (1)	3
20/06/14	4	NW6- Brent	2	8	20/06/14- (1) 20/06/14- (2) 20/06/14- (3) 20/06/14- (4)	3
23/06/14	2	HA4- Hillingdon	2			
24/06/14	1	UB3- Hillingdon		1	24/06/14	
25/06/14	4	UB3/UB8- Hillingdon	4	7	25/06/14 (1) 25/06/14- (2) 25/06/14- (3) 25/06/14- (4)	3
27/06/14	5	HA0/HA9- Brent	2	8	27/06/14 (1) 27/06/14- (2) 27/06/14- (3) 27/06/14- (4) 27/06/14- (5)	2 1
01/07/14	3	HA5- Harrow	5	9	01/07/14- (1)	
02/07/14	2	HA2- Harrow	3	7	02/07/14- (1)	
04/07/14	2	HA1- Harrow	3	2	04/07/12 (1)	

2nd June 2014- Headcount comparison with HENWL GP Survey to UWL Numbers of Practice Nurses, Nurse Practitioners, Health Care Assistants as of 8th July 2014

- Headcount/workforce comparison. Initial analysis started.
- Headcount comparison of HENWL GP Survey to UWL numbers.

SURVEY DISSEMINATION RESULTS

The survey was disseminated using 4 different methods:

1) Email correspondence

Telephone correspondence

2) Attending Practice Nurse Forums
3) Field visits

Method 1- Emailing

- Emailed (sent mass mail) from 12th May. Out of 286 emails collated from Internet sources 115 bounced back so sent emails to 171 practice nurses, health care assistants and nurse practitioners.

- Referred back and analysed survey results every few days to monitor response rates. **Refer to Diagram - Survey Response Rates**.
- To increase response rates sent reminders via emails. In addition, emailed key contacts (Ursula Gallagher, Annette Alcock).

Survey Response Rates by Dissemination Date

Week/Dates	Weekly Response Rate
Week 1- 16th May- 23rd May	27
Week 2- 23rd May- 30th May	52
Week 3- 30th May- 6th June	70
Week 4- 6th June- 13th June	93
Week 5- 13th June- 20th June	121
Week 6- 20th June- 27th June	125
Week 7- 27th June- 4th July	137
Week 8- 4th July- 11th July	146
Week 9- 11th July-18th July	147
Week 10- 18th July-25th July	148
Week 11- 25th July-31st July	149
Week 12/13 1 August -14 August Data cleaning	**Final response rate 142**

Method 2- Telephoned GP practices

- On 2nd June, checked response rates and found a low response rate from practices in Hillingdon and Harrow therefore called approximately 25 GP

Surgeries on 2nd, 3rd, 5th, 18th and 30th June with the view to be able to speak to and inform PN's, HCA's and NP's of the importance and rational of survey.

- Found this method to be not as effective as anticipated as unable to speak to Practice nurses, HCA's or nurse practitioners directly.

- However, did manage to speak to practice managers on a few occasions whom assured to forward survey on to their practice nursing staff. In addition did manage to get names of more staff working in primary care which was later added to our list.

Method 3- Attended Practice Nurse Forum

- On 18th June, Attended practice nurse forum in Brent (Harness locality) - managed to get 11/13 surveys completed. Printed hard copies of surveys as well as taking an ipad for surveys to be completed electronically. Self-addressed envelopes were also provided so 2/13 practice nurses said they would post the survey back.
- The 11 surveys were then entered manually onto BOS. This resulted in being a very fruitful event to attend.
- Also, posted survey link on RCN forum.

Method 4- Field visits

- Carried out field visit to GP practices in Harrow, Hillingdon and Brent.
- The Research Assistant visited 42 practices over 10 days. On average went to 4-5 practices a day. This increased response rate rapidly.
- Targeted and prioritised visits by downloading up to date survey responses (specifically, Practice Nurse, Health Care Assistants, Nurse Practitioners name and email address and post code of GP practice) and after evaluating the data found it was evident Hillingdon had the lowest response rate so targeted Hillingdon practices first.
- Another strategy used was to target the bigger health centres with a larger number of primary care staff present.
- The Research Assistant found this method to be most effective as she was able to have direct access to PN's, NP's and HCA's and explain the purpose of the exercise, the benefits and importance of completing the survey and inform there was funding available for educational opportunities.
- She was able to get surveys filled there and then as well as leave hardcopies with self-addressed/pre-paid envelopes, which could be completed and returned at their own convenience. Surveys left with self-addressed envelopes to be completed were coded so they could be tracked (which practice they came from) on their return.

16th July 2014- Survey Overview- Percentage Return Rate

- Number of respondents: 146
- Expected number of respondents: 264
- Response rate: 55.3%
- Launch date: 08 May 2014 Close date: 31 July 2014

APPENDIX 4 – Royal College of General Practitioners Practice Nurse Competences

See separate PDF attachment

APPENDIX 5 – EDUCATION MAPPING

See separate attachment

Scoping the Educational Needs of Nurses and Support Workers in Primary Care

Introduction to the Survey

The purpose of this survey is to describe the current education and training needs of nurses and support workers in primary care, the community and out--of--hospital settings.

Health Education North West London (HENWL) has asked us to send you this survey to help them understand what education and training you have so they can provide more of the kinds of training you need.

We would be grateful if you could complete the following survey.

The information you provide will be combined with data from across North West London to help make plans for providing education and training in your locality. Your individual details will be kept confidential and will not be shared or published as being linked specifically to you.

Please complete the following questions, answering as best as you can, and then click on the 'continue' button. We expect this survey to take no more than 15 minutes.

If you have any questions please feel free to contact:

Dr Laura Nasir MSN PhD RN FNP FHEA email: laura.nasir@uwl.ac.uk
office: 0208 209 4055

Thank you very much for your time.

About You and Your Education

Please provide the following information about yourself

1. What is your job title?

- ◯ Practice Nurse
- ◯ Specialist Practitioner
- ◯ Advanced Nurse Practitioner
- ◯ Support Worker/ Health Care Assistant (Bands 1--4)
- ◯ Other *(please specify)*:

2. Please indicate your professional qualifications
(select all that apply)

- ☐ Registered Nurse
- ☐ District Nurse
- ☐ Health Visitor
- ☐ School Nurse
- ☐ Advanced Nurse Practitioner
- ☐ Assessor/Mentor
- ☐ V 100 prescribing
- ☐ V 300 prescribing
- ☐ Other *(please specify)*:

3. Please indicate your academic qualifications

(select all that apply)

- ☐ NVQ Level 1
- ☐ NVQ Level 2
- ☐ NVQ Level 3
- ☐ Foundation Degree
- ☐ Diploma in Higher Education
- ☐ BSc

☐ MSc
☐ PhD
☐ Other *(please specify)*:

4. What year did you enter primary or community care as a registered nurse?

5. Are you part of any professional network?

◯ Yes ◯ No

If **Yes** please specify:

About Your Training

Please tell us about the education and training you receive or would like to receive to maintain and increase competency in your role

6. What training have you attended in the last **12 months?** (Please indicate whether 'in--house, in--person or Online)

	How effective was this training 1 (poor) -- 5 (excellent)						Who provided this training	Would training in this area be of interest to		
	1	2	3	4	5	N/		Ye	N	N/
a. Cardio--pulmonary resuscitation (CPR)	◯	◯	◯	◯	◯	◯		◯	◯	◯
b. Adult Safeguarding	◯	◯	◯	◯	◯	◯		◯	◯	◯
c. Child Safeguarding	◯	◯	◯	◯	◯	◯		◯	◯	◯
d. Infection Control	◯	◯	◯	◯	◯	◯		◯	◯	◯
e. Fire Safety	◯	◯	◯	◯	◯	◯		◯	◯	◯
f. Moving and Handling	◯	◯	◯	◯	◯	◯		◯	◯	◯
g. Health And Safety	◯	◯	◯	◯	◯	◯		◯	◯	◯
h. Equipment Training	◯	◯	◯	◯	◯	◯		◯	◯	◯
i. Immunisation and Anaphylaxis Training	◯	◯	◯	◯	◯	◯		◯	◯	◯
j. Cervical Cytology Training	◯	◯	◯	◯	◯	◯		◯	◯	◯
k. Ear Care	◯	◯	◯	◯	◯	◯		◯	◯	◯
l. Flu Update	◯	◯	◯	◯	◯	◯		◯	◯	◯
m. Independent Non--medical Prescribing Training	◯	◯	◯	◯	◯	◯		◯	◯	◯
n. Independent Non--medical Prescribing Annual Update	◯	◯	◯	◯	◯	◯		◯	◯	◯
o. Specialist COPD Training	◯	◯	◯	◯	◯	◯		◯	◯	◯
p. Specialist Diabetes Training	◯	◯	◯	◯	◯	◯		◯	◯	◯
q. Specialist LTC Training	◯	◯	◯	◯	◯	◯		◯	◯	◯
r. CVD Training	◯	◯	◯	◯	◯	◯		◯	◯	◯
s. Health Check Training	◯	◯	◯	◯	◯	◯		◯	◯	◯
t. Consultation Skills Training	◯	◯	◯	◯	◯	◯		◯	◯	◯
u. Phlebotomy	◯	◯	◯	◯	◯	◯		◯	◯	◯
v. Customer Service Training	◯	◯	◯	◯	◯	◯		◯	◯	◯
w. Leadership	◯	◯	◯	◯	◯	◯		◯	◯	◯
x. Mentoring	◯	◯	◯	◯	◯	◯		◯	◯	◯

7. Have you identified any additional training needs? Please list

8. Are you currently studying for an academic award?

Yes No

a. If **Yes** please name the award

b. Which University are you studying with?

9. Do you have a **clinical mentor**?

Yes No

10. Do you receive/have access to **clinical supervision?**

Yes No

11. Do you mentor or supervise others?

Yes No

If **Yes** what training did you receive?

About Your Role

Please provide the following information about your training for your current role

12. What preparation and responsibilities do you have for the following areas?

	Academic level of training						Do you take responsibility for these services			
	uncertified	certificate	diploma	degree	post graduate	N/A	Minimal	Shared	Sole	N/A
a. Asthma	○	○	○	○	○	○	○	○	○	○
b. Diabetes	○	○	○	○	○	○	○	○	○	○
c. COPD	○	○	○	○	○	○	○	○	○	○
d. CHD	○	○	○	○	○	○	○	○	○	○
e. Family Planning	○	○	○	○	○	○	○	○	○	○
f. Triage/Minor Illness	○	○	○	○	○	○	○	○	○	○
g. Travel Health	○	○	○	○	○	○	○	○	○	○

13. If you have received a certificate please briefly describe the type and length of training.

14. Do you have a specialist area of clinical interest

Do you have a specialist area of		Do you run a nurse--led clinic in this	
Yes	No	Yes	No

a. Asthma	◯	◯	◯	◯
b. Diabetes	◯	◯	◯	◯
c. Heart Disease	◯	◯	◯	◯
d. COPD	◯	◯	◯	◯
e. Family Planning	◯	◯	◯	◯
f. Sexual Health	◯	◯	◯	◯

15. Are there any other specialist clinics that you run?

◯Yes ◯No

If **Yes** please specify:

About You At Work

16. What is your current grade/band?

◯1--3
◯4
◯5
◯6
◯7
◯8a
◯8b
◯8c
◯9
◯Other *(please specify)*:

17. What are your working hours?

◯part--time ◯full--time ◯not employed ◯agency/bank staff

If part--time how many hours do you work per week?

◯1--8
◯9--16
◯17--24
◯25--32
◯over 32
◯occasional

18. Do you work out--of--hours?

◯Yes ◯No

19. Who does your appraisal?

◯GP
◯Nurse
◯Practice Manager
◯Other *(please specify)*:

Please give the date (month/year) of your last appraisal

Location of Your Place of Work

20. Please provide us with the Post Code of where you work. This will help us map educational needs by locality.

Your Details

If you are willing to provide us with your name and **email address**, we will add it to a list of nurses and support workers in primary care for use by

Health Education North West London to inform you of future opportunities for education and training.

This information will not be connected with your survey answers but may be shared with groups offering education and training to nurses and support workers in primary care, the community and out--of--hospital settings.

21. Optional-- Please provide your Email address

22. Optional-- Please provide us with your name

End of Survey

Please click on the 'continue' button to submit your answers.

Continue >

Survey testing only

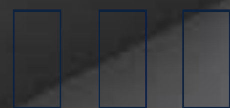
Check Answers & Continue >

General Practice Foundation

RCGP General Practice Foundation

General Practice Nurse competencies

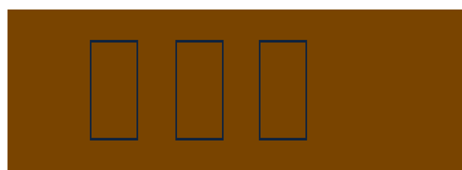
December 2012



Acknowledgments

Recognising there have been, over the years, a number of competence models for General Practice Nursing, this particular framework represents a continuation of the work commenced in 2001 as an output from an Educational Advisory Group comprising of experienced General Practice Nurses (GPNs) from the South West of England. In 2003, Avon Gloucestershire and Wiltshire Strategic Health Authority established a project group of personnel drawn from general practice, higher education institutes and the South West Deanery. They developed the work further, incorporating the job descriptions produced by Charnwood and North Leicestershire PCT, and aligning it with the Knowledge and Skills Framework (Version 6) of the NHS. In 2004, a Toolkit was completed and piloted. It is this Toolkit (called the AGS/SWD Toolkit) in 2006 that was further developed and incorporated into the NHS Working in Partnerships Programme (WiPP) General Practice Nursing Project and in 2009 was hosted within the GPN Toolkit on the Royal College of Nursing (RCN) website.

This current framework has been updated and expanded by the development team below three of whom were members of the original working party. They would like to acknowledge the work of all individuals and organisations involved in previous versions of the framework. They would also like to thank the Royal College of General Practitioners (RCGP) for providing the structure and facility to further publish this framework through the General Practice Foundation.



RCGP Competence Framework Development Team

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Tricia Smith, Practice Nurse Lead for NHS Plymouth and Project Lead, GP Unit, Plymouth University.

Our thanks also go to the following leading GPNs and Advanced Practitioners who have peer reviewed this framework and provided valuable comment and feedback much of which has been incorporated into this final version.

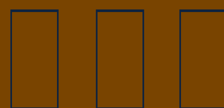
Jenny Aston, Chair, RCN Advanced Nurse Practitioner Forum, Chair RCGP Nursing Group, General Practice Foundation

Susan Kennedy, National Co-ordinator for General Practice Nursing NHS Education for Scotland

Rose, McHugh, Lead Primary Care Nurse, Public Health Agency, Nursing & Allied Health Professionals (Northern Ireland)

Eileen Munson, Chair of the Welsh Practice Nurses Association

December 2012

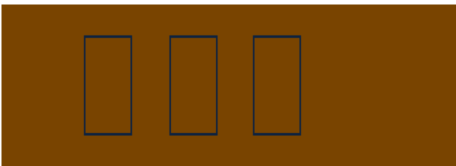


Introduction

This competency framework addresses the common core competencies and the wider range of skills, knowledge and behaviours a nurse needs in order to be a fully proficient GPN. It is important to recognise that these competencies may take time to fully develop and consolidate; progress will vary according to working context and the individual. It is recognised that novice GPN's may already have a significant level of nursing capability in other fields, however the wide remit of the GPN role encompasses many are[illegible] y the new entrant. It is also acknowledged that some nurses may become expert in a more specialist area o[illegible] they achieve and maintain a minimum level of competency across all areas of the generalist role.

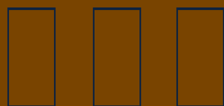
The document is presented in a format that aligns the competencies with the Knowledge and Ski[illegible] H 2004). This has at times resulted in certain competencies seeming to overlap with or be equally appropriate [illegible] e included. The document assumes an entry point to level 5 (newly registered nurse) progressing to level 6 and in some instances level 7 as expert specialist proficiency is achieved.

The document is written for use in the four countries of the United Kingdom and users will need [illegible] appropriate.



How can the framework be used?

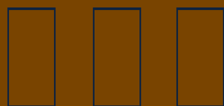
- It provides a detailed picture of the role of the GPN. As already stated this role is wide ranging and it may take time for you to acquire all the competencies. This will depend on various factors including your existing level of experience, working hours and the nature of the employing organisation. We recommend that the competencies that are specifically related to your initial responsibilities are given priority. It is anticipated the full range of competencies will be achieved within 18 months of commencing employment.
- It is designed as an initial self-assessment tool to help individuals recognise their current level of competence and identify specific areas for further development. We recommend that this is completed at the outset of an individuals' employment within the domain of general practice nursing to ensure that individuals new to the role recognise gaps in their knowledge and work within the scope of professional practice (NMC 2008).
- During the preceptorship / training period it can be used to as a tool to review and demonstrate progress, recognise the acquisition of specific skills and knowledge and provide evidence of assessment of safe clinical practice. We suggest three and six monthly reviews are done jointly with senior practice nurse or educator. The final assessment of competence may be carried out by an educator or a suitably qualified health professional. On this occasion a record of how the evidence of competence was demonstrated and achieved should be included.



- It can form the foundation of a portfolio of continuing professional development to assist all practitioners regularly review their level of competence and ensure they continue work within their scope of their professional practice.
- The document can also inform and support commissioning process; the design and delivery of education and training; workforce planning as part of recruitment, retention and progression (for example, job design, benchmarking candidates and the framing of interview questions); practice revalidation and evidence of meeting national quality standards.

Assessment of Competence and Progression

- Reviews conclude that there is no generally accepted 'gold standard' for the assessment of competence. Therefore a multi method approach to assessment of self and of others is recommended. Examples of approaches include direct observation, video, written evidence including reflection, specific case analysis, and feedback from patients, colleagues and other sources. This optimises reliability and validity. Assessment of practice should combine the holistic approach with the need to achieve very specific clinical skills.
- The Nursing and Midwifery Council (NMC) uses competence to describe skills and ability to practice safely and effectively without the need for supervision (Dolan 2003).



A very well acknowledged and valuable concept is Benner's 'novice to expert model' (1984)

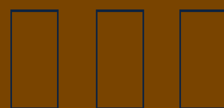
- Novice – stage in skill acquisition where no background understanding of the situation exists, so that context-free rules and attributes are required for safe entry and performance. Requires rigid protocols from which to work and can only work under supervision.
- Advanced beginner – can demonstrate a marginally acceptable performance. The advanced beginner has enough background experience to recognise aspects of the situation, and can vary the approach used according to the needs of individual patients, although still requires supervision.
- Competent – a stage in skill acquisition typified by considerable, conscious, deliberate planning. The competent stage is evidenced by an increased level of proficiency, the individual no longer requires supervision for routine tasks, but is aware of the limits of her/his knowledge and skills, and refers to others appropriately.
- Proficient – the proficient performer perceives situations as a whole rather than in terms of aspects, and performance is guided by maxims. The proficient performer has an intuitive grasp of the situation based upon a deep background of understanding, the individual is experienced in the field of work, competent to modify procedures appropriately to match differing circumstances, and able to advise others on how to perform tasks.
- Expert – developed only when theoretical and practical knowledge is tested and refined in real-life clinical situations.
  An expert has a deep background of understanding in clinical situations based upon many past cases, is very experienced, their work tested in difficult situations and has the ability to teach others,

The framework which now follows contains the overarching attitudinal competencies that are essential to meeting the GP Foundation standards for General Practice Nursing. These are aligned with the personal and professional responsibilities identified in the training curriculum for General Practitioners.

www.rcgp-curriculum.org.uk/PDF/curr_1_Curriculum_Statement_Being_a_GP.pdf

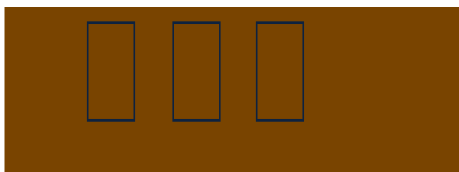
This training curriculum is also informed by the 11 fundamental characteristics of General Practice as defined by WONCA* (2005); (see Appendix 1)

*World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians, or World Organization of Family Doctors for short.

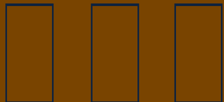


Contents

- Communication 9
- Communication with Patients 9
- Communication within teams 10
- Personal and People Development 12
- Health, Safety and Security 15
- Quality and Service Improvement 19
- Equality and Diversity 22
- Health & Well-Being 24
- Management of Emergency Situations 25
- Therapeutic Monitoring 25
- Ear Care 26
- Wound Management 27
- Minor Surgery 28
- Health Promotion 30
- Health Screening 31
- Cervical Sampling 32



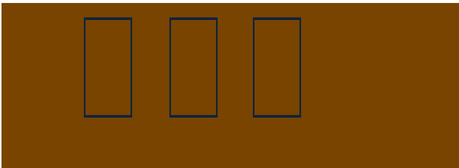
- Immunisation of children and adults 33
- Travel Health 34
- Mental Health 35
- Men's Health 37
- Women's Health 38
- Family Planning and Sexual Health 39
- Care of Patients with Long Term Conditions: Diabetes 40
- Care of Patients with Long Term Conditions: Chronic Obstructive Pulmonary Disease (COPD) and Asthma 41
- Care of Patients with Long Term Conditions: Hypertension 42
- Care of Patients with Long Term Conditions: Cardiovascular Disease 43
- Care of Patients with Long Term Conditions: Other Conditions 44
- Information and Knowledge IK1, IK2, IK3 46
- General – Learning and Development G1 49
- General – Development and Innovation G2 51



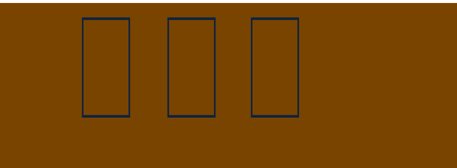
Contact Details

First name: .... Surname: ...... Name of Practice: ..... Start

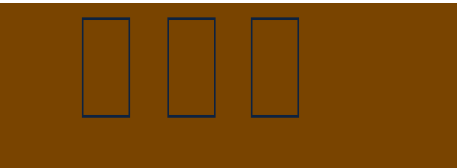
Date: .... Reviewer name: ......



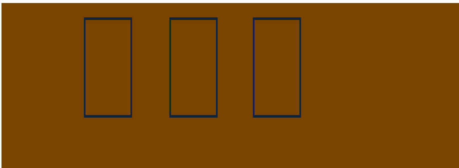
Communication **Communication with Patients**	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and Final assessment of competence	Type of Evidence, signatures (Please list your evidence below)
Manage routine consultations with patients including: · Initiating the session/time management · Using a holistic approach gather information and receive a history · Identifying problems appropriate for nurse management · Clinical reasoning: identifying possible courses of action for you to undertake or the level and speed of referral Being able to assist the patient to make decisions in a style appropriate to their wishes · Planning and exploration · Closing the session · Being aware of potential barriers to communication, being mindful of needs of specific					
Manage clinical risk within consultations including: · Recognising signs and symptoms which may indicate the presence of serious medical conditions ('Red flags') and taking appropriate action · Working at all times within personal professional and clinical boundaries					
Respond appropriately and communicate effectively with patients who have specific needs including: · Children and Adolescents · Learning Disability and Difficulty · Physical Disability · Mental Illness including those with memory loss · Bereavement · Terminal illness · Distressed or angry patients · Difficulty in communicating and understanding the English Language					



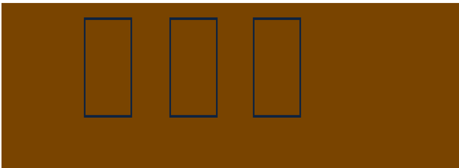
Communication	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and Final assessment of competence	Type of Evidence, signatures (Please list your evidence below)
Have an understanding of the ethical issues and clinical audit that impinge on general practice including: · The responsibilities and obligations of the Data Protection Act regarding patient confidentiality · The requirements of Information Governance · Clearly representing the patient's viewpoint to others **Additional Resources:** **http://www.ico.gov.uk/for_organisations/data_protection/the_guide.aspx**					
Communication within teams					
Communicate effectively with other disciplines to enhance patient care					
Work effectively in your team and support structures that are in place for the smooth running of the practice					



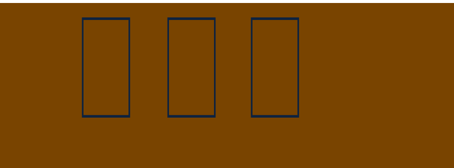
Communication	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Be able to delegate clearly and appropriately including assessment of clinical risk and application of the principl Please see Royal College of Nursing (2011) "Principles of Accountability and Delegation" www.rcn.org.uk/__data/assets/pdf_file/0003/381720/003942.pdf					



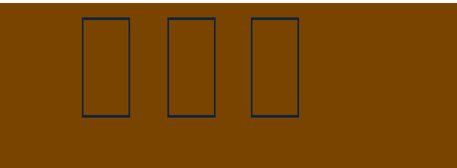
Personal and People Development	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Recognise and promote the wide remit of the General Practice Nurse					
Apply clinical governance principles and practice to your work					
Recognise and understand the roles of individuals working within the Primary Health Care team and understa					



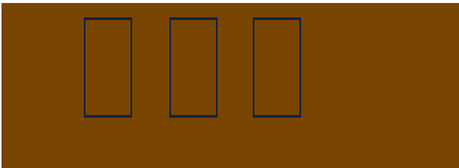
Personal and People Development	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Appreciate and work with the changing structures of health care provision and understand the key issues as they affect your practice such as: · The contractual arrangements · How Quality and Outcomes are measured, monitored and rewarded · Local and National Quality improvement strategies and approaches · Map of Medicine					
Have an understanding of how the current National Service Frameworks, National Standards, NICE guidelines and other national and local policies impact on your work. Understand how these are communicated and implemented within the work place					
Be aware of the Legal and Professional issues pertinent to working as a General Practice Nurse including: · Accountability and delegation · Consent including Young People's Competency to Consent · Mental Health and Capacity requirements. · Safeguarding children and vulnerable adults including statutory child health procedures and local guidance · Access to Health Records · Notification of Infectious Diseases (NOIDs) Professional · Duty of care · Vicarious liability · Record keeping · Use of clinical guidelines/protocols/patient group directions/ patient specific directions					



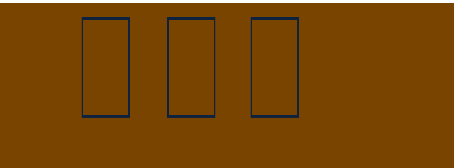
Personal and People Development	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Understand the benefits of clinical supervision for the individual, the organisation and the service: Identify sources of provision within your area and ensure you are involved in it					
Use the principles of reflective practice to support and maintain your own personal portfolio and professional development plan whilst working with the senior nurse to participate in effective assessment and training support					
Identify specific training and support as required for your continuing professional development and work with the practice to access this **Additional guidelines and resources** www.nmc-uk.org/Documents/Standards/nmcStandardsToSupportLearningAndAssessmentInPractice.pdf Under direction, if qualified to do so, act as a mentor/teacher/assessor to others in a clinical situation.					



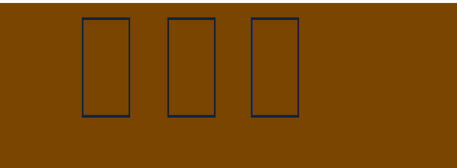
Health, Safety and Security	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Have a working knowledge of Health & Safety requirements within the workplace, including fire procedures. Follow procedures to report any concerns identified					
Work with patients and colleagues in adopting sound infection control measures					
Be able to identify, and if appropriate take action on the risks to health of microbiological and chemical hazar					



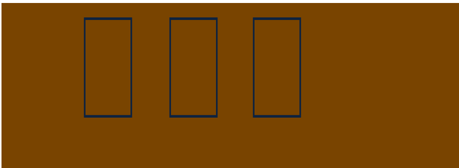
Health, Safety and Security	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Vaccine and Drugs · Ensure cold chain, safe storage, vaccine stability, rotation and disposal of drugs · Where appropriate oversee the monitoring, stock control and documentation of controlled drug usage according to legal requirements					
Emergency situations When appropriate, be able to manage the emergency response and treatment using local guidelines; see '**Management of Emergency Clinical Situations**'.					
Infection control Apply infection control measures within the practice according to local and national guidelines including: · Hand washing · Universal hygiene precautions · Collection and handling of laboratory specimens · Segregation and disposal of waste materials · Decontamination of instruments and clinical equipment · Reporting and treatment of sharps injuries · Dealing with blood and body fluid spillages					



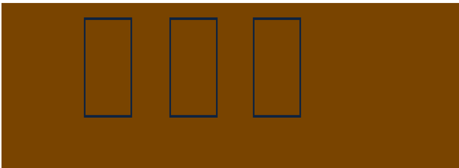
Health, Safety and Security	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Recognise and manage situations where specific training is a requirement in order to work within scope of practice					
Mandatory Training Be aware of and undertake mandatory training and updates in: · Anaphylaxis · Basic Life Support · Child Protection awareness · Manual Handling · Fire Safety · Infection control · Safeguarding					
Know how to use the personal security systems within the workplace					



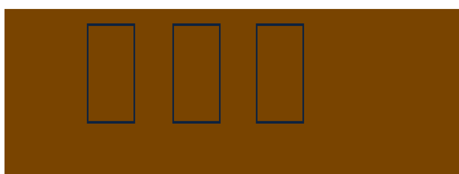
Health, Safety and Security	Date and level Initial self assessmen t	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Practice Policies Be aware of and abide by: · Procedures and systems · Health and safety documentation · The monitoring and reporting of the state of equipment and furniture · Current recommendations for the safe use of VDU screens					



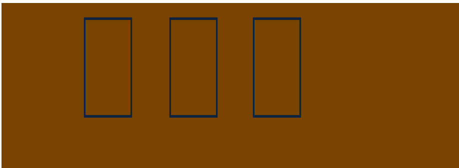
Quality and Service Improvement	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Work with others as appropriate on the development of current and new services and initiatives					
Audit: · Know the audit policies of local general practice · Understand how they are developed · Contribute to the preparation of local guidelines, protocols and standards · Be involved in clinical audits					
Be aware of and promote the current approaches to patient involvement and experience in service design and delivery					



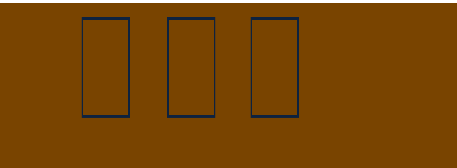
Quality and Service Improvement	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Be familiar with current national and local policies, procedures and initiatives relating to quality maintenance and improvement					
Personal practice and development · Through reflective practice and training, ensure your work is aligned with current evidence based practice for General Practice Nursing · Recognise and work within your own competence and current professional code as regulated by the Nursing and Midwifery Council · Contribute to team development with suggestions based on your own clinical experience · Give and receive useful feedback professionally · Attempt to defuse challenging situations using problem resolution skills to reduce potential for formal complaints. Ensure these situations are reported to the appropriate individuals · Be able to manage your own time effectively					
For areas within own responsibility: · Be aware and manage situations of potential risk using the principles of clinical governance · Recognise and report any significant, adverse and seriously adverse events · Facilitate access for patients to appropriate professionals in the practice team and beyond · Know and implement practice policies: including the policy regarding 'whistle blowing' · Ensure your working area is maintained and stocked appropriately for yourself and other colleagues using the area					



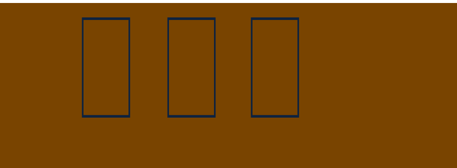
Quality and Service Improvement	Date and level Initial self assessmen t	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Be aware of and understand the cost implications of the work undertaken, ensuring compliance with local pre					



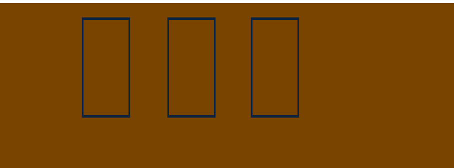
Equality and Diversity	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Know the demographics of your practice population and locality in order to actively promote equality and diversity in your work					
Understand and implement with patients, patient's relatives and colleagues the latest guidelines issued by professional bodies such as the NMC/2008, ("Code for Standards of conduct, performance and ethics for nurses and midwives" www.nmc-uk.org/Documents/Standards/The-code-A4-20100406.pdf). Relevant areas might include · Confidentiality · Consent · Personal preferences and beliefs' (the patient's and your own) · The patient's right to make their own decisions · Different cultures and ethnicity					
Ensure within your own clinical practice adherence to local chaperoning policies					



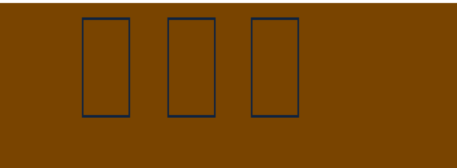
Equality and Diversity	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Recognise the signs of and adhere to local policies demonstrating the ability to effectively follow up concerns relating to: · Family violence · Vulnerable adults · Substance abuse · Addictive behaviour · Child abuse					
Know the local contact and access information for voluntary and statutory services that may be useful to patients. Guide and support patients in accessing these as appropriate.					



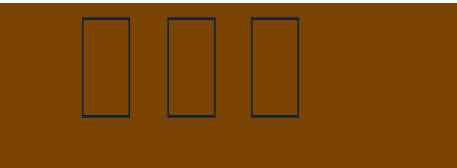
Health & Well-Being	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Assessment: (please see **Communications Dimension** for the Consultation Process)					
Follow guidelines for, undertake and record the following tasks: · Urinalysis and preparation of specimens for Path lab investigation · Blood pressure · Pulse rate and rhythm · Respiratory rate · Temperature · Height and Weight · Waist Circumference · Visual acuity · Legs prior to prescribing of support hosiery · ECGs and Cardiocall / ambulatory blood pressure monitoring (ABPM). · Blood glucose monitoring · Venepuncture · Identifying and using the Body Mass Index · Patients inhaler techniques and undertaking peak flow readings · Spirometry					
Obtaining samples: Following recommended processes, be able to obtain samples and/or swabs from patients as a delegated task or based on clinical presentation (for example: ear, Chlamydia, high vaginal swabs) Taking into account communication and legal issues ensure that patient is fully informed and understands: · The background and rationale for the test · The process for obtaining and communicating results					



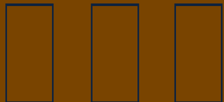
Management of Emergency Situations	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Following practice protocols and evidence based treatment be competent to assess the degree of urgency and take necessary action in the following situations · Collapse · Asphyxia · Anaphylaxis · Vasovagal Syncope · Acute chest Pain · Cerebrovascular episode · Convulsions · Head Injury · Hyper and Hypoglycaemia · Acute respiratory problems · Haemorrhage · Poisoning · Burns · Fractures					
Therapeutic Monitoring					
Use a holistic patient approach to check concordance with and adherence to prescribed treatments Be able to Have knowledge of and work within local and practice guidelines to monitor and advise patients on the revie · Hypothyroid · Hyperthyroid · Rheumatoid arthritis · Iron deficiency anaemia · Pernicious anaemia · Epilepsy · Mental health disorders · Anticoagulant therapy					



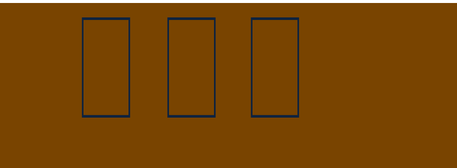
Management of Emergency Situations	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Ear Care					
Have a working knowledge of anatomy and physiology of the ear Display an understanding of the need for preventative care including patient education and advice Demonstr the removal of cerumen, aural toilet and irrigation Undertake ear toilet based on knowledge of the latest evidence based practice in relation to ear care. Recognise the specific needs of patients with hearing loss including provision of advice for patients on safe ea **Additional guidelines and resources** www.earcarecentre.com/protocols.asp					



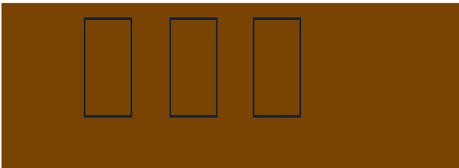
Wound Management	Date and level Initial self assessmen t	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Be able to: · Undertake initial assessment of patients presenting with injuries · Demonstrate knowledge of wound classification · Demonstrate knowledge of your local formulary · Demonstrate knowledge and understanding of the healing process and factors that inhib · Assess and care for uncomplicated wounds · Select appropriate treatments based on knowledge of dressing types and properties · Apply a range of dressings according to assessed need · Assess pain using an appropriate using a recognised tool and recommend self manageme · Undertake suture removal · Be aware of current guidelines on tetanus prophylaxis · Educate the patient in wound self care and monitor as appropriate · After having completed appropriate training undertake Doppler Assessment and compre · After further training, assess and care for more complex wounds **Additional Resources** Simple Wound Management and suturing **www.patient.co.uk/doctor/ Simple-Wound-Management-** Venous Leg Ulcers, RCN Clinical guideline **www.rcn.org.uk/development/practice/clinicalguidelines/venous_leg_ulcers** Injuries Clinical Knowledge Summaries **www.cks.nhs.uk/ clinical_topics/by_clinical_specialty/injurie** National Burn injury referral guidelines **www.britishburnassociation.org/referral**					



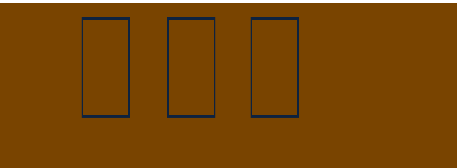
Minor Surgery	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
In relation to Minor Surgical Procedures recognise the role of the GPN in assisting with the provision of minor surgery Provide appropriate support for the Patient before during and after the procedure including dealing with emergencies Work within the medico legal and professional requirements relating to the provision of minor surgery in general practice					
Pre Operatively: Based on sound knowledge and understanding be able to prepare and check · Documentation · Infection control procedures · Surgical instruments and appropriate suturing material · Personal protective equipment · The clinical environment including lighting and other equipment					
Intra operatively Support and assist practitioner and patient as appropriate					



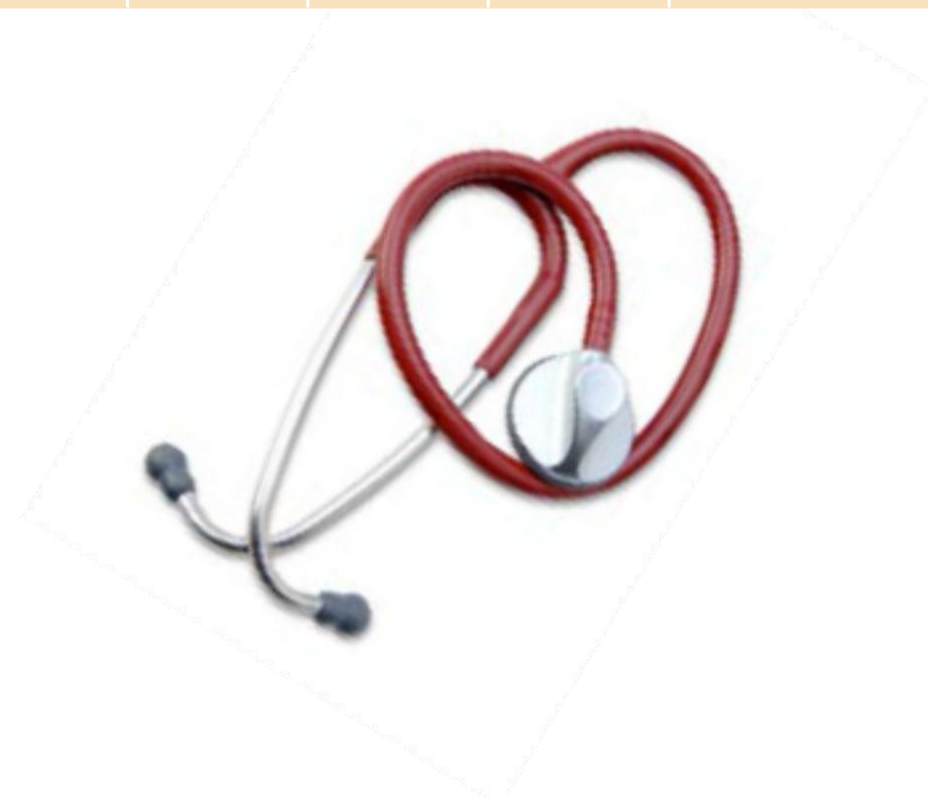
Minor Surgery	Date and level Initial self assessmen t	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Post operatively · Undertake post operative care of patient and management of the wound · Provide verbally and where appropriate in writing after care instructions for the patient · Ensure safe decontamination of instruments and safe disposal of hazardous waste · Ensure histo-pathological specimens and paperwork are effectively managed in accordan · Ensure effective record keeping in accordance with local and national policies.					

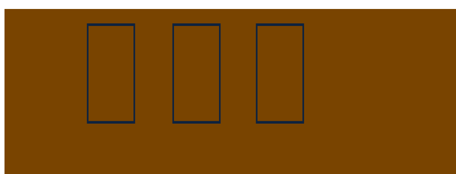


Health Promotion	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Demonstrate · Assessment skills with regard to patients' readiness to change · Awareness of screening, its effectiveness and potential limitations, and the willingness to undertake training to perform cervical screening · Ability to deliver safely primary prevention interventions such as vaccination and immunisation · The ability to identify determinants of health in the local area · A knowledge of public health issues in the local area including health inequalities · An awareness of both local and national health policy · An insight into issues which have a bearing on the wider health economy · An ability to identify patients whose health could be at risk and offer brief, focused lifestyle advice including the 'Brief Intervention' and 'Motivational Interviewing' approaches					
Provide support and make referral where appropriate for · Smoking cessation · Diet, overweight / obesity prevention and management in adults · Exercise/activity · Alcohol use · Sexual health					
Be familiar with sources of reliable information on health promotion topics, nationally and in your locality.					

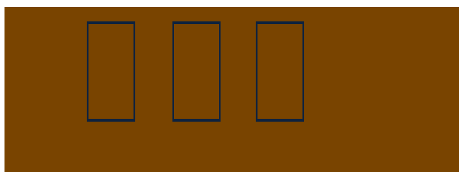


Health Screening	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Undertake new patient checks recognising health promotion opportunities Be aware of the factors that may contribute to health inequalities particularly in relation to screening uptake Be sensitive to individual values of all patients and possible additional needs of patients with · learning difficulties · language and communication barriers including patients of other ethnicities					
Be familiar with the National Health Cancer Screening Services including, Breast Cancer, Cervical Cancer, Bowel Cancer and Prostate Cancer Risk Management, Abdominal Aortic Aneurysm, especially regarding local implementation and the national and local call and recall system					

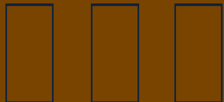




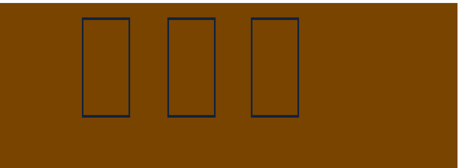
Cervical Sampling	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Understand and be able to explain the rationale for Human Papilloma Virus (HPV) screening and the consec … mear taking according to NHSCSP standards including: Preparation of the patient, equipment and environment Management of the consultation including: · Good communication skills · Appropriate history taking · Record keeping · Correct evidence based procedure for sample taking, including assessment of cervix and a · Management of the sample · Explanation of procedure for obtaining results · Comply with requirements regarding personal and practice audit **Additional Resources** www.rcn.org.uk/__data/assets/pdf_file/0007/78730/003105.pdf					



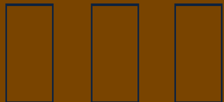
Immunisation of children and adults	Date and level Initial self assessmen t	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
· Be able to give accurate information regarding contra-indications and side effects and to a · Be aware of up to date UK childhood immunisation schedule and know who to consult if · Ensure correct handling and reconstitution of vaccines · Apply medico legal principles of informed consent · Ensure access to emergency equipment Demonstrate : · Understanding the importance of maintaining the cold chain and what to do if a breach is · Knowledge of vaccine preventable diseases covered by UK immunisation schedule · Knowledge of management of anaphylaxis · Knowledge of differences between intramuscular and subcutaneous injections · Correct vaccination technique, including choice of needle, angle, and site of administration · Understanding of adverse events, knowledge of system for reporting adverse events · Assess and if appropriate, administer injections under an individualised prescription or Pa · Dispose of sharps appropriately and safely · Recognise the importance of and apply principles of excellent record keeping to this situati · Contribute to the development of practice guidelines **Additional Resources** Your local Health Protection Agency NHS Immunisation Information **www.immunisation.nhs.uk** National Minimum Standards for Immunisation Training **www.hpa.org. uk/web/HPAwebFile/HPAweb_C**					



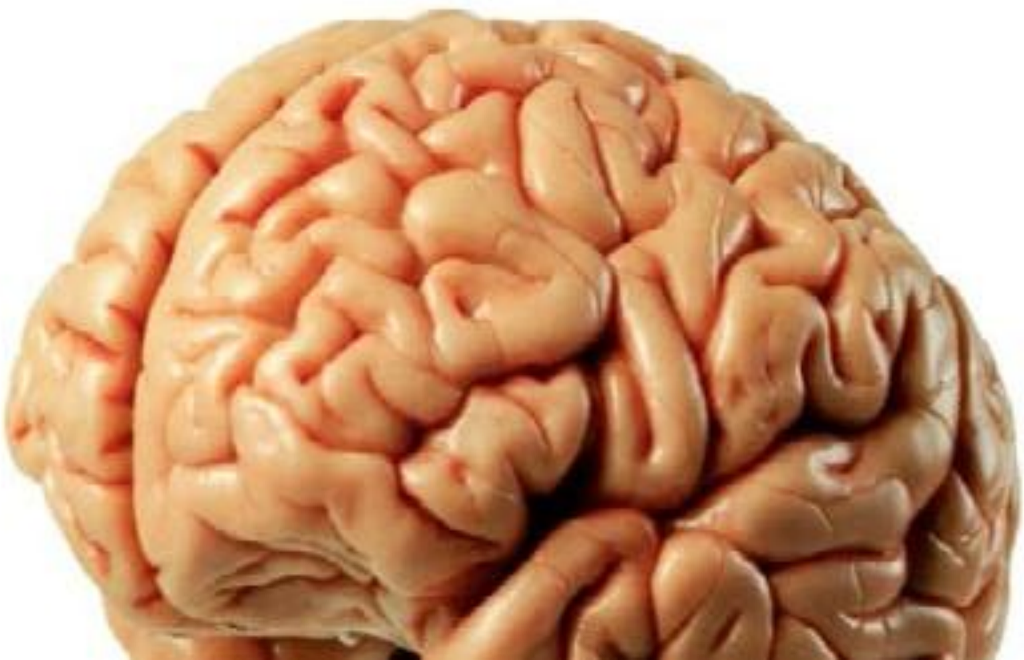
Travel Health	Date and level Initial self assessmen t	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Supported by senior colleague, assess travel health needs of patients and provide a holistic approach and com · Vaccinations and medications · Malarial prophylaxis and bite avoidance · Safe sex/sexual health · Food hygiene · Sun protection · First aid and emergency medication · Risk of travel/need for health insurance · Appropriate written information · Self care measures Provide guidance in accordance with guidelines and identify any potential problems for the patient. Administe **Additional Resources** National Travel Health Network and Centre (NaTHNaC) www.nathnac.org International Travel and Health WHO,2010 www.who.int/ith Competencies: RCN (2012) Travel Health: Career and Competence Development www.rcn.org.uk/__data/assets/pdf_file/0006/78747/003146.pdf					

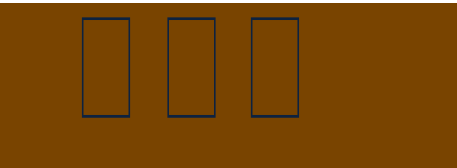


Mental Health	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Be aware of risk factors and recognise early signs of mental health problems for the following conditions and have a basic understanding of their management in General Practice: · Depression · Generalised anxiety disorders · Suicide awareness · Self Harm · Bipolar disorder · Post –partum affective disorders · Schizophrenia · Dementia · Substance abuse · Eating disorders					
Demonstrate awareness of the importance of promoting mental health Recognise and if necessary take a proactive and appropriate approach to meeting the physical health needs of patients with mental health problems Provide care and support for patients and carers in accordance with the NSF for Mental Health Acknowledge and reflect on potential barriers that may impact on care provision in this area					

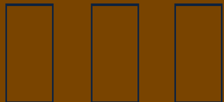


Mental Health	Date and level Initial self assessmen t	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Administer appropriate prescribed therapies and monitor for side effects contraindications and adverse drug r Understand the role of the key worker and communicate as required. **Additional guidance and information** NICE www.guidance.nice.org.uk/CG113 www.RCPSYCH.ac.uk/mentalhealthinfoforall.aspx www www.guidance.nice.org.uk/CG28 www.sign.ac.uk/pdf/sign114.pdf www.guidance.nice.org.uk/C					

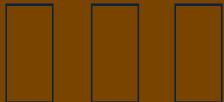




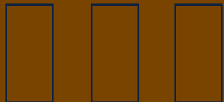
Men's Health	Date and level Initial self assessmen t	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Be aware of the morbidity and mortality statistics relevant to Men's Health. Provide support, advice and if app · Well man checks · Sexual health problems · Testicular cancer · Prostate disease, including cancer · Breast cancer · Libido · Erectile dysfunction **Additional Resources** Men and Long Term Health Conditions www. menshealthforum.org.uk Best practices and services relating to men and boys www.workingwithmen.org NHS Choices Erectile Dysfunction www.nhs.uk/ conditions/Erectile-dysfunction Prostate UK www.prostateuk.org Testicular Cancer www.nhs.uk/Conditions/Cancer-of-the-testicle					



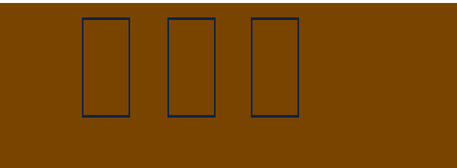
Women's Health	Date and level Initial self assessmen t	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Provide support, advice and if appropriate be involved with care for patients presenting with: · Vaginal discharge · Urinary incontinence Make an initial assessment, referring as appropriate, patients presenting with: · Abnormalities of menstruation, including pre-menstrual syndrome · The effects of the menopause, management of symptoms, HRT, osteoporosis · The effects of hysterectomy · Infertility and pre-conceptual issues Teach and encourage patients to be 'breast aware'. **Additional Resources** Women's Health Concern www.womens-health-concern.org The British Menopause Society www.thebms.org.uk Polycystic ovarian syndrome NHS Choices www.nhs. uk/conditions/Polycystic-ovarian-syndrome					



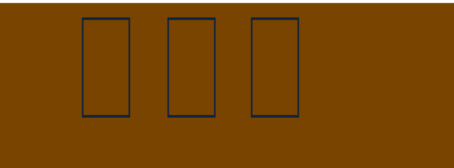
Family Planning and Sexual	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Be aware of, implement and provide advice on: · Protocols and PGDs for dispensing of emergency contraception · Local agencies providing advice for unwanted pregnancies · Referral for insertion of IUDs/IUS including emergency contraception · Local HIMP policies for reducing teenage pregnancies · Local infertility guidelines and referral pathways · STIs – local referral pathways and associate life style risk factors · Local HIV/AIDS policies and referral pathways · Local Genito Urinary medicine (GUM) clinical service provision					
Be able to advise on precautions and contraindications regarding: · Oral contraception · Emergency contraception · Natural methods · Barrier Methods/condoms · Male and female sterilization · Long acting reversible contraception including hormone injections, implants, intrauterine devices and systems (IUDs / IUSs) **Additional** Faculty of Sexual and Reproductive Healthcare www.fsrh.org British Association for Sexual Health and HIV www.bashh.org Family Planning association www.fpa.org.uk					



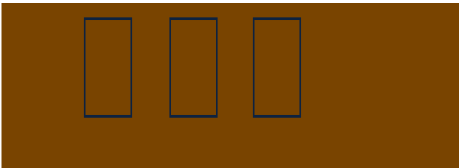
Care of Patients with Long Term Conditions: Diabetes	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Areas of knowledge and skills should include: · Primary Prevention and screening · Signs and symptoms including differentiation between type 1 and type 2 · National and Local Guidelines · Recommendations for management in Primary Care including targets for metabolic contr · Current treatments · Nutrition · Blood glucose monitoring · Hypoglycaemia · Hyperglycaemia · Microvascular and macrovascular complications · Other complications · Patient education and self care · Concordance and adherence to treatment **Additional Resources** NHS Diabetes www.diabetes.nhs.uk RCN Diabetes www.rcn.org.uk/development/practice/diabetes Diabetes NSF(2006) www.dh.gov.uk/healthcare Relevant NICE guidelines www.guidance.nice.org.uk/ Topic/EndocrineNutritionalMetabolic/Diabete WHO/IDF reports www.who.int/diabetes/publications/en/					



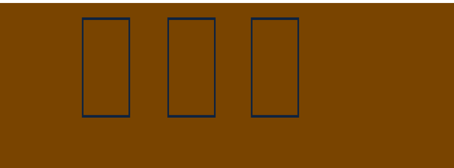
Care of Patients with Long Term Conditions: Chronic Obstructive Pulmonary Disease (COPD) and Asthma	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Areas of knowledge and skills should include: · Primary Prevention and Lung Health · Patient Education and self care · Concordance and adherence to treatment · National and Local Guidelines · Signs and symptoms · Asthma triggers · Diagnostic criteria · Recognition and management of acute exacerbations · Pharmacological and non - pharmacological management for current treatments · Inhaler devices and inhaler technique · Pulmonary rehabilitation · Complications **Additional Resources** British Thoracic Society/Scottish Intercollegiate Guidelines Network Guideline on The Management of Asthm www.brit-thoracic.org.uk/guidelines/asthma-guidelines.aspx NICE Clinical Guideline CG101 Manag NICE guidelines pertinent to Asthma TA138,TA133, TA131, TA10, TA38, TA201, TA31 British Lung Foundation Global Initiative for Asthma www.ginasthma.org Global Initiative for COPD www.goldcopd.org					



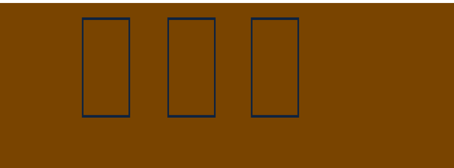
Care of Patients with Long Term Conditions: Hypertension	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Areas of knowledge and skills should include: · Primary Prevention and lifestyle measures · Diagnosis and classification · Monitoring Blood Pressure · Understanding targets · National and Local Guidelines · Current treatments · Patient education and self care · Concordance and adherence to treatment · Complications **Additional Resources** NICE Clinical Guideline CG127 Hypertension :management of Hypertension in adults in primary care www.guidance.nice.org.uk/CG127 British Hypertension Society www.bhsoc.org Blood Pressure Association www.bpassoc.org.uk					



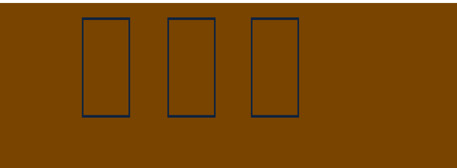
Care of Patients with Long Term Conditions: Cardiovascular Disease	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Areas of knowledge and skills should include: · Primary and secondary prevention and modifiable and non modifiable risk Factors · Tools for risk assessment · Cardiac Arrhythmias including atrial fibrillation Diagnoses within CVD including: · Angina, Stroke, Transient Ischaemic Attack (TIA) and Heart Failure · Signs and symptoms · Investigative procedures · Current Treatments · Cardiac Rehabilitation · National and Local Guidelines · Patient education and self management · Concordance and adherence to treatment **Additional Resources** NSF for CHD (2000) www.dh.gov.uk NICE Cardiovascular Guidelines CG36, CG95, CG108, CG71, CG67, CG48, CG126, CG68, CG92 and CG94 Primary Care Cardiovascular Society www.pccs.org.uk British Heart Foundation www.bhf.org.uk					



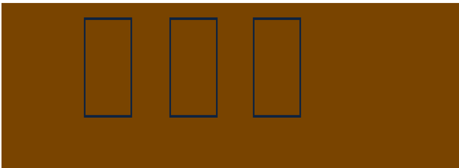
Care of Patients with Long Term Conditions: Other Conditions	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
In addition have a working knowledge of the following conditions, their impact upon patients and carers and the ways in which they may manifest in Primary Care and assist in diagnosis monitoring and treatment as appropriate: Cancers NHS Cancer Screening **www.cancerscreening.nhs.uk** Cancer Research UK Health Professionals Page **www.publications.cancerresearchuk.org/healthprofs** Macmillan Cancer Support **www.macmillan.org.uk/Aboutus/Healthprofessionals/Healthprofs.aspx**					
Chronic Kidney Disease NSF for renal services part 2:CKD, Acute Renal failure and end of life care. Search: **www.dh.gov.uk** Liver Disease NICE guideline CG73 **www.nice.org.uk/CG73** British Liver Trust **www.britishlivertrust.org.uk** NICE Guidelines CG100 Alcohol-use disorders: physical complications **www.nice.org.uk/CG100** Information on Hepatitis from **www.hepctrust.org.uk**					
Epilepsy NICE Guideline CG20. The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care **www.nice.org.uk/CG020** Epilepsy Action **www.epilepsy.org.uk** Neurological conditions, e.g. multiple sclerosis NICE guidelines: CG8, (Multiple Sclerosis),CG35, (Parkinson's Disease), CG53 (Chronic Fatigue) Muscular Dystrophy Campaign **www.muscular-dystrophy.org** Motor Neuron Disease Association **www.mndassociation.org**					



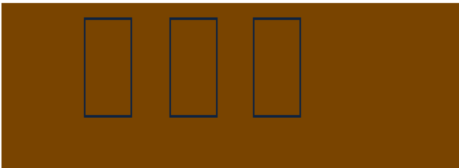
Care of Patients with Long Term Conditions: Other Conditions	Date and signatures 1st review	Date and signatures 2nd review	Date and Final assessment of competence	Type of Evidence signatures (Please list your evidence below)
Osteoporosis The Assessment and Prevention of Falls in Older People CG21 www.nice.org.uk/CG21 National Osteoporosis Society www.nos.org.uk Osteoporosis – Primary Prevention NICE Guideline TA160 www.nice.org.uk/TA160 Osteoporosis – Secondary Prevention TA161 www.nice.org.uk/TA161				
Rheumatoid Arthritis National Rheumatoid Arthritis Society www.nras.org.uk NICE guideline CG79 Rheumatoid Arthritis: The Management of rheumatoid arthritis in adults www.nice.org.uk/CG79				
Thyroid Disease British Thyroid Foundation www.btf-thyroid.org				



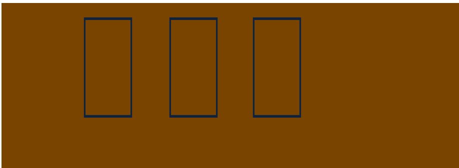
Information and Knowledge IK1, IK2, IK3	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Ensure accurate documentation/record keeping procedures in line with practice policies and NMC guidelines				
Use a computer and manage files				
Record, retrieve and access information				



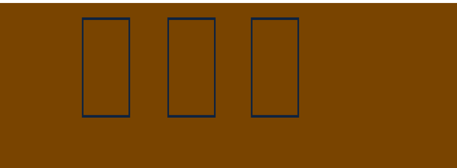
Information and Knowledge IK1, IK2, IK3	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Review and process data using accurate read codes about patients, in order to ensure easy and accurate retrieval for monitoring and audit purposes, for example Quality Management and Analysis System (QMAS) and Calculating Quality Reporting System (CQRS) including the appointment system				
Be able to access and send emails including attachments				
Manage information searches using the internet and local library databases for example the retrieval of relevant information for patients on their condition/diagnosis Understand the nature and hierarchy of medical evidence. **www.patient.co.uk/ doctor/Different-Levels-of-Evidence-(Critical-Reading).htm**				



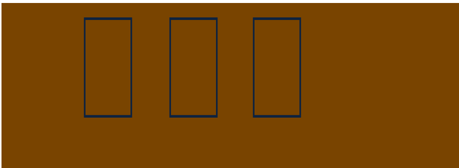
Information and Knowledge IK1, IK2, IK3	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Understand and be able to describe role of the Caldicott Guardian / Personal Data Guardian, knowing the nan				



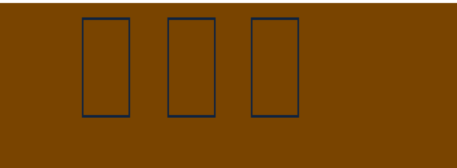
General – Learning and Development G1	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Contribute to the provision of learning opportunities for colleagues					
Act as a mentor/coach for more junior staff (e.g. pre- registration nurses or HCAs) if appropriately qualified assessing competency against set standards as requested					
Disseminate learning and information gained to other team members in order to share good practice and inform others about current and future developments (e.g. courses and conferences)					



General – Learning and Development G1	Date and level Initial self assessmen t	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
As requested undertake specific training exercises such as observed clinical practice and shadowing of role					



General – Development and Innovation G2	Date and level Initial self assessment	Date and signatures 1st review	Date and signatures 2nd review	Date and signatures Final assessment of competence	Type of Evidence (Please list your evidence below)
Critically evaluate and review innovations and developments that are relevant to your own area of work					
Keep up to date with new developments locally and nationally identifying those that will enhance your team's work. Influence other team members to undertake trials of changes in care delivery					



Appendix 1(WONCA 2005)

Characterising the discipline of general practice/family medicine

General practice/family medicine is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical specialty orientated to primary care. These 11 characteristics of the discipline relate to 11 abilities that every family doctor should master and should be the basis for developing the curriculum for training in general practice.

General practice

1. Is normally the point of first medical contact within the healthcare system,* providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex or any other characteristic of the person concerned
2. Makes efficient use of healthcare resources through coordinating care, working with other professionals in the primary care setting and by managing the interface with other specialties. It also means taking on an advocacy role for the patient when needed
3. Develops a person-centred approach, orientated to individuals, their family and their community
4. Has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient
5. Is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient
6. Has a specific decision-making process determined by the prevalence and incidence of illness in the community
7. Manages simultaneously both the acute and chronic health problems of individual patients
8. Manages illness that presents in an undifferentiated way at an early stage in its development, some of which may require urgent intervention
9. Promotes health and wellbeing both by appropriate and effective intervention
10. Has a specific responsibility for the health of the community
11. Deals with health problems in their physical, psychological, social, cultural and existential dimensions

References :

Benner, P (1984) From novice to expert: excellence and power in clinical nursing practice Munao Park: Addison –Wesley

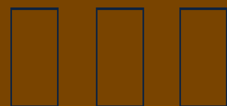
Department of Health, (2004). The NHS Knowledge and Skills Framework (NHS KSF) and Development Review Process

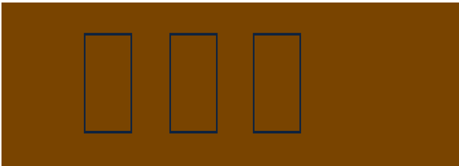
Dolan, G (2003) Assessing student competency: will we ever get it right? Journal of Clinical Nursing 31: 288-297

The code: standards of conduct, performance and ethics for nurses and midwives 39 page 6 www.nmc-uk.org

The General Practice Nursing Career Framework Working in Partnership Programme www.rcn.org.uk/development/general_practice_nursing_career_framework/the_gpn_career_framework

WONCA Europe. The European Definition of General Practice/Family Medicine London: WONCA Europe, 2005





*under the self-care strategy, general practice may not be the first point of contact with the healthcare system

FF73 Health Education North West London

Next page

The Shape of Caring review – Lord Willis' visit to North West London

Tuesday 15th July 2014, 10:45 – 13:00
The Hellenic Centre, 16-18 Paddington Street, Marylebone, W1U 5AS

Purpose and agenda

Purpose

Our guest, Lord Willis, is leading the national Health Education England „Shape of Caring Review‟ into the education and training of nurses and health care assistants. To inform this review, he is visiting North West London to meet innovative front line staff and collect evidence.

Agenda

Time	Session
10:45	Welcome, introduction and objectives David Sines, Emeritus Professor in Community Healthcare, Buckinghamshire New University
10:50	Shape of Caring Review: Thinking about the future Lord Willis of Knaresborough
11:20	North West London Context Tim Spicer, Chair of Hammersmith and Fulham CCG
11:40	Introduction to innovative staff in North West London Tim Spicer, Chair of Hammersmith and Fulham CCG
12:15	Integrated education and training Thirza Sawtell, Director of Strategy and Transformation, NHS North West London Collaboration
12:45	Summary and relevance for Shape of Caring Review David Sines, Emeritus Professor in Community Healthcare, Buckinghamshire New University
13:00	Close of meeting

Developing people for health and healthcare

15 July 2014

Shape of Caring review: Thinking about the future

Lord Willis of Knaresborough

Visit to North West London Collaboration of CCGs

NHS
Health Education England

Nursing & Midwifery Council

NHS Health Education England

Shape of Caring review

- What we are doing?
- How we are doing it?
- **Why will this be different to reviews that have gone before?**

Nursing & Midwifery Council

NHS Health Education England

- Growing population – 3 million by 2020
- Challenge of Aging population
- Challenges of obesity, dementia, diabetes, multimorbidities
- Changes in care delivery
- Changes in technology – personalized medicine
- Changes in patient demand
- Changes in Commissioning

Nursing & Midwifery Council

NHS Health Education England

A vision for the future…

- The majority of healthcare will be managed out of the acute setting, with more care being provided in the community. Patients will be encouraged to self-care as much as possible:
  - Patients will be better supported to manage their own health, with better outcomes for individuals and better value for money
  - Patients will receive high quality care wherever they are and at the time of their choosing, reducing inequalities and outcomes
  - Patients will have higher quality relationships with healthcare professionals, reducing unnecessary visits to different specialists, leading to satisfaction for patients
  - Patients will benefit from the latest research and technology, whilst being treated with care and compassion

(Framework 15: HEE's Strategic Framework 2014-2029)

Nursing & Midwifery Council

Health Education England

What will be the constant factors?

- Patients and their families
- ‘Caring’ workforce
- Cost control !

Nursing & Midwifery Council

NHS Health Education England

Healthcare support and nurses in England

- HCSWs in healthcare – 270,000
- HCSWs in social care – 1.2 million
- Registered nurses – 500,000

These staff deliver most hands-on patient care

Their access to education and training vary

Nursing & Midwifery Council

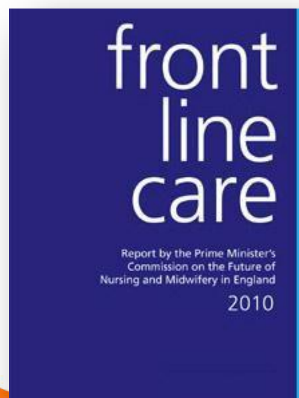
Health Education England

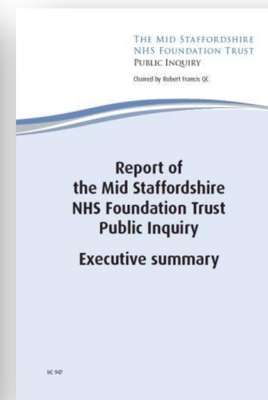
How to best train them?

- Prime Minister‟s Commission on the Future of Nursing and Midwifery (2010): 20 recommendations relating to nursing/midwifery
- Willis (2012): 29 recommendations relating to nursing

•Francis (2013): 29 recommendations for nursing/HCSW

•Cavendish (2013): 18 recommendations for HCSWs





Currently we lack a coordinated response

www.hee.nhs.uk

www.nmc-uk.org

@NHS_HealthEdEng @NMCnews #shapeofcaring

Nursing & Midwifery Council

NHS Health Education England

Shape of Caring review

- **Why will this be different to reviews that have gone before ?**

Solution and evidence based!

www.hee.nhs.uk

www

Nursing & Midwifery Council

NHS Health Education England

The Shape of Caring review

- Commissioned by HEE
- Sponsoring Board jointly chaired by HEE and the NMC
- A review of nurse and HCA education and training across England (with significant input from other UK countries)
- Independent chair: Lord Willis of Knaresborough
- Report with recommendations: February 2015

Call for evidence/engagement

- Review of the literature
- Engagement events:
    - HCAs, nurses, educationalists and the public
    - Involving a cross section of staff:
        - Independent sector, prison health, community, acute, voluntary sector
        - Commissioning Groups
- Social media
- Surveys and questionnaires.

Nursing & Midwifery Council

NHS Health Education England

Thank you

Contact details:
willisg@parliament.uk

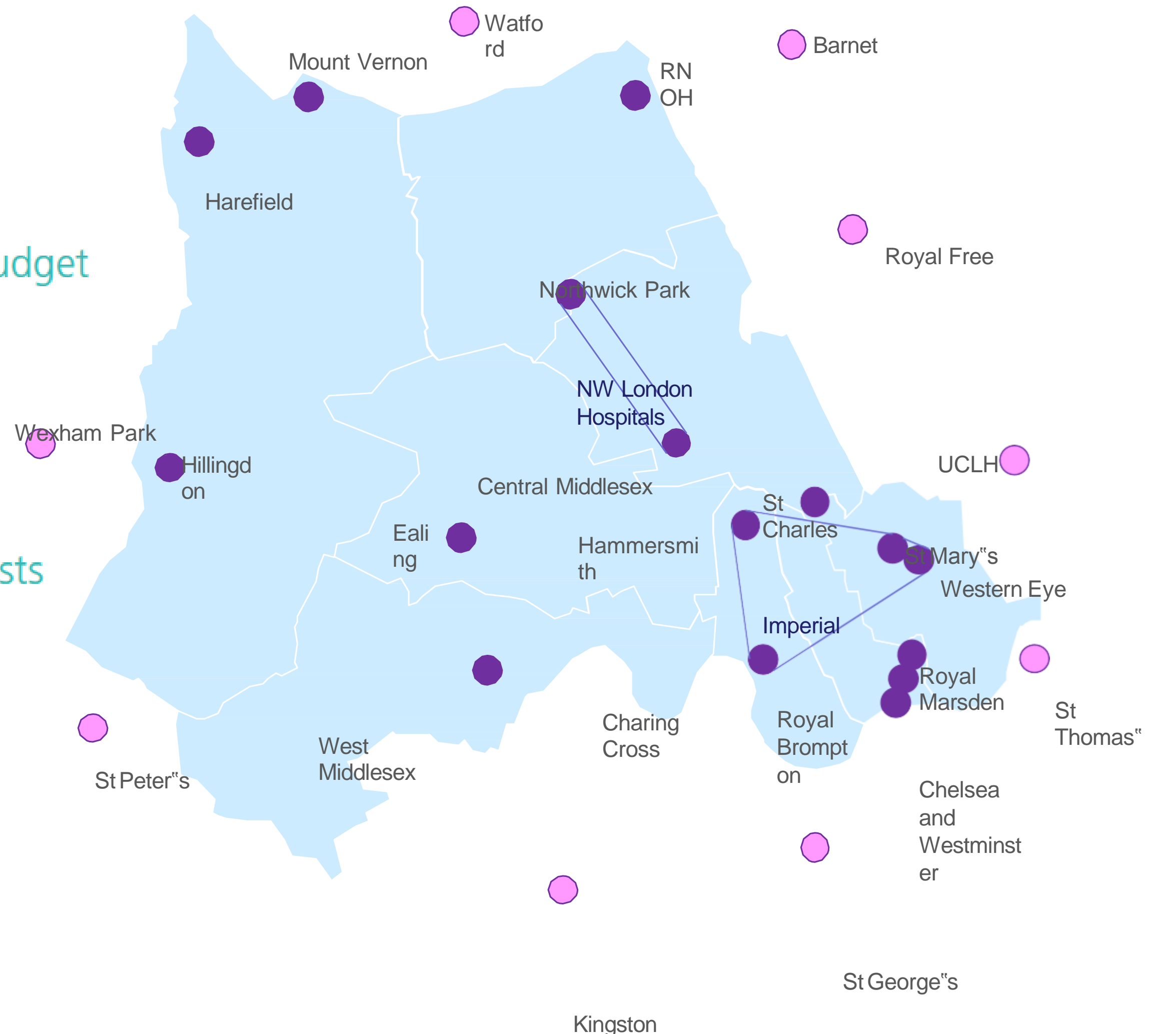
North West London Context

Session One - Lord Willis briefing

Tim Spicer, Chair of Hammersmith and Fulham CCG

SaHF is a clinically led whole system transformation aimed at improving health and care services for the 2 million people living in North West London

8 London boroughs
2 million people
£3.4 billion annual health budget
400+ GP practices
and **1,100+** GPs
8 clinical commissioning groups
10 acute and specialist hospital trusts
2 mental health trusts
2 community health trusts



Shaping a healthier future

In response to these challenges clinicians developed a vision for health and care focused on delivering what people told us was important to them

People told us that what they want from their health and care services is choice and control and for their care to be planned to help them reach their goals: they want their care to be delivered by people and organisations that show dignity, compassion and respect at all times. To achieve this we developed three pillars of a clinical vision.

1

Localise

- *Reduced admissions due to better local management of care*
- *Improved support for patients with LTCs and mental health problems*
- *Improved patient experience and*

2

Centralise

- *Better clinical outcomes including reduced morbidity and mortality*
- *Reduced readmission*
- *Reduced lengths of stay*
- *Increased staff training, skills and job satisfaction*

3

Integrate

satisfaction

- *Improved carer experience*

4

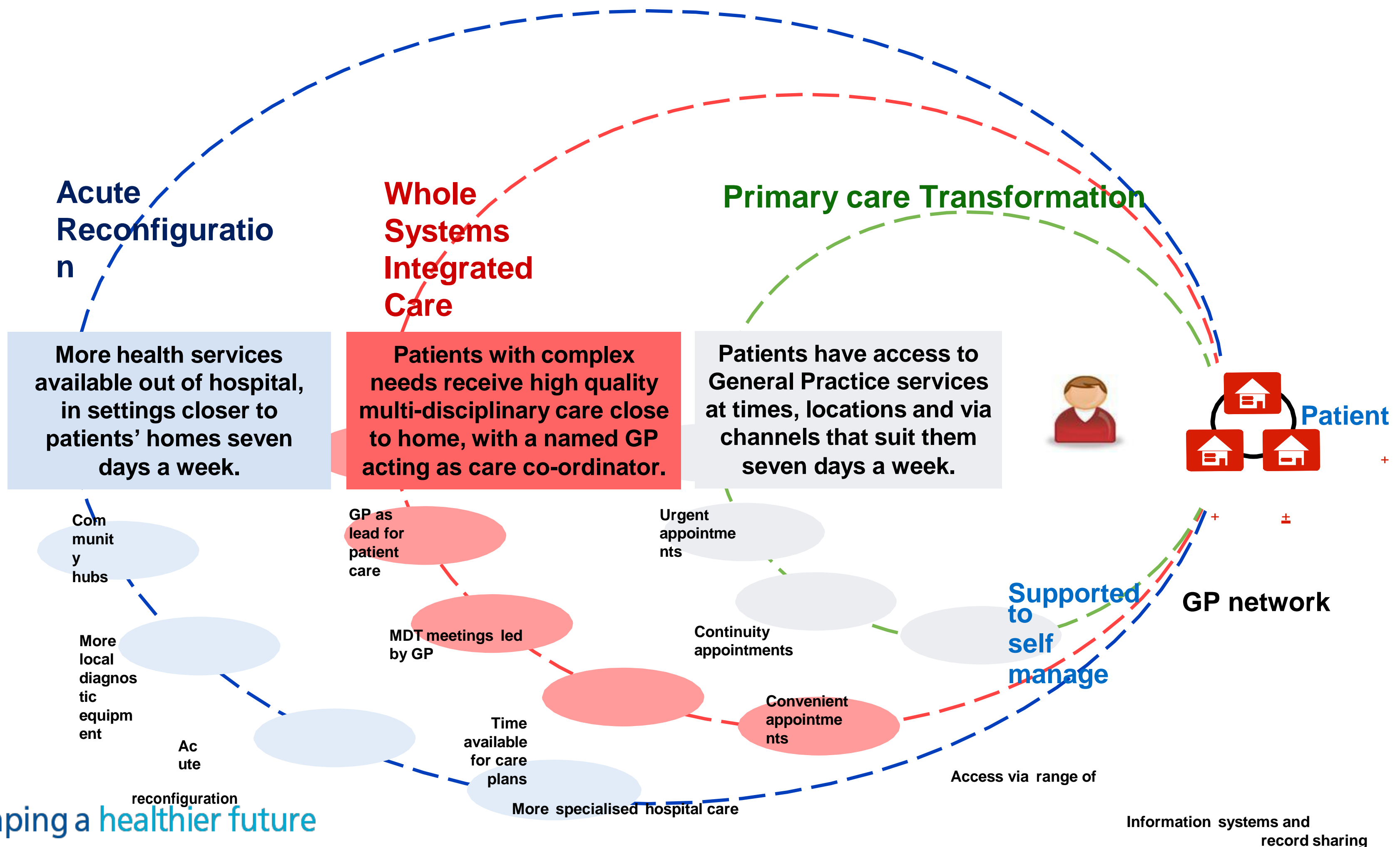
Personalise

- *Increased multidisciplinary working – improved coordination*
- *Improved access to information leading to better patient care*
- *Reduction in unnecessary investigations and duplicate assessments*
- *Improved efficiency &*

pathways

- *Patients feel more empowered and better able to manage their own care*
- *Care is tailored to individual needs*
- *This leads to better outcomes*

To deliver these changes we are transforming the whole system through a number of programmes, so care is more integrated, delivered closer to home and where appropriate provided in the best facilities



Shaping a healthier future

Capitated budgets

channels

Less inappropriate time in hospital

We are doing this in partnership with a wide range of stakeholders including Local Authorities. With this consortium we have become a National Pioneer for Whole Systems Care

NHS
Brent
Clinical Commissioning Group

NHS
Central London
Clinical Commissioning Group

NHS
Ealing
Clinical Commissioning Group

NHS
Hammersmith and Fulham
Clinical Commissioning Group

NHS
Harrow
Clinical Commissioning Group

NHS
Hounslow
Clinical Commissioning Group

NHS
West London
Clinical Commissioning Group

NHS
Hillingdon
Clinical Commissioning Group

Brent

City of Westminster

Ealing
www.ealing.gov.uk

h&f
hammersmith & fulham

Harrow COUNCIL
LONDON

London Borough of Hounslow

THE ROYAL BOROUGH OF
KENSINGTON AND CHELSEA

Central London Community Healthcare NHS
NHS Trust

Central and North West London NHS
NHS Foundation Trust

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Ealing Hospital NHS
NHS Trust

Hounslow and Richmond Community Healthcare NHS
NHS Trust

Imperial College Healthcare NHS
NHS Trust

The Hillingdon Hospitals NHS
NHS Foundation Trust

The North West London Hospitals NHS
NHS Trust

West London Mental Health NHS
NHS Trust

West Middlesex University Hospital NHS
NHS Trust

Our vision for Whole Systems Integrated Care is driven by peoples" needs and delivering empowerment

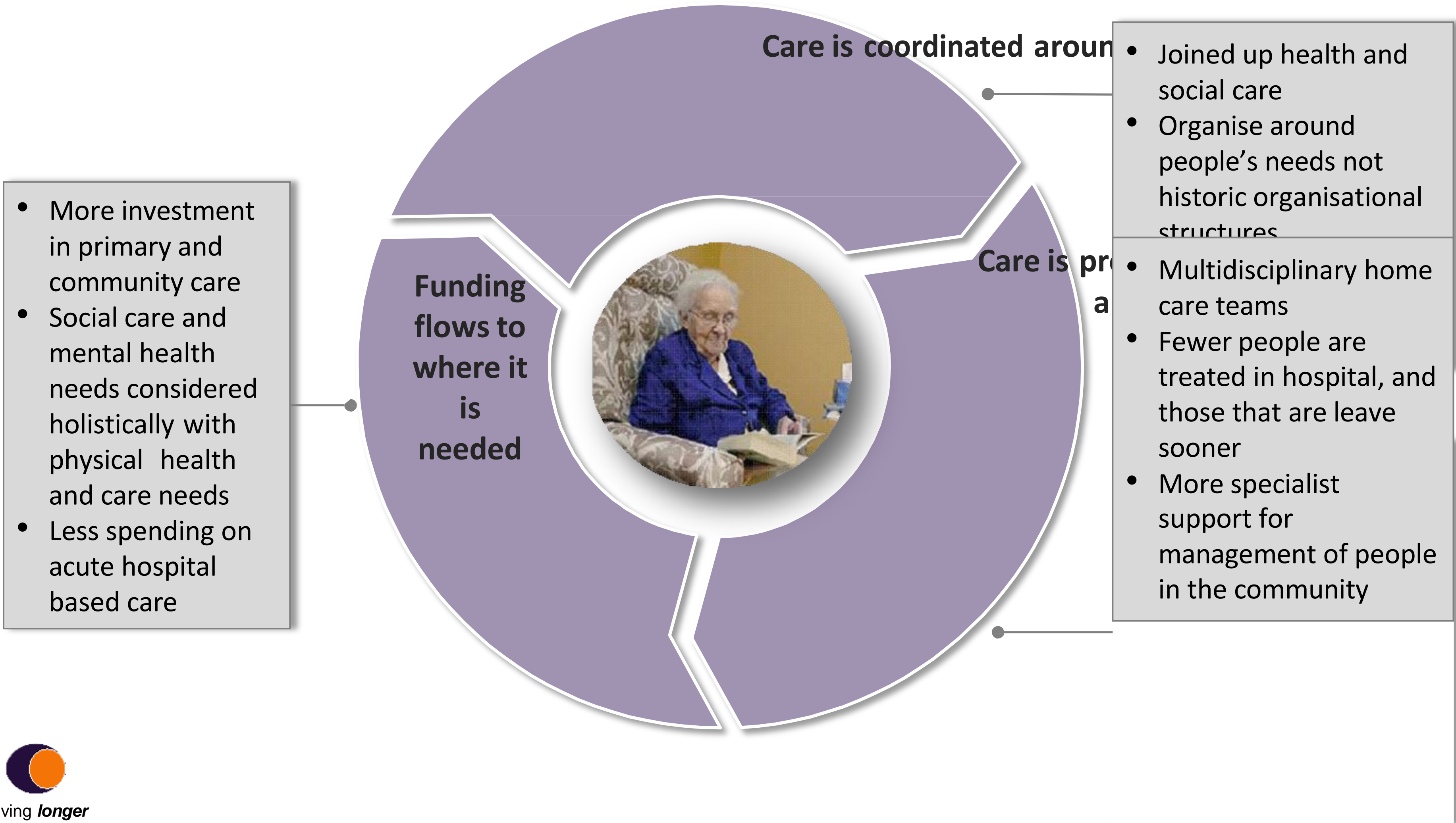
Our shared vision of the WSIC programme …

We want to improve the **quality of care** for individuals, carers and families, empowering **and supporting** people to maintain independence and to **lead full lives** as active participants in their community

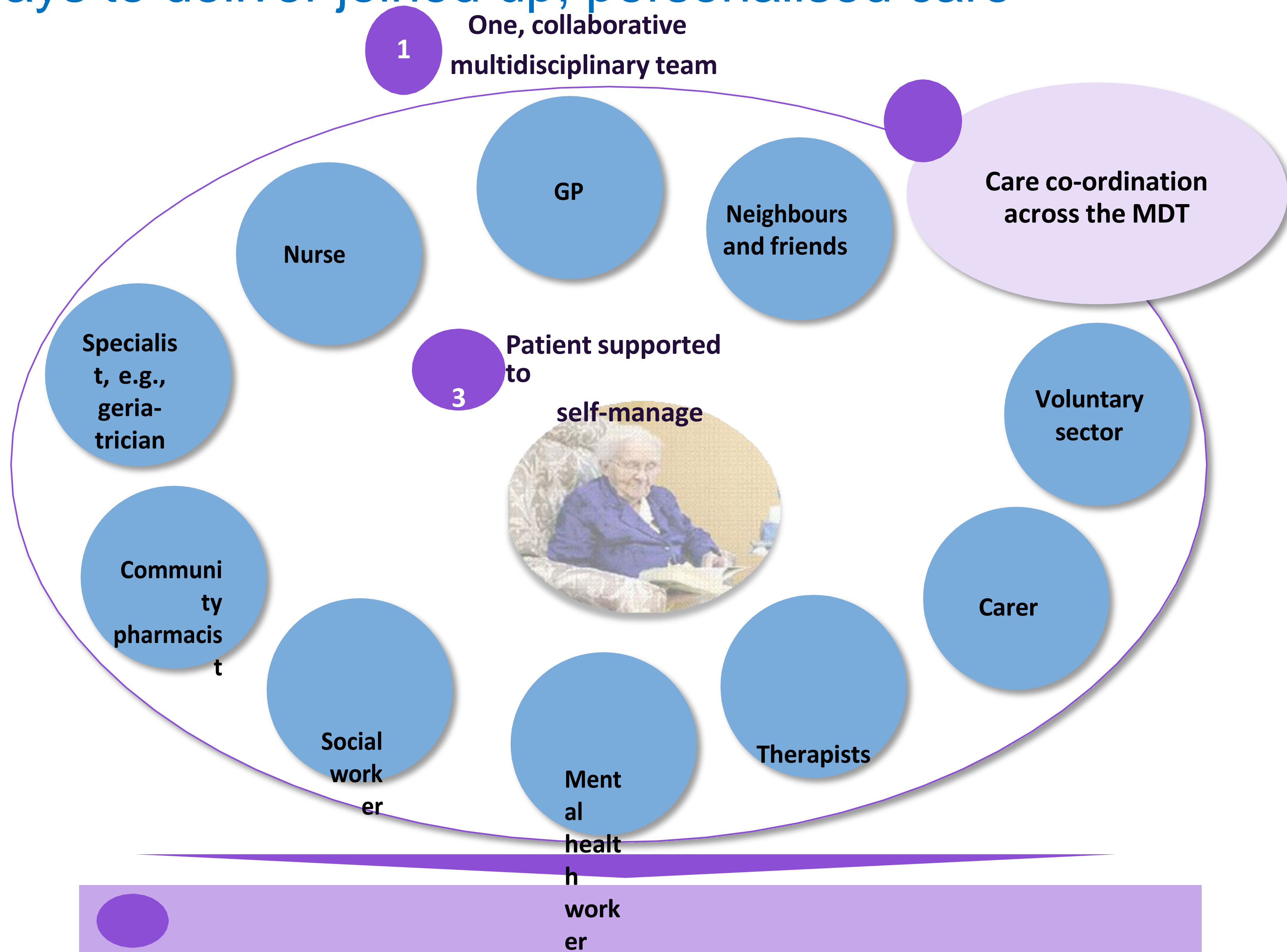
… supported by 3 key principles

1. People will be empowered to direct their care and support and to receive the care they need in their homes or local community.
2. GPs will be at the centre of organising and coordinating people"s care.
3. Our systems will enable and not hinder the provision of integrated care.

What do we mean by whole systems integrated care?



We thought about how frontline staff could work together in new ways to deliver joined up, personalised care



Single shared care plan

- Multi-disciplinary team undertakes care planning together with the user and her carers

The outputs of the co-design phase have been collated into a 'Toolkit' for Whole Systems Integrated Care

- **Materials include:**
- Content from co-design working groups
- Check and challenge questions and checklists to support the implementation of WSIC
- Cross referencing between chapters and supporting materials

Living *longer*

How will provider networks develop and support new models of care?

How could risks and savings be shared?

How could performance be managed?

How can provider networks agree to change how resources are distributed?

What are the benefits of provider networks?

What are provider network governance options?

10

Delivering high quality integrated care will require providers to work more closely together. They will need to be able to manage integrated teams and make joint decisions about changing financial flows. This chapter explains the options for how providers can come together as networks to support these changes. It also provides guidance about how they can agree changes in funding needed to support new models of care, manage performance across the network and share risks and savings.

READING THIS SECTION WILL HELP YOU ANSWER:

- What are the benefits of building provider networks?
- What are the structures that can help networks deliver their chosen model of care?

What are provider network governance options?

HOW SHOULD PROVIDER NETWORKS BE STRUCTURED

	Description	Contracting options
No formal contracting	No formal ties between providers	1 No contract but cooperate informally
Horizontal governance	Providers come together as equals, requiring some form of multilateral decision-making	2 Contractual joint venture (no new organisation); 3 Corporate joint venture (new organisation)
Hierarchical governance	Single organisation commissioned to provide services and subcontracts with other providers as needed	4 Prime contractor model with existing organisation as; 5 contractor model with third party as broker
Single organisation	Single organisation commissioned to provide all services	6 Single integrated provider

1. NO CONTRACTING

What is it and how would it work?

REFERENCE NOTE

See appendix for more detail and for case examples of the models

2. CONTRACTUAL JOINT VENTURE MODEL (NO NEW ORGANISATION)

What is it and how would it work?

3. CORPORATE JOINT VENTURE (NEW ORGANISATION SET UP)

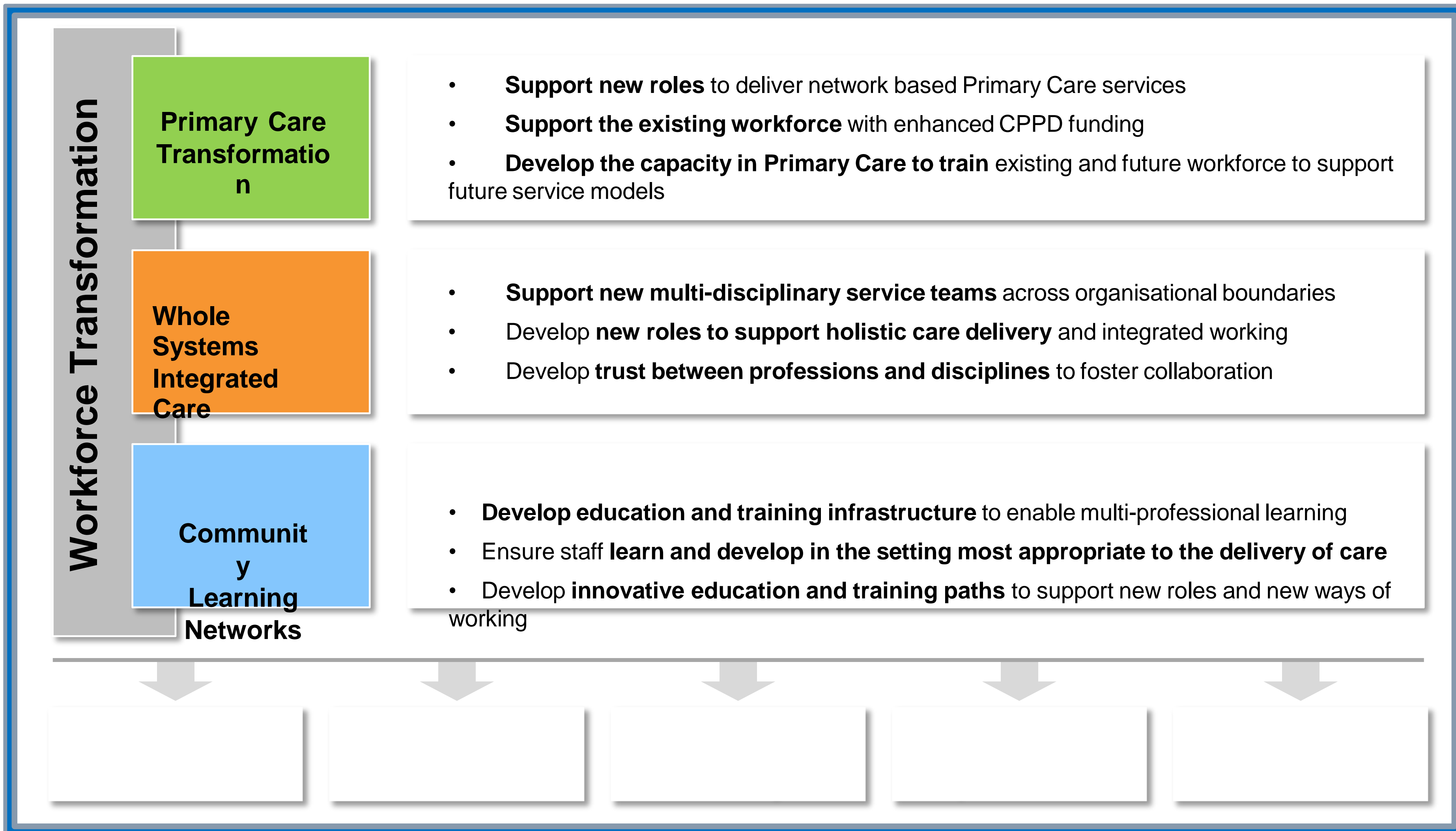
What is it and how would it work?

REFERENCE NOTE

A fuller discussion of the legal options concerning VAT can be found in the DAC Beachcroft Appendix on page XXX

Workforce is a key enabler for all these elements of transformation

The diagram below summaries the key themes form the workshop that have shaped the workforce plans



Multi disciplinary facility independent culture	Right investment in the current and future workforce	Education & training reflecting service delivery	Skills in settings most appropriate for patient care	Attractive career paths

Session Two: Introduction to innovative frontline staff

Chair: Tim Spicer, Chair of Hammersmith and Fulham CCG

Over the next 15 minutes, there will be three short presentations from innovative frontline staff working in North West London, followed by 20 minutes for questions and answers.

1. **Care Navigator Role as part of 'Village Working'**
   Caroline Durack, Clinical Transformation Lead, Central London Community Healthcare NHS Trust

2. **Merging nursing and therapist roles**
   Edgar Swart, Lead Nurse, Short Term Assessment, Rehabilitation and Reablement Service Louise Archer, Senior Therapist, Short Term Assessment, Rehabilitation and Reablement Service

3. Nursing leadership and innovation in Primary Care

Sally Armstrong, Practice Nurse and Nurse Member, Ealing CCG

Julie Belton, Nurse Practitioner & Director of a Nurse Led Alternative Provider Medical Services Practice

Further background information about this work can be found in Appendix One of the pack.

Session Three: Integrated education and training

Chair: Thirza Sawtell, Director of Strategy and Transformation, NHS North West London Collaboration of CCGs

Over the next 15 minutes, there will be three short presentations about the workforce development required to enable successful integrated care, followed by 15 minutes for questions and answers.

1. **Patient-centred education for integrated care**
   Professor Lis Paice, Medical Chair of North West London Integrated Care Pilot

2. **Integrated education and training from a social care context**
   James Cuthbert, Assistant to the Executive Director, Tri-borough Adult Social Care
   Jane Royes, Social Work Continuous Professional Development Lead, Tri-borough Adult Social Care

3. **Building a responsive educational infrastructure**

Professor David Sines, Emeritus Professor in Community Healthcare, Buckinghamshire New University

Further background information about this work can be found in Appendix Two of the pack.

Summary and relevance for the Shape of Caring Review

NHS

Appendix One

Background information to Session Two -

Introduction to innovative frontline staff

Care Navigator Role as part of „Village Working‟

Caroline Durack, Clinical Transformation Lead Central London Community Healthcare NHS Trust

Why was the initiative established?

- The aim of this initiative was to develop a locality-based approach to establish strong, robust links between primary care, social care and community health care providers through the introduction of a care navigation service, via a „care navigator role‟.
- Central London Community Health Care NHS Trust (CLCH) worked in partnership with Central London Clinical Commissioning Group (CL CCG) to co-design a new way of working that would improve care for patients through the introduction of a patient care navigation service. This would allow for a joined-up, seamless experience for patients, whilst at the same time ensuring patients were able access the diverse services available to them across the Borough/ CCG, in order to ensure that patients have the best chance of keeping well and out of hospital for as long as possible.
- To support the development of „Whole Systems Integrated Care‟, CL CCG sought to transform community provision by dividing their CCG localities into „Sub Locality Units‟ known locally as „villages‟.
- Each village brings together a group of GP practices, colleagues from local community-based NHS services (e.g. diabetes and community nursing) and colleagues from local Adult Social Care and Environmental Health. The Care Navigator‟s role is to co-ordinate patient discussions, track progress and report any problems in the referral process/ delivery of care as they arise both in and outside the village meeting. The Care Navigator will also liaise with other services, including discharge teams, to provide updates to general practice.
- This process has also allowed for a well organised referral pathway to be put in place for patients, as well as producing efficiencies through less duplication and improved communication across service providers.

How does 'village' working work?

- CL CCG approached CLCH to develop „village" working across the CCG area with the brief that partners in care had to be incorporated within the design and implementation process of the village working initiative, as part of the CCG"s out of hospital strategy.
- As a first stage of this work, CLCH re-organised its community nursing and rehabilitation staff into nine teams and re-located them into localities, and is now working to improve practice-level interactions. Social care has also been working towards a similar locality re-design plan to sit alongside localities/villages.
- CLCH has recruited nine care navigators, one per village, to act as a single point of access between GP Practices, CLCH, mental health, social care and other providers. The role is a non-clinical, co-ordination one that essentially is both GP and provider-facing.
- CLCH have been instrumental in co-designing the care navigator role in partnership with CL CCG. Village meetings have been taking place across the localities within CL CCG and have been attended by all care partners such as GPs, social care and third sector providers.
- Early in the design of the care navigator role, it was identified that the care navigators would require appropriate training and education opportunities in order to ensure high standards of quality within patient care coordination. Such areas of training have included:
    - Information governance training when handling patient identifiable information.
    - Training in the various clinical systems such as System One, RiO and EMIS.
    - Motivational interviewing skills.
    - CLCH"s mandatory training programme for all staff, which covers, for example, adult safeguarding.

How is success measured?

Outcomes related to the care navigator role include:

- A joined-up, seamless experience for the patients so that they benefit from all services available to them and have the best chance of keeping well and out of hospital for as long as possible.
- Patients can be “stepped up/ stepped down” effectively and quickly according to need, ensuring service capacity and turnaround, and enabling discharge from hospital to effective community/ voluntary organisation care, when required.
- A positive and open relationship between the providers and the care navigators.
- A positive and open relationship between the care navigators and the GP Practices
- Regular referral status/ issue reports from providers to the care navigators.
- A cohesive and integrated structure with patient information/ data shared between providers, supported by effective governance structures.

Some of the challenges that have been encountered include:

Challenges	Learnings applied
Engagement of local providers to attend village meeting	Marketing the village meetings/ care navigator role as an opportunity for providers to raise awareness of the services that they provide and increase referrals into their respective services
Information governance issues relating to sharing of patient information securely across multi-agency providers	The implementation and use of secure email systems across social care providers to ensure that health and social care could share information
Knowing what services are available to patients across multiple providers, ensuring visibility of the services to enable patients to access the most appropriate service	A „live‟ service data base has been designed and implemented, which can be shared across all providers and kept up to date as and when new services are launched

What are the plans for developing the service?

Future planned operational developments include:

- To date, the village meetings and care navigator role has focussed on adults. Going forward from later this year access to services for children will also be incorporated into village working/ care navigator role.
- It is also planned to incorporate the involvement of the discharge teams from the local hospitals into the village meetings.

Merging nursing and therapist roles

Edgar Swart, Lead Nurse and Louise Archer, Senior Therapist
Short Term Assessment, Rehabilitation and Reablement Service

What is STARRS?

- The Short Term Rehabilitation and Reablement Service (STARRS) was established to keep patients out of hospital where possible and to achieve an earlier discharge for those who were admitted. This would enable patients to retain more independence and to receive coordinated support by continuing the care at home and providing community rehabilitation.
- STARRS uses a multi- disciplinary team of nurses, physiotherapist, occupational therapists, consultant physicians, speech and language therapists (SALT), dieticians and health care support workers as well as an administration team to provide a single point of access.
- Working across a number of institutions, STARRS provides a range of services including rapid response, discharge support and rehabilitation. It also facilitates access to community health beds at Willesden Hospital, Denham Unit and social care.
- The service is commissioned by Brent and Harrow CCGs and Local Authorities, and managed by the North West London Hospitals NHS Trust, operating 12.5 hours per day, 7 days per week (14.5 hours per day in A&E).
- The team is able to care for number of conditions which include: exacerbations of Chronic Obstructive Pulmonary Disease (COPD), exacerbations of heart failure, falls, deep vein thrombosis (DVT), reduced mobility, intravenous antibiotics, urinary tract infections, post op care for patients undergoing knee and hip replacements, breast and gynaecology surgery. Life-threatening conditions that require immediate medical intervention are referred to A&E.

Services include:

- *Rapid response team* - assessing patients at home within two hours of telephone referral, the team provides clinical, rehabilitation and social support.
- *Hospital discharge team* - providing a „hospital at home" service to help reduce patient"s length of stay in hospital.
- *Community rehabilitation team* - providing neurological and general rehabilitation at home within 72 hours of referral.
- *Social care reablement* - assessing and referring patients directly for packages of care via reablement.

What progress has been made in achieving objectives?

The service has over-performed against key performance indicators, indicating that the service is well-received by patients and wider stakeholders. The service has succeeded in providing rapid access to diagnostic screening, and more seamless patient care from initial assessment at rapid response to discharge post rehabilitation.

The service has had to respond to a number of challenges, including:

- Supporting the continuous increase in demand.
- Managing and supporting increasing expectations.
- Recruiting the right staff with the right level of expertise.
- Managing interdependencies across support services both internal and external to the organisation.
- Linking in with locality based whole systems initiative.

In response, the team has initiated changes such as consulting with staff to adjust working patterns as required (for example: extending working hours, staff working across different sites and restructuring weekend and out of hours services).

What are the plans for developing the service?

In order to continue to develop the service and meet demand, we recognise there will be a need for:

- Additional investment, whilst acknowledging the financial constraints of the organisations.
- Early staff engagement and understanding of the need for extension of service.

In 2014/15, we plan to:

- Expand the single point of access (SPA) working hours to 7 days week, 08:00- 19:00.
- Expand of the Harrow team due to increased annual targets.
- Recruitment more staff, including the recruitment of paramedics.

Nursing leadership and innovation in Primary Care

Sally Armstrong, Practice Nurse and Nurse Member, Ealing CCG

What is the challenge?

- Practice Nurses will be key to the success of managing patients more effectively out of hospital. If appropriately trained and experienced, they can manage patients with long term conditions such as diabetes, Chronic Obstructive Pulmonary Disease (COPD), asthma and hypertension.
- If all stable patients were managed by Practice Nurses, it would significantly increase the amount of time a GP could spend with more complex patients and with patients who have more urgent needs. However, recruiting and training of Practice Nurses is variable and challenging and they are an aging group with a high number now retiring.
- As independent businesses, general practices will employ a nurse recruited from somewhere else in the system (acute, community, etc) and at best send them on good training courses in basic Practice Nurse skills and provide on-going practice level support to embed these skills, or, at worse expect them to „learn on the job‟.
- There are no funded routes in to practice nursing in NWL for nurses wanting to make this transition and very little practice support available. There are no human resources departments to map continuous personal and professional development (CPPD) needs or to support appraisal and we do not yet have an accurate record of who the primary care workforce are.

What is being done to address this challenge?

There are several activity programmes occurring across NWL:

- A scoping exercise to measure the existing Practice Nurse workforce and their educational needs with a gap analysis to inform Health Education North West London (HENWL).
- A leadership, mentorship and training programme to:
    - Train current senior Practice Nurses to be mentors and gain clinical and managerial leadership skills. This will then support nurses who wish to transition in to practice nursing in practices and will enable clinical skill assessments to happen in a structured way that has proper governance integral to it.
    - Encourage nurses from other areas of the NHS to retrain as a Practice Nurse seeing NWL as an example of strong nursing leadership and place they want to work.
- A CPPD update programme of educational sessions to bring existing PN‟s up-to-date with all core areas of practice nursing.
- Roll out of a web-based nurse revalidation and appraisal toolkit that will also be adapted for use by Healthcare Assistants (HCAs) with particular emphasis on obtaining the core skills for the Care Certificate.
- Supporting the development of the Care Certificate so that the mentorship skills gained by the Practice Nurses as above can be used to assess HCAs who will undertake the Care Certificate Training.
- Working with the Shaping a Healthier Future (SaHF) Transformation teams and HENWL workforce groups to inform and enable future direction.
- There is a nurse-led practice in Ealing which is an innovative model of primary care and one which can inform how care can be delivered in an alternative way to the traditional model of general practice.

What progress has been made in achieving objectives?

Although each initiative has its own funding stream and working group, in NWL we are trying to develop them organically and collaboratively so that eventually we have system-wide changes that are connected and make sense to the workforce. Therefore:

- The scoping work is progressing swiftly and the final report will be submitted next month.
- The leadership, mentorship and training programme is piloting processes with two nurses about to start online modules who will need in-practice support and mentorship.
- The CPPD taught sessions will start later this month.
- Roll out of the toolkit will also hopefully start next month.
- The Care Certificate development for primary care is in its infancy and there is a stakeholder workshop planned for the end of July.
- On-going evaluation will be key to the success of these programmes as each step will inform the next and will change as needed.

What are the plans for developing the service?

- Sustainability is something that is key to the future of the NHS‟s out of hospital strategy and hence the need to „grow‟ rather than „complete‟ these programmes. Training of new Practice Nurses will always be needed so continually providing support to develop mentorship and leadership skills should become a core commissioning activity as should providing CPPD, appraisal and HCA training.
- There are future plans to encourage Health Education Institutes (HEIs) to have pre-registration nurses spend a significant amount of their training time in primary care and to encourage nurses to enter practice nursing at an earlier age and make a career choice. Developing a career structure to promote primary care nursing would go a long way to making this happen.

Appendix Two

Background information to Session Three -

Integrated education and training

Patient-centred education for integrated care

Professor Lis Paice
Medical Chair of North West London Integrated Care Pilot

Work done to date

The North West London Integrated Care Programme (NWL ICP) champions patient-centred joined-up care, focussed on fuelling a social movement.

2011

- The NWL ICP Patients and Carers Group identified the need for front-line staff to be educated in the concept and vision of integrated care.
- There were several discussions with local educators, as well as local experiments.

2012

- A symposium bringing together clinical educators from all professions was held to agree the educational needs of the existing workforce to support integrated care and explore the range of potential interventions.
- There were 80 clinical educators and patients participating and it was supported by NWL Health Education Institutes.
- Success was achieved with paired learning, mock multidisciplinary teams and integrated care rotations - mainly aimed at junior doctors.

2012-2014

- With support from Professor Roger Kneebone of Imperial, educational events for frontline staff centred around a simulated patient pathway were developed by patients, based on their experiences.
- These can be adapted for any staff group or a mixed group. Staff view a simulation then sit at tables with patients to discuss how things could be improved. The scenario is then replayed with their suggestions incorporated.
- This has proved to be a moving and inspiring educational intervention helping front-line staff to understand the patients‟ perspective, and the power of staff and patients working together to find solutions.
- Five of these events have been held so far, with another three coming up soon, and they have initially

targeted receptionists and community pharmacists.

Why is this innovative?

- The NWL ICP introduces the concepts of co-production at a very practical level, providing both patients and staff with each others‟ perspectives and allowing both parties to experience their ability to change the way things work, through working together.
- Participants have said this was a novel experience and inspired them to further local efforts.
- Involving patients in the design, delivery and evaluation of educational events takes patient-centred care to a new level.

Challenges and priorities to address

- This is an adaptable and sustainable introduction to integrated care and the development of a more patient-focused collaborative workforce. Events require administration, venues, catering, actors, props and facilitation so funding will be required to scale this up.
- Front-line staff do not always get the supervision and continuous development they need. The more effort is directed to their development, the better they will care for patients and for the system of care and the more they will engage with their work.
- Engaging staff at all levels and in all settings of care is key to the success integrated care

Integrated education and training – social care context

James Cuthbert, Assistant to the Executive Director, Tri-borough Adult Social Care (ASC)
Responsible for two major reforms of ASC operations, both of which must change front-line skills and practice if they are to improve the quality and financial sustainability of our services. James is also a member of Paul Burstow‟s Commission on the Future of the Home Care Workforce.

Felicity Jones, Learning & Organisational Development Consultant for Workforce Development, Tri-borough ASC
Responsible for delivering relevant training solutions for all Tri-borough ASC staff as part of a planned, holistic approach to improving organisational effectiveness. This now includes working with health colleagues in integrated teams and assisting with their development where appropriate.

Work done to date

- A research programme called "Customer Journey" comparing the experience of people who use adult care services with the experience of staff who deliver them.
- Specific training provision to address the needs of integrated teams, as and when a need arises.
- On-going programme for approved mental health practitioner (AMPH) training provided by Tri-borough, delivered in collaboration with NHS Trust colleagues and reviewed regularly to ensure relevance and legal compliance.
- Annual conferences for occupational therapy staff, mental health staff, leaders and managers across ASC and health. Good dialogue has created shared work and best practice.
- South West London Region Continuous Professional Development (CPD) programme on integrated and inter-professional training (early stages).
- A quality review of assessments for continuing healthcare.
- Skills matrices developed to understand the skill sets in the teams and how they can be respected and utilised in integrated teams.

Why is this innovative?

- Developing creative, time and cost-effective ways to ensure staff in integrated teams are able to access development opportunities through online learning and focused learning.
- Working in partnership with health colleagues to deliver training and education provision for integrated teams across Tri-borough and other London boroughs.

Challenges and priorities to address

- Home care is an important part of out-of-hospital services. It must help people stay safe and as independent as they can be. This means better coordination with other community services, especially community nurses and therapists, primary care and voluntary and community organisations.
- The workforce must grow substantially to keep up with demand and its skills must improve to meet growing acuity and complexity of need. The recruitment and training of home care workers must change to support this.
- Case management teams have had to address issues on an individual basis; there is no one size fits all and no benchmark to use. Case management competencies that sit across ASC and health would be beneficial and help managers to manage teams and workloads.
- There is duplication of training for health staff who are asked to attend statutory training such as safeguarding for ASC requirements. Staff are also asked to attend healthcare-run training on these areas. More link-up with health partners who lead on education and training is required.

Building a Responsive Educational Infrastructure

Professor David Sines
Emeritus Professor in Community Healthcare, Buckinghamshire New University

Work done to date

- The Shaping a Healthier Future Joint Workforce Steering Group has done a full stakeholder mapping exercise to identify capacity and sector-wide motivation for multi-agency and inter-professional education.
- Commitment gained to building a multi-agency approach to shared learning and patient/ person centred educational delivery.
- Design of a comprehensive community learning network infrastructure.
- Recognition that new multi-agency roles are required to support frail, older people at home.
- Reconfiguration of existing inter-professional population models of workforce development to provide a „whole systems‟ response.
- Implementation of a range of multi-agency educational pilot projects and programmes.

Why is this innovative?

- Full stakeholder mapping exercise to identify capacity and sector-wide motivation for multi-agency and inter-professional education.
- Commitment gained to building a multi-agency approach to shared learning and patient/person centred educational delivery.
- Design of a comprehensive community learning network infrastructure.
- Recognition that new multi-agency roles are required to support frail, older people at home.
- Reconfiguration of existing inter-professional population models of workforce development to provide a „whole systems" response.
- Implementation of a range of multi-agency educational pilot projects and programmes.

Challenges and priorities to address

- Design of inter-professional and multi-agency mentorship programmes for learners.
- Identification of a new learner placements in out of hospital settings.
- Provision of multi-agency supervision and assessor development programmes.
- Further investment in simulation and technology led education to facilitate work based learning and competence-based learning.

Health Education England

Primary Care Workforce Commission

Evidence submitted by members of the Urgent Care Commission
March 2014

Contents

Overview **2**

1. Ironing out perverse incentives **3**

2. Working more effectively with hospitals **4**

3. Information sharing **5**

4. Creating a sustainable workforce **7**

Primary Care Workforce Commission – Q1 .... **11**

Evidence from visits by David Colin-Thomé, Independent Healthcare Consultant, Chair of the Urgent Care Commission 11

Primary Care Workforce Commission – Q2-4 .... **14**

Evidence submitted by Christine Johnson, GP, NHS Clinical Lead East Midlands and Chair of Vale of Trent RCGP faculty 14

Evidence submitted by Marjorie Gillespie National Medical Director for Primary Care 16

HEALTH EDUCATION ENGLAND:
PRIMARY CARE WORKFORCE COMMISSION

Evidence submitted by the Urgent Care Commission,[1] chaired by Professor David Colin-Thomé.

Overview

This document contains the evidence that three Urgent Care Commission (UCC) members have submitted to Health Education England's (HEE) Primary Care Workforce Commission, chaired by Professor Martin Roland.

Members that have contributed are: Dr Christine Johnson GP, NHS Clinical Lead East Midlands and Chair of Vale of Trent RCGP faculty, Dr Marjorie Gillespie National Medical Director for Primary Care, Care UK and Professor David Colin-Thomé, Independent Healthcare Consultant, Chair of the Urgent Care Commission.

We have also included recommendations from the UCC report, *'Urgent and Important: the future for urgent care in a 24/7 NHS'* which was published in November 2014 by all members of the UCC. The report can be found in full here: http://www.careuk.com/futureforurgentcare.

The Primary Care Workforce Commission has asked for the following evidence:

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

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

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

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

[1] The Urgent Care Commission is an independent expert commission, chaired by Professor David Colin-Thomé and supported by Care UK. It brings together thought-leaders and independent experts, drawn from across the urgent care sector including: public and private providers; policy makers; professional bodies and GPs. The UCC's work so far has focussed on quality, workforce and the patient pathway in the urgent and out-of-hours sector with the aim to:

- Investigate the way in which out-of-hours services are commissioned, designed and delivered in England today.
- Make independent, evidence-based, practical recommendations on how these services might be further improved in order to ensure patients in England have access to a rapid, high quality and responsive service.

In November last year, the UCC published a report titled "Urgent and Important: The Future for Urgent Care in a 24/7 NHS", which gave eight recommendations under the three themes.

The Urgent Care Commission would like to submit their report findings, specifically highlighting recommendations 5-8 within the report (labelled 1-4 within this document). The report contains a number of case studies, quotes and findings from stakeholders across the emergency and urgent care sector. These were all approved for use within the report by the author, and have been copied directly into this document.

Recommendations:

1. **Ironing out perverse incentives:** To better enable out of hours providers to work with A&E/acute providers, perverse incentives relating to the tariff and contracting system must be rectified.

2. **Working more effectively with hospitals:** Hospitals should be better integrated with out of hours providers to ensure a holistic service offering for the community. Front-ending A&E/co- locating GPs in acute settings should be more widely modelled to allow for a better understanding of potential impact on outcomes.

3. **Information sharing:** Data sharing requires a national solution. This must rely upon agnostic, non-proprietor data systems, it must be user defined and user-tested. Roll out should be supported by a national education programme to help patients understand how their data will be used and by whom.

4. **Creating a sustainable workforce:** Workforce planning is critical to the long-term sustainability of the urgent care sector, mitigating the risks posed by ongoing recruitment challenges.
    a. A multi-disciplinary approach must be taken to staffing urgent care services. The spectrum of advanced practitioners available to deliver services should be expanded to include pharmacists; nurses; physician associates; and healthcare assistants. Practitioners should then have the appropriate skills mix, enabling an out of hours team to call upon paediatric, mental health and long-term condition expertise at any one time.
    b. Medical indemnity providers should take into account the quality and performance record of the provider when looking to associate levels of risk for the provider workforce.

1. Ironing out perverse incentives

- To better enable out of hours providers to work with A&E/acute providers, perverse incentives relating to the tariff and contracting system must be rectified.

If getting community and hospital sectors to join up with out of hours services is a desirable outcome, then finances will be an important part of making it happen.

Currently too many hurdles exist in how different NHS organisations are paid and this is frustrating attempts to create the pooled budgets to meet shared outcome measures and integrated working. In particular, the clash between the payment-for-performance systems that are characteristic of the GP setting versus the payment-for activity based systems commonly found in hospital sector. To create multi-organisation, whole system care requires vision and committed leadership from commissioner(s) and providers. This will require not just a set of system-wide quality standards, but it will also be necessary to utilise whole system commissioning technologies (e.g. alliancing contracts and/or prime provider leadership) and optimally a whole system single budget. Currently there are different methods of payment for the key providers, which is often cited as a barrier to integrated working, but

the commission believe local examples of integration already exist. Hospital services and GP out of hours services are both commissioned by CCGs and despite contrary expressed views, CCGs, even before the advent of co-commissioning, can commission primary care even if the contracts are held nationally. Contracting and commissioning are not synonymous. The recently published NHS England Five Year Forward View offers a more amenable environment for locally funded integrated care and out of hours care would be a high value area to generate local innovation through these freedoms.

It says "urgent and emergency care services will be redesigned to integrate between A&E departments, GP out of hours services, urgent care centres, NHS 111, and ambulance services. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget and national leadership of the NHS provide meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied."

2. Working more effectively with hospitals

- Hospitals should be better integrated with out of hours providers to ensure a holistic service offering for the community. Front-ending A&E and collocating GPs in acute settings should be more widely modelled to allow for a better understanding of potential impact on outcomes.

A recurring challenge for the out of hours sector is the perception that it provides a "contingency" or "overflow" service" for when A&E becomes too busy. Ensuring that patients receive the right care and in the most appropriate setting is a real challenge for urgent care; A&E should not be considered the default provider. If patients are to access consistent care, irrespective of whether it is a busy Saturday night or a quiet Monday morning, it is vital that hospitals and out of hours GP services are more aligned in the way they work. The widespread inability to refer patients directly from out of hours services into hospital departments was identified as a major weakness of the current system. The tendency for hospitals to require admissions to enter via A&E creates a doubling up of triage and a significantly worse experience for the public. The Commission felt that the case for locating GPs in hospital emergency departments needed more analysis to prove the concept workable, as mixed views were expressed. The role of GPs effectively taking on a triage role was widely considered to be a positive benefit and that their use was seen as holding potential to reduce hospital admissions. The Commission felt that evidence for this was currently limited and that hospital admissions alone, while an appealing metric to policy makers, should not be the sole driver to wide-spread adoption. It was noted that a "one size fits all" approach would not be desirable, and that any model would need to take into account regional variations, in particular if the setting is rural or urban. It was therefore agreed that a broader understanding of the impact on patient outcomes was needed. The recent NHS Five Year Forward View was explicit in suggesting a locally developed organisation of providers that get different parts of the health service working more closely together and breaking down traditional boundaries. The Commission discussion and consultation response reveal a clear goal that out of hours be prioritised for this kind of service innovation. Sharing more quality metrics was agreed as a means to achieving better integration. The out of hours sector across the UK is already widely using the Urgent & Emergency Care Clinical Audit Toolkit (jointly developed by RCGP, College of Emergency Medicine and RCPCH), but that commissioning of the hospital sector has been slower to respond.

This is particularly pertinent to paediatrics where ways of working better across in hours and out of hours have been developed:

"In spite of children never being healthier there has been a huge increase in demand for them to be assessed when they are, or are perceived to be unwell. Most such children require a short period of observation of around 4 hours at the end of which an experienced assessment can rule out the

majority of serious issues. Short stay assessment units are now widely available for this purpose. However, staffing these out of hours can be problematic especially for small populations. Public education to use services within the hours that they are open has been shown to be possible in a number of places, and only the very occasional child needs to be seen outside of these hours when they might have to travel to a more regional unit which can justify being open 24 hours a day. Increasingly the model is for a regional or sub regional 24 hour units surrounded by 8 till late 'ambulatory' units. Examples of this include Sunderland/South Tyneside; Gloucester/Telford; Grantham/Nottingham and the Greater Manchester conurbation."

Professor Alan Craft, Newcastle University

3. Information sharing

- Data sharing requires a national solution. This must rely upon agnostic, non-proprietor data systems, it must be user-defined and user-tested. Roll out should be supported by a national education programme to help patients understand how their data will be used and by whom.
- Data sharing was highlighted as desirable to:
    - Enable speedier identification of underlying health conditions, which may influence clinical decision-making;
    - Support a better national epidemiological understanding of disease prevalence to support planning and understand risk;
    - Enable GPs, who are currently accountable for people >75 and next year for all patients, to potentially track patients through the system.

The issue of sharing patient records has long been a hot-button issue both on technical obstacles and on perceived issues around consent. The Commission were very clear that a national IT solution would be doomed to technical failure and would never deliver a system that worked for everyone on the ground. However, an agreed national standard of data collected and shared between NHS services would be desirable. As would a nationally agreed set of IT specifications that enabled different organisations to be more agile in connecting databases rather than facing hard barriers of propriety systems. The Summary Care Record is a good example of this. In spite of being strongly advocated in the Carson Review, integrated health records are still not a reality in the NHS. Some Commission members suggested that locally agreed shared IT systems had been successful and should be encouraged if they made sense within a defined health economy. But this had to be developed from the bottom up rather than imposed at a national level and be fully tested by clinicians to ensure they serve better clinical consultations rather than actuarial calculations. NHS Scotland was cited as an example of how a national NHS service had opted for a single IT framework, which much could be learnt from and applied in England. The issue of consent for patient record sharing has recently focused on privacy and the possibility of records going outside the NHS system. The Commission felt that concerns about consent were now holding back efforts to integrate information across NHS organisations when most people would assume and find it desirable for those treating them to have the right information to hand. The Commission agreed that a concerted national public information campaign would help overcome this stumbling block to information sharing. One example of how data sharing is being trialled at scale, and could prove a test-bed for the rest of medicine, is in palliative care. The Coordinate My Care (CMC) initiative is being run out of the Royal Marsden for the whole of London for these services. The system enables people undergoing palliative care for a terminal condition to have their notes and wishes shared across out of hours providers. However, even this advanced approach does not formally link to the summary care record.

"AACE strongly believes there will be clear benefits from providers within health communities working in a more integrated way to provide the most appropriate patient pathways – these may include Single

Point of Access Directory of Services; ambulance clinicians working alongside GPs both in their practices and in the community and GPs based in ambulance control rooms; stronger communications between hospital clinicians and paramedics to ensure patients receive timely access to the right care rather than filtering all patients through EDs e.g. direct admission to stroke and coronary care units."

Association of Ambulance Chief Executives, Urgent Care Commission consultation 2014
Recommendations

"It seems clear that compatible patient data systems remains a critical aspect that needs addressing to gain consistency across the health and social care services if service provision is going to be transformed in a safe and effective way. In addition the compulsory use of the NHS number as the primary identifier will facilitate access to GP records etc. although this currently poses logistical challenges within the 999 system. Involvement in and ready access to integrated care plans is essential for ambulance clinicians in providing expedient and effective assessment and treatment for patients, and not only enhances outcomes, but the patient experience overall. This is not yet widespread."

Association of Ambulance Chief Executives, Urgent Care Commission consultation 2014

Case Study
The Summary Care Record (SCR) is a centrally stored, electronic record that has been created to provide healthcare staff with faster access to key clinical information when treating patients in an emergency or out of hours. The SCR contains critical information on patients' allergies, medications and adverse reactions, and it is Government's intention that patients will have online access to their records before April 2015. Although patients have the option to opt out of the scheme, more than 40 million patients in England have a record, and the SCR has been implemented in A&E, NHS 111, and GP out of hours services where clinicians are using the SCR more than 19,000 times a week.

More information: http://systems.hscic.gov.uk/scr

- Who would have access?
- What levels of data would be provided?
- Would it be read only or would there be capability to update the system?
- What auditing mechanisms would be in place to assure appropriate use?
- Where will funding come from?
- What would be the timescales?

Case Study
Coordinate My Care (CMC) was developed in 2012 to give people with chronic health care conditions and/or life-limiting illnesses an opportunity to create a personalised urgent care plan in order that they might express their wishes and preferences for how and where they are treated and cared for.
This care plan can be shared electronically with all legitimate providers of urgent care, especially in the emergency situation and is fully integrated with London NHS 111, London Ambulance Service and OOH GP providers. All the organisations involved have signed formal agreements that govern how care plan information is used and protected, and they undertake to provide CMC with updated lists of staff that are trained and authorised to access the system. At the heart of CMC is a care plan that is developed with a patient by their nurse or doctor if and when both feel it is appropriate. The care plan contains information about them and their diagnosis, key contact details of their regular carers and clinicians, and their wishes and preferences in a range of possible circumstances. This care plan is uploaded to the CMC system to which only trained professionals involved in their care can have access. These include ambulance control staff, NHS 111 operators, GPs, out of hours GP services, hospitals, nursing and care homes, hospices and community nursing teams. Over 17,000 personalised care plans have been created across London, and the outcomes show that 80% of patients with a CMC care plan have died in their preferred place and where patients had a CMC record 83% died outside of hospital; nationally 54% of patients die in hospital.

For more information: www.coordinatemycare.co.uk

"In Derbyshire Health United's RightCare service, the in-hours GPs created patient care plans with the patient's permission and that plan was shared with out of hours providers."

Professor David Colin-Thomé, Commission Chair

In their consultation response the BMA GPC helpfully suggested some key questions that need to be addressed if data-sharing technology is to be rolled out. They suggested that there should be careful information governance policies around how access would be enabled:

"In certain areas in Sussex, the palliative care team and the musculoskeletal team have begun using a common and popular IT system. This means that any visits or patient updates are shared and immediately available to view by the practice. It's an efficient way of recording and making the patient journey visible to clinicians in the community."

Dr Farah Jameel, Sessional GP

"As more end of life care plans are incorporated into Coordinate My Care, with visibility to GP out of hours, the ambulance service, NHS 111 and Emergency Departments, the numbers of patients on the end of life pathway dying in hospital in London has markedly declined."

Dr Agnelo Fernandes, Urgent & Emergency Care Lead – Royal College of General Practitioners.

4. Creating a sustainable workforce

- Workforce planning is critical to the long-term sustainability of the urgent care sector, mitigating the risks posed by ongoing recruitment challenges.
- A multi-disciplinary approach must be taken to staffing urgent care services. The spectrum of advanced practitioners available to deliver services should be expanded to include: pharmacists; nurses; physician associates; and healthcare assistants. Practitioners should then have the appropriate skills mix, enabling an out of hours team to call upon paediatric, mental health and long-term condition expertise at any one time.

While it was agreed that having the full multidisciplinary team staffing out of hours services would be inefficient, access and pathways into specialist care should be more easily and systematically available when needed. Availability of high quality GPs has been an ongoing problem for urgent out of hours for many years. Ideally a service would be staffed by GPs within the geographic region, familiar with the local health service and with a long-term commitment to remaining within the area. But frequently services need to cast further afield and pay high locum rates. This fragmentation of the out of hours workforce has led to some members of the workforce being under-regarded or providing a default out of hours service but not being commonly recognised and integrated. Pharmacists in particular were noted as a resource and whose urgent care training was not currently well captured.

While it was acknowledged that diversification of roles and skills in the workforce should be encouraged, this is not being consistently applied across the country. For example, some services have looked at the potential of physician assistants, paramedics and advanced nurse practitioners roles, where others have insisted upon a GP-only service. It is important to recognise that with workforce diversification will come additional complexity for the management of services. Using healthcare professionals with extended roles can be invaluable to the efficiency and effectiveness of a service. However, there will be limits to their professional ability, and there will be instances where a trained GP will need to be deployed. To get the most out of a diverse workforce, the provider will need

to ensure the service is well choreographed, deploying the right clinical skills, at the right time to meet the needs of the patient. The BMA GPC agreed in their consultation response but expressed caution that more needs to be done to understand if the willingness of other professionals is there:

"Many hospital pharmacists enjoy working as part of acute in-take teams, but GPC understands that many can get cold feet when working autonomously. We need to assure ourselves of what staff can and will do. There is too much variability, so more must be understood about where staff fit into the jigsaw."

BMA GP Committee, Urgent Care Commission consultation 2014

"When using multiple agencies, it is vital that new staff receive a formal induction process is in order to maintain high standards."

Dr Farah Jameel, Sessional GP

The impact of commissioning on workforce planning is considered a critical issue. The challenge is two-fold: firstly looking at how the commissioning of other services impacts on workforce planning for out of hours; and secondly how that planning for an out of hours workforce should take into account an appropriate mix of skills that will secure the future of the service in the longer term.

The Commission found that out of hours frequently experienced ebb and flows of work that were based not on a clear definition of its role, but the commissioning state of other services. Where services such as district nursing have been decommissioned, it is out of hours services that pick up the caseload as a "provider of last resort". Likewise, NHS 111 as a new service has been attributed as the cause of a dramatic drop in GP out of hours cases. These unintended consequences of commissioning decisions elsewhere in the system make workforce planning for out of hours unpredictable and challenging. What became clear is the view that good commissioning involves knowing how out of hours fits into the wider local urgent care strategy. When planning for an urgent care workforce, commissioners and providers must first consider the future demands of the healthcare economy, and then which professions would be best placed to deliver this service. They should plan for flexibility in roles and consider interrelated services such as A&E and general practice, where the workforce may already reside and would ultimately need to work alongside.

"We find people forget it [workforce planning]. When we're talking about workforce and we say 'how are we going to get the workforce we need?' we get, 'someone else is looking after it'. If someone doesn't think about education and training, there is no sustainability."

Professor Sheona MacLeod, Health Education East Midlands

Good workforce planning is central to high quality commissioning for urgent care. It encourages the consideration of which professional groups would be best placed to deliver an urgent care service fit for now and the future, allowing for the appropriate commissioning of education and training for healthcare professionals. The core principles of workforce planning are as follows:

- Whole-system approach: Workforce planning is the responsibility of the urgent care system as a whole and cannot be conducted in isolation. Commissioners and providers must work together to ensure a whole-system approach is taken to training, education and recruitment.
- Forward-planning: Workforce planning must be built on the basis of a clear vision of what future services need to look like in order to meet the needs of the local health economy. This will require commissioners and providers to work together to map demand and supply in the long-term.

- Short-term and long-term view: Developing a 10-year plan is advisable, allowing for the time required to train highly skilled healthcare professionals. However, where there is an urgent need, planning for 2 year and 5 year intervals is also recommended.
- Accounting for regional variation: There are significant variations in the make-up of health economies across regions. Building a workforce planning model for urgent care must take into account the different types of service-need in rural, urban and mixed populations.
- Planning for the pathway: Workforce planning using care pathways works well in that it considers the requirements of the patient on their journey and who's best placed to deliver the services. It also allows for consideration of the inter relationships between professionals and between services. Health Education England has published Framework Fifteen, designed to guide the investments, decisions and actions the healthcare system will take in the short, medium and longer term to ensure the right numbers, skills, values and behaviours are in place to provide high quality care.

More information:
http://hee.nhs.uk/wpcontent/uploads/sites/321/2014/06/HEE_StrategicFramework15_final.pdf

"…Ongoing CPD is useful and revalidation requires GPs to include reference to whole practice appraisal. GPC agrees that greater emphasis is needed on enhancing urgent care training for GP trainees. Too many are not adequately trained to practice autonomously in urgent care settings."

BMA GP Committee, Urgent Care Commission consultation 2014

- Medical indemnity providers should take into account the quality and performance record of the provider when looking to associate levels of risk for the provider workforce.

GPs working in out of hours operate with high levels of personal professional exposure and low support resources to mitigate those risks. The Commission expressed concern that indemnity providers are focused on mitigating against the risk of a single, rare case that will have significant financial consequences. The result is soaring costs of indemnity in out of hours, which has led to many healthcare professionals stepping back as the work offers low financial incentive. The challenge is how indemnity providers might work with urgent care providers to seek assurances on how this heightened risk is effectively managed. The indemnity outlook for other healthcare professionals is currently unclear and the Commission established that there was little consensus on whether post-graduate medical trainees working outside of hospitals were adequately covered by Crown indemnity.

The Commission believe that more support for GP trainers and the deaneries was needed to ensure out of hours was given the focus it warrants on the curriculum and as part of any in-training programmes. Trainee organisations are currently not sufficiently involved in deciding what out of hours training should look like, which compounds the lack of engagement from potential candidates. Central to this challenge is ensuring that the workforce is prepared to respond to the breadth and complexity of patients they are likely to see in an out of hours setting. The profile of patients coming through out of hours increasingly represents an ageing population, with multiple, complex comorbidities. On the other end of the spectrum, they will see a high number of paediatric patients. The challenge in this case is differentiating between a child who is unwell, and who will most likely get better in a matter of hours; with a child who is unwell and likely to decline over night. The prevalence of mental health conditions is also rising; requiring specialist knowledge and experience. Currently the training available to GPs and their practical exposure to out of hours services is limited and therefore we have a workforce ill-prepared to meet the demands placed upon out of hours services. The Royal College of GPs produced a competency framework for GP out of hours, in conjunction with partners at the General Medical Council, the British Medical Association and the Department of Health. However, following the 2004 contract change, out of hours lost a significant share of its trainers as out

of hours training was no longer considered compulsory. The current situation, whilst varied from region to region, suggests a reduced emphasis on out of hours for trainee GPs, posing a real risk to the future sustainability of the service. Professional bodies such as the Royal College of GPs are best placed to position greater emphasis on enhanced urgent care training within the mandatory curriculum for trainee doctors. Once qualified, all urgent care practitioners should have access to advanced and ongoing training and professional development. Individuals within the RCGP and College of Emergency Medicine could act as "curriculum champions" to ensure adequate coverage during training. It is imperative that Health Education England's Local Education and Training Boards (LETBs) and regional specialty schools have this on their agenda as a way to ensure they deliver a GP out of hours workforce for the future.

There is currently no recognition of how rewarding and valuable a training experience in GP out of hours care can be. This is particularly stark when compared to how out of hours care in the acute sector is perceived as a great way to rapidly gain varied clinical experiences. Healthcare organisations at a national and local level need to be better at valuing and recognising those working within GP out of hours settings. Out of hours work is a different way to be a GP offering greater problem-solving and immediate impact on patients than the longer term management of in-hours care.

"Out of hours is a risk sink. If you are in an environment with high exposure reflected in the indemnity, then what we've got is a risk management system where the resources available don't allow us to reduce that risk."

Dr Fay Wilson, Badger Group

"Paramedics now have the skills and equipment to deliver treatments that would only have been done by doctors 10 years ago. With these capabilities and by working closely with improved community services, ambulance clinicians can safely manage many more patients at scene, either treating them in their own home or referring them on to other appropriate community based health or social care services. There are opportunities for extending provision of training of paramedics to increase capacity of advanced and specialist paramedics with enhanced responsibilities, allowing them to assess, prescribe for and manage patients with exacerbations of chronic illnesses. The distribution of funds across, and general coordination between, health and social care education and training is uneven. HEE, Skills for Care, NHS Employers and professional representative groups should ensure that there is recognition of the need for health and social care training to be more closely connected, to facilitate a joint approach. HEE need to take on responsibility for these considerations within national workforce planning and ensure that core NHS funding is in place to deliver sufficient capacity within the paramedic pool for NHS ambulance trusts, allowing access for paramedics to bursaries and financial support as with other AHPs."

Association of Ambulance Chief Executives, Urgent Care Commission consultation 2014

Primary Care Workforce Commission – Q1

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

Evidence from visits by David Colin-Thomé, Independent Healthcare Consultant, Chair of the Urgent Care Commission

All 5 are examples of; Models of primary care that work well and are likely to meet the future needs of the NHS; it is too early in their creation to have developed a significant evidence base but all have delivered on complexity as a consequence of good leadership (CQC domain well-led). *Experience of hospital chains in Germany (Monitor report 'Exploring international acute models' 2014) is of strategic leaders having different attributes to many operational leaders. We need to choose positional leaders for their technical knowledge AND behavioural attributes (evidence of past behaviours).*

CASE STUDY: Wirral All Day Health Centre

Summary: Integration of GP 'in and out-of-hours' services and walk in service

The OOH service is sited in the building named the All Day Health Centre also housing an 08.00-22.00 nurse led Walk in Centre (WIC) and a GP practice (a 'Darzi' practice) which provides a 7 day/week service for its 600 registered patients and provides a GP service for patients referred for a medical opinion from the WIC. The whole site also provides an Emergency Department within Arrowe Park hospital.

CASE STUDY: Partnership of East London Cooperatives (PELC)

Summary: a GP OOH provider managing complexity for the benefit of patients

PELC Out-of-hours Service GPs provide traditional GP OOH services to 1.1 million people including face-to-face clinics OOH on 3 sites in West Essex.

Under separate commissioning arrangements, PELC provides the NHS 111 service for Outer North East London and for East London and City; the urgent care centres at Whipps Cross Hospital in Leyton and King George's Hospital in Goodmayes; and Single Point of Access and Outbound Calling services in Waltham Forest. There were coordinated pathways of care across these services designed to meet patients' needs in a timely way and in the most clinically appropriate setting. Specific contracted point of contact service for Waltham Forest CCG for community district nursing services.

So multiple contracts and stated role of PELC is to provide a one stop responsive service to patients rather than patients having to make several calls to different organisations. This principle is achieved optimally by the integration of 111 and OOH services for ONEL (outer North East London) and enhanced by the point of access community nursing contract for Waltham Forest CCG.

CASE STUDY: Croydon Urgent Care Centre

Summary: Integration, non-clinical streaming and assessment, use of early warning methodology

The UCC and Emergency Department (ED) share responsibility for delivery of the four-hour ED target. Good joint working between the ED and UCC even though two separate organisations – joint protocols, clinical governance of clinical handovers and joint review of serious incidents.

Non-clinical streaming of patients
Croydon Urgent Care Centre took over the initial reception of patients and the treatment of minor illnesses and injuries. As part of the reception process, receptionists questioned patients about their condition to decide whether they should be treated by Croydon Urgent Care Centre or the ED Patients streamed to the Emergency Department waited for further assessment by an ED triage nurse.

The patients who are streamed to the UCC are now assessed by a Healthcare Assistant (HCA) with the aim of being seen within 20 minutes. The assessment utilises an early warning system (EWS) locally modified. If the patient has a high EWS score an UCC clinician is called to transfer the patient to the hospital ED as per local protocol. When available a band 5 nurse supports the HCA.

Initially clinical streaming used a modified Manchester screening tool but created a large 'bottleneck' for patients with resultant very long waiting times. The Emergency Care Intensive Support Team (ECIST) was invited to review the processes. They recommended that Croydon Urgent Care Centre adopt a process of "See and Treat" and non-clinical streaming to replace triage. Croydon Urgent Care Centre adopted these recommendations of the ECIST review after consultation with Croydon University Hospital and the PCT (succeeded on 1 April 2013 by the Clinical Commissioning Group). Streaming and See and Treat were introduced on 9 October 2012. The CCG support the process and is part of their contract specification. The receptionists are specifically trained by Virgin Care the training includes clinical scenarios and the receptionists are then 'shadowed'/mentored.

The EWS is a clinically related process and that in general waiting times became much improved. Any handover of patients to the ED is always the most senior UCC clinician to the most senior EDD clinician on site. The ED and UCC share a cramped waiting area and a new build ED is planned for next year. During the future decant to temporary accommodations, the non-clinical streaming will be suspended and all patients will be triaged by a hospital employed nurse paid for by the UCC.

All children (below age 17) are assessed and triaged by a hospital employed paediatric registered nurse. The children assessed as urgent care are then seen and treated by UCC clinical staff. All these arrangements are under the jointly agreed protocols agreed by both hospital and UCC.

CASE STUDY: Glover St Badger OOH service Birmingham

Summary: GP Registrar training in OOH care, non-financial incentives for education and quality.

Badger provides the OOH training programme for all Birmingham registrars – approximately 120/year. Registrars are offered a structured programme. Two GP registrars were working on the evening shift who confirmed the excellence of the Vocational Training Scheme (VTS). One GP registrar was 'restricted' and the other 'unrestricted'. Registrars have a nominated OOH GP 'buddy' and experience and are trained in all 3 aspects of the OOH clinical service: triage and face-to-face consultations either at the PCC or the patient's home. This phase is described as restricted and lasts for 72 hours of clinical activity. After 72 hours through to the required 108 hours training they undertake 'unrestricted' clinical patient contact, but there is always immediately available GP advice. If the GP registrar has completed training within the year but has not begun work, they must undertake at least a further buddy session of 4 hours and their competence to begin autonomous work has then to be signed off by the Medical Director.

Badger offers GPs a Continuous Professional Development (CPD) membership for £70 per annum of semi-monthly programmes. If a member is CPD compliant, the GP is given preferential weighting for their choice on the GP OOH rota. A similar weighting is offered if a GP can demonstrate clinical audit compliance. Badger uses an adaptation of the Royal College of GPs (RCGP) audit toolkit. All GPs consultations are audited 3 monthly (quarterly). Badger has records of all consultations audits since 2010. A red, amber, green (RAG) rating is used in the assessment of each GPs patient consultation audit. If assessed at 50% or below audit compliant their records are flagged red and if a red rating occurs more than once, the GP is interviewed by the Medical Director – this is a rare occurrence. If assessed as over 80% (green) on 2 consecutive audits, they earn an audit free quarter. The scoring is fed back to the individual GP with comparative information of other clinician's anonymised scoring.

CASE STUDY: Derbyshire Health United (DHU) GP OOH provider

Summary; Integration in particular between a GP OOH service and 'in hours' general practice

RightCare – a scheme which was instigated in 2004 by DHU clinicians to ensure that seamless patient care takes place out of hours, when General Practitioner (GP) practices are closed. RightCare is designed for patients with long term conditions and complex healthcare needs, including end of life patients. Over seven thousand patients are currently in the scheme with plans to continue to offer the service to at least over eight thousand. All the RightCare patients have a care plan completed at their GP practice, which can be accessed with the patients consent via the Adastra software system by the integrated 111/GP OOH service. The Care Plan is accessible to the Emergency/A&E department of the hospital only through an established information governance protocol. The RightCare patients DHU Adastra screen includes patient (and/or their carer where appropriate) consent to access the notes. These patients have their own special phone number and dial in operator to access DHU. Since the service inception there has been a reduction in ambulance call outs and hospital admissions for these patients.

Primary Care Workforce Commission – Q2-4

- The Commission will be interested in evidence of work that may demonstrate ways of using the skills of different professional groups as well as new approaches to deploying traditional skills,
- Evidence you have for why you think these models work well,
- Problems you perceive in implementing these models within the NHS at present.

Evidence submitted by Christine Johnson, GP, NHS Clinical Lead East Midlands and Chair of Vale of Trent RCGP faculty

- When considering models the Primary Care Commission should take the whole 24/7 period into account, not just "in hours" working.

- Urgent care models must work across interfaces with aim for integration and effectiveness.

- Training of the current and future workforce must ensure that the different professional groups are familiar with urgent care models and confident (not just competent) to work in them.

- The recent Barbara Hakin letter in January 2015 requesting greater clinical input into 111 and ambulance hubs does not bring with it any suggestion of how we might achieve a workforce willing and able to undertake the work, in sufficient numbers. There are pockets of success such as Professor Veronica Wilkie in Worcester with ST4 fellowships in urgent care. There is real difficulty replicating this nationally although perception is that they would be very popular. Supporting such fellowships could allow HEE to bring real added value. In addition to such "clinical advisory hubs involving expert generalists such as GPs" Other models involve PC24 at the front door of ED as well as formal urgent care centres. OOH providers continue to modify as well.

- Pharmacists are increasingly placed within NHS 111 clinical hubs. If these are to succeed, they will need appropriate urgent care training and a confidence to close the management of the patient not just sign post the patient back into the system.

- Dental advice in urgent care is crucial as is access to and colleagues clearly linked into the local mental health team.

- Expert Generalists should be able to deal with the complex co-morbidity issues as well as risk assess other factors that may show themselves on special patient notes etc.

- The last 10 years have shown how a variety of models ignoring the input of GPs have ultimately struggled in performance or incident terms.

- GPs with 10 years' experience perform well in terms of dispositions from call handlers in 111. It could be an attractive option for many but the training along with the appropriate remuneration and indemnity package is key. It is right that the commission is about education and training but there also needs to be a clear recognition that highly trained and effective practitioners will demand a higher payment. It is economically wasteful to train up advanced practitioners and then not pay them as they are unlikely to work at certain rates. So the close association with how urgent care organisations treat clinical colleagues is crucial to ensuring any decisions by the Roland Review and associated training, also acknowledges such market factors.

- Ironically using expert generalists is "cheaper" for the "whole system" if unnecessary admissions, ambulances and ED attendances are prevented, but such savings are rarely felt

by the provider organisation employing such expensive but effective resources. The savings are felt remotely and "downstream".

- The current attrition of 111 call handlers varies from 5-30% in different areas. While the model of a call advisors using a pathways algorithm is laudable it requires adequate staffing of rotas to ensure phones are answered. Currently there is no central training of this group so any deficit falls to each individual provider which is costly and impacts on the provider performance as well as not creating a clear career journey for 111 staff.

- Some areas have trained their local student populations, specifically clinical students. This has advantages as they understand the 111 system but are also likely to stay in the locality for 3-5 years and be looking for a salary. However the training for a call handler requires 10 weeks full time, which few students can undertake without substantial planning. The question is, would a modified programme work?

Evidence submitted by Marjorie Gillespie National Medical Director for Primary Care Care UK

- Medical indemnity costs are major barriers to recruitment in out-of-hours care. Medical indemnity providers assess any non-traditional primary care settings as higher risk and charge accordingly. There is no means to demonstrate to the indemnity providers that the risk has been mitigated – for example by having access to the full GP record. Some newer indemnity providers may not cover everything in primary care – for example excluding meningitis. This will hinder the delivery of unscheduled, undifferentiated urgent care in primary care. In order to ensure that that new models of primary care can be implemented, a sustainable solution to these issues is critical.

- Advanced Nurse Practitioners (ANP) can work well in primary care but there is considerable variability in the experience and training of ANPs and currently there is a severe workforce shortage too.

- Emergency Care Practitioners have similarly been used to assess patients in urgent care settings. Healthcare Assistants that undertake some patient visits in general practice. In the urgent care setting, there is scope for using a wider skill mix

- There is huge potential for the role of Physician Assistants (PA), but the unfamiliarity with the role can be a barrier to realising the potential of this group of professionals. Accreditation will therefore be key to overcome this issue.

- The largest barrier to implementing new models of primary care is tradition. Primary care appointments need to be at the times patients need them and for the length of time the patient needs. Adapting from the traditional 10-minute GP consultation would mean that planned care for chronically ill patients is more effective and is less likely to result in urgent care demands. Addressing all the patient's needs – rather than the tradition of just one problem per 10 minute consultation – means more thorough examination and diagnoses and treatments – and patients who are less likely to need the urgent care environment to address their concerns.

- Primary care work environments that offer more flexibility for their clinicians working patterns are more successful in recruitment and retention.

- GP practices that allow GPs to focus on highly skilled, quality clinical care have more engaged, satisfied, stable workforce.

- Primary care work environments that adjust availability of appointments to meet patient demand – e.g. Monday mornings, Saturdays, and Sundays – have more satisfied patients who are less likely to call upon urgent care.

- To deliver more effective medical care in the out of hospital environment, primary care clinicians will need more availability of diagnostic testing, will need rapid results and will need to be equipped to act upon these results. An example is the role of CRP testing in the latest NICE guidance on assessment and treatment of community acquired pneumonia.

FF77 South East CSU

Next page

General Practice Nursing Team Newsletter

January 2015

NHS South East Commissioning Support Unit

The Practice Nurse Advisor Team would like to wish you all a happy and healthy 2015

Patient Group Directives (PGDs)

There are several PGDs due to expire at the end of January. These have been reviewed and will be available shortly. The PGDs will be emailed to practices and also will be available on learningpool - http://kmgp.learningpool.com

The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives is due to be published early this year. During the revalidation process, due to start in January 2016, nurses and midwives will be required to reflect on their practice against this new Code; it is intended that the revised code will be at the center of everyday nursing and midwifery practice. As part of the revalidation process, nurses and midwives will be required to seek feedback from peers and patients on how they uphold their professional standards as set out in the Code. Nurses and midwives will also be required to obtain confirmation from a third party on their continuing fitness to practice. It is proposed that this will come from someone well placed to comment on a nurse or midwife's practice, usually their employer. Appraisals normally focus on assessing an individual's performance against their specific job requirements. Revalidation will enhance this by requiring individual nurses and midwives to reflect on their adherence to the professional code as well as their performance against their job objectives– and as a result reflect on their professionalism and the standards that underpin them as regulated professionals.

Cervical Cancer Prevention Week 25 - 31 January 2015 the focus of the week is on all things to do with cervical cancer, including information about symptoms, causes and ways to prevent the disease. Every day in the UK, 9 women are diagnosed with cervical cancer and 3 women will die from the disease. Cervical cancer is largely preventable thanks to cervical screening and the HPV vaccination programme, yet around 20% of women in the UK decline the invite to be screened. Early detection is the key in increasing survival rates – prevention, education and awareness of symptoms are key to preventing the disease. Cervical Cancer Prevention Week provides us with an opportunity to do just that.
Further information at: http://www.jostrust.org.uk

Cervical Screening invitations: Kent Primary Care Agency sends out invitations to women six months before each woman's 25th birthday to ensure that women are screened by the age of 25. Sample takers, GPs and administrative staff in all primary care settings must be informed of the need to screen women from age **24½.** Women appearing on the Prior Notification List should not have their tests postponed until age 25, and women should not be refused screening if they attend in response to an invitation. It would appear that women are still being advised that they need to be 25 years before eligible for cervical screening, so please ensure that reception staff are aware that invites are sent out to women at **24½** years of age.
Inadequate sample results; following an inadequate result, please ensure that samples are repeated after 3 months. The labs advise that they are frequently receiving samples that are taken too early nhs.uk/cervical/hpv-triage-test-flowchart-201407.pdf

HPV Primary Testing: There have been a number of enquires to KPCA relating to HPV Primary Screening. Women who have moved to Kent and Medway from a HPV primary screening pilot site will come under a different protocol. HPV primary screening means that the HR-HPV test is the first test performed on the cervical screening sample. Cytology then becomes the triage test, performed only when the HR-HPV test confirms HR-HPV to be present. HR-HPV testing is known to be more sensitive for high-grade CIN than cytology and gives a high negative predictive value. Pilots of HPV primary screening are being undertaken in six centers across England to assess how this approach could be used across the programme as a whole. The majority of women who have cervical screening at a primary screening pilot site will receive a negative HR-HPV test result. These women will be returned to routine recall and advised that their next test will be due in 3 or 5 years, depending on their age.

Women who test positive for HR-HPV will have a cytology test performed. If the cytology test shows abnormal cells (borderline changes or worse) women will be referred for a colposcopy examination.

If the cytology test is normal, women will be advised to return for a repeat test in 12 months. If the woman remains HPV positive/cytology normal at this 12-month repeat test, then a further repeat test in another 12 months' time will be advised. At the next repeat test (24 months after the initial test) the woman will either be referred to colposcopy if she remains HR-HPV positive (with no cytology performed), or returned to routine recall if she is found to be HR-HPV negative.

Details of women's screening history can be viewed on Open Exeter, https://www.csp.nhs.uk/files/F000224_Protocol% 20algorithm.pdf

Lithium booklets, warfarin booklets and insulin passports can be ordered from KPCA by emailing andy.hayward@nhs.net, tel 01622 751201. He will require name, contact details, delivery address, products and quantity required.

Meningitis B: It was recommended by the Joint Committee on Vaccination and Immunisation (JCVI) that immunisation against Meningitis B should be offered to children, with the first dose starting at 2 months. These recommendations were dependent on the vaccines being procured at a cost effective price. If negotiations are successful, it is planned that UK will become the first country in the world to roll out a national immunisation programme to protect children from Meningitis B.

Question; should the bubble of air in the pre-loaded flu vaccine syringes be expelled before giving the injection?

Answer; No, when trying to expel the air there is a risk of accidently expelling some of the vaccine and therefore not giving the patient the full dose. The air bubble is also there for a reason – the air injected into the muscle forms an airlock preventing the medication seeping out along the needle tract into subcutaneous tissue and onto the skin. The small bolus of air injected following administration of medication clears the needle and prevents a localised reaction from the vaccination.' (Vaccine Update Dec 2014)

National Review of Asthma Deaths have reported that almost half of deaths due to asthma were avoidable, citing lack of specific asthma expertise and lack of knowledge in the UK Asthma Guidelines in the professionals caring for the patients. The UK has one of the highest asthma death rates in the western world. **https://brit-thoracic.org.uk/guidelines-and-quality-standards/asthma-guideline**

Tissue Viability Support.

To refer a patient to the Tissue Viability Service, please complete a Tissue Viability referral form and send with a photograph of the wound to;

kcht.tissueviability@nhs.net tel 01795 562190

Respiratory Forum
Sevenoaks, dates to be arranged Contact Ruth
ruthwilson5@nhs.net

Respiratory Forum
Maidstone; dates to be confirmed and will be sent out by email.

Thanet Respiratory Group
24th Feb 2015 18.45 – 21.00
Global Generation Church Unit 2 Westwood Business Park, Margate CT9 4JJ. Please email kcht.respteam-thanet@nhs.net

Diabetes Forums
Are due to start in both East Kent and Maidstone. If you are interested in attending, please contact Sue Gassor (East Kent) Hilary Loft (Maidstone)

Guidelines in Practice UK clinical guidelines and related information, www.guidelinesinpractice.co. uk

Asthma Guidelines 2014
https://www.brit-thoracic.org.uk/guidelines-and- quality-standards/asthma- guideline/

Lymme Disease eLearning
Lymme disease is the most common vector borne human disease in the UK, steadily rising to 1200 per year. RCGP have a number of free eLearning programmes- www.eLearning.rcgp.org.uk

Human basal insulin (Lilly)
E- Learning Module
www.humulinonline.co.uk

Type 2 Diabetes; An ongoing challenge. The Village Hotel Maidstone. 26/02/15. Please email currante@lilly.com

A conference for HCAs was held in November at the Ashford International Hotel. The organising committee included the PNA team with the help of other lead practice nurses in the area. The theme for the day was 'Celebrating the Role of the Health Care Support Worker', the day was oversubscribed with 160 HCSW attending.
A number of exhibitors (sponsors and other organisations) supported the conference. Speakers at the conference included;
Sarah Deans, Specialist Diabetes Nurse, KCHT. Hilary Andrews, Clinical Educator,
Nicola Reynolds, Health Trainer with Kent Community Health Trust Damian Fearns, Clinical Psychologist and Stop Smoking specialist Rowena Chilvers and Sarah Ansell -Infection Control Nurses with KCHT. Lorraine Hicking-Woodison, HCSW Advisor
Tanis Hand, UK Adviser for HCAs and Assistant Practitioners at the RCN, Liz Jewel, CEO from the Alzheimer and Dementia Support Services, Liz introduced David Evans, a dementia sufferer, and Kay, his wife. They both gave a very moving, inspirational and at times amusing talk, giving the conference an insight into the challenges faced by families living with dementia.
The conference concluded with an award ceremony: Practices had been invited to nominate their HCAs for an award for 'Outstanding Contribution to General Practice and Patient Care'. Fifteen HCAs were nominated by their practices. Peter Bradley, Editor for the British Journal of Healthcare Assistants presented all the nominees with a certificate. The winner and two runners up were also presented with an additional gift. The comments and appreciation expressed by the practices for the contributions their HCAs make towards the practices and patient care was very humbling and we were all left in no doubt what a valuable contribution HCAs make towards the care of patients and the smooth running of general practice. The day was very well evaluated and appreciated by the HCAs
The presentations from the conference are on available on the LearningPool
http://kmgp.learningpool.com

British Journal of Healthcare Assistants (BJHCA) have offered a saving of 20% when you pay by annual (£71.20 instead of £89) or quarterly (£18.40 instead of £23) direct debit www.magsubscriptions.com/bjhca Quote promotional code HCA5T at the checkout. Valid until 02/02/2015. The journal offers a CPD module in every issue to keep you up to date with your practice and fully prepared for the changes that are affecting your profession.

Progesterone-only Injectable Contraceptive December2014
Updated guidance from the Faculty of Sexual Health and Clinical Guidance
www.fsrh.org/pdfs/CUEGuidanceProgesteroneOnlyinjectables.pdf

Where does the fat go when you lose weight? Many health professional cannot answer this question with many of us believing that it is converted into energy or heat. The correct answer is that most of the mass is breathed out as carbon dioxide, it goes into thin air, according to Ruben Meerman, the lead author of a study looking into this question BMJ,2014; 349

The KCHT First Choice Dressings Formulary Group will be reviewing the BNF sections for Foams and Alginates during February 2015. KCHT Medicines Management Team invite as many nurses and podiatrists as possible to come along and view the exhibits. Your feedback will be considered by the Formulary Group when evaluating Foam and Alginate dressings for inclusion in the First Choice Dressings List. This is the first of a rolling programme of four monthly forums.
Please email if you intend to attend; kcht.pharmacy@nhs.net
Chartham Village Hall CT4 7JA 4th February 2015 Pop in for 30-60 minutes between 10.15am-3.15pm

West Kent Practice Nurse Group Monday 19th January 2015 Supper 7pm, meeting 7.45 Tunbridge Well Nuffield Hospital Kingswood Road TN2 4UL.
Inhaler Devices & Pulmonary Rehabilitation. Speaker; Cath Plumb.
Contact Alison Thorn, Warders Medical Centre, Tonbridge, 01732 770088 or athorn@nhs.net

Maidstone Practice Nurse Group - Meeting currently being arranged for March 2015 if anyone would like to assist in the planning and organizing of the forums, please contact Caroline Flasse

Medway CCG P/N PLT 20th January 2015 at the Village, Maidstone from 1.30-4.30pm.
Topic: Public Health matters- 3 invited speakers to talk on "Quality Sample to Lab" "Contraception services in the community" and "Workforce Development/CPD fund" from Primary Care Facilitator, Marie Boxall.

DGS P/N Lunchtime meeting 28th January 2015 from 12.30-2.30pm GCH room C Topic- Sexual Health Services.

DGS CCG Meeting 11th February 2015 Brand Hatch Thistle Hotel, Dartford
1st session for PN only - TB awareness and infant TB. Speaker TB Specialist Nurse. 2nd session will be joint with GPs.

Swale P/N PLT 21st January 2015
The Best Western and Coniston Hotel (note change of venue) Education for Health trainer on inhaler techniques, and Depression from CPN.

East Kent Details of events will be emailed out to Practice Nurses. Please contact Sue Gassor if you have any queries.

Practice Nurse Adviser Team contact details

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The practice nurse appraisal form

This form is recommended for use as a basis for discussion between a nurse and their appraiser. It is important that the nurse be given sufficient time to prepare this form and gather information at least 1 month before their appraisal interview is due. Not all the sections will be relevant to all nurses.

Section 1: General information

Evidence suggested: job description, NMC registration, prescribing scope of practice statement

Name of Appraisee NMC Number Re-registration date Professional organisation membership (e.g. RCN) Are you named under the practice's indemnity cover? Is it sufficient if you have an extended role? Mailing Address Email Address Practice telephone number Name of the Appraiser(s) Role/relationship (Nurse lead, GP, PM, external Appraiser Date of the Appraisal interview	

What effective qualifications do you hold on the NMC register relevant to your current job?

Examine your role within the practice, broadly describing your clinical work, including any duties which require particular clinical knowledge or skills or for which you have a particular clinical responsibility. Are you a specialist working with a specific group of patients, are you a generalist? Have you developed new skills or extended your role and your level of autonomy? (Non-medical prescribing, minor surgery/illness/injuries, IUD fittings…) Does your job description need updating?
For nurse prescribers, please fill in the Scope of practice document in the appendices

Details of management/administrating responsibilities and activities
Partnership role (i.e. partner in the practice) Management role (within the practice and/or nursing team) Administrative role (data collection, analysis, call/recall audit)

Details of teaching and/or research activities
Staff mentoring (yearly update required) Clinical supervision Teaching (all staff levels) Research activities

Details of work for regional, national or international organisations

Details of other professional activities (forums, special interest groups, clinical supervision)

Section 2: Quality of practice/Good clinical care

This section allows self reflection and helps you to identify key strengths and areas where you may be less skilled. The areas chosen may be clinical and non clinical. ***Fill in the sections that are relevant to you****. You may choose to share your reflection following an audit, a significant event or clinical supervision for instance and through looking back at your last PDP. Evidence suggested: your last PDP, audits, significant event, prescribing data (PACT)*

What have been your main achievements over the last year? (professional or personal)

What strengths or skills do you possess which help you deliver a high standard of care?

What skills would you like to develop to benefit you and the practice in your role?

Are there any barriers in place which prevent you from developing or utilising certain skills?

What could you do to improve this? How could you develop these skills? How could the practice help you improve these skills?

As you look at your objectives from last year, which objectives have you met and how did you meet them?

How has this helped you maintain or improve your delivery of care?

Which objectives have you not met? Have you reflected on why this has happened? Please consider any barriers you encountered and how you might overcome them in the future. Have you identified new learning needs?

Reflection following a significant event
What happened? What did you learn from this? What action was taken to prevent it from happening again? What impact has the change had? How has it improved the way you work? Have you identified areas requiring development and learning?

Reflection following a clinical audit (cervical smear inadequacy rates, prescribing data)
What were the main findings of the audit? Are you satisfied with your performance? What were the learning outcomes? What action was taken? Has it changed your practice? What is your new audit target? Have you identified areas for further development and learning?

Non-medical prescribers and working under PDG/PSD for other nurses
What steps do you take to review your prescribing? How do you audit it? Do you receive clinical supervision? How do you keep up to date? What protocols/guidelines do you work to? Have you identified new learning needs? Do you feel that you are under-using your skills? Have you identified any barriers? How can the practice help you to overcome these? If you are not a prescriber, are you aware of the legislation relating to Patient Group Directions (PGD) and patient Specific directions (PSD)? Are all your PGDs up to date? For situations when there is no PGD, is there a protocol/procedure in place for PSDs?

Reflection issued from clinical supervision
What clinical supervision/support activities have you taken part in the last year? What is the issue you wish to share in your appraisal? What did you learn from the discussion in clinical supervision? What impact has it had or changes have you made to improve your practice? Have you identified further development/learning needs?

Teaching, Training, /mentoring
What are your main strengths and weaknesses as a mentor, or teacher? How has this role changed in the last year, has it improved? What would you like to do better, what are your development needs? What factors constrain you in achieving your aims?

Management activities
What are your strengths and weaknesses? Has your management work improved over the last year? What are your development needs? What factors constrain you?

Section 3: Education/learning activities

Suggested evidence: your learning activity log (CPD), certificates, PREP folder, your last PDP.

In your previous personal development plan, you identified specific learning needs. Which of these have you met and how did you meet them?

How has this helped you maintain or improve your delivery of care?

Which learning needs have you not met?

Why has this happened? Consider any barriers you encountered and how these might be overcome

Have you identified further learning needs?

What other learning activities have you engaged in (not included in your PDP) to maintain and improve your knowledge and skills? (courses, reading, group discussion)

How has this helped to maintain or improve your delivery of care?

Have you identified further learning needs?

How do you like to keep up to date? What is your preferred learning style? What do you find the most effective for you?

Section 4: Relationship with Patients and Colleagues

Suggested evidence: patient questionnaires or surveys, letter of compliments from patients, complaints, perception from colleagues, relevant significant event reports, practice protocols. Colleague feedback questionnaire, teem meetings, structure of the team

What are the main strengths and weaknesses in your relationship with patients?

How has it improved over the last year? What would you like to do better?

What factors constrain you in achieving your aims?

What are your development needs in this area?

What are your main strengths and weaknesses in your relationship with your colleagues?

How has it improved in the last year? What would you like to do better?

What factors constrain you in achieving your aims?

What are your development needs in this area?

Section 5: Accountability

Read the NMC code of conduct and reflect on an issue of your choice (delegation, consent, boundaries of your role…)

Section 6: health and personal circumstances

How is your health? Do you feel that there are any health related issues for you that may put patients at risk or are there any circumstances in your personal or professional life which could have an impact on your personal health and /or affect your ability to carry out your work role in the practice? You may wish to record your HepB status.

What positive steps have you taken to address this? Is there any further action required? Or support needed?

How is your work/life balance? How do you cope with stress? How do you relax?

Section 7: Any other topic you wish to discuss at your appraisal

Highlight any other personal of professional area you would find helpful to discuss. This may include time management, work load management, skill mix, autonomy.

Section 8: New objectives and Personal Development Plan (PDP)

Throughout the course of the year, you will have identified development needs to help maintain the delivery of a high level of patient care. During the appraisal, you will have reflected on your needs, the needs of the practice (Practice Professional Development Plan (PPDP)) and the wider practice population.
This will assist you in agreeing your PDP for the coming year. Areas to cover will be actions to maintain skills and the level of service to patients, actions to develop or acquire new skills and actions to change or improve existing practice.

This section should be drafted prior to the appraisal, discussed at the appraisal interview then finalised once agreed.

Your new performance objectives

Agreed objectives/ What you are hoping to achieve, improve/develo	How does it fit in with the PPDP?	How will you achieve it? What action do you need to take?	Time scale: When does it need to be achieved by?	Measure of success. How will you know when you have achieved it?
1. 2. 3. 4. 5.				

Personal Development Plan/training needs

Development /learning need (knowledge or skill)	How will this be met? Learning method	By what date?	Resources/suppor t needed/cost	Review/how will your practice change as a result of the learning?
Statutory/mandator				
1. 2. 3.				
Essential to professional role				
1. 2. 3.				
Personal/career development needs				
1. 2. 3.				

Objectives and PDP discussed and agreed

Appraiser signature Date

Appraisee signature Date Review

Section 9: Summary of the Appraisal Interview and actions to be taken (by both the appraiser and appraisee)

This section is to be completed after the appraisal and should be used to record any actions required to meet the learning needs identified in the personal development plan and to summarise any detail of the appraisal interview that both the appraisee and appraiser agree should be noted. The summary will be written by the appraiser.

Summary of the appraisal

Action points to be highlighted (for both the appraiser and appraisee)
- - - -

Appraisal summary discussed and agreed

Appraisee signature Date

Appraiser signature Date Review date

Section 10: Appraisee Feedback Form

Name of the appraiser: **Date of the appraisal:** **Name of the practice nurse:**

During the appraisal

How at ease did you feel during the appraisal?

Ill at ease throughout	Ill at ease at times	At ease most of the time	Completely at ease from the start

How well did this appraisal help you to plan your learning needs?

Not very well	Not well	Quite well	Very well

Did you feel that you had a clear and achievable development plan by the end of the interview?

yes	No	Not sure

Did the appraisal interview challenge you to think about your development?

Yes	No

Overall, how did you feel by the end of the appraisal interview?

Very negative	Slightly negative	Slightly more positive	Very positive

Your appraiser

How organised was your appraiser throughout the appraisal process?

Completely	disorganised	Organised	Very well organised

How understanding was your appraiser to you as a nurse?

Appraiser had no understanding	Appraiser had little understanding	Appraiser was fairly understanding	Appraiser was very understanding

Did your appraiser address all the issues you wanted to discuss?

Did not address any issued I wanted to	Addressed some of the issues I wanted to	Addressed most of the issues I wanted to	Addressed all the issues I wanted to

Did your appraiser sum up the appraisal at the end?

yes	No

After the Appraisal

What went particularly well in this appraisal?

What could your appraiser have done to make your appraisal better/easier for you?

Do you have any further comments about your appraisal?

Practice nurse

Signature: **Date:**

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Guidelines for Practice Nurse Appraisals

NHS Kent and Medway 2012

Add logo(do we need to put name too somewhere?)

These Guidelines have been developed by the Practice Nurse Advisors from the Primary Care Development Unit (PCDU) NHS Kent and Medway

Table of contents

1. Introduction
2. Definition
3. Who should carry out the appraisal?
4. Training
5. Confidentiality
6. Phases of the appraisal process
7. Suggested time table for the appraisal
8. Preparing the appraisal
9. The appraisal interview
10. Appraisal summary and Personal Development Plan (PDP)
11. Appraisal Feedback
12. Development
13. Resources
14. Appendices

Appendix 1: The appraisal form (sections 1 to 7)
Appendix 2: Objectives and PDP form (Section 8 of the appraisal form)
Appendix 3: The appraisal summary form and action points (Section 9 of the appraisal form)
Appendix 4: The feedback form (Section 10 of the appraisal form) Appendix 5: Record of learning
Appendix 6: Significant event template
Appendix 7: 360 degree/multisource feedback structured reflective template Appendix 8: Case review structured reflective template
Appendix 9: Patient survey structured reflective template Appendix 10: Data collection/audit structured reflective template
Appendix 11: Scope of Practice statement for Non-medical prescribers (NMP) Appendix 12: Clinical supervision

1. Introduction

Appraisals have long been recognised as an important process that helps both organisations and individuals achieve their goals. The process provides many benefits including:

- A clear idea of what is expected regarding the job responsibilities and roles, increasing job satisfaction
- Helpful feedback giving the nurse a chance to develop and feel valued
- An opportunity to reflect and identify learning needs
- The agreement of a Personal Development Plan (PDP) enabling the nurse to work effectively within the organisation
- Improved communication.

For a number of years, annual appraisals and personal development plans have been mandatory for practice nurses under the GMS contract in order to achieve the management quality indicators. More recently, a series of outcomes and standards developed by the CQC cover this domain too.

A need to develop local guidelines in Kent and Medway was identified in 2011 when it became apparent that the format of appraisals varied very much from one practice to another as well as the range of skills and knowledge amongst individuals carrying out nurse appraisals.

It was felt that guidelines for both practice nurses and their appraisers would help to reduce this disparity and ensure minimum standards. Excellent work has already taken place on this topic with the appraisal handbook produced by NHS Education for Scotland and the RCN practice nurse Appraisal guidelines. We have integrated some of their ideas. We have also looked at GP appraisals as much work has taken place in this field.

The aim of this guideline is to provide GPs, nurses and practice managers with a standard but flexible resource to use in the appraisal process and also to help practices and nurses become comfortable with the idea of appraisal for nurses. The resources provided may be adapted to suit the needs of each practice.

The guidelines and the forms may be downloaded from the following websites:
http://kmgp.nhslearn.com and www.kentlmc.org

2. Definition

The appraisal is a formal review in protected time to reflect on performance, to celebrate achievements, to identify disappointments and to look at the nurse’s developmental needs through setting goals and identifying learning needs in conjunction with the Practice Professional Development Plan (PPDP) for the coming year.

There should be a climate of development rather than blame. Regular staff appraisals are essential for effective team-working and developing good practice.

The appraisal/review is a two-way process, allowing for joint solving of a problems that may hamper performance or development and for joint objective setting. The process should be balanced, with the appraiser being supportive and providing constructive feedback.

Annual appraisals are part of Continuing Professional Development (CPD), a continuous process in order to maintain and further develop competence and performance across all areas of practice, a requirement of the Nursing and Midwifery Council.

The Appraisal process is not about creating unrealistic expectations, a time for disciplinary procedures or a substitute for the appraiser's responsibility to provide ongoing feedback to staff or a counseling session. There should be no surprises.

3. Who should carry out the appraisal?

We recognise the diverse range of employment settings for practice nurses. They are also in a unique position with their diverse roles often varying very much from one practice to another and as an employee of another clinician.
We therefore have outlined a few options inspired from the NHS Education for Scotland Appraisal Handbook.

1. A Lead practice nurse, external to the surgery or a practice nurse advisor from Kent and Medway Commissioning Support
This option is essentially similar to the GP appraisal model and would ensure appropriate professional input to the process. However, the nurse appraiser is unlikely to know the practice well, so would be unable to agree appropriate objectives with the nurse and could not commit practice funds or resources to meeting any agreed development plan. The issue of funding also needs to be taken into consideration. This may be looked into by the CCGs.

2. A senior Nurse within the practice Team
Where there is an identified nurse with responsibility for leading the team, he/she will be ideally placed for the appraisal of staff nurses and health care assistants. In order to work effectively, the practice would need to be prepared to support development plans identified from the process and the appraiser would need to be well informed on the practice's plans and priorities.

3. GP or Practice Manager
This option has the benefit of ensuring that the practice nurse's objectives fit within the overall practice plans and giving a practice commitment to development plans. However, expertise in professional nursing issues will be lacking, which may make it more difficult to agree an appropriate development plan or to appropriately explore and challenge the nurse's self assessment. The appraiser will need to familiarise themselves with the NMC code of conduct and the NHS Kent and Medway Practice nurse competency Framework (please refer to the resource section).

4. A combination of 1 and 3
This Option essentially would involve a professional component of the appraisal taking place with an external appraiser, with a discussion within the practice to agree the coming year's work objectives and to sign off the personal development plan. In considering these, the most important points to consider are:

- The nurse needs to be confident in the person identified as appraiser
- The practice must have confidence in the appraiser if they are to commit to meeting the identified development needs.

4. Training

In order to get the most out of the appraisal process, it is essential that both the appraisee and appraiser be appropriately trained.

The appraisee should be able to reflect on their practice, formulate objectives and identify learning needs in order to fully participate the appraisal process and writing of the Personal development Plan.

The appraiser will need to be suitably trained too, including in the skills of giving feedback to ensure a positive experience and constructive outcomes. GP appraisers will have undergone training so will not be required to attend further training. However, if the appraiser is not a nurse, in order to understand issues relating to nurses, they will need to become familiar with this guideline, the NMC code of conduct and the Practice nurse competences document (please refer to the resource section).

Training is currently available for appraisees (Half day) and for appraisers (1 day) via the Kent and Medway GP staff training centre. Training is also provided in Clinical supervision. http://kmgp.nhslearn.com

It is also recommended that the appraiser attend clinical supervision in order to reflect on their role and share good practice with other appraisers. This could be organised by Kent and Medway Commissioning Support (KMCS) in the future.

5. Confidentiality

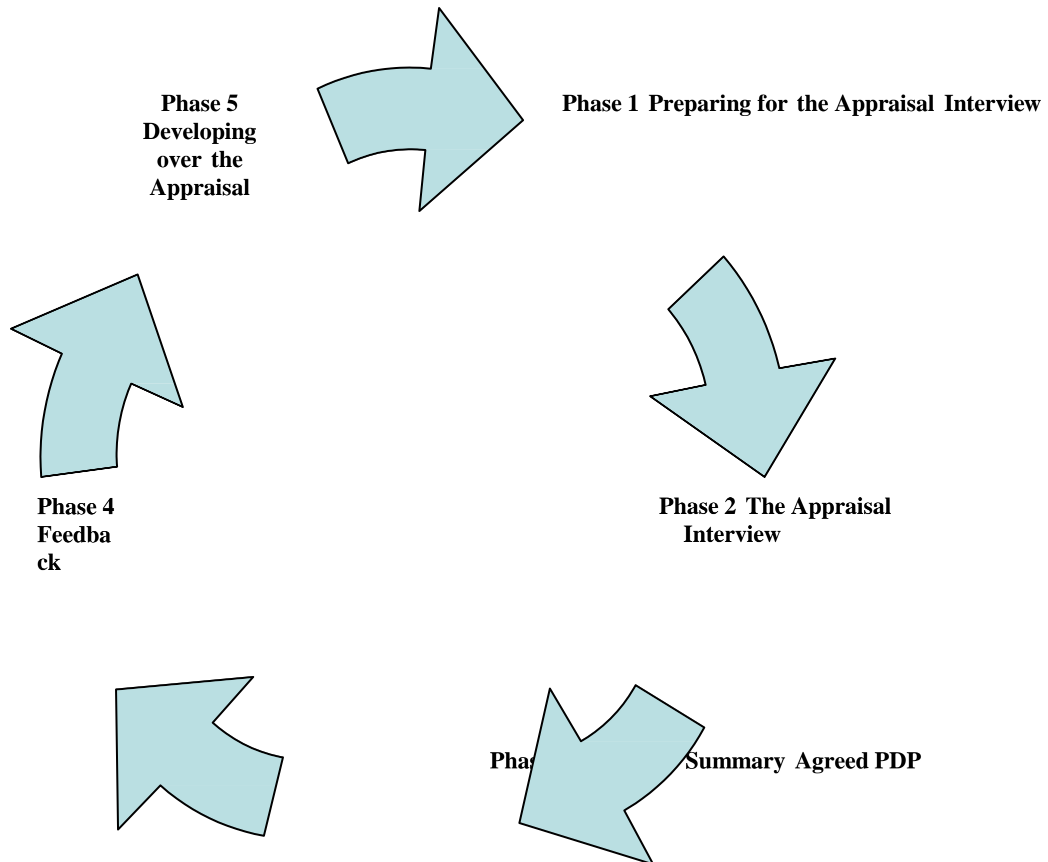
It is essential that the appraisal interview and the documentation surrounding it remain confidential in order to instill confidence in the integrity of the process and encourage openness. The confidentiality will also apply to the appraisee's portfolio. Patient identifiable information should be removed from the documents (names and dates of birth) as well as names of other members of staff.

The only exception to maintaining the confidentiality is in the event of the appraisee acting in breach of the NMC Code of Professional Conduct, when patient safety might be compromised or if an issue arises which requires the appraiser to conform with his/her duties under the appropriate code of conduct**,** Good Medical Practice or the IHM Healthcare Management Code (please refer to the resources section)

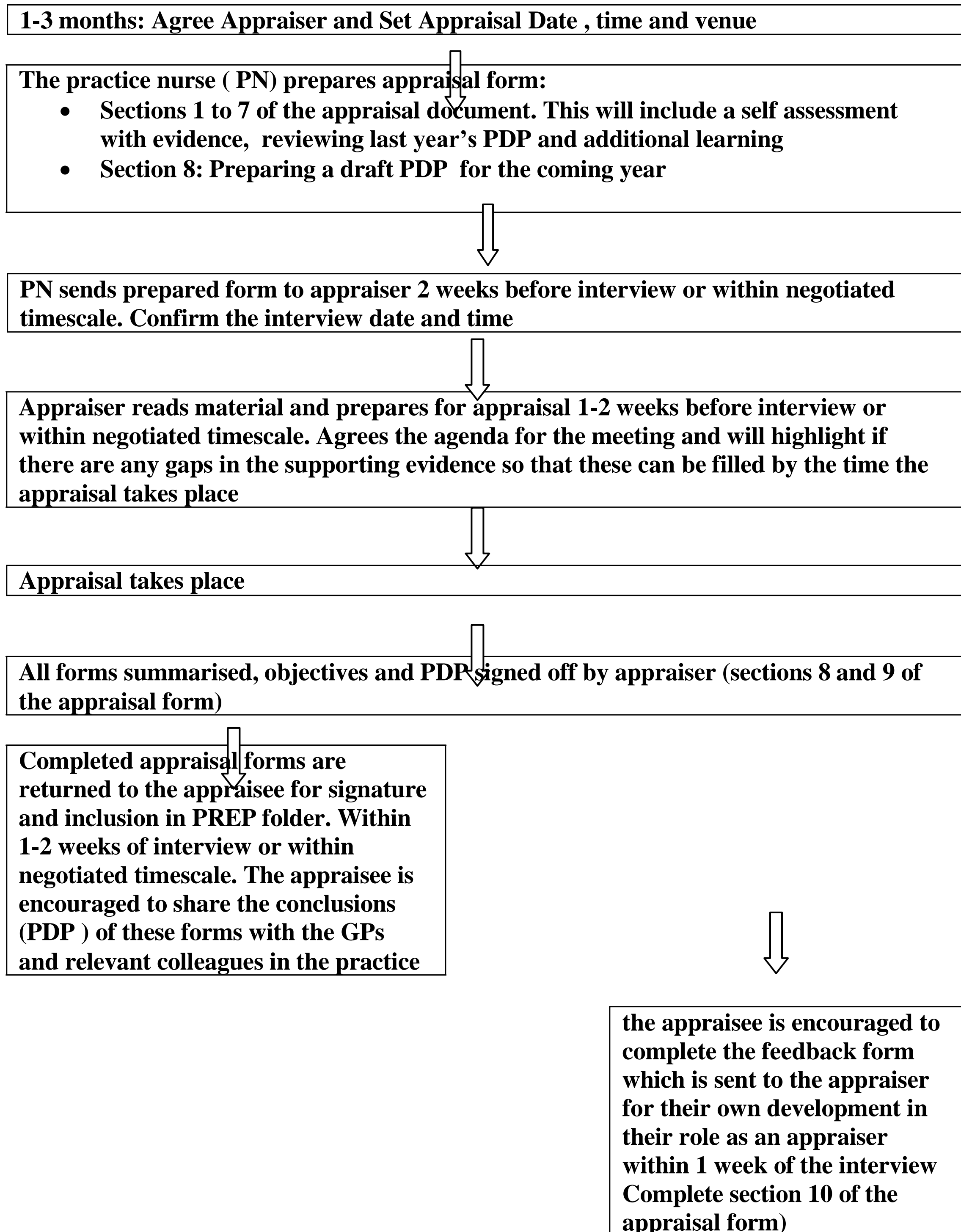
However, the agreed summary of the appraisal and the Personal development Plan may be shared with the appropriate staff in the practice.

6. Phases of the Appraisal process

We suggest the following phases for the appraisal process.



7. Suggested timing for the appraisal process



8. Preparing the appraisal

Between 1 and 3 months prior to your appraisal, you should agree a date for the appraisal interview with your appraiser. You should then start to complete the appraisal form to allow time to reflect and collate the necessary forms and evidence. This will allow the appraiser sufficient time to read through the documentation you send them.

Collecting evidence about the way you meet your objectives and professional development needs as well as identifying new professional needs and objectives should be a continuous process throughout the year. You should start reviewing these 3 months before your appraisal interview.

The work you put into completing the form is your main preparation for the appraisal and the value of your appraisal will largely depend on it as it will be a basis for much of the discussion.

At this stage, sections 1 to 7 should be completed and a draft PDP in section 8. Sections 8 to 10 will be completed after the appraisal interview. It is not expected that you will provide exhaustive details about your work but the material should convey the important facts, themes or issues and reflect the full span of your work as a nurse. It may be that some sections are not relevant to your work so may be left out.

This chapter will offer helpful notes to assist in completing the appraisal forms. These may be downloaded from the following website: http://kmgp.nhslearn.com. The appraisal form can be found in Word format to allow you to adjust it to your requirements.

Section 1: General Information

This section covers your personal details, where you work, your NMC registration.

You are also invited to look at your scope of practice, your current roles and responsibilities. You should include your current entries in the NMC register. The template will allow you to consider the wider aspects of your work. Have you developed new skills or extended your role and your level of autonomy? Does your job description need updating? Is your indemnity cover sufficient for your extended role (Minor illness, injuries, Non-medical prescribing, family planning, leadership, management, teaching, mentoring, research, minor surgery…)?

Helpful tools will include

- The **NHS Kent and Medway Practice Nurse Competency Framework**. This can be found at: http://kmgp.nhslearn.com
- **The Knowledge and Skills framework** accessed on the Department of Health website: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090843
- The **Practice Nurse Toolkit** from the Royal College of Nursing (RCN) http://www.rcn.org.uk/development/general_practice_nurse_toolkit

Suggested evidence: NMC registration documents, current job description, indemnity cover document, activity log (smears, IUCD or implant fittings, minor surgery, prescribing data, the scope of practice statement for non-medical prescribers)

NMC registration: Employers have a dedicated service at the Nursing and Midwifery council (NMC) to confirm registration of nurses http://www.nmc-uk.org/Employers-and-managers/

Section 2: Quality of Practice/Good clinical care

This section allows you to reflect on the key strengths of your role and to identify areas where you may wish to develop. You should also consider any barriers to developing or using your existing skills. Once these have been identified, consider how this situation could be altered in terms of actions you could take and how the practice could help you develop existing strengths.

This is not about being unable to deliver a particular aspect of care because of lack of training. It is less about what you do and more about how you do it, the personal attributes you possess or may wish to develop.

You will need to demonstrate that you regularly participate in activities that review and evaluate the quality of your work.

Now review your past objectives and Personal Development Plan (PDP).

Reflect on your past objectives and what you have achieved. It is not always possible to achieve all objectives within the year, so you may wish to explore why you have not achieved your objective, do you still have a need in this area that should be carried forward? Were there any barriers to achieving the objective? How might these factors be minimised in the future?

Now look at your last PDP, were you able to achieve it? How has the clinical care you provide improved in the last year? Were there any barriers? Was there congruence between your PDP and the practice learning plan? How can your present an action plan to overcome the barriers? Have you identified new learning needs? What is your evidence

to confirm that you have completed your PDP? Have you reflected on why areas may not have been adhered to?

You should also consider other achievements that were not included in your plan.
You may look at your contribution to a particular achievement (as an individual or as part of a team) and analyse how this achievement came about in order to celebrate and learn from your successes.

Suggested evidence: Your last PDP, Reflective diary, reflection and outcomes issued from clinical supervision, the scope of practice statement for Non-medical prescribers, significant events or clinical audits for instance.

Significant Events also known as untoward or critical incidents are any unintended or unexpected event which could or did lead to harm of one or more patients. This includes incidents that did not cause harm but could have done, or where the event could have been prevented. You should discuss significant events that have involved you at your appraisal, with a special emphasis on what has been done to change practice or demonstrate learning. The appraiser will be interested in any action you took or any changes you implemented to prevent such event or incident happening again. *A template has been included in the appendices.*

Clinical audits: cervical smear inadequacy rates, data from chronic disease clinics, vaccination uptakes, smoking cessation success rates, PACT (prescribing data + reflection). What were the main findings of the audit? What were the learning outcomes and what action was taken?
A template has been included in the appendices.

Clinical supervision: participation in clinical supervision is recommended by both the NMC and the Royal College of Nursing. It encourages reflective practice and leads to improved skills and knowledge. *Further information may be found in the appendices*.

Section 3: Education/learning activities

Nursing in General Practice covers a very broad spectrum of skills and involves caring for a wide range of patients (children, the elderly, the healthy, patients with chronic diseases or acutely unwell). This requires practice nurses to keep up to date in many areas and they should embrace the principle of "lifelong learning" supported by the NMC. A practice nurse must demonstrate continuing professional development (CPD) and achieve as a minimum the NMC Post-Registration Education and Practice standards (PREP).

The NMC PREP standards (NMC 2011) require that all nurses maintain a personal, professional profile of their learning activity and must comply with any request from the NMC to audit compliance with these activities. Guidance is available on the NMC website www.nmc-uk.org.

The PREP standards are requirements set up by the NMC and are a legal requirement in order to maintain registration for Nurses and Midwives. **The PREP practice standard** requires practice for a minimum of 450 hours during the 3 years prior to the renewal of the registration. **The PREP CPD standard** requires a minimum of 35 hours of learning activity relevant to your practice during the 3 years prior to the renewal of the registration.

The learning need not be formal and can take other forms such as shadowing colleagues, reading, debating and discussion with colleagues, reflection on your skills and knowledge and actions resulting from this reflection. How do you like to keep up to date? What professional journals do you read regularly? What steps in the past year have you taken to improve your knowledge and skills? What is your preferred learning style? Simply attending learning activities is not sufficient, you should be able to demonstrate your reflection on the learning activity and explain the impact on your practice. Has it lead to any changes in your practice? What has improved?

Statutory and Mandatory training:
Fire safety, Basic Life support, child/adult protection awareness, anaphylaxis training and infection control

Other training will be required in order to attain and maintain competences:
Immunisations (Yearly update), cervical screening (3yearly update in Kent and Medway), diplomas in chronic disease management, family planning…, various updates

Further opportunistic day to day learning may also be added in addition to the planned learning in your last PDP.

Suggested evidence:
Last PDP and reflection on learning that took place, with the impact on your practice, learning log (*example in appendices*), and certificates.

Section 4: Relationship with Patients and colleagues

4.1. Relationship with Patients

What are the main strengths and weaknesses in your relationship with patients? How has it improved over the last year? What would you like to do better? What factors constrain you in achieving your aims? What are your development needs in this area?

Suggested evidence: Patient questionnaires or surveys (what have you learned from them and how have you changed your practice?), patient leaflets, protocols, consent guidelines, relevant significant event reports, letters of appreciation, compliments or complaints. These should be discussed at the appraisal and any change or action taken as a result of any compliment or complaint. Are there further development needs identified?

4.2. Relationship with Colleagues

What do you think are your main strengths and weaknesses, how has it improved in the last year? What would you like to do better? What are your development needs it this area? What factors constrain you in achieving your aims?
A colleague feedback questionnaire is sometimes used. It is usually anonymised and aims to provide you with information about your work through the eyes of those you work with. If you used this tool in for your last appraisal, share your reflection on the feedback and the actions you have taken. *A template has been included in the appendices.*
Suggested evidence: 360 degree feedback form/multisource feedback, team meetings, structure of the team.

Section 5: Accountability

Take the opportunity to review the NMC code and consider whether there are issues surrounding your accountability in the practice (boundaries of your role, accountability to other staff, delegation, confidentiality…).

Section 6: Health and personal circumstances

How is your health? Do you feel that there are any health related issues for you that may put patients at risk? What steps have you taken to address this? Is there further action required? Are there any circumstances in your personal or professional life that could have an impact on your personal health and /or affect your ability to carry out your work role in the practice?
How is your work/life balance? How do you cope with stress? Relax?

Section 7: Any other topic you wish to discuss

Use this section to highlight any other personal or professional area you would find helpful to discuss at your appraisal.

Section 8: New objectives and Personal Development Plan

Prior to the appraisal, you should aim to draft your personal development/action plan. At the appraisal, your appraiser will discuss it with you and assist you in formulating your development needs before agreeing the final version.

The development of your PDP is a central part of the appraisal process. The contents will set your learning agenda for the coming year and should facilitate reflective practice. Through looking at the previous sections of the appraisal, you will have identified learning needs or actions and may incorporate these in your PDP.

The PDP is not a wish list but rather a process of individual development that fits in with the practice development plan and the needs of the patient population and identifies what you need to be effective in your role. Look at additional skills and knowledge you may need to acquire to help you do your job better. The learning must be relevant to the current and emerging knowledge and skills required for your specialty of practice, professional responsibilities and areas of development in your work.

The final version of the performance objectives and PDP will represent a formal agreement between the appraisee and appraiser on the learning and development needs, with an outcome based learning plan for the subsequent year. This will be reviewed at the next appraisal together with evidence of completion.

Best Practice for Non Medical Prescribers (NMP) is to complete a Scope of Practice Document and identify training needs depending on the areas of clinical care that they are prescribing for. This can be a challenge and difficult to define when a clinician has a wide role and is prescribing for a number of conditions. The Scope of Practice document can assist to highlight discrete clinical areas e.g. Diabetes or Family Planning or the NMP may wish to identify entire BNF chapters as their area of practice.
A template for the scope of practice document can be found in the appendices.

The objectives need to be **SMART**: Specific, Measurable, Achievable, Relevant and Timed.

> **Specific:** you need to identify the area that needs to be improved and what action needs to be taken, state clearly what is to be achieved and who is going to make the change. A task may be best achieved as a series of smaller tasks.
> **Measurable:** You need to state how you are going to check or measure that you have achieved this objective, who will do this? Usual measures can include times and quantities
> **Achievable:** check that the measures to be put in place can be achieved or realistic and are sustainable. An objective may be achievable but it may not be realistic at present because of lack of resources (time, money or staffing).
> **Relevant:** The objective needs to be relevant to what you are aiming to achieve and relevant to your work
> **Timed:** You should agree a date by which the improvements will be made

Beware of being over ambitious and setting too many objectives. In order to meet your objectives, you will need an action plan and this will constitute your PDP, identifying your training and development needs and the support and resources required to achieve your goals.

A useful resource is the **Practice Nurse Toolkit** from the Royal College of Nursing (RCN) http://www.rcn.org.uk/development/general_practice_nurse_toolkit

9. The appraisal interview

The appraisal interview provides an opportunity to discuss your job, hopes, aspirations and plans, look at your progress and development, reflect on your performance, and how your personal plan fits in with the wider planning of the practice, give and receive feedback that is honest, sensitive and respectful.
The completed self-assessment forms a starting point to this discussion.

The interview should be held in private at an agreed venue and sufficient time should be allocated for the appraisal: between 60 and 90 minutes. It is important that time is committed to the process if it is to offer an opportunity for positive discussion.

It is essential that the appraiser set a positive and supportive tone from the outset of the interview. The appraisal interview should be mainly appraisee led, however it is also important that the appraiser to offer both positive and constructive feedback whilst looking at the past year's achievements.

The appraisal interview could be structured as follows:

- The parameters around confidentiality
- The aims of the appraisal interview
- The role of the appraiser and their expectations of the appraisee during the interview
- Go through the agenda and ensure there is an agreement on the topics and order to be discussed
- Discuss the completed description of the appraisee's work and update it if needed (may need to update job description)
- Review the PDP and learning activities and objectives from the previous year and consider how this has been adhered to, does it comply with the NMC PREP standards?
- Presentation of the evidence as required (is the quality and the quantity of evidence sufficient?) Explore the reflection and actions taken
- Agree objectives and a plan for the coming year and the concurrence of this plan with the practice strategic plan.
- Discussion and agreement on learning needs for the coming year
- Cover any other issue that the appraisee wishes to discuss

Take sufficient notes to complete the appraisal forms, including the PDP.

In Summary, the main outcome of the interview should be an agreement on how to build for the future, based on the evidence provided. The focus of the appraiser should be to ensure that the appraisee has:

- Provided information for the areas discussed
- Completed objectives and a PDP that is relevant and prioritised
- Consider whether the PDP is achievable in the time limits stated.

If at any time, the appraiser has a significant cause for concern regarding the appraisee's health, conduct or performance, the interview should be stopped and they should be aware of the procedure in place to deal with this situation and be guided by their professional regulations.

The NMC Code (NMC, 2008) states "you must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk".

The GMC (GMC, 2006) states "you must protect patients from risk of harm posed by another colleague's conduct, performance or health. The safety of patients must come first at all times. If you have concerns that a colleague may not be fit to practice, you must take appropriate steps without delay, so that the concerns are investigated and patients protected where necessary. This means you must give an honest explanation of your concerns to an appropriate person from your employing or contracting body, and follow their procedures".

"If there are no appropriate local systems, or local systems do not resolve the problem, and you are still concerned about the safety of patients, you should inform the relevant regulatory body. If you are not sure what to do, discuss your concerns with an impartial colleague or contact your defense body, a professional organisation, or the GMC for advice".

10. Appraisal summary and PDP

This involves completing sections 8 and 9 of the appraisal document.
After the appraisal, the summary will be completed by the appraiser, recording the main outcomes of the interview. The PDP should then be completed, both documents should be agreed by both parties, signed and each keep a copy.

With the appraisee's consent, a copy of this summary and PDP may be put on file in the practice. The appraisee should file their copy in their PREP folder.

11. Appraisal feedback

After the appraisal, the appraisee may complete section 10 of the appraisal form. This consists of feedback to be given to the appraiser in order to allow reflection on their role as an appraiser and help them to identify their own learning needs and areas that may need improvement.

12. Development

The PDP can be used throughout the year to plan, manage and monitor the appraisee's own development.
Follow up actions by both the appraiser and appraisee need to be actionned and there may be an informal 6 months review or earlier if required, to coincide with the timing of the objectives. This continuous process will facilitate the preparation of the next annual appraisal and will help to address any constraints preventing the completion of objectives.

13. Resources

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14. Appendices

Appendix 1: The appraisal form (sections 1 to 7)
Appendix 2: Objectives and PDP form (Section 8 of the appraisal form)
Appendix 3: The appraisal summary form and action points (Section 9 of the appraisal form)
Appendix 4: The feedback form (Section 10 of the appraisal form) Appendix 5: Record of learning
Appendix 6: Significant event template
Appendix 7: 360 degree/multisource feedback structured reflective template Appendix 8: Case review structured reflective template
Appendix 9: Patient survey structured reflective template Appendix 10: Data collection/audit structured reflective template
Appendix 11: Scope of Practice statement for Non-medical prescribers Appendix 12: Clinical supervision

FF80 South East CSU

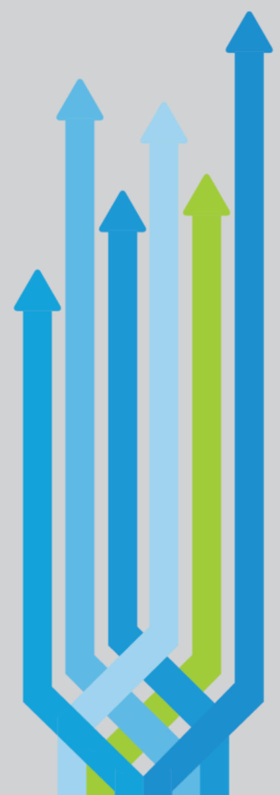
Next page

KMCS>

Service Offer Specification Practice

Nurse Advisory Service Version 1.1

11 July 2014



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Service specification	
Service:	Practice Nurse Advisory Service
Customer:	West Kent CCG
Customer lead:	
KMCS lead:	Amelia Stecher
Version:	Version 1.1
Date:	11 July 2014
Document Status:	Proposed specification

Document history			
Version	**Date**	**Author**	**Comments**
1.0	24 June 2014	Caroline Flasse	Proposed specification
1.1	11 July 2014	Caroline Flasse	Edits and additions from WK feedback

Approvals records			
Version	**Date**	**Approver**	**Comments**

Proposed specification

1 Service Overview		
Servi		10 Practice Nurse Advisory Service

The PNA service will support the Quality Agenda for the Area Team and the CCGs by providing professional support and leadership for Primary Care Nursing Teams employed by GP practices across Kent and Medway.

This service specification covers the following service lines:

Code	Service Line Description
10.1	Professional support for Primary Care Nursing Teams
10.2	Advice to GP Staff Training Team (GPSTT) and CCGs on PN Training requirements
10.3	Benchmarking Primary Care Nursing Standards
10.4	Supporting the Quality Agenda for Primary Care Nursing Services

2 Benefits and Outcomes for Customers

The key value and benefits of the service are as follows:

Advisory

- Act as a resource for Kent and Medway CCGs and GP practices within their area of specialist clinical practice. Each Practice Nurse Advisor has a thematic lead area which will be shared collaboratively across Kent and Medway CCGs
- Local knowledge and established relationships with the CCGs members
- Familiarity with the local provider landscape
- Extensive skills, understanding and unique local knowledge of primary care
- Act as a Broker and support GP Practices to access appropriate training and resources
- Expert knowledge of local services and trends

Quality

- Work Collaboratively across Kent and Medway CCGs
- CCG Board assurance
- Potential to reduce risk for patients and practices, reduce health inequalities and improve health outcomes for patients
- Support for Primary care SI investigation (work for the Area Team)
- Benchmarking standards for Primary Care Nurses, Assistant Practitioners and Health Care Assistants for training and competencies
- Providing clinical expertise and supporting the GP Staff Training team in the organisation of Bi-annual Practice Nurse and Health Care Assistant Conferences with the aim of updating General Practice delegates in essential topics and upcoming changes to areas of practice.
- Interpretation of national guidance and policy for ease of implementation locally

For example in Cervical cytology, immunisation, the role of the health care assistant

- Established relationships with key stakeholders – local, regional and national.
- Assistance to the Area Team and CCGs to ensure quality assurance and continuous improvement of primary medical services (via Newsletter, representation at the Quality Hub, advising the GP staff training team on the provision of high quality education for primary care

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2 Benefits and Outcomes for Customers
staff, developing guidelines for Health care support workers)

3 Service Specification					
Code	**Service Description**	**Service Type**	**Core/ Additional**	**KPI(s)**	**Pricing Approach**
10.1	**Professional Support to Primary Care Nursing teams**				
10.1.1	Telephone and e-mail professional support to Primary Care Nursing Teams and their employers.	Provision	Core	OCS31	Block
10.1.2	Bi –monthly practice nurse newsletter	Output	Core	OCS32	Block
10.1.3	Provision of support and clinical expertise to the GPSTT for the Bi-annual Primary Care Nursing Conferences (Practice nurses and HCA) in order to produce a balanced and relevant educational programme, including stat and mandatory training and taking into account the CCGs' commissioning intentions affecting primary care and Health Education England strategy	Provision	Core	OCS33	Block
10.1.4	Provision of Clinical Supervision	Provision	Additional and Bespoke	-	TBC
10.1.5	Direct mentoring and assessment of nursing staff within primary care	Provision	Additional and Bespoke	-	TBC
10.2	**Advice to GP Staff Training Team and CCGs on PN Training requirements**				
10.2.1	Telephone, e-mail and face to face advice to GPSTT and CCGs. This will help to shape the training requirements for primary care nursing teams alongside the training needs assessment	Provision	Core	OCS34	Block
10.2.2	Assist with facilitation of Protected Learning Time events for Primary Care Nursing Teams	Provision	Core	OCS35	Block
10.2.3	Work collaboratively with Primary Care Tutors to deliver priorities for each CCG	Provision	Core	OCS36	Block

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3 Service Specification					
Code	Service Description	Service Type	Core/ Additional	KPI(s)	Pricing Approach
10.2.4	Supportive visits to GP practices	Provision	Additional	-	TBC
10.2.5	Delivery of direct training to Primary Care Nursing Teams	Provision	Additional and Bespoke if requested	-	TBC
10.2.6	Co- production with the GP Staff training Department E learning provision through its dedicated learning platform. Authoring of bespoke e-learning	Provision	Additional and Bespoke if requested	-	TBC
10.3	**Benchmarking Primary Care Nursing Standards**				
10.3.1	Producing and disseminating Guidance to GP practices regarding Health Care Support Workers, appropriate delegation, scope of practice and preparing for regulation in line with National guidance (Skills for health) and bodies	Output	Core	OCS37	Block
10.3.2	Sharing knowledge and learning from professional performance issues	Provision	Core	OCS38	Block
10.3.3	Identification in variations in the quality of care and agree bespoke interventions that will reduce variation and support practices at risk of failure (reporting from individual practice nurses or GP practices, Public health (Immunisations and Cervical cytology), the area team (Quality Hub), audits of primary care provision of services (Work for the Area Team)	Provision	Additional	-	TBC
10.3.4	Providing advice to contracting of Local Enhanced Services (LES) and Reviewing the delivery and effectiveness of the LES (audit)	Provision	Additional	-	TBC

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3 Service Specification					
Code	**Service Description**	**Service Type**	**Core/ Additional**	**KPI(s)**	**Pricing Approach**
10.3.5	Support to failing practices and, where appropriate, assistance with the return to good standards of Practice Nursing (Providing recommendations including up to date policies and guidelines)	Provision	Additional	-	TBC
10.4	**Supporting the Quality Agenda for Primary Care Nursing Services**				
10.4.1	Interpretation of National guidance and informing local implementation	Provision	Core	OCS39	Block
10.4.2	Primary Care Nursing Link between K&M CCGs and NHS England.	Provision	Core	OCS39	Block
10.4.3	Help to inform the Primary Care Strategy (Health Education England) (workforce, mentorship)	Provision	Core	-	Block
10.4.4	Providing advice regarding SI affecting primary care (Work for the Area Team)	Provision	Core	-	Block

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4 Customer Responsibilities			
Specific customer responsibilities are set out below:			
Ref	**Description**	**Service line(s) affected**	**Frequency**
1	Providing a lead contact person within each CCG to liaise with PNA service	10.1 10.2 10.3 10.4	Ad-hoc
2	Written feedback report	10.1 10.2 10.3 10.4	Quarterly

5 Service Delivery Model		
Service delivered remotely with close liaison with CCG team Use of PN database to support work Use of local and national best practice and policy The service delivery model will be support by the following process maps, methodologies and/or operating procedures :		
Ref	**Type**	**Description**
1	Lead Practice Nurse Advisor	0.5 WTE for Kent and Medway. Responsible for team co-ordination, direct reporting to NHS England Area team and quarterly reports to CCGs.
2	Practice Nurse Advisors for all 8 CCGs	One PNA responsible for DGS, Medway and Swale One PNA responsible for West Kent CCG One PNA responsible for Eastern and Coastal CCGs
3	Health Care Support Worker Lead Kent and Medway	0.2 WTE Lead for Health Care Support Workers. Expertise informing primary care providers on scope of practice and appropriate delegation.
4	All PNAs will have a Thematic Lead Area	The following thematic lead areas will be used collaboratively across the Kent and Medway CCGs. Respiratory, Diabetes, Non Medical Prescribing, Immunisation and Vaccination.

6 Key Performance Indicators			
Success will be measured using the following KPIs:			
Ref	**Description**	**Methodology**	**Target/Threshold**
OCS3 1	Routine enquiries will be triaged (e-mail, phone) and processed within 3 working days	Audit	90%
OCS3 2	Bi-monthly newsletter (6 a year)	Number of letters sent	100%
OCS3 3	Bi-annual HCA and PN conference	Production of a balanced and relevant educational programme	(Positive evaluation from 90% delegates)
OCS3 4	Triage routine enquires regarding training requirements processed within 3 days	Audit	90%
OCS3 5	Number of PLT events facilitated	Service delivered	80%
OCS3 6	Liaise at least once a quarter with primary care tutors from each CCG	Evidence of meetings	100%
OCS3 7	Initial guidance on HCSW sent out to GP practices by the end of July 2014	Guidance sent out	Y/N
OCS3 8	Quarterly brief to CCGs on knowledge and learning from professional performance issues	Brief report delivered	100%
OCS3 9	Briefing regarding quality issues affecting primary care nursing and actions taken	Brief report delivered	100%

7 Internal/External Dependencies			
Delivery of the service is dependent on the following:			
Ref	**Description**	**Service line(s) affected**	**Internal/External**
1	Co-dependency on GP staff training team	10.2	Internal
2	HR – finance – IT	10.1 10.2 10.3 10.4	Internal
3	OCS unit manager	10.1 10.2 10.3	Internal

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7 Internal/External Dependencies			
		10.4	

8 Service Boundaries

Please see additional (non-core) service offers subject to further funding.

The following areas are specifically excluded from this service offer:

Ref	Description	Service line(s) affected
1	Leading on Specific Serious Incidents (SI) in primary care	10.4.4
2	Advertising for job vacancies in primary care	10.1.1

**** END****

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FF81 South East CSU

Next page

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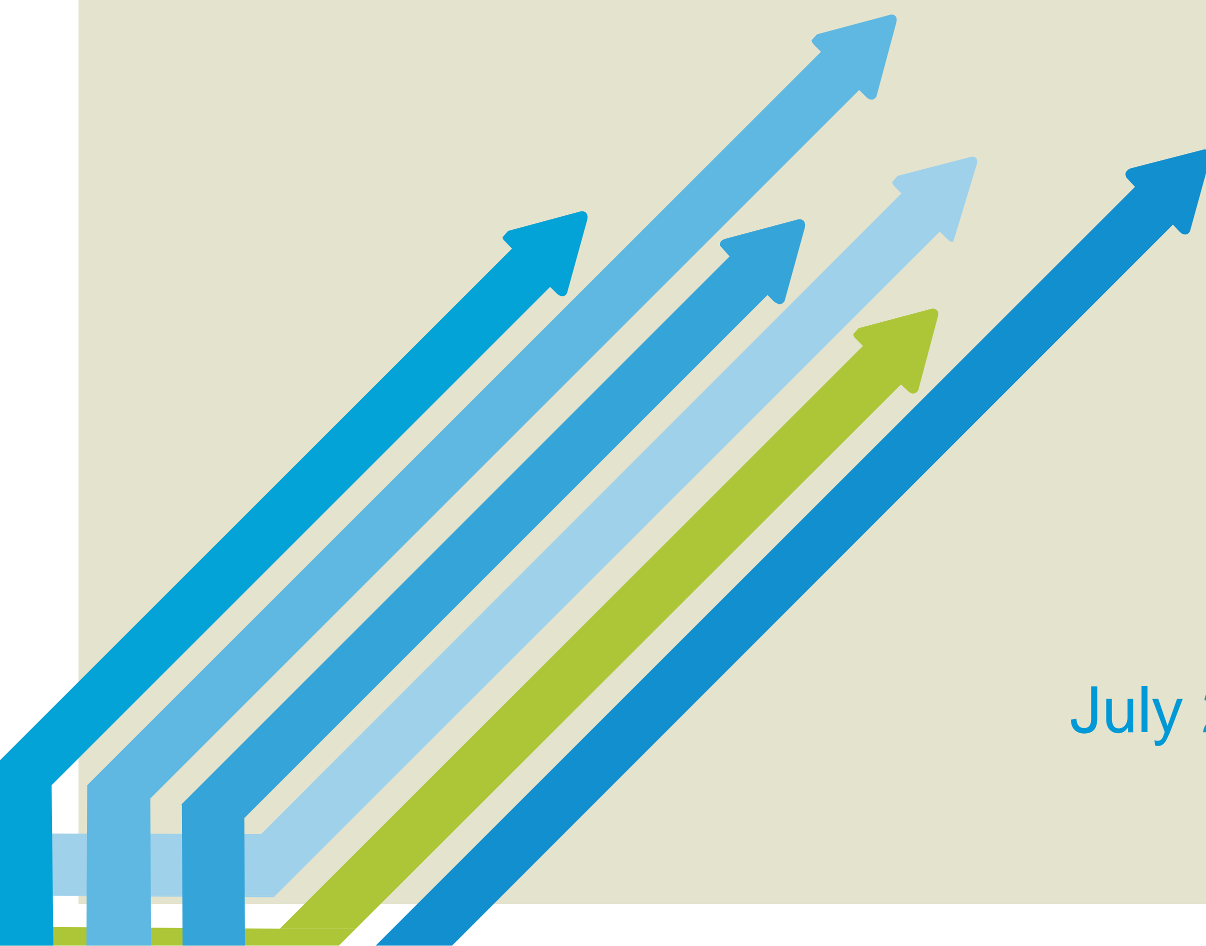
Code of Conduct for Kent and Medway G.P. Practice Healthcare Support Workers.



July 2014

Code of Conduct for Kent and Medway G.P. Practice Healthcare Support Workers.

Contents:

Contents:	Page:
Foreword	2
Acknowledgements for contributions	3
Introduction	4
Code of Conduct	6
Glossary of Terms	14
References	15

July 2014

Foreword

The role of health care support workers (HCSWs) in GP surgeries has developed considerably in recent years and yet, in the absence of regulation for HCSWs there is relatively little good quality guidance for their practice. This suite of resources is a much welcomed addition to the practice shelf, and will be useful for every team member in the practices within which they work. They will benefit staff and patients alike and should be implemented consistently across the region.

The resources build on national standards for HCSWs from across the UK and make them relevant to general practice. The core standards reflect the knowledge and values that support quality care, and the code of conduct will give HCSWs confidence in understanding the standards that are expected of them. The resource pack for HCSWs not only explains key issues including mentorship, accountability and training, but also provides examples of key documents that will be useful for the practice team from sample job descriptions to PSDs.

The resource suite will also support employers in understanding their responsibilities in enabling HCSWs to work in the most appropriate and effective ways within the practice. They have been well researched and are written in a language that is accessible to all. Most importantly they reinforce the importance of patient centred care throughout.

Tanis Hand HCA Adviser, Royal College of Nursing

This document has been compiled by Lorraine Hicking-Woodison, Assistant Practitioner, Healthcare Support Worker Adviser, and part of the Practice Nurse Adviser team for Kent and Medway Commissioning Support (KMCS)

Acknowledgements for Contributions

Caroline Flasse - Lead Practice Nurse Adviser (KMCS) Sue Gassor - Practice Nurse Adviser (KMCS)

Tanis Hand- Health Care Assistant Adviser. Royal College Nursing (RCN). Hilary Loft- Practice Nurse Adviser (KMCS)

See Skoda- Practice Nurse Adviser (KMCS)

This document can be found on the Kent LMC website at
http://www.kentlmc.org/kentlmc/website10.nsf/pages/home/

And GP staff training e-learning platform http://kmgp.learningpool.com/login/index.php

Introduction.

This is a Code of Conduct for Kent and Medway G.P. Practices. It has been developed by the Practice Nurse Adviser team at Kent and Medway Commissioning Support Unit. It is a guideline to ensure service users and the public receive a consistent, high-quality, safe and effective service from Healthcare Support Workers (HCSW) and comes in conjunction with **Essential Knowledge and Core Standards** for Healthcare Support Workers and a **Code of practice for G.P. Employers**. **A HCSW resource pack** has been developed to support this code. These can be found on the same website.

This code of conduct has been inspired by the excellent work that has already been undertaken by Skills for Health which can be found at http://www.skillsforhealth.org.uk/workforce-transformation/code-of-conduct-and-national-minimum-training-stan/

Healthcare Support Workers make a valuable and important contribution to the delivery of high quality healthcare. This Code of Conduct describes the standards of conduct, behaviour and attitude recommended of all Healthcare Support Workers employed within Kent and Medway G.P Practices.

Health Care Support Workers are responsible, and have a duty of care, to ensure their conduct does not fall below the standards detailed in the Code and that no act or omission on their part harms the safety and wellbeing of service users and the public, whilst in their care.

Scope.

The Code applies to all Healthcare Support Workers employed within G.P.Practices within Kent and Medway as a benchmark to ensure high quality safe care.

What will this Code mean for Healthcare Support Workers?

- This will provide a set of standards, to ensure Healthcare Support Workers can know the standards they are expected to meet.

- Healthcare Support Workers can use the Code to identify areas for personal development and improvement.

- The Code will support Healthcare Support Workers to fulfil the requirements of their role, in order to protect service users, public and others from harm.

How will this Code help Managers?

- The code will help employers to understand the standards they can expect of Healthcare Support Workers.
- It will assist employers in identifying training and support needs.

How will this Code help the Public?

- It provides an assurance framework to ensure that the public understands the standards they can expect of Healthcare Support Workers.
- The code aims to give services users the confidence that they will be treated with dignity, respect and compassion at all times.

Healthcare Support Workers should:

1. Be accountable for their actions or omissions.

2. Promote and offer compassionate care at all times.

3. Work in collaboration with their supervisor and colleagues as part of a team to ensure the delivery of high quality safe care to service users and their families.

4. Communicate in an open, transparent and effective way to promote the wellbeing of service users and carers.

5. Respect a person and their carers' right to confidentiality, dignity and wellbeing.

6. Strive to improve the quality of healthcare through continuing personal and professional development.

7. Uphold and promote equality, diversity and inclusion.

1.Be accountable for their actions or omissions.

Guidance statements.

As a Healthcare Support Worker employed within Kent and Medway G.P.Practices You should:

1. Be honest with yourself and others about what you can do, recognise your abilities and the limitations of your competence and only carry out those tasks agreed in your job description and for which you are competent.

2. Always behave and present yourself in a way that does not call into question your suitability to work in a health care environment.

3. Be able to justify and be accountable for your actions or omissions.

4. Always seek guidance from your supervisor or employer if you do not feel able or adequately prepared to carry out any aspect of your work, or you are unsure how to effectively deliver a given task competently and safely.

5. Establish and maintain clear and appropriate professional boundaries in your relationships with service users, their carers and colleagues at all times.

6. Not accept any offers of loans, gifts, benefits or hospitality from anyone in your care or anyone close to them which may be seen to compromise your position.

7. Comply with your employers policies and agreed ways of working.

8. Report any actions or omissions by yourself or colleagues that you feel may compromise the safety or care of service users, and if necessary use whistleblowing procedures to report any suspected wrongdoing.

Please see Resource Pack for HCSW's for further guidance

2. Promote and offer compassionate care to service users and their carers.

Guidance statements.

As a Healthcare Support Worker employed within Kent and Medway G.P.Practices You should:

1. Always act in the best interests of people who use health and care services.

2. Always treat people with respect and compassion.

3. Take into consideration the goals and aspirations of people who use health and care services.

4. Promote people's independence and ability to self-care, assisting those who use health and care services to exercise their rights and make informed choices.

5. Always gain valid consent before providing healthcare, care and support. You must also respect a person's right to refuse to receive healthcare**,** care and support if they are capable of doing so.

6. Always maintain the privacy and dignity of people who use health and care services, their carers and others.

7. Be alert to any changes affecting a person's needs or progress and report your observations in line with your employer's agreed ways of working.

8. Always make sure that your actions or omissions do not harm an individual's health or wellbeing.

9. Challenge and report dangerous, abusive, discriminatory or exploitive behaviour in practice.

10. Always take comments and complaints seriously, respond to them in line with agreed ways of working and inform a senior member of staff.

3. Work in collaboration with your colleagues to ensure delivery of high quality, care and support.

Guidance statements.

As a Healthcare Support Worker employed within Kent and Medway G.P.Practices You should:

1. Value and understand the part you play in the team, recognise and respect the roles and expertise of colleagues in the team and from other agencies and disciplines and work in partnership with them.

2. Work openly and co-operatively with service users and their families and treat them with respect.

3. Work openly and co-operatively with colleagues including those from other disciplines and agencies, and treat them with respect.

4. Honour work commitments, agreements and arrangements and be reliable and dependable.

6. Actively encourage the delivery of high quality healthcare, care and support.

4. Communicate in an open and effective way to promote the health, safety and wellbeing of service users and their carers.

Guidance Statements.

As a Healthcare Support Worker employed within Kent and Medway G.P.Practices You should:

1. Communicate respectfully with service users and carers in an open, accurate, effective and straightforward way ensuring confidentiality.

2. Communicate effectively and consult with colleagues as appropriate.

3. Always explain and discuss the care or procedure you intend to carry out with the service user and only continue if they give valid consent.

4. Document and maintain clear and accurate records of your care and report any changes or concerns in the condition of individuals immediately to a senior member of staff.

5. Recognise both the extent and the limits of you role, knowledge and competence when communicating with service users, carers and colleagues.

Please see Resource Pack for HCSW's for further guidance

5. Respect a person's right to confidentiality.

Guidance Statements.

As a Healthcare Support Worker employed within Kent and Medway G.P.Practices You should:

1. Treat all information about all service users and carers as confidential.

2. Only discuss or disclose relevant information about service users and carers in accordance with legislation and agreed ways of working.

3. Always seek guidance from a senior member of staff regarding any information or issues that you are concerned about.

4. Always discuss issues of disclosure with the **Caldicott Guardian** of your practice.

6. Strive to improve the quality of healthcare through continuing professional development.

Guidance Statements.

As a Healthcare Support Worker employed within Kent and Medway G.P.Practices You should:

1. Ensure up to date compliance with all statutory and mandatory training in agreement with your supervisor.

2. Participate in continuing professional development (training and education) to achieve the competence required for your role as agreed at annual appraisal.

3. Maintain an up to date record of training and development.

4. Contribute to the learning and development of others where appropriate.

Please see Resource Pack for HCSW's for further guidance

7. Uphold and promote equality, diversity and inclusion.

Guidance Statement.

As a Healthcare Support Worker employed within Kent and Medway G.P.Practices You should:

1. Respect the individuality and diversity of service users, carers and your colleagues.
2. Not discriminate or condone discrimination against service users, carers or your colleagues.
3. Promote equal opportunities and inclusion for service users and carers.
4. Report concerns regarding equality, diversity and inclusion to a senior member of staff as soon as possible.

GLOSSARY OF TERMS.

1. **ACCOUNTABILITY -** To be responsible and answerable for actions.

2. **CAPABILITY -** The power or ability to do something.

3. **COLLABORATION** - The action of working with someone.

4. **COMPETENT** - Having the necessary ability, knowledge, or skill to do something successfully.

5. C**OMPETENCE** - The knowledge, skills, attitudes and ability to practise safely and effectively without the need for direct supervision.

6. **COMPETENCIES** - Specific knowledge, skills, judgment, and personal attributes required to practice safely.

7. **CONSENT** - Permission for something to happen or agreement to do something.

8. **DEPENDABLE -** Worthy of trust; reliable.

9. **DISCLOSE** - To make (secret or new information) known.

10. **EFFECTIVE -** To be successful in producing a desired or intended result.

11. **HEALTH CARE SUPPORT WORKER-** In a General Practice setting this usually refers to an Assistant Practitioner or a Healthcare Assistant.

12. **MENTOR** - An experienced person who trains and counsels employees or students.

13. **OMISSION** - To leave out or exclude.

14. **PROCEDURES-** An established or official way of doing something.

15. **PROFESSIONAL** - A person competent or skilled in a particular activity.

16. **PROMOTE** - To support or actively encourage.

17. **RESPECT** - To have due regard for someone's feelings, wishes, or rights.

18. **RESPONSIBLE** - Morally accountable for one's behaviour and having an obligation to do something, as part of one's job or role.

19. **SERVICE USER** - A person who uses services.

20. **SKILL** - The ability to do something well; expertise.

21. **SUPERVISE** - The active process of directing, guiding and influencing the outcome of an individual’s performance of a task.

22. **TRANSPARENT** - To be open to public scrutiny.

23. **UPHOLD**- To maintain (a custom or practice).

References

Skills for Care (2013) Code *of conduct for Healthcare Support Workers and Adult Social Care Workers in England*, available at http://www.skillsforhealth.org.uk/about-us/news/code-of-conduct-and-national-minimum-training-standards-for-healthcare-support-workers/

NHS Wales (2011) *Code of conduct for Healthcare support workers in Wales*, Available at

http://www.wales.nhs.uk/sitesplus/documents/829/Final%20-%20NHS%20HSW%20Booklet%20ENG.pdf

NHS Scotland (2009) *Code of conduct for healthcare Support workers in Scotland,* Available at http://www.hcswtoolkit.nes.scot.nhs.uk/resources/hcsw-standards-and-codes/

Useful websites

http://www.rcn.org.uk/development/practice/principles

http://www.england.nhs.uk/wp-content/uploads/2012/12/6c-a5-leaflet.pdf

http://rcnhca.org.

FF82 South East CSU

KMCS>

Kent and Medway
Commissioning Support Unit

Code of Practice for G.P. Employers of Healthcare Support Workers in Kent and Medway

July 2014

Code of Practice for G.P. Employers of Healthcare Support Workers in Kent and Medway.

Contents: Page:

Foreword	**3**
Acknowledgements for contributions	**4**
Introduction	**5**
Code of Practice	**6**
Glossary of Terms	**11**
References	**11**

July 2014

Foreword

The role of health care support workers (HCSWs) in GP surgeries has developed considerably in recent years and yet, in the absence of regulation for HCSWs there is relatively little good quality guidance for their practice. This suite of resources is a much welcomed addition to the practice shelf, and will be useful for every team member in the practices within which they work. They will benefit staff and patients alike and should be implemented consistently across the region.

The resources build on national standards for HCSWs from across the UK and make them relevant to general practice. The core standards reflect the knowledge and values that support quality care, and the code of conduct will give HCSWs confidence in understanding the standards that are expected of them. The resource pack for HCSWs not only explains key issues including mentorship, accountability and training, but also provides examples of key documents that will be useful for the practice team from sample job descriptions to PSDs.

The resource suite will also support employers in understanding their responsibilities in enabling HCSWs to work in the most appropriate and effective ways within the practice. They have been well researched and are written in a language that is accessible to all. Most importantly they reinforce the importance of patient centred care throughout.

Tanis Hand HCA Adviser, Royal College of Nursing

This document has been compiled by Lorraine Hicking-Woodison, Assistant Practitioner, Healthcare Support Worker Adviser, and part of the Practice Nurse Adviser team for Kent and Medway Commissioning Support (KMCS)

Acknowledgements for Contributions

Caroline Flasse - Lead Practice Nurse Adviser (KMCS) Sue Gassor- Practice Nurse Adviser (KMCS)

Tanis Hand- Health Care Assistant Adviser - Royal College Nursing (RCN) Hilary Loft- Practice

Nurse Adviser (KMCS)

See Skoda- Practice Nurse Adviser (KMCS)

This document can be found on the Kent LMC website at
http://www.kentlmc.org/kentlmc/website10.nsf/pages/home/

And GP staff training e-learning platform http://kmgp.learningpool.com/login/index.php

Introduction.

The Code of Practice is for G.P. Employers. It has been developed by the Practice Nurse Adviser team at Kent and Medway Commissioning Support. It is an important assurance mechanism, supporting the employment of healthcare Support Workers (HCSW) in Kent and Medway. It has been inspired by excellent work that has already been completed by NHS Wales which can be found at http://www.wales.nhs.uk/sitesplus/documents/829/Final%20-%20NHS%20HSW%20Booklet%20ENG.pdf

This Code comes in conjunction with **Code of Conduct** and **Essential knowledge and Core Standards** guidance for Healthcare Support Workers. **A HCSW resource pack** has been developed to support the codes and standards.These can be found on the same website as this document.

All Codes support the basic principles of service user safety and public protection and should underpin the day to day working practices of G.P. Employers in Kent and Medway.

Employers will need to establish and implement systems and processes to support Healthcare Support Workers to achieve the standards in the Code of Conduct. In addition, employers need to use the workplace as an opportunity to develop Healthcare Support Workers by providing fulfilling working conditions that help staff carry out their roles effectively, whilst preparing them to progress to new and extended roles in the future.

Employers should ensure each Healthcare Support Worker has a named workplace supervisor to monitor their progress towards achieving all the standards in the Code of Conduct and Essential Knowledge and Core Standards for Healthcare Support Workers.

Mentoring, supervision, monitoring and assessment mechanisms need to be established and implemented. Trained supervisors should provide formal assessments and undertake personal development planning with all staff to meet Knowledge and Skills Framework (KSF) requirements.

To meet their responsibilities in relation to supporting Healthcare Support Workers to comply with their Code of Conduct, and Essential Knowledge and Core Standards it is recommended that employers:

1. Ensure staff are suitable to be employed within the healthcare workforce, and that they understand their roles, accountabilities and responsibilities.

2. Have procedures in place to ensure that Healthcare Support Workers can meet the requirements of the Code of Conduct, Essential Knowledge and Core Standards.

3. Provide timely, appropriate and accessible education, training and development opportunities to enable Healthcare Support Workers to develop and strengthen their skills and knowledge.

4. Promote this Code of Practice, the Code of Conduct and Essential Knowledge and Core Standards for Healthcare Support Workers to staff, service users and other stakeholders and ensure its application within their organisation.

1. Make sure staff are suitable to be employed within the healthcare workforce, and that they understand their roles, accountabilities and responsibilities.

Guidance Statements.

As an Employer it is recommended that you :

1. Use rigorous and thorough recruitment and selection processes to ensure appointment of Healthcare Support Workers who have the appropriate knowledge and skills and who are suitable and eligible to work in healthcare.

2. Ensure that all Healthcare Support Workers complete a robust induction process.

3. Ensure Healthcare Support Workers have clear information on their roles and responsibilities and are not expected to work outside their level of competence.

4. Make sure that all tasks undertaken appear on the Healthcare Support Workers job description.

5. Ensure that Healthcare Support Workers have the appropriate indemnity insurance cover.

6. Make certain that Healthcare Support Workers are aware of all relevant legislation, policies and procedures they must follow and that they understand their obligations and have access to this information.

7. Support Healthcare Support Workers to deliver high quality and safe care to service users.

8. Assist Healthcare Support Workers who report that they are being asked to perform outside of their role and ability and investigate any concerns thoroughly.

Please see the HCSW resource pack for further information

2. Have procedures in place to ensure that Healthcare Support Workers can meet the requirements of the Code of Conduct and Essential Knowledge and Core Standards.

Guidance Statements

As an Employer it is recommended that you:

1. Implement and review written policies and procedures to support Healthcare Support Workers to meet the requirements of the employee Code of Conduct and The Essential Knowledge and Core Standards.

2. Ensure awareness amongst Healthcare Support Workers of policies and procedures to report incident or events affecting themselves or those in their care, in order to protect patients and individuals safety.

3. Have policies, procedures and systems in place to enable Healthcare Support Workers to report inadequate resources or operational difficulties which might impede the delivery of safe care.

4. Ensure the health and safety of all is a priority by providing appropriate advice and assistance to Healthcare Support Workers whose work is affected by ill health.

3. Provide timely, appropriate and accessible education, training and development opportunities to enable Healthcare Support Workers to develop and strengthen their skills and knowledge.

Guidance Statements.

As an Employer it is recommended that you:

1. Provide access to appropriate education, training and other learning opportunities to ensure continued development of the Healthcare Support Workers role.

2. Establish effective ways to mentor, supervise, monitor and assess Healthcare Support Workers.

3. Ensure all Healthcare Support Workers have access to supervisory staff who are competent to mentor, coach and review their development and support compliance with the Code of Conduct and Essential Knowledge and Core Standards.

4. Address any capability or competence issues that arise.

5. Ensure that a registered professional who delegates a task is aware of their responsibility to delegate appropriately and to support Healthcare Support Workers to perform those tasks.

6. Provide consistent opportunities for Healthcare Support Worker to work at their level of competence and utilise the full range of their education, knowledge and skills.

Please see the HCSW resource pack for further information

4. Promote this Code of Practice, the Code of Conduct and Essential Knowledge and Core Standards for Healthcare Support Workers to staff, service users and other stakeholders and ensure its application within their organisation.

Guidance Statements.

As an Employer it is recommended that you:

1. Inform Healthcare Support Workers and all other staff about the Code of Practice and the employers' responsibility to comply with it.

2. Ensure Healthcare Support Workers understand the requirements of the Code of Conduct and Essential Knowledge and Core Standards.

3. Reinforce the personal responsibility of Healthcare Support Workers, managers and supervisors to meet the standards within the Code of Conduct and Essential Knowledge and Core Standards for Healthcare Support Workers.

4. Promote the Code of Conduct and Essential knowledge and Core Standards for Healthcare Support Workers in relevant and accessible communication material, within the organisation and for the public as appropriate.

GLOSSARY OF TERMS

1. **ACCESSIBLE -** Able to be easily obtained or understood.

2. **ACCOUNTABILITY** - To be responsible and answerable for action.

3. **APPROPRIATE**- Suitable or proper in the circumstances.

4. **ASSIST** - To give help or support to (a person, cause, etc); by doing a share of the work.

5. **COMPETENCE** - The knowledge, skills, attitudes and ability to practise safely.

6. **DELEGATE** - Entrust a task or responsibility to another person, typically one who is less senior than oneself.

7. **HEALTH CARE SUPPORT WORKER**. In a General Practice setting this usually refers to Assistant Practitioners or Health Care Assistants.

8. **KNOWLEDGE -** Facts, information, and skills acquired through experience or education.

9. **MENTOR** - An experienced person who trains and counsels employees or students.

10. **PROCEDURES** - An established or official way of doing something.

11. **PROMOTE** - To support or actively encourage.

12. **RESPONSIBLE** - Morally accountable for one's behaviour and having an obligation to do something, as part of one's job or role.

13. **RIGOROUS** - To be extremely thorough and careful.

14. **ROBUST -** Able to withstand or overcome adverse conditions, uncompromising.

15. **SKILL** - The ability to do something well; expertise.

16. **STAKEHOLDERS** - A person or group with an interest or concern in something.

17. **SUPERVISE** - The active process of directing, guiding and influencing the outcome of an individuals performance of a task.

References

Code of Practice for NHS Wales Employers - Health in Wales

http://www.wales.nhs.uk/sitesplus/documents/829/Final%20-%20NHS%20HSW%20Booklet%20ENG.pdf

Useful links

http://rcnhca.org.uk/

FF83 South East CSU

Next page

KMCS>

Kent and Medway
Commissioning Support Unit

Essential Knowledge and Core Standards for the role of Healthcare Support Workers employed in G.P. Practices in Kent and Medway.

JULY 2014

Essential Knowledge and Core Standards for the role of Healthcare Support Workers employed in G.P. Practices in Kent and Medway.

Contents: Page:

Foreword 3

Acknowledgements for contributions 4

Introduction 5

Core Standards 6

Glossary of Terms 17

References 20

July 2014

Foreword

The role of health care support workers (HCSWs) in GP surgeries has developed considerably in recent years and yet, in the absence of regulation for HCSWs there is relatively little good quality guidance for their practice. This suite of resources is a much welcomed addition to the practice shelf, and will be useful for every team member in the practices within which they work. They will benefit staff and patients alike and should be implemented consistently across the region.

The resources build on national standards for HCSWs from across the UK and make them relevant to general practice. The core standards reflect the knowledge and values that support quality care, and the code of conduct will give HCSWs confidence in understanding the standards that are expected of them. The resource pack for HCSWs not only explains key issues including mentorship, accountability and training, but also provides examples of key documents that will be useful for the practice team from sample job descriptions to PSDs.

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And GP staff training e-learning platform http://kmgp.learningpool.com/login/index.php

Introduction

The Essential Knowledge and Core Standards document has been developed in the absence of national guidance by the Practice Nursing Adviser team at Kent and Medway Commissioning Support. These guidelines are for G.P. practices in order to help ensure that service users and the public receive a consistent, high quality, safe and effective service from Health Care Support Workers (HCSW). It comes in conjunction with a **Code of Conduct** for Healthcare Support Workers and a **Code of Practice for Employers**. There is a **HCSW resource pack** available to support this work.These can be found on the same website.

This Essential Knowledge and Core Standards document has been inspired by the excellent work that has already been undertaken by Skills for health, NHS Wales and NHS Scotland. This can be found at http://www.skillsforhealth.org.uk/about-us/news/code-of-conduct-and-national-minimum-training-standards-for-healthcare-support-
http://www.wales.nhs.uk/sitesplus/documents/829/Final%20-%20NHS%20HSW%20Booklet%20ENG.pdf
http://www.hcswtoolkit.nes.scot.nhs.uk/resources/hcsw-standards-and-codes/ .The recommended knowledge and skills may be acquired throughout a period of induction in the first weeks or months of your employment. While meeting these minimum standards is not the same as being competent in your role, they do provide the foundation for safe and effective practice. The standards do not seek to set out competences for workers, but correspond to the underpinning knowledge within the Core Competences for Healthcare Support Workers (skills for health, 2013).

These guidelines apply to Healthcare Support Worker employed in GP Practices in Kent and Medway under the supervision of a registered clinican.

The Essential knowledge and Core Standards cover:

1. **The roles of the Healthcare Support Worker**
2. **Your personal development**
3. **Effective communication**
4. **Equality, diversity and inclusion**
5. **Duty of care**
6. **Safeguarding**
7. **Person-centred care and support**
8. **Health and safety**
9. **Information Governance**
10. **Infection prevention and control**

1. The Roles of the healthcare Support Worker

1. Understanding your own role

- Understand your main duties and responsibilities.
- Understand the essential knowledge core standards; code of conduct and practice that relate to your role.
- Be aware of how your previous experiences, attitudes and beliefs may affect the way you work.

1.2. Your relationship with others

- Know your responsibilities to the individuals you support.
- Understand how your relationship with individuals must be different from your personal relationships outside of work.

1.3. Working in ways that have been agreed with your employer

- Understand your employment rights and responsibilities.
- Be aware of the aims, objectives and values of the service in which you work.
- Know where to access practice protocols and guidelines.
- Know how and when to escalate any concerns you might have (whistleblowing).

1.4. Working in partnership with others

- Recognise the importance of working as a team.
- Understand why it is important to work in partnership with key people, advocates and others who are significant to an individual.
- Contribute constructively to team work to improve partnerships with others.

Please see HCSW resource pack for further guidance.

2. Your personal development

2.1. Produce a personal development plan

- Work in collaboration with your supervisor or line manager for your personal development plan.
- Prioritise your learning needs and development opportunities.
- Seek feedback from others to help develop and improve the way you work. (Patients and colleagues).
- Keep a record of the progress you make in relation to your personal development plan.

2.2. Use learning opportunities and 'reflective practice' to contribute to personal development

- Take part in reflective practice to continuously improve the quality of the service you provide. (E.g. clinical supervision).
- Regularly measure your own knowledge, performance and understanding against relevant standards.
- Be aware of the learning opportunities available to you and how you can use them to improve the way you work.
- Actively take part in learning activities e.g., in house training, mentorship or more formal courses, putting the newly acquired knowledge and skills into practice as agreed with your supervisor.
- Understand the importance of your own continuing professional development.

Please see HCSW resource pack for further guidance.

3.Effective communication

3.1. The importance of effective communication at work

- Understand the different ways that people communicate.
- Understand how communication affects your relationships at work.
- Observe and be receptive to an individual's reactions when communicating with them.

3.2. Meeting the communication and language needs, wishes and preferences of individuals

- Know how to establish an individual's communication and language needs, wishes and preferences.
- Communicate in a range of methods and styles that could help meet an individual's communication needs, wishes and preference.

3.3. Promoting effective communication

- Recognise barriers to effective communication.
- Be aware of ways to reduce barriers to effective communication.
- Seek feedback from patients as to whether the messages have been understood appropriately.
- Know where to find information and support or services, to help you to communicate more effectively.

3.4. Understand the principles and practices relating to confidentiality

- Understand what confidentiality means in your role.
- Be aware of any legislation and agreed ways of working to maintain confidentiality in day-to-day communication.
- Be aware of situations where information, normally considered to be confidential, might need to be passed on.
- Know who to ask for advice and support about confidentiality.

4.Equality, diversity and inclusion

4.1. The value and the importance of equality and inclusion

- Understand what is meant by diversity and discrimination.
- Know how discrimination might occur in your workplace.
- Understand what is meant by equality and inclusion.
- Know how practices that support equality and inclusion reduce the likelihood of discrimination.

4.2. Providing inclusive support

- Be aware of any legislation and agreed ways of working that relate to equality, diversity, discrimination and rights.
- Know how to ensure that your own work is inclusive and respects the beliefs, culture, values and preferences of individuals.
- Know how to challenge discrimination in a way that leads to positive change

4.3. Accessing information, advice and support about equality and inclusion

- Know where to find a range of sources of information about equality, diversity and inclusion.
- Know who to ask for advice and support about equality and inclusion.

5.Duty of care

5.1. Understand how duty of care contributes to safe practice

- Know what it means to have duty of care in your role.
- Know how duty of care contributes to the safeguarding or protection of individuals.

5.2. Know how to address dilemmas that may arise between an individual's rights and the duty of care

- Be aware of potential dilemmas that may arise between the duty of care and an individual's rights.
- Be aware of what you must and must not do within your role in managing conflicts and dilemmas.
- Know who to ask for advice about anything you feel uncomfortable about in relation to dilemmas in your work.

5.3. Comments and complaints

- Know how to respond to comments and complaints in line with legislation and agreed ways of working.
- Know who to ask for advice and support in handling comment and complaints.
- Recognise the importance of learning from comments and complaints to improve the quality of service.

5.4. Incidents, errors and near misses

- Know how to recognise adverse events, incidents, errors and near misses.
- Identify the required actions in relation to adverse events.
- Know the procedures in relation to reporting any adverse events, incidents, errors and near misses in your practice.

5.5. Dealing with confrontation and difficult situations

- Be aware of the factors and difficult situations that may cause confrontation.
- Know how communication can be used to solve problems and reduce the likelihood or impact of confrontation.
- Know how to assess and reduce risks in confrontational situations.

- Know the agreed ways of working to follow and to whom you must report any confrontations.

6.Safeguarding

6.1. Recognising harm or abuse

- Identify the main types of abuse.
- Recognise what constitutes harm.
- Know what constitutes restraint and restrictions.
- Recognise the signs and symptoms associated with abuse.
- Be aware of the factors that make an individual more vulnerable to harm or abuse.
- Be aware of where to get information and advice about your role and responsibilities in preventing and protecting individuals from harm and abuse.

6.2. Reducing the likelihood of abuse

- Be aware of how the likelihood of abuse can be reduced by: a) working with person- centred values b) putting people in control c) managing risk d) focusing on prevention.

6.3. Responding to suspected or disclosed abuse

- Report to the practice safeguarding lead if you suspect an individual is being harmed or abused or if an individual discloses harm or abuse.

6.4. Protecting people from harm and abuse

- Be aware of any legislation and practice protocols relating to the protection of individuals from harm and abuse.
- Be aware of your own role and responsibilities in safeguarding individuals.

Please see HCSW resource pack for further guidance.

7.Person-centred care and support

7.1. Person-centred values

- Practice person-centred values in your day-to-day work.
- Work in a way that promotes these values when providing support to individuals.
- Promote dignity in your day-to-day work with the individuals you support.

7.2. Working in a person-centred way

- Find out the history, preferences, wishes and needs of the individual patient.
- Take the changing needs of an individual into consideration for their care or support plan.
- Support individuals to plan for their future wellbeing and fulfilment, including end- of-life care where appropriate.

7.3. Recognising dementia and other cognitive or mental health issues

- Know the possible signs of dementia and other cognitive issues in the individuals with whom you work and refer to the appropriate clinician.
- Understand why depression, delirium and age-related memory impairment may be mistaken for dementia.
- Understand why early diagnosis is important in relation to cognitive issues.
- Understand when assessments of capacity need to be made and used in accordance with legislation and agreed ways of working.
- Identify who to ask for advice and support if you suspect an individual is showing signs of having cognitive or mental health issues.

7.4. Supporting active participation

- Enable individuals to make informed choices about their lives and encourage active participation.

7.5. Supporting an individual's right to make choices

- Understand how risk assessment processes can be used to support the right of individuals to make their own decisions.
- Your personal views must not influence an individual's own choices or decisions.
- Understand that there may be times when you need to support an individual to question or challenge decisions made about them by others.

7.6. Promoting the emotional and spiritual wellbeing of those you support

- Adapt attitudes and approaches that are likely to promote emotional and spiritual wellbeing.
- Enable individuals to develop skills in self-care and maintain their own network of support within their communities.

8.Health and safety

8.1. Roles and responsibilities

- Be aware of key legislation and the agreed ways of working relating to health and safety at work.
- Know the main health and safety responsibilities of: a) yourself b) your manager c) the individuals you support d) others.
- Know what you must and must not do in relation to general health and safety until you are competent.
- Know who to ask for advice and support about health and safety at work.

8.2. Risk assessments

- Know why it is important to assess the health and safety risks posed by particular work settings, situations or activities.
- Understand how and when to report health and safety risks that you have identified.

8.3. Moving and assisting

- Be aware of tasks relating to moving and assisting that you are not allowed to carry out until you are competent.
- Understand how to move and assist people and objects safely, maintaining the individual's dignity, and in line with legislation and agreed ways of working.

8.4. Responding to accidents and sudden illness

- Be aware of the different types of accidents and sudden illness that may occur in the course of your work.
- Understand the agreed ways of working to be followed if an accident or sudden illness should occur at work.
- Know which emergency first aid you are and are not allowed to carry out.

8.5. Medication and healthcare tasks

- Know the agreed ways of working in relation to medication.
- Know the agreed ways of working in relation to healthcare tasks.
- Know the tasks relating to medication and health care procedures that you are not allowed to carry out until you are competent.

8.6. Handling hazardous substances

- Be aware of the hazardous substances in your workplace.
- Be aware of safe practices for storing, using and disposing of hazardous substances.

8.7. Promoting fire safety

- Understand how to prevent fires from starting or spreading .
- Know what to do in the event of a fire.

8.8. Security at work

- Understand the measures that are designed to protect your own security at work, and the security of those you support.
- Know the agreed ways of working for checking the identity of anyone requesting access to premises or information.

8.9. Managing stress

- Recognise common signs and indicators of stress in yourself and others.
- Be aware of circumstances that tend to trigger stress in yourself and others.
- Know ways to manage stress.

8.10. Food safety, nutrition and hydration

- Understand the importance of good nutrition and hydration in maintaining health and wellbeing.
- Recognise signs and symptoms of poor nutrition and hydration.
- Know how to promote adequate nutrition and hydration.

9.Information Governance

9.1. Managing information in agreed ways

- Identify the agreed ways of working and legislation regarding the recording, storing and sharing of information.
- Understand why it is important to have secure systems for recording, storing and sharing information.
- Know how to keep records that are up to date, complete, accurate and legible.
- Know who the Practice **Caldicott Guardian** is and report any issues or questions regarding information governance to them.

10. Infection prevention and control

Preventing the spread of infection

- Understand the basic principles of infection control.
- Know and apply the principles of effective hand hygiene.
- Understand how your own health or hygiene might pose a risk to the individuals you support or work with.
- Use personal protective clothing, equipment and procedures as required.
- Handle infected or soiled linen and clinical waste in accordance with guidance.

Glossary of terms.

ABUSE: Abuse may be physical, sexual, emotional or psychological. It may be related to a person's age, race, gender, sexuality, culture or religion and may be financial, institutional in nature. It includes both self-neglect and neglect by others.

ACTIVE PARTICIPATION: Active participation is a way of working that recognises an individual's right to participate in the activities and relationships of everyday life as independently as possible. The individual is regarded as an active partner in their own care or support, rather than as a passive recipient. Ways to support active participation may include assistive technology, for example use of electronic or other devices. Healthcare Support Workers should refer to the Essence of Care Department of Health Publication (2010).

ADVICE AND SUPPORT: Advice and support can come from within or outside of your organisation and may include raising any concerns you may have.

AGREED WAYS OF WORKING: This refers to company policies and procedures. This includes those less formally documented by individual employers and the self-employed, or formal policies such as the Dignity Code, Essence of Care and Compassion in Practice. **AT WORK:** The definition of 'at work' may include within the home of the individual you are supporting.

BARRIERS: These can include barriers of culture, gender, religion, language, literacy, health issues, disability, sensory or physical impairment.

CARE AND SUPPORT: Care and support enables people to do the everyday things like getting out of bed, dressed and into work; cooking meals; seeing friends; caring for our families; and being part of our communities. It might include emotional support at a time of difficulty or stress, or helping people who are caring for a family member or friend. It can mean support from community groups or networks: for example, giving others a lift to a social event. It might also include state-funded support, such as information and advice, support for carers, housing support, disability benefits and adult social care.

CLINICAL WASTE: This includes 'sharps', such as needles, bodily fluids and used dressings.

COGNITIVE ISSUES: Examples of cognitive issues include dementia, learning disabilities, anxiety, depression and eating disorders.

COMMUNICATION: This includes verbal and non-verbal communication such as signs, symbols, pictures, writing, objects of reference, human and technical aids, eye contact, body language and touch. Communication may take place face to face, by telephone, email, text, via social networks, written reports and letters. **CONTINUING PROFESSIONAL DEVELOPMENT:** This is the way in which a worker continues to learn and develop throughout their careers, keeping their skills and knowledge up to date and ensuring they can work safely and effectively. **DILEMMA:** A difficult situation or problem.

DIVERSITY: celebrating differences and valuing everyone. Diversity encompasses visible and non-visible individual differences and is about respecting those differences.

DUTY OF CARE: Your duty of care means that you must aim to provide high quality care to the best of your ability and say if there are any reasons why you may be unable to do so.

EQUALITY: being equal in status, rights, and opportunities.

FUNCTIONAL LEVEL: The essential elements of literacy, numeracy and communication skills you need to perform your work confidently and effectively. **HANDLING COMMENTS AND COMPLAINTS:** This includes recording them. **HARM:** Harm includes ill treatment (including sexual abuse, exploitation and forms of ill treatment which are not physical); the impairment of health (physical or mental) or development (physical, intellectual, emotional, social or behavioural); self-harm and neglect; unlawful conduct which adversely affects a person's property, rights or interests (for example, financial abuse).

HEALTH AND SAFETY: This could be in relation to the safety of yourself, your colleagues or the people you support.

HEALTHCARE SUPPORT WORKER: In a General Practice setting this usually refers to an Assistant Practitioner or a Health Care Assistant.

HEALTHCARE TASKS: These include any clinical procedures carried out as part of a care or support plan, for example those relating to stoma care, catheter or injections.

INCLUSION: ensuring that people are treated equally and fairly and are included as part of society.

INDIVIDUAL: This refers to any adult, child or young person accessing care or support; it will usually mean the person or people supported by the worker. **INDUCTION:** This is the initial introduction to work that employees receive. The length of induction is determined by local employers and will vary in length and delivery.

KEY PEOPLE: The people who are important to an individual and who can make a difference to his or her wellbeing. Key people may include family, friends, carers and others with whom the individual has a supportive relationship.

LEGISLATION: Important legislation includes the Data Protection Act, the Human Rights Act and the Mental Capacity Act.

MANAGING RISK: Supporting individuals to exercise their choices and rights, recognising the balance between managing risk and enabling independence, choice and control.

MOVING AND ASSISTING: This is often referred to as 'moving and handling' in health and 'moving and positioning' in social care.

NEEDS: Assessed needs can include a variety of physical, emotional, social, spiritual, communication, learning, support or care needs.

OTHERS: For example, your own colleagues and other professionals across health and social care.

PERSONAL DEVELOPMENT PLAN: Yours may have a different name, but it will record information such as agreed objectives for development, proposed activities to meet those objectives and timescales for review.

PERSON-CENTRED VALUES: These include individuality, independence, privacy, partnership, choice, dignity, respect and rights.

REFLECTIVE PRACTICE: This is the process of thinking about every aspect of your work, including identifying how and where it could be improved. **REPORTING:** This includes the recording of adverse events, incidents, confrontations, errors and issues.

RESTRAINT AND RESTRICTIONS: Section 6 (4) of the Mental Capacity Act 2005 states that someone is using restraint if they use or threaten to use force to make someone do something that they are resisting; or restrict a person's freedom of movement, whether they are resisting or not.

SECURE SYSTEMS: This includes both manual and electronic systems.

SELF-CARE: This refers to the practices undertaken by people towards maintaining health and wellbeing and managing their own care needs. It has been defined as: "the actions people take for themselves, their children and their families to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital." (Self care – A real choice: Self care support – A practical option, published by Department of Health, 2005).

SOURCES OF SUPPORT: These may include formal or informal support, supervision and appraisal.

STANDARDS: These may include codes of conduct and practice, regulations, registration requirement (quality standards), National Occupational Standards and the Human Rights Act.

STRESS: While stress can have positive as well as negative effects, but in this document the word is used to refer to negative stress.

WELLBEING: A person's wellbeing may include their sense of hope, confidence and self-esteem, their ability to communicate their wants and needs, to make contact with others, to show warmth and affection, and to experience and show pleasure or enjoyment.

WHISTLEBLOWING: Whistleblowing is when a worker reports suspected wrongdoing at work. Officially this is called 'making a disclosure in the public interest' and may sometimes be referred to as 'escalating concerns.' You must report things that you feel are not right, are illegal or if anyone at work is neglecting their duties. This includes when someone's health and safety is in danger; damage to the environment; a criminal offence; that the company is not obeying the law (like not having the right insurance); or covering up wrongdoing.

References

Skills for care (2013) *National Minimum Training Standards for Healthcare Support Workers and Adult Social Care Workers in England* Available at http://www.skillsforcare.org.uk/Standards/National-minimum-training-standards/National-minimum-training-standards.aspx

www.skillsforhealth.org.uk/.../2264-core-competences-healthcare-support.
htmlCachedSimilar

Useful websites

http://www.rcn.org.uk/development/practice/principles

http://www.england.nhs.uk/wp-content/uploads/2012/12/6c-a5-leaflet.pdf

http://rcnhca.org.uk/

FF84 South East CSU

Next page

KMCS>

Kent and Medway
Commissioning Support Unit

Resource Pack for Health Care Support Workers Employed in G.P. Practices in Kent and Medway.

July 2014

KMCS/Resource Pack for Health Care Support Workers/LHicking-Woodison/2014

Contents Page

Foreword 4

1. Introduction 6

2. Induction for Health Care Support workers (HCSW) 7

2.1Basic Training level 7

2.2Gaining Competence 8

3.3 Accountability and Delegation 8

3. Mentorship of HCSWs 9

3.1Who should mentor 9

3.2The role of the mentor 9

3.3Responsibilities of a mentor 9

3.4Competence assessment pack 10

4. Accountability and Delegation 11

4.1Criteria for accountability 11

4.2Principles of delegation 12

5. Training and Education 14

5.1First Steps 14

5.2Knowledge and Skills in Primary Care (KaSPaC) 15

5.3Qualification and Credit Framework (QCF)(formally National vocational Qualification (NVQ) in Health and Social Care) 15

5.4Certificate of Higher Education- Primary Care qualification 16

5.5Assistant Practitioner Foundation Degree 19

5.6Staff G.P. learning pool courses 20

5.7Other requirements 21

6. The Role of the HCSW 22

6.1Job Summary 22

6.2Purpose of the role 22

6.3Key responsibilities 22

6.4Tasks that a HCSW should not undertake 27

7. Appendices 28

7.1Draft Job Description 28

7.2Sample Person Specification 32

7.3Example of a Patient Specific Direction (PSD) 34

7.4Example of a reflective/significant event diary sheet 35

Foreword

The role of health care support workers (HCSWs) in GP surgeries has developed considerably in recent years and yet, in the absence of regulation for HCSWs there is relatively little good quality guidance for their practice. This suite of resources is a much welcomed addition to the practice shelf, and will be useful for every team member in the practices within which they work. They will benefit staff and patients alike and should be implemented consistently across the region.

The resources build on national standards for HCSWs from across the UK and make them relevant to general practice. The core standards reflect the knowledge and values that support quality care, and the code of conduct will give HCSWs confidence in understanding the standards that are expected of them. The resource pack for HCSWs not only explains key issues including mentorship, accountability and training, but also provides examples of key documents that will be useful for the practice team from sample job descriptions to Patient Specific Directions.

The resource suite will also support employers in understanding their responsibilities in enabling HCSWs to work in the most appropriate and effective ways within the practice. They have been well researched and are written in a language that is accessible to all. Most importantly they reinforce the importance of patient centred care throughout.

Tanis Hand HCA Adviser, Royal College of Nursing

This document has been compiled by Lorraine Hicking-Woodison, Assistant Practitioner, Healthcare Support Worker Adviser, and part of the Practice Nurse Adviser team for Kent and Medway Commissioning Support Unit (KMCS).

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This document can be found on the Kent LMC website at http://www.kentlmc.org/kentlmc/website10.nsf/pages/home/

And GP staff training e-learning platform http://kmgp.learningpool.com/login/index.php

1.Introduction

Welcome to the Health Care Support Workers(HCSW) Resource Pack.

Health Care Assistants and Assistant Practitioners come to work in Primary Care from many different settings. General Practice is a unique environment requiring a sound understanding of primary care and a variety of clinical skills that are often not part of other HCSWs roles. Each practice will require different skills depending on the needs of their patients. The role of the HCSW has grown considerably in recent years. HCSWs are seen as an integral part of the nursing team.

This resource pack has been developed for HCSWs by the Practice Nurse Adviser team in Kent and Medway in response to the many questions and requests we receive for information. It has been produced to support the **Code of Conduct for HCSWs**; **Essential Knowledge and Core Standards for HCSWs** and the **Code of Practice for G.P.Employers.** These documents can also be accessed on the following websites**:** http://www.kentlmc.org/kentlmc/website10.nsf/pages/home/ and the GP staff training e-learning platform http://kmgp.learningpool.com/login/index.php

2.Induction for HCSW

There are various routes to becoming a HCSW in general practice. Whether new to the career or coming from a different health care setting it is important that all have a robust induction. Well planned induction programmes help everyone. If induction can be seen as a process of learning new facts, systems and relationships, it will act as a building block for future learning. As a new employee, a HCSW will feel supported and in a better place to learn the new job routines, meet new colleagues and understand their role in relation to patient experience.

The knowledge and skills framework defines the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services. It provides a framework on which to base review and development. Its purpose is to facilitate the development of services so that they better meet the needs of users and staff and it supports effective learning and development of staff.

http://www.aop.org.uk/uploads/uploaded_files/frameworkksfaug04.pdf

Employers will need to ensure hepatitis B protection for their HCSWs, and set up the appropriate indemnity insurance cover.

Benefits of a good induction experience include:

- A new HCSW will feel valued and welcome.
- They will understand quickly how their role fits into the wider team.
- They will understand the role boundaries- what can and cannot be undertaken safely.
- Public protection and patient safety is built in from day one.
- A strong foundation is built for developing the HCSW future capability within the role.
- Team members can share their knowledge by playing an active part in supporting their new colleague.

2.1. Basic training level

In order to work as a HCSW in Kent and Medway we recommended that you have achieved a **level 3 NVQ /Qualification and Credit Framework (QCF)** in Health and Social Care or complete Knowledge and Skills in Primary Care (KaSPaC) as a basic training level.

Once trained to level 3 and experience has been gained it is possible to extend the role by attending further training as required by the needs of the practice. This may include competencies such as Ear care; influenza, pneumonia vaccinations and B12 injections.

It is important to note regarding immunisations there is a minimum standard as set out by the HPA document 'National Minimum Standards and Core Curriculum for Immunisation Training of Healthcare Support Workers' ''' It is recommended that only HCSWs who have achieved care training to Level 3 of the Qualifications and Credit Framework (QCF) or equivalent in England, Wales or Northern Ireland with at least two years' experience as a HCSW should be considered for immunisation training. HCSWs working at this level are likely to be at level three of the NHS Career Framework. http://www.nhscareers.nhs.uk/working-in-the-nhs/developing-your-career/

2.2. Gaining competence

After attending training and courses it is essential that the HCSW is given protected time to sit in and watch the registered clinician and then for the HCSW to be observed and assessed .

2.3. Accountability and Delegation

All tasks and duties must be appropriately delegated by a registered nurse or doctor (see Chapter 4 on accountability and delegation for more guidance). **The HCSW should not work independently until they have been deemed competent and confident in that particular task** and their competency record is stored in their portfolio. The HCSW should work within practice protocols and all tasks should be documented on the HCSWs job description. The practice must have the appropriate indemnity insurance in place to cover the HCSW. HCSWs are encouraged to check this with their employer.

Please refer to chapter 5- Training and education for more information.

3. Mentorship of HCSWs

3.1. Who should mentor

HCSW's should be mentored by experienced, competent, knowledgeable registered clinicans. Mentors should preferably hold a mentorship qualification.

The mentor is required is to work closely with the HCSW and offer support and guidance in the practice area.

3.2. The role of the mentor

It is to enable HCSW to make sense of their practice through:

- Facilitating teaching and learning in the workplace.
- Assessing, evaluating and giving constructive feedback. The mentor should ensure that the

HCSW is fit:

- For purpose – can function effectively in practice.

A mentor is a positive role model, knowledgeable and skilled. The effective mentor:

- Helps HCSWs develop skills and confidence.
- Promotes professional relationships with HCSWs.
- Provides the appropriate level of supervision.
- Assists with planned learning experiences.
- Offers honest and constructive feedback.

3.3. Responsibilities of a Mentor

The role of the mentor is important because ultimately it is about public protection. A mentor supporting HCSWs will undertake the responsibility of assessing competence/ incompetence and should be able to provide evidence of assessment of the HCSW's competencies.

Responsibilities of a mentor include ensuring that they:

- Are prepared to undertake the role.
- Share knowledge of patient care and act as a positive role model.
- Are familiar with HCSWs practice assessments.

- Identify specific learning opportunities and that the learning experience is a planned process.
- Observe HCSWs practicing skills under the appropriate level of supervision.
- Provide time for reflection, feedback, monitoring and documenting of a HCSWs progress.
- Assess competence and patient safety.
- Give HCSWs constructive feedback, with suggestions on how to make improvements to promote progress.
- Report any untoward incidents or concerns to the Practice manager.
- Liaise with practice education staff as necessary.
- Maintain own professional knowledge including mentorship updates.
- Engage in clinical supervision and reflection in relation to this role.

3.4. Competence assessment pack

To formalise a HCSW’s learning there is a competence assessment pack available to download.

The pack contains the performance criteria from a range of National Occupational Standards (NOS). It can be used by a HCSW’s mentor or registered nursing colleagues to record competence that has been achieved. It can also be used as a template for additional National Occupational Standards (NOS).

We recommend that HCSWs also have an annual review of competence.

This pack can be found at http://rcnhca.org.uk/files/First_steps_competence_checklist_pack.pdf?v=2

4. Accountability and Delegation.

All patients should expect the same standard of care regardless of who delivers it. There is often confusion about who is accountable for the care delivered by a HCSW.

Guidance

Registered practitioners are accountable for the decision to delegate care, and should only delegate an aspect of care to a person who has had appropriate training and has the relevant assessed and recorded competency. When a registered practitioner is delegating they must be assured that the HCSW fully understands the nature of the task, particularly in relation to what is expected of them.

Health service providers are accountable to both criminal and civil courts to ensure that their activities conform to legal requirements. Employees are accountable to their employer to follow their contract of duty. The law imposes a duty of care on practitioners whether they are HCSWs, student registered nurses or doctors when it is "reasonably foreseeable" that they might cause harm to patients through their actions or their failures to act (Cox, 2010).

HCSWs have a duty of care and therefore a legal liability with regard to the patient. They must ensure they perform competently. They must also inform their manager or mentor if they are not able to do so.

Employers have the responsibility to ensure that their staff are trained and supervised properly until they can demonstrate competence in their role.

Employers accept **'vicarious liability'** for their employees. This means that providing that the employee is working within their competence and in connection with their employment, the employer is also accountable for their actions.

4.1. Criteria for accountability

In order for anyone to be accountable they must:

- Have the ability to perform the task.
- Accept the responsibility for undertaking the task.
- Have the authority to perform the task within their job description, and the policies and protocols of the practice.

Registered nurses have a duty of care and a legal liability with regard to the patient and must work within the NMC code of conduct (NMC,2014).If they have delegated a task they must ensure that this has been done appropriately.

This means that:

- The task is necessary and delegation is in the patients' best interest.
- The HCSW understands the task and how it should be performed.
- The HCSW has the skills and ability to perform the task competently.
- The HCSW accepts the responsibility to perform the task competently.

4.2. Principles of delegation

- Delegation must always be in the best interest of the patient and not performed to save money or time.
- The HCSW must be trained to perform the task.
- The HCSW must keep a record of training given including dates.
- There should be written evidence of competence assessment preferably against recognised standards such as national occupational Standards.
- **There should be clear guidelines and protocols in place so that the HCSW is not required to make a clinical judgement that they are not competent to make.**
- The role should be within the HCSW job description.
- The practice team (including receptionists and administrators) need to be informed that the task has been delegated.
- The person delegating the task must ensure that an appropriate level of supervision is available and that the HCSW has the opportunity for mentorship. The level of supervision and feedback provided must be appropriate to the task being delegated. This will be based on the recorded knowledge and competence of the HCSW, the needs of the patient and the tasks assigned (RCN et a., 2006).
- On-going development to ensure competency is maintained is essential.
- The whole process must be assessed for the degree of risk .

More information can be found on the RCN website at:-
https://www.rcn.org.u data/assets/pdf_file/0003/381720/003942.pdf
k/

References

Cox C: Legal responsibility and accountability; Nursing Management 17:3: 18-20 June 2010

NMC 2014, Delegation: Available at http://www.nmc-uk.org/Nurses-and-midwives/advice-by-topic/a/advice/Delegation/

NMC, 2014 The Code: Available at http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/

RCN (Royal College of Nursing) et al,: Intercollegiate paper: Supervision, accountability and delegation of activities to support workers: a guide for registered practitioners and support workers; Jan 2006

5. Training and Education

HCSW are valued and integral members of the nursing team. They should be supported to develop the knowledge and skills required to deliver competent and compassionate patient centred care. HCSWs should not be expected to perform tasks for which they have not been trained or deemed competent to perform. They have a responsibility to work within their limits, and to inform colleagues if expected to perform a task for which they are not competent. Roles and responsibilities must be in the HCSW job description and the practice must have appropriate indemnity insurance in place.

Training should be competence based, quality assured and assessed against nationally recognised standard. Training and courses are important but there must be a process of assessment in practice.

Kent and Medway provide a comprehensive training programme for HCSWs working in General Practice to enable them to have the opportunity to obtain qualifications that often will lead to having more responsibility within their roles.

5.1. First Steps

This is an online resource for HCAs developed by the Royal College of Nursing (RCN). It is based on the Knowledge and Skills Framework, and is a really good introduction to a career in health care. It would be ideal for a HCSW who is on the waiting list for KaSPaC or any HCSW wanting a refresher course. It is important to note that this resource is not assessed and does not lead to an accredited qualification. The HCSW would need to complete KaSPaC or NVQ 3/QCF before than can progress with their career.

After completing all section the learner should be able to:

1. Describe the principles of effective communication.

2. Explain the policies and practices that protect the safety of staff and others within the workplace environment.

3 .Describe the principles of infection prevention and control including the importance of good hand hygiene.

4. Describe legal requirements regarding confidentiality, consent and best practice for recording and accessing medical records.

5 Explain the process for identifying and reporting suspected abuse of vulnerable people

6. Explain the importance and benefits of continuing professional development and reflective practice of a lifelong learner.

7. Describe the principles of quality care in terms of: teamwork; accountability and delegation; and best practice guidelines.

8. Describe the principles of equality, diversity and rights in terms of: the legal requirements; promoting and treating people with dignity, respect and privacy; and the process for raising concerns.

9. Explain the procedures for undertaking a range of observation tasks.

10. Describe the principles of promoting health.

This is a free resource and there is no requirement to be a member of the RCN. It can be accessed via http://www.rcn.org.uk/firststeps

5.2. The Knowledge and Skills in Primary Care (KaSPaC)

This is the recommended induction programme for HCSWs in Kent and Medway G.P. Practices It

consists of 6 taught sessions :

1. Working with people, accountability.
2. Record keeping, confidentiality.
3. Chaperoning.
4. Blood pressure.
5. Height, weight and urinalysis.
6. Infection control (e-Learning.)

Upon completion of the course successful candidates will gain a credit certificate qualification with OCN (Laser).

This course can be accessed through the learning pool at http://kmgp.learningpool.com

5.3. Qualification and Credit Framework (QCF) – formerly National Vocational Qualification (NVQ) Health and Social Care

The Qualifications and Credit Framework(QCF) have now replaced National Vocational Qualifications (NVQs). Each qualification is made up of a selection of 'units' which are chosen with you to best

match your needs and aspirations. You can choose from a bank of these units. Each unit has a credit value, you simply choose the units you feel are appropriate to your role, and add to your credit total as you complete them. A QCF qualifiaction is ideal for people who have been working in health and social care for more than six months, who have some responsibility in the workplace and are able to work without supervision at times. This qualification gives you the opportunity to demonstrate both the knowledge and practical skills you need to be able to work effectively and respectfully with people who use health and social care services.

There are three sizes of qualification in the QCF

- Award (1-12 credits)
- Certificate (13-36 credits)
- Diploma (above 36 credits)

http://ofqual.gov.uk/qualifications-and-assessments/qualification-frameworks/

Please access further information via the learning pool at http://kmgp.learningpool.com

5.4. Certificate in Higher Education Primary Care qualification

Students are required to complete a series of university accredited modules- It sits between the KaSPaC course and Foundation Degree (Assistant Practitioner).

40 weeks of self-directed study is facilitated by a distance learning pack and includes two compulsory study days at the start of the course and one optional day normally after 12 weeks.

This course forms the core module of our Cert. HE Primary Care qualification. Study time 600 hours

Duration 40 weeks

Outline Content.

The course is aimed at Primary Health Care Assistants who wish to expand their role and enhance their knowledge and skills in relation to working as a primary health care assistant. However, it will also be appropriate for those individuals who are relatively new to the role and wish to develop a greater understanding for the role. The content covers administrative, practical and clinical matters to enable the student to assist health care professionals in their clinical activities. The course forms the core module of our Certificate in Higher Education (Cert. HE) Primary Care but may also be undertaken as a stand-alone course.

Students accessing this course must be working within the primary care setting alongside a registered nurse for a minimum of 8 hours per week.

All students are required to have a registered nurse mentor who will support them in the clinical environment and have a responsibility for signing off student competencies.

As part of the assessment involves writing three essays, it is important that students have a good ability to write clearly in English. You must be able to complete the Literacy & Numeracy Assessment Tools at the Skills for Health website.

Learning Outcomes.

- Describe and explain key concepts, theories and principles that underpin the structure of the primary health care team and the role of the health care assistant within it.
- Describe and explain key concepts for health and well-being and describe contemporary approaches to health promotion as undertaken as part of the health care assistant's role.
- Describe and explain how legal and ethical issues within primary care can be applied to the role of the health care assistant to enhance safe and effective practice.
- Recognise the evolving and developing clerical, clinical and treatment room roles of health care assistants in primary care teams.
- Perform and explain the techniques used in carrying out clinical activities in primary care settings.
- Act under supervision or guidance within defined guidelines to ensure health and safety and infection prevention and control requirements are met.
- Contribute to the preparation and maintenance of the environment for clinical procedures in accordance with agreed clinical guidelines.
- Identify own learning needs and develop a personal development plan to maximise own learning.
- Demonstrate effective communication and writing skills.
- Engage in team activities to enhance a cooperative approach to learning and working.

Reflect on own performance.

Section Headings.

- The structure of Primary Health Care services, including the role of the healthcare assistant.
- Patients' rights.

- Methods of communication, data protection and confidentiality.

- Health promotion .
- Clinical skills and competencies including physiological measurements (e.g. pulse,

blood pressure, etc.).

- Infection control.
- Health and safety.
- Accountability, ethical issues, scope of practice.
- Personal development including the use of the SWOT tool and developing a personal

development Action Plan.

- Using a reflective approach.
- Portfolio development.

Assessment.

There are two components to the assessment. Both are submitted in Week 40.

Component 1: the student will successfully achieve five compulsory competencies and four practice competencies chosen from a designated list of options provided by The Primary Care Training Centre. The registered nurse signs to confirm that the student has achieved competence in the compulsory and practice competencies in the practice setting. The competencies are adapted from the National Occupational Standards Skills for Health Competency database.

Compulsory competencies: Common Competencies; Confidentiality, Consent and Documentation; Health and Safety; Infection Control; Undertake a blood pressure measurement.

Optional Practice Competencies (a choice of 4): Check and store biomedical specimens; Waste disposal; New patient interview; Measure Body Mass Index and waist circumference; Obtain and analyse urine specimens; Obtain and test capillary blood samples; Perform an electrocardiogram.

We suggest that the choice of competencies should help to expand the HCA role as opposed to choosing ones where they are already competent.

Component 2: The student will complete three essays as specified below:

1. Explain the role of the Primary Health Care Team and the Healthcare Assistant role including promoting better health (2,000 words).

2. Reflect and discuss a clinical activity, related to the competencies, which includes consideration of patients' rights as well as legal and professional issues (2,000 words).

3. Discuss their learning experience and achievement of their personal objectives. Include: two SWOTs - one from the beginning of the module and one from the end and a learning contract. These are essential evidence and can be included as appendices (1,000 words).

For more information please visit http://kmgp.learningpool.com

Or contact Jo Purkis joanne.purkis@nhs.net

5.5. Assistant Practitioners Foundation Degree

This is a work-based programme which means that you work and learn at the same time. The learning available within this programme will enable you to gain a higher level of work-related skills, these skills may include communication, problem-solving and/or clinical skills, and you will also have the knowledge and understanding to underpin your work-place practice.

The programme aims to equip you with the knowledge and skills to become a more reflective, independent and critical member of the workforce. The programme aims to enable more people from the health and social care sector to access and participate in University education. Core principles run throughout the programme to support; best practice, effective communication and professionalism.

By the end of the programme you should have a deeper awareness and understanding of the work you perform. This may include an appreciation of the history of the health and social care sector, the current context in which you work and future initiatives and plans for the sector. You will have the skills to search for information to support evidence-based practice and once you find information you will have the ability to differentiate between sources that are and are not suitable to inform practice. You will have a greater awareness of the wider context of health, the role and function of those around you and an emerging critical awareness of your own role within the service.

For more information please visit: kmgpstafftraining@nhs.net

Other helpful links

https://www.canterbury.ac.uk/StudyHere/Undergraduate/courses/c.asp?courseUrl=health-and-social-care

https://www.rcn.org.uk/nursing/work_in_health_care/become_an_assistant_practitioner

5.6. GP staff learning pool courses

Other courses for HCSWs are available via the learning pool at http://kmgp.learningpool.com

Accountability and delegation: What you need to know. Anaphylaxis Update.

B12 for HCAs. Basic Life Support.

Complaints- Diagnosing and resolving complains in General Practice. CQC Cleaning Standards.

Diabetes Basics for HCAs- NEW COURSE. Ear Syringing for HCAs .

ECG workshop.

Flu Update for HCAs. Health & Safety.

KaSPaC (Knowledge & Skills in Primary Care).

Medical Terminology - Introduction URL Medical Terminology – Intermediate. Medical Terminology - Advanced URL Mental Capacity Act.

Minor Ops - Assisting with. Phlebotomy Training (taught course) . Prescription Medicines Explained .

Professional Development. Respiratory Workshop for HCAs.

Safeguarding. **It is recommended that HCSW should attain level 3 safeguarding - eLearning safeguarding courses available at:- http://www.nsahealth.org.uk/**

Safeguarding Vulnerable Adults. Summarising Medical Record.

Understanding Investigations. Weight management.

Wound Care for HCAs.

5.7.Other requirements HCSWs should also receive :

- Annual mandatory training (e.g. basic life support, infection control).
- An annual appraisal of performance and training needs.
- Support to compile a personal training and development plan (PDP).
- Informal training either in-house or in training practice Protected time for education and mentorship.
- Future opportunities.

6.The role of the HCSW in General Practice.

This document offers guidance and suggestions regarding the role of a HCSW in general Practice.

The range of tasks undertaken by HCSWs in primary care varies from practice to practice. It is therefore important that practices employing an HCSW are familiar with the particular needs associated with the role, ensure that resources are put in place to support them and that delegation of tasks is appropriate.

6.1. Job summary

The HCSW works under indirect supervision of a registered professional and undertakes tasks and duties delegated by a practice nurse or a suitably qualified registered professional. HCSWs work collaboratively with the general practice team to meet the needs of the patients, following policies and procedures. In the interest of patient safety it is essential that patients are able to identify and understand the different roles within the nursing team. For this we recommend the wearing of different uniforms and named badges.

6.2. Purpose of the role

To assist the G.P.s and practice nurse team in the service delivery and management of patients by providing high quality evidence based care to meet the health needs of the practice population.

6.3. Key responsibilities

6.3.1. Guidance for Clinical skills- health and wellbeing

Undertake, record and follow guidelines for delegated tasks for which you have received appropriate training and are confident and competent (See principles of delegation in chapter 4).

6.3.2. Guidance for tasks at entry level:

- Urinalysis and preparation of specimens for investigation by the pathology laboratory.
  - Measuring and recording the following physiological measurements in routine presentations. Blood pressure recording.

    Pulse rate and rhythm. Temperature.

    Height and weight - body mass index. ECG recording.

6.3.3. Guidance for more experienced HCSWs after training and competence has been reached may also wish to undertake

- Venepuncture.
- Capillary blood sample.
- Capillary sampling for INR testing (**NOT dose adjustment of Warfarin** this is the responsibility of the registered professional).
- Smoking cessation.
- Simple wound care.

6.3.4. Guidance for Senior HCSWs after training and competence has been achieved may also wish to undertake

- Assist in minor surgery clinics.
- NHS Health Checks.

Dementia screening

www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources_and_training_development_tools/dementia_resources/

- Ear irrigation.
- Influenza and pneumococcal vaccination. Using patient specific directions (PSD) administer to adults the influenza, pneumococcal vaccine with indirect supervision of a regulated professional.
- Basic wound care.
- Vitamin B12 injections. Under patient specific direction (PSD), administer to adults under indirect supervision of a regulated professional.

6.3.5. Guidance for Assistant Practitioners after foundation degree, training and competence has been achieved may also take on additional delegated responsibilities.

Definition of an Assistant Practitioner

The Assistant Practitioner role developed is at Level 4 of the Career Framework. An Assistant Practitioner is defined as a worker who competently delivers health and social care to and for people. They have a required level of knowledge and skill beyond that of the traditional healthcare assistant or support worker. The Assistant Practitioner would be able to deliver elements of health and social care and undertake clinical work in domains that have previously only been within the remit of registered professionals. The Assistant Practitioner may transcend professional boundaries. They are accountable to themselves, their employer and, more importantly, the people they serve.'(Skills for Health 2009).

Assistant Practitioners occupy an intermediate position just below the level of professionally regulated staff. Perhaps most importantly though, in terms of both defining the roles and understanding their importance for future workforce planning, is that they provide opportunities for task delegation downwards from professionally regulated staff.

In principle the tasks that are delegated down to Assistant Practitioners are mostly those that are more simple and/or routine and can be performed safely with training and under protocol and supervision. Delegation of these tasks to Assistant Practitioners in turn (and again in principle) is seen as enabling professionally qualified staff to extend their scope of practice and move into more advanced roles.

The scope of the role enables the post holder to make limited assessment of patient needs and act upon their assessment. For example:

- Undertaking hypertension reviews.
- Being able to instigate certain blood tests. (E.G. Fasting glucose HBA1c if BMI in in excess of 30).
- Deliver weight management clinics.
- Assess a patients 'readiness to change' and give advice with regards to making lifestyle changes.
- Make limited referrals and sign post to other agencies e.g. - refer appropriate patients for 24 hour ambulatory blood pressure monitoring, dietician, weight counselling service.
- Identify when statin therapy is indicated give patient the relevant information/leaflets and sign post them to the appropriate clinician.

- Perform Doppler tests with a practice nurse.
- Limited assessment of wound care

6.3.6. In addition to the above clinical skills HCSWs at any level may be required to:

- Acts as a chaperone for patients as required, preserving the patient's dignity.
- Organise, call and recall patient on long term conditions register.
- According to practice needs and having undertaken appropriate training provide clinical care including monitoring and reviews of non-complex patients with long term conditions.
- Provide support and advice as appropriate for smoking cessation, weight management, exercise and lifestyle change.
- Provide relevant health information to patients and carers within defined protocols.
- Where appropriate provide support and encouragement to patient to self-monitor their conditions.
- Order and maintains stock of Health Information leaflets / literature.
- Undertakes a range of clinical support functions including preparing and stocking clinical areas in line with Practice protocols.
- Deal with clinical waste.
- Order and maintain stocks of dressings and equipment as directed.
- At all times observe infection control procedures to protect self, patients and colleagues.
- Assist in maintaining a safe working environment for self, patients, carers and the multi- disciplinary team, alerting other members of the Practice team to issues of quality and risk identified in work with patients.
- Work within established systems of clinical governance, contributing as appropriate to Practice audit activity.
- Convey relevant information and receive feedback from Senior Nurse / GPs.

6.3.7. Organisational requirements:

- Practices and promotes confidentiality at all times.
- Maintain accurate records of patient contacts, providing clear written and verbal information as required by the practice.
- Refer back to other members of the clinical team any patient that does not fit within established protocols.

- Actively participate in the smooth running of the service.

6.3.8. Systems and equipment:

- Record vaccine fridge temperatures and cleaning as required.

- Ensure that all patient information is properly recorded within the patient record using the clinical software provided.

- Actively participate in the care and maintenance of equipment, demonstrating economy in the use of supplies.

6.3.9. Decisions and judgements:

- Work at all times within the established policies, standards and guidelines of the Practice.

- Undertake clearly defined clinical duties that have been agreed and taught.

- Refer back to a registered health care professional any patient where an informed clinical judgement is required before proceeding with treatment.

6.3.10. Communications and relationships:

- Actively communicate with all colleagues, patients, relatives, carers, visitors and other agencies in a professional manner at all times.

- Communicate effectively with patients and carers, recognising patients' rights and responsibilities.

- Work as member of the Practice nursing team, seeking advice, guidance and support from other members of the team.

- Communicate concerns identified in patient contacts to other health care professionals in the team.

- Work under the supervision of a named health care professional, who ensures that skills are maintained and developed to meet the needs of the post.

6.3.11. Personal development

- Actively participate in the In-House training opportunities available.

- Maintain responsibility for own personal development under supervision and guidance from registered staff.

- Demonstrate a positive attitude to suggested changes and development in practice through the introduction of evidence-based practice.

Required to undertake annual Mandatory training, e.g. Basic Life support.

6.4. Tasks that a HCSW should not undertake:

- Childhood immunisations.
- Travel advice or immunisation.
- Family planning.
- Cervical Screening.
- A task that has not been appropriately delegated.

7 . Appendices

7.1. SAMPLE DRAFT JOB DESCRIPTION

This is a draft. Before using this material, Practices should check the contents and adapt the text to suit their circumstances and style.

JOB TITLE: HEALTHCARE ASSISTANT

REPORTS TO: SENIOR PRACTICE NURSE (Clinically)

PRACTICE MANAGER (Administratively)

HOURS:XX hours per week Job Summary:

Working under the direct supervision of the nurse manager and Practice nurses and strictly in accordance with specific Practice guidelines and protocols, the Healthcare Assistant will assist the Practice clinical team in the provision and delivery of prescribed programmes of patient care.

Duties and Responsibilities:

- Patient health checks
- ECG recording
- Phlebotomy
- Spirometry
- Ear irrigation
- Chaperoning duties
- Processing and management of laboratory samples requested by GPs/Nurses
- Cleansing and maintenance of surgical equipment
- Surgical equipment re-stocking and stock rotation

- Clearing and re-stocking consulting rooms
- Preparing and maintaining environments and equipment before, during and after patient care interventions including assisting GPs during the performance of minor operations
- Assisting in the assessment and surveillance of patients' health and well-being
- Undertaking specific clinical activities for named patients that have been delegated and taught specifically in relation to that individual
- Helping to raise awareness of health and well-being and how it can be promoted
- Assisting with the collection and collation of data on needs related to health and well-being

- **Confidentiality:**
    - In the course of seeking treatment, patients entrust us with, or allow us to gather, sensitive information in relation to their health and other matters. They do so in confidence and have the right to expect that staff will respect their privacy and act appropriately
    - In the performance of the duties outlined in this Job Description, the post-holder may have access to confidential information relating to patients and their carers, Practice staff and other healthcare workers. They may also have access to information relating to the Practice as a business organisation. All such information from any source is to be regarded as strictly confidential
    - Information relating to patients, carers, colleagues, other healthcare workers or the business of the Practice may only be divulged to authorised persons in accordance with the Practice policies and procedures relating to confidentiality and the protection of personal and sensitive data

Health & Safety:

The post-holder will implement health and safety as defined in the practice Health & Safety Policy, the practice Health & Safety Manual, and the practice Infection Control policy and published procedures. This will include (but will not be limited to):

- Using personal security systems within the workplace according to Practice guidelines
- Awareness of national standards of infection control and cleanliness and regulatory / contractual / professional requirements, and good practice guidelines

- Responsible for the correct and safe management of the specimens process including collection, labelling, handling, use of correct and clean containers, storage and transport arrangements

- Management and maintenance of Personal Protective Equipment (PPE) for the practice including provision, ordering, availability and ongoing correct usage by staff

- Adhere to hand hygiene Policy

- Active observation of current working practices across the practice in relation to infection control, cleanliness and related activities, ensuring that procedures are followed and weaknesses / training needs are identified, escalating issues as appropriate

- Identifying the risks involved in work activities and undertaking such activities in a way that manages those risks across clinical and patient process

- Making effective use of training to update knowledge and skills, and initiate and manage the training of others across the full range of infection control and patient processes

- Monitoring practice facilities and equipment in relation to infection control, ensuring that provision of hand cleansing facilities, wipes etc are sufficient to ensure a good clinical working environment. Lack of facilities to be escalated as appropriate.

- Safe management of sharps procedures including training, use, storage and disposal

- Using appropriate infection control procedures, maintaining work areas in a tidy, clean and sterile, and safe way, free from hazards. Initiation of remedial / corrective action where needed or escalation to responsible management

- Actively identifying, reporting, and correction of health and safety hazards and infection hazards immediately when recognised

- Keeping own work areas and general / patient areas generally clean, sterile, identifying issues and hazards / risks in relation to other work areas within the business, and assuming responsibility in the maintenance of general standards of cleanliness across the business in consultation (where appropriate) with other sector managers

- Undertaking periodic infection control training (minimum annually)

- Routine management of own team / team areas, and maintenance of work space standards

- Waste management including collection, handling, segregation, container management, storage and collection

- Spillage control procedures, management and training

- Decontamination control procedures, management and training, and equipment maintenance

- Maintenance of sterile environments

Equality and Diversity:

The post-holder will support the equality, diversity and rights of patients, carers and colleagues, to include:

- Acting in a way that recognizes the importance of people's rights, interpreting them in a way that is consistent with Practice procedures and policies, and current legislation
- Respecting the privacy, dignity, needs and beliefs of patients, carers and colleagues
- Behaving in a manner which is welcoming to and of the individual, is non-judgmental and respects their circumstances, feelings priorities and rights.

Personal/Professional Development:

The post-holder will participate in any training programme implemented by the Practice as part of this employment, such training to include:

- Participation in an annual individual performance review, including taking responsibility for maintaining a record of own personal and/or professional development
- Taking responsibility for own development, learning and performance and demonstrating skills and activities to others who are undertaking similar work

Quality:

The post-holder will strive to maintain quality within the Practice, and will:

- Alert other team members to issues of quality and risk
- Assess own performance and take accountability for own actions, either directly or under supervision
- Contribute to the effectiveness of the team by reflecting on own and team activities and making suggestions on ways to improve and enhance the team's performance
- Work effectively with individuals in other agencies to meet patients needs
- Effectively manage own time, workload and resources

Communication:

The post-holder should recognize the importance of effective communication within the team and will strive to:

- Communicate effectively with other team members
- Communicate effectively with patients and carers
- Recognize people's needs for alternative methods of communication and respond accordingly

Contribution to the Implementation of Services:

The post-holder will:

- Apply Practice policies, standards and guidance
- Discuss with other members of the team how the policies, standards and guidelines will affect own work
- Participate in audit where appropriate

7.2. SAMPLE PERSON SPECIFICATION

Before using this material, Practices should check the contents and adapt the text to suit their circumstances and style

Below are key words or phrases which may be appropriate for inclusion in the Person Specification for a Health Care Assistant

1. Qualification

KaSPaC or equivalent

A demonstrable commitment to professional development

2. Experience

Experience of VISION/EMIS clinical systems Experience of Microsoft Office

Software

Experience of dealing with the public/patients

3. Knowledge/Skills

Competent in basic clinical duties required for the post Specific nursing

skills/qualifications

Excellent communication skills

4. Quality/ Attributes

Able to demonstrate enthusiasm to develop clinical skills

An understanding, acceptance and adherence to the need for confidentiality

Ability to use own judgement, resourcefulness and common sense

Ability to work without direct supervision within agreed boundaries Ability to work as part of an integrated multi-skilled team

Pleasant and articulate

Able to work under pressure

Ability to determine own workload priorities Able to work in a changing environment Able to use own initiative

Other

Flexibility of working hours/ able to work at the desired times Role could change to reflect the needs of the practice population Experience of Primary Care

Driving licence

References

First Practice Management

http://www.firstpracticemanagement.co.uk/index.php/hr_guidance/library_of_job_descriptions_and_person_specifications/ (Accessed 11/07/2014).

Skills For health, 2009, Definition of an Assistant Practitioner, Available at http://www.skillsforhealth.org.uk/component/docman/doc_view/1761-skills-for-health-assistant-practitioners-expert-paper.html

7.3. EXAMPLE OF A PATIENT SPECIFIC DIRECTION (PSD)

Surgery Name :……………………………………………………….

Doctors /prescriber Name(s) ……………………………… Supervisor

Name:……………………………………………………

Patient Specific Directive for a Health Care Assistant/Assistant Practitioner to administer a

Influenza – Pneumococcal vaccination - Hydroxocobalamin injection (ring as appropriate)

I, Dr/Prescriber ………………………………………………………………………………………………… Hereby

instruct my Health Care Assistant/ Assistant Practitioner

…….

To administer the injection to specific patients in this surgery. I am satisfied that he/ she is competent to safely administer the vaccine or injection as stated above and has undergone the relevant training and supervision and I have provided the necessary legal cover for her to undertake this task to the benefit of the patients at this surgery.

Patients Name	D.O.B

Signature G.P. / Prescriber……………………………………………………………… Signature

Supervisor……………………………………………………………………………. Signature

HCA/AP……………………………………………………………………………….

Date ………………………………………………………………………….

7.4. EXAMPLE OF A REFLECTIVE/SIGNIFICANT EVENT DIARY SHEET

Experience - Describe the experience
- What were the essential Contributing factors?
- What are the significant back ground factors to this experience?
Reflection - What were you trying To achieve?

- Why did you intervene?

Alternative Actions

- What other choices did You have?

- What would have been the Consequences of opting for those other choices?

Learning

- How did you feel About this experience?

- Could you have dealt with The situation better?

- What have you learned from this experience?

- What are the consequences of the experience?

- How will this experience Change you future practice?

Discussed with mentor/supervisor……………………………………………………………………………(Mentor signature)

……………………………………………………………………………(Student signature)

Date…………………………………………….

FF85 South East CSU

Next page

Kent conference for HCSWs in general practice

Hilary Loft, Practice Nurse Adviser, South East Commissioning Support Unit

A conference for healthcare support workers (HCSWs) employed in GP practices was held in November 2014 at the Ashford International Hotel. The event was the second conference organised for practice HCSWs in Kent and Medway.

This year, the organising committee included the Practice Nurse Advisor Team from the South East Commissioning Support Unit (SECSU), with help and support from other lead practice nurses in the area. The GP Staff Training Team provided some support for the financial arrangements.

The theme for the day was 'Celebrating the Role of the Health Care Support Workers'. The event was over-subscribed, with an audience that included 160 HCSWs. The positive post-conference evaluations suggested that most HCSWs left feeling included, valued and inspired.

NHS South East Commissioning Support Unit

A crowded hall and a crowded agenda for practice HCSWs in Kent.

The aims of the conference were to include essential education, to share guidelines about the role and development of HCSWs, to inspire and motivate by celebrating their role and contribution to general practice and to provide the opportunity to network.

A number of exhibitors (sponsors and other organisations, including *BJHCA*) supported the conference and they were all relevant to the work of HCSWs in general practice. The stands were well attended by the delegates during the breaks and the exhibitors have given very positive feedback and expressed the wish to participate in future events.

Speakers at the conference included Sarah Deans, a specialist diabetes nurse with Kent Community Health NHS Trust (KCHT). Sarah presented an informative session on the contribution that HCSWs can make to patients affected by diabetes, discussing prevention, diet and understanding hypoglycaemia. Clinical educator Hilary Andrews further developed this theme by presenting information on cardiovascular disease and the risk factors, cholesterol, hypertension and making sense of what all these figures mean. Hilary then provided a helpful summary of guidelines on how to take patients' blood pressure.

Nicola Reynolds, a health trainer with Kent Community Health Trust, spoke about the health trainer programme and other local services available (healthy eating, weight, activity, stop smoking) and how patients may be referred to them. 'Motivational interviewing' by clinical psychologist, Damian Fearns, further contributed to this theme. Damian, a stop smoking specialist, gave an inspirational talk and shared some very practical tips on how to engage with patients for all types of lifestyle changes.

An infection control and prevention update was presented by Rowena Chilvers and Sarah Ansell, infection control nurses with KCHT. They gave an overview of the general principles of infection control, and talked about aseptic technique and the correct method for putting on and removing personal protective equipment (gloves, aprons, masks).

Lorraine Hicking-Woodison, HCSW advisor, spoke about the Code of Conduct, Standards for HCAs in General Practice and the resource pack that she has recently developed for HCSWs employed in GP practices in Kent and Medway. These documents have been endorsed and will be shared by the Royal College of Nursing. Lorraine also spoke about delegation, training and the new Care Certificate that will be mandatory for all new HCSWs after March 2015. We were very fortunate to have Tanis Hand, UK adviser for HCAs and assistant practitioners at the RCN, attend and support the conference. Tanis gave an interesting talk about the future and opportunities available to HCSWs and provided further discussion on

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FF86 South East CSU

Next page

competencies, accountability and safe delegation and clarified the boundaries between roles in the nursing team.

Liz Jewel, CEO from the Alzheimer and Dementia Support Services, gave an informative talk about the needs of patients suffering from dementia and their families. Liz then introduced David Evans, a dementia sufferer, and Kay, his wife. They both gave a very moving, inspirational and at times amusing talk, giving the conference an insight into the challenges faced by families living with dementia. This talk was particularly well received at a time when HCSWs are involved in screening for dementia. The talk highlighted the importance of screening, but also the need to listen to patients and offer support to them and their carers. They received a well-deserved standing ovation.

The conference delegates were presented with a quiz to complete at registration. The aim of the quiz was to encourage networking. This had been identified as one of the important functions of a conference for HCSWs and also provided a good learning opportunity. The answers to the questions were revealed after lunch and it was evident that the questions had generated much discussion and debate.

The conference concluded with an award ceremony. Practices had been invited to nominate their HCSWs for an award for 'Outstanding Contribution to General Practice and Patient Care'. Some 15 HCSWs in all were nominated by their practices. Peter Bradley, editor for the *British Journal of Healthcare Assistants*, presented all the nominees with a certificate. The winner and two runners up were also presented with an additional gift. The comments and appreciation expressed by the practices for the contributions their HCSWs make towards the practices and patient care was at times very humbling and we were all left in no doubt what a valuable contribution HCSWs make towards the care of patients and the smooth running of general practice.

NHS South East Commissioning Support Unit

Overall winner: Allison Gilhooly, Kings North Medical Practice, Ashford.

Runners up: Joanne Stevens (left), Vine Medical Centre, Maidstone and Jayne Curry, Balmoral Surgery, Deal.

Another view: Lorraine Hicking-Woodison

It was great to see so many delegates at the conference. The programme offered a good mixture of clinical and professional updates—something for everyone. The delegates gave some clear indications of how they want to take our profession forward. There was a very strong message from the audience regarding the regulation of HCSWs. When asked if they wanted regulation, the majority of delegates raised their hand in favour.

Other issues highlighted were the need for more training and education and a structure for the HCA/AP role within the general practice setting. I strongly endorse the need for our workforce to achieve all of those very important matters and hope that in my role of HCSW advisor I can move some things forward in the future.

It was great chatting to the delegates. I love the enthusiasm of our workforce and the passion of the many that I spoke to who want to be part of a safe and effective workforce that delivers high-quality compassionate care, and of course to be recognised and valued for the very important work they deliver.

I really enjoyed the awards ceremony at the end. It was very inspiring listening to the fantastic work that the nominees had undertaken—it was lovely to be able to recognise and honour their achievements. **BJHCA**

Lorraine Hicking-Woodison, assistant practitioner, and HCSW adviser for Kent and Medway GP Practices.

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FF87 South East CSU

Report for the ET in November 2014 on the Practice Nurse Advisory team in Kent and Medway

1. The team is currently composed of 4 Practice nurse advisers and 1 HCA adviser (all part time, please see the attached document for the team structure).All team members also hold clinical posts in primary care to ensure a good understanding of issues arising in primary care and particularly local knowledge and therefore provide the most appropriate support and advice.

2. The PNA SLA (06/14) covers the various aspects of our role in more detail (see attached SLA)

3. This team, in place for many years for primary care teams in Kent and Medway, provides support, advice and education .We believe in early intervention or the sharing of lessons learned from incidents, therefore supporting the quality agenda in primary care and reducing the risk of further incidents from occurring. Due to the preventive nature of a big part of our work, the avoidance of incidents in primary care is difficult sometimes to quantify.

4. **Advisory role:** To support practice nurses and teams, we provide e-mail and telephone advice and each receives between 30 and 50 emails a day. Topics include concerns regarding quality or safety of practice, education needs, guidance for specific issues (immunisations, safe delegation, training requirements). This service is particularly appreciated by PNs and HCAs who often work in isolation and ensure that all are aware of best practice guidance. This is reflected in the number of e-mails or calls received.

5. **Supporting the quality agenda through sharing of information**:The team also writes and distributes a bi-monthly newsletter sharing learned lessons, guidance and information about learning opportunities. The feedback from this newsletter is excellent. The newsletter now also provides information for HCAs who are a growing group of care providers in General Practice.

6. **We benchmark standards for Primary care nurses and HCAs when a need or gap is identified**:

- A PN induction and resource pack for new practice nurses (2009)
- Guidance and toolkit for practice nurse appraisals (2012). Aware of the big disparity in the quality of PN appraisals in general practice and the missed opportunities for development and reflection (See attached documents) we developed this guidance to ensure that both nurses and employers understand the requirements for appraisals and have the necessary tools.
- More recently (2014), we have written 4 important documents: Code of conduct, Code of practice, Essential knowledge and Core standards (for GP employers), and a Resource pack for Health Care Assistants in General practice. Following the Francis report and in the absence of any national guidance for HCAs, our team has developed these documents to ensure that HCAs are trained, supported and employed appropriately in General practice and ensure high level of care for patients. The documents are endorsed by the Royal College of Nursing and will be shared in the 4 countries (Minimum training standards , a better understanding of their role and responsibilities, safe delegation and mentorship in the workplace).

7. **We work alongside the area team (Nursing quality) and Public Health England teams** when incidents occur to help with investigations, identify necessary remedial actions and support

practices. (Please see the incident summary document). Both teams rely on the PNA team for this role due to our extended knowledge of the primary care environment. There are no other nurses in place to cover this role. We also participate in the Primary Care safety Improvement Group to encourage the sharing of learned lessons from SIs. Furthermore, thanks to our close contact with the PC nursing teams, we quickly pick up quality issues that would not be normally reported through more formal routes and can address them promptly before patients are put at risk.

8. **We have established links with key stake holders:** We also work alongside various regional bodies to develop effective care pathways by representing practice nurses on various committees (collaborative group for pressure ulcers, diabetes pathways, working with community respiratory teams, Tissue viability teams (wound care formulary), workforce planning, nurse prescribing pathways). As we work across Kent and Medway, each PNA takes the lead in specific areas, representing the team in meetings then shares the information which is a more cost effective way of working.

9. **We liaise regularly with primary care tutors** in post in each CCG and support their work (mentoring in general practice, distribution of information to the PN databases)in developing the PN workforce .

10. **We provide education** through running ***practice nurse educational forums***, including respiratory forums, that are well attended. We also organise ***sessions for practice nurses during CCG Protected Learning afternoon (PLT)***. Nurses appreciate these sessions as they feel that they are relevant and a good use of their time. They are well attended in comparison to the joint sessions with GPs. Additionally, we teach some courses for the GP staff training team outside our PNA role.

We are currently organising a ***regional conference for Health Care Assistants on the 25th November*** in Ashford and have 150 HCAs booked. The programme will provide education, inspiration and the opportunity for HCA to develop and network. We aim to run a similar event for practice nurses in 2015.

11. **We regularly advise the GP staff training team** on the provision, requirements and contents of courses for the primary care teams. Our clinical expertise is highly valued also in this context to ensure the provision of quality education in primary care and consistency across the region.

12. **On a National level**, our team represents PNs and HCAs at the Royal College of Nursing to drive forward the agenda for quality in primary care and we have been invited to join the recently formed National Community and Primary Care Nursing forum within NHS England. This involvement drives and guides our work at a regional level and in return we are able to inform and contribute to the development of National strategies.

13. **In conclusion**, the PNA advisory service is a unique and precious resource for primary care teams but also organisations commissioning primary care services. We will consider expanding the team into Surrey and Sussex to provide an equitable service throughout the region (there is currently a part time post unfilled). If this service were no longer to be funded after March 2015 by the area team, primary care commissioners will need to envisage an alternative funding strategy to ensure continuity in the support for primary care teams and services.

FF88 South East CSU

PNA team- incidents involving practice nurses in Kent and Medway

Column1	Column2	Column3	Column4	Column5	Column6	Column7	Column8	Column9
Date	**NameCCG**	**Name of Practice**	**issue raised**	**Action taken**	**issue resolved**	**Follow up due**	**Resolved**	**PNA**
29/04/2014	Ashford	xxxxxx	concern about a PN, reported by Lead CCG nurse	PNA, SG assessed nurse, advised	Nurse left the surgery	no		Hilary Loft and Sue Gassor
01/05/2014	Ashford	xxxxxx	high inadequacy rate for CX screening,ST0489same nurse	PNA assessed by Hilary loft and advice given	Nurse left the surgery	no		
14/05/2014	ashford	xxxxxx	follow up with same nurse (quality issues)		Nurse left the surgery	no	yes	
08/05/2014	Ashford	xxxxxx	Smear taking errors	PNA visit for assessment	Follow up 3/12	30/08/2014	yes	Sue Gassor and Hilary Loft
02/06/2014	SKC	xxxxxx	High inadequacy for CX ST1622(labelling errors) and Men C errors	PNA visit and assessment	follow up phone call - all going well	30/09/2014	yes	Caroline Flasse and Hilary Loft
02/06/2014	SKC	xxxxxx	high inadequacy rate for CX screening	visit and advice give	follow up 3/12	30/09/2014	yes	Sue Gassor and Hilary Loft
04/06/2014	DGS	xxxxxx	high inadequacy rate for Cx, contacted by PN	Visit, worked with PN	Follow up Sept. reduction in inadeq.rate	30/09/2014	yes	Hilary Loft
18/06/2014	North Kent	xxxxxx	HCA unsafe delegation	contacted via e-mail with GP , met with PN, sent advice,	HCA has job description, indemnity in place, safe delegation	No	yes	See Skoda/Caroline Flasse
18/07/2014	West kent	xxxxxx	Inadequate CX (taken too earlyand labelling errors)ST 4166	advice over phone and info sent, PN upset (contacted by lab,+ public health)	follow up 3/12	10/10/2014	yes	Hilary loft
10/07/2014	DGS	xxxxxx	high inadequacy for CXs	Advice by phone		10/10/2014	yes	Hilary loft
20/06/2014		xxxxxx	Email enquiry Re cytology sampling	advice given by e-mail	N/A	no	yes	Hilary loft
18/08/2014	West Kent	xxxxxx	ST1354, high inadequate rate	advice given over the phone	Follow- up early October	10/10/2014	yes	Hilary loft
07/09/2014		xxxxxx	Query about sampling	phone advice	N/A	no	yes	Hilary loft
15/08/2014	North kent	xxxxxx	High inadequacy rate ST1153, over due update	Phone advice to PN and PM for support for online Tx	follow-up 3/12	15/11/2014	yes	See Skoda
15/08/2014	North kent	xxxxxx	High inadequacy rate ST 1342 , over due update	Phone advice to PN and PM for support for online TX	follow-up 3/12	15/11/2014	yes	See Skoda
31/07/2014	West Kent	xxxxxx	report by a patient (Pn). Concerns Re vaccines given by HCA	Caroline phoned surgery. Spoke to Anne White PN				caroline Flasse and Hilary Loft
04/08/2014			confirmed that HCA giving travel, zostavax, whooping cough vaccine	Caroline sent e-mail to GP (Dr Fincham)				Caroline Flasse
07/08/2014			no response from GP. Escalated to Area team as AL	Alison Milroy spoke to GP				Caroline Flasse
19/08/2014			e-mail sent to GP by Hilary Loft asking for assurance re training, PSD in place, adequate documentation, indemnity cover, job description		do we need to have evidence to back up as unusual practice? GP replied to queries by e-mail. No visit			Caroline Flasse
			email received but not full assurance	arranged visit to practice to understand delegation etc	follow up 21/10/14 assurance given . Meeting with GP, PM and 2 HCAs	21/10/2014	yes	Caroline Flasse
15/08/2014	East Kent	xxxxxxx	PN (SB)worked for 2 Y for this practice. When applied for post at IC4, discovered that was unregistered with NMC. Reported to Hazel Carpenter. Issue: GP practice did not check PN registration status when employed by them. Potential risk to patients if worked unregistered (smears/imms)	SG contacted Practice, unable to confirm registration status of PN. No help in finding out from the nurse or NMC. Subsequently applied for information from the NMC who are also not sharing the information. Need to apply via employer code/password.	NMC confirmed that nurse not registered from 1/1/14 until 25/07/14..	ongoing		Sue Gassor and Caroline Flasse
15/11/2014		xxxxxxxxxx	issues: any risk to patients? Management issue with practice not keeping record of NMC registration or training records/no protocols in place	2 visits to practice. Meeting with practice manager. Nurse manager come in to help set up safe practice, SG checked through sample of notes (diabetes, imms, wound care etc)	No risk to patients indentified. Public health report no concerns for Cx screening or imms.Improved management of nursing team (nmc register, training records, PGDs, protocols)	final report sent on 06/02/15	yes	Sue Gassor + Caroline Flasse
02/10/2014	West Kent	xxxxxxx	contacted by PM. Concerns Re new PN. Expererienced PN on long term sick leave. Incomplete reviews/care of patients	CF worked with PN for 1/2 day and gave recommendations for mentorship, support and further training. Fed feedback to PN and PM.	follow- up 15/11/14. pn has PNA contact details for support and attending monthly PN forums	no	no	Caroline Flasse
15/10/2014	West Kent	xxxxxx	double childhood vaccine error on same patient (same PN)	reported as SI. CF spoke to lead nurse. Error reporting procedure reviewed with Nurse andactions to reduce repeat of error (vaccine schedule on fridge and treatment room wall. Sufficient appointment time)	actions implemented and team discussion at the practice including the need to report errors immediately (NMC code of conduct)	No	no	Caroline Flasse
22/10/2014	North Kent	xxxxxxx	2 patients' identity switched for cervical screening leading to IG governance issue as well as risk to patients. Potentially other patients affected?	Followed up on 30/10 by phone and e-mail.(problem occurred in September). Both patients informed and Cx follow up addressed. No other patients affected	reason for error identified and addressed (IT issue on the day)	no	no	caroline Flasse

FF89 George Freeman

‘Segmentation of care’ has been proposed as a way of improving primary care delivery, particularly in hard-pressed inner-city areas. I became aware of the concept when recently Mike Farrar spoke in favour of the motion:

‘This conference believes that general practice should be

(a)) organised among people with similar diagnoses and care needs, and

(b)integrated with secondary care providers.’

The motion attracted no support in a meeting of generalist clinicians (in this case GPs) but I wondered where the idea came from.

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

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

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

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

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

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

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

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

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

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

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

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Attachment 1

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

Attachment 2

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

Attachment 3

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

Attachment 4

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

FF90 BAcC

BMC Complementary and Alternative Medicine

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Research article

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The impact of NHS based primary care complementary therapy services on health outcomes and NHS costs: a review of service audits and evaluations

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Abstract

Background: The aim of this study was to review evaluations and audits of primary care complementary therapy services to determine the impact of these services on improving health outcomes and reducing NHS costs. Our intention is to help service users, service providers, clinicians and NHS commissioners make informed decisions about the potential of NHS based complementary therapy services.

Methods: We searched for published and unpublished studies of NHS based primary care complementary therapy services located in England and Wales from November 2003 to April 2008. We identified the type of information included in each document and extracted comparable data on health outcomes and NHS costs (e.g. prescriptions and GP consultations).

Results: Twenty-one documents for 14 services met our inclusion criteria. Overall, the quality of the studies was poor, so few conclusions can be made. One controlled and eleven uncontrolled studies using SF36 or MYMOP indicated that primary care complementary therapy services had moderate to strong impact on health status scores. Data on the impact of primary care complementary therapy services on NHS costs were scarcer and inconclusive. One controlled study of a medical osteopathy service found that service users did not decrease their use of NHS resources.

Conclusion: To improve the quality of evaluations, we urge those evaluating complementary therapy services to use standardised health outcome tools, calculate confidence intervals and collect NHS cost data from GP medical records. Further discussion is needed on ways to standardise the collection and reporting of NHS cost data in primary care complementary therapy services evaluations.

Background

To make informed decisions about the usefulness of com- plementary therapies, service users, clinicians and NHS commissioners need good quality information on the contribution complementary therapies can make to improving health outcomes and reducing NHS costs. Although there has been extensive debate on the best way to assess the impact of complementary therapy treatments on health outcomes [1-3], randomised controlled trials tend to dominate. Randomised controlled trials are con-

ducted in tightly controlled experimental environments in which a particular intervention is targeted to a medi- cally defined symptom (e.g. acupuncture for migraine headaches). When treatments are removed from this experimental context and integrated into the real world of healthcare service delivery, these tight controls disappear and local contextual factors may alter the impact of the treatments. Hence, in investigating the potential useful- ness of complementary therapies as part of mainstream healthcare provision, research into the effectiveness of treatments and the impact of services is necessary.

To date, however, the majority of research has been into the therapeutic effectiveness of complementary therapy treatments, with approximately 1500 trial based papers published annually [4]. More recently, the cost effective- ness of complementary therapy treatments has become a focus. A review of 14 studies of complementary therapy treatments meeting quality criteria found that seven treat- ments were cost effective, including guided imagery, relax- ation and potassium diets for cardiac patients and osteopathy and chiropractic for neck pain [5]. Another economic review of five complementary therapy treat- ments concluded that four treatments resulted in addi- tional costs to the NHS compared to usual care, largely to cover the costs of the practitioner. They also found that the estimates of cost of the complementary therapy treat- ments compared favourably with other interventions approved for use in the NHS [6]. Nonetheless, although research evidence on the clinical and cost effectiveness of complementary therapy treatments is growing, we have less information on the impact of complementary therapy services on health outcomes or NHS costs.

One attempt to address this was a report by Christopher Smallwood and colleagues published in 2005 [7]. Draw- ing on three case sites where complementary therapy serv- ices were provided in NHS settings, the authors came to the conclusion that *[In the] majority of cases, specific condi- tions have improved, as have patients' general health and sense of well-being... [and] there seems to be good reason to believe that a number of CAM (complementary and alternative) treat- ments offer the possibility of significant savings in cost* [7].

Perhaps unsurprisingly, given the controversy surround- ing NHS provision of complementary therapies, the cred- ibility of this report was challenged [8]. Notwithstanding, these were possibly overly bold assertions, in light of the limited quantity and questionable quality of some of the case study data.

Aim of this study

In a previous exercise, we collected evaluations of 25 com- plementary therapy services to identify the methodologies used to assess services [9]. In addition, we explored the

relationship between evaluation content and methodol- ogy and NHS funding and found that a favourable report did not necessarily result in NHS funding. Subsequently, we interviewed NHS funders and found that although health outcome information was useful, information on the impact of complementary therapy services on NHS resource utilisation (e.g. GP consultations, prescription and hospital services) was necessary to inform commis- sioning decisions [10].

We have since continued to collect service evaluations and the purpose of this paper is to report on the data con- tained within this larger collection of documents. Specifi- cally, our aim is to identify the potential impact of primary care complementary therapy services on health outcomes and NHS costs, as reported in complementary therapy service evaluations. The target audiences for this paper are NHS commissioners, who may be considering provision of complementary therapy services, and current and future providers of NHS based complementary ther- apy services, who can build on the experiences of col- leagues conducting earlier evaluations.

Methods

Search strategy

Because the majority of complementary therapy services are located within primary care, we limited our review to this sector. We collected published and unpublished eval- uations from November 2003 to April 2008. A rigorous, comprehensive searching strategy was devised including:

Contacting colleagues at the Foundation for Integrated Health, mid-Devon Primary Care Research Group and the Universities of Bristol, Sheffield, Thames Valley and West- minster, who had conducted evaluations and/or were net- worked to identify others who had.

Telephoning professional complementary therapy organ- isations e.g. Society of Homeopaths, British Council of Acupuncture, General Chiropractic Council, General Osteopathic Council.

Identifying potential studies from bibliographies of reports previously collected.

Searching the database of registered users for the SF36 and MYMOP questionnaires.

Searching PubCAM, AMED (Allied and Complementary Medicine) and Google Scholar.

Hand searching the archives of several journals including *Complementary Therapies in Medicine*, *Homeopathy* and *Acu- puncture in Medicine*.

Search terms were: audit, general practice, primary care, complementary, alternative, homeopathy, acupuncture, evaluation and service. A full list of all evaluations located is available on request.

Inclusion and exclusion criteria

We included documents if the service was located within England or Wales, was delivered by NHS clinicians or pro- fessional therapists and was situated in a NHS primary care setting. An exception was the inclusion of the Lewi- sham service [11]. Although outpatient hospital based, this evaluation was included because it was one of only two which employed a randomised controlled trial meth- odology and was similar to other primary care based serv- ices. We excluded evaluations if:

they reported throughput alone (e.g. numbers of patient seen)

they described solely the setting up of the service

the service setting was private, a charity or outside Eng- land or Wales

the service was part of an acute hospital department e.g. physiotherapists using acupuncture for pain

Because of the lack of high quality evaluations, no studies were excluded on methodological grounds.

Data extraction and analysis

We devised a proforma to identify the type of information contained in the reports including health outcome tools (e.g. SF36, SF12, MYMOP, Glasgow Homeopathic Hospi- tal Outcome Score, etc.) and NHS cost data (i.e. hospital, GP consultation or prescription costs). We then selected evaluations which collected health status data, using SF36 or MYMOP. These outcome tools were chosen because they were the most commonly used standardised health status questionnaires and so comparison across different services was easier.

The SF36 is a questionnaire which asks the service user to assess their health status in eight domains, including physical functioning, role physical, social functioning, pain, vitality, mental health, role emotional and general health [12]. For example, for 'physical functioning' respondents are asked to score a number of statements about their specific abilities to climb stairs or walk a mile while for 'role physical', respondents score statements about the extent of their ability to perform physical tasks generally. Although there is considerable debate about interpretation of SF36 scores, it is generally held that an improvement of 10 points or more indicates a strong

effect (see http://www.sf36.org 'norm based scoring and interpretation').

MYMOP asks the service user to identify and then rate the first and second priority symptoms that "bother" them the most, an activity affected by those symptoms and overall wellbeing on a scale of 0 to 6 [13]. In some cases, a profile score, which amalgamates the scores from symptoms 1 and 2, wellbeing and activity, is calculated. An improve- ment of 1 point or more is considered clinically signifi- cant (see http://www.pms.ac.uk/mymop).

In addition to selecting evaluations with SF36 and MYMOP health status data, we also selected evaluations with extractable NHS cost data obtained from medical records. Once all relevant documents were identified, we then extracted details including:

number of service users data collection time points

baseline and follow up health status scores

baseline and follow up rates and costs of prescriptions, GP consultations and hospital consultations

confidence intervals p values.

If confidence intervals were missing and it was possible, we calculated the confidence intervals ourselves.

We gathered the results from individual service evalua- tions into outcome specific tables (i.e. SF36, MYMOP, prescriptions and GP consultations) and compared results across the services. For costs relating to use of hospital services, the data could not be combined into one table and so the data from the two relevant complementary therapy services are presented separately. We considered synthesizing the data for each table, but decided against this as the therapies offered, service models and ways of collecting the data differed considerably between sites.

Results

In total, we collected 49 documents for 40 services. Fur- ther details about the methodology and content of the reports have been published previously [9]. Of the docu- ments collected, we found 21 documents for 14 services contained extractable data on NHS costs and/or health status. Details of the services and evaluation documents are summarised in Additional file 1.

Health status – SF36

Of the 14 services meeting our criteria, six administered and reported SF36 data that could be extracted (Addi- tional file 2) [11,14-17]. Confidence intervals were avail- able for four of the six service evaluations. Across the evaluations, four of the eight SF36 domains consistently have confidence intervals which do not cross zero for the average difference between baseline and follow up scores (role physical, social functioning, pain and vitality). This suggests that the complementary therapy services in this review have had a positive effect on the scores for the health status domains for these samples of service users. The pain scores showed the largest change. The fewest changes across these four services appear to have been made in role emotional, mental health and general health.

Of those using the SF36, only the Lewisham service also administered this questionnaire to a waiting list control group. The Lewisham service provided homeopathy, acu- puncture and osteopathy delivered by professional thera- pists for over 20 different conditions. The baseline SF36 was administered before the first treatment and follow up occurred at the last session or three months after baseline (whichever came first). One hundred and seventy nine people in the treatment group and 151 in the control group completed baseline and follow up SF36 question- naires. Results suggest a moderate to strong improvement for seven of the eight SF36 areas; only physical function- ing showed no change [11].

Health status – MYMOP

Of the 14 services included in the review, nine reported MYMOP data, but only seven provided extractable data (Additional file 3). In comparing the scores for the five services with confidence intervals, overall the first symp- tom identified by service users showed the greatest change followed by the second symptom. The average change in score was consistently greater than one, and in some cases it was closer to a two and half point difference. This sug- gests that these complementary therapy services had a substantial effect on health status scores, as measured by MYMOP, for these service users. Only the confidence intervals for the activity domain for the Sheffield service crossed zero (average difference 1.9, 95% CI -0.4 to 4.2), which suggests that the Sheffield complementary therapy service did not have a positive impact on the activity scores for this sample of service users. This may be under- standable as service users were suffering from the meno- pause and symptoms do not tend to impact on activity levels.

NHS costs

The quality and quantity of data on NHS costs was less robust or available than data for health status. Seven eval-

uations reported cost data extracted from GP medical records, one of which used randomised controlled trial methodology. Although all of the reports had methodo- logical flaws, two were of especially poor quality (Newcas- tle [18] and St. Margaret's [19]). In these evaluations, a sub-sample of patients was identified (unclear as to how selected), relevant medical records were extracted and then the findings for the sub-samples were extrapolated across the entire service populations, resulting in guessti- mates of potential savings. Nonetheless, as both of these evaluations justified further funding of these services by the NHS, and in the absence of better cost data, they are reported here.

A recurring methodological problem is that NHS cost data are less easily standardised than health status data. We found that the different evaluations used different ways to calculate costs. For example, prescription data was col- lected and analysed as average costs of prescriptions per month per patient, average number of prescriptions per month per patient, proportion of patients who reduced their number of prescriptions overall, total number of pre- scriptions and total cost savings of reduction in prescrip- tions by the entire sample. GP consultation data were more homogeneous in that all data were reported as con- sultation rates, but the time period varied between average consultation rates per patient per month, per six months or per year.

In looking at prescription costs, three out of six uncon- trolled evaluations reported that service users reduced their prescriptions substantially by 57% (Coventry [20]), 45% (Glastonbury [21]) and 39% (Newcastle [18]). St. Margaret's reported potential savings of £8944. Results from the Impact evaluation suggested that there was no change in the number of prescriptions (change of 0.04, 95% CI -0.99 to 0.87) [16]. The prescription costs for serv- ice users of Get Well UK increased after using the service (average baseline cost per patient per month £3.24, 95% CI £1.80 to £4.80 and average follow up cost per patient per month £3.75, 95% CI £1.74 to £6.49) [22]. (Addi- tional file 4)

In looking at GP consultation rates, three of the six uncon- trolled evaluations reported that their sample of service users consulted their GPs about a third less often (Glas- tonbury [21] Newcastle [18] and Coventry [20]), while the St. Margaret's evaluation [19] found that service users consulted their GPs over two thirds less often. The results for the Impact service evaluation found that there was almost no change (change of 0.14, 95% CI -0.97, 1.83) [22]. Data from Get Well UK indicated that GP consulta- tion rates amongst their sample of service users increased from an average of 0.5 per patient per month (95% CI 0.4, 0.7) at baseline to an average of 0.8 (95% CI 0.6 to 1.1) at

follow up. Moreover, the Get Well UK evaluation sug- gested an increase in GP consultation costs per patient per month with an average baseline cost of £11.27 (95% CI
£8.60, £13.90) and an average follow up cost of £17.53 (95% CI £11.40, £24.00) [22]. To put consultation rate data into context, the average practice consultation rate per listed patient per month in England was 0.44 in 2006 [23]. (Additional file 5)

The Get Well UK and Glastonbury reports provided data on secondary care consultations. The Get Well UK evalua- tion found that the rates of secondary care referrals and diagnostic tests combined per month were reduced (aver- age combined of 1.38 at baseline to average combined of
0.70 at follow up), as were their corresponding costs (mean £112.64 at baseline to mean £64.72 at follow up) [22]. The Glastonbury evaluation found that usage of physiotherapy, x-rays, blood and urine, tests and consult- ant referrals were all reduced for a sub-sample of 41 patients with a total saving of over £2500 [21].

Only the Randomised Osteopathic Manipulation Study (ROMANS) collected NHS cost data for a control group. This was a pragmatic randomised controlled trial to eval- uate a medical osteopathy service [24]. Two hundred and one patients with neck and back pain were randomised into two groups: usual GP care or medical osteopathy from a single GP practitioner. Service users in the active group received three to four medical osteopathy consulta- tions. Medical record data on healthcare utilisation for 101 people in the usual care group and 86 in the medical osteopathy group were collected. Data for over twenty dif- ferent NHS healthcare activities were collected, including rates for prescriptions, GP consultations and secondary care activities such as consultant and physiotherapy con- sultations. When calculating costs for all conditions suf- fered by the osteopathy service users and non-users, there was no difference between the medical osteopathy group and the control group (average total costs £22, 95% CI -
£159, £142). Costs related to spinal pain were higher in the group using medical osteopathy than those who did not (average cost difference of £65, 95% CI £32, £155). This might be partly explained by the inclusion of the costs of the medical osteopathy consultations themselves [25]. (Table 1)

Discussion

Summary of key points

Few services collected data on health status using stand- ardised health outcome tools and even fewer collected data on NHS costs. Of those that did, the quality of the evaluations was variable.

Table 1: NHS healthcare utilisation rates for ROMANS medical osteopathy service users and non-users for six months (during and after)

		Activity Non-service users (SD) Medical osteopathy service users (SD)	**Difference (95% Confidence Intervals*)**
All GP contacts	3.26 (2.69)	3.16 (2.81)	**-0.10**
GP contacts for spinal pain	1.75 (2.22)	1.49 (2.0)	**-0.26**
All prescriptions	5.11 (7.41)	5.28 (8.62)	+0.17
Analgesic/non-steroidal anti-inflammatory drug prescriptions	1.3 (2.17)	1.21 (1.9)	**-0.09**
All consultant contacts	0.28 (0.62)	0.26 (0.49)	**-0.02**
Consultant contacts for spinal pain	0.09 (0.38)	0.06 (0.24)	**-0.03**
All physiotherapy	0.81 (1.96)	0.38 (1.76)	**-0.43**
Physiotherapy for spinal pain	0.73 (1.96)	0.36 (1.73)	**-0.37**
Average total healthcare costs	£307 (£687)	£328 (£564)	+£21 (-£142, £159)

Average total spine related costs	£64 (£90)	£129 (£283)	+£65 (£32, £155)

* 95% confidence intervals of the difference cannot be calculated as standard deviation not provided Differences in bold = difference in favour of medical osteopathy group
SD = standard deviation

In comparing research into the effectiveness of comple- mentary therapy *treatments* and the impact of comple- mentary therapy *services* on health outcomes, we found that service evaluations were largely positive. All service evaluations collecting data on health status (SF36 or MYMOP) without a control group showed a substantial improvement in scores. When data were also collected for a control group (Lewisham), health status scores contin- ued to demonstrate positive changes. With regard to the SF36, across evaluations both with and without a control group, the greatest changes were consistently found in role physical, social functioning, pain and vitality. Although more studies are needed, this suggests that NHS complementary therapy services may have an impact on health outcomes.

Data from complementary therapy service evaluations on NHS costs were much scarcer and less robust. Uncon- trolled service evaluations found increases, decreases and no change in prescriptions and GP consultations. Both uncontrolled evaluations found decreases in secondary care usage. The only controlled study investigating the impact of a complementary therapy service on NHS costs (ROMANS) found that the medical osteopathy service made no impact on healthcare utilisation costs for all con- ditions. Costs associated only with spinal pain, which included the costs of the medical osteopathy consulta- tions, were increased.

Strengths and limitations

A strength of this study is that this is the first comprehen- sive attempt to collect and review the growing number of evaluations of NHS complementary therapy services in primary care. However, because of the scarcity of good quality data, we can draw few conclusions about the impact of these services on health status and NHS costs.

One limitation of this study is that very few evaluations met our selection criteria of reporting standardised health status or NHS cost data. A second limitation is that amongst those who did, there were gaps in the reporting of the data collection processes and inconsistencies across the evaluations that made comparison difficult e.g. vary- ing data collection time points, different health outcome tools, prescriptions calculated as rates, costs and total sav- ings etc. A third limitation is that only two service evalua- tions collected data for control groups. Control groups are used to demonstrate that any changes that have occurred can be attributed to the intervention (in this case a com- plementary therapy service) and would not have occurred anyway. This is necessary to assure some (scientifically minded) clinicians and Primary Care Trust managers of the potential impact of complementary therapies on health outcomes and NHS costs [26].

Implications

Because NHS based complementary therapy services are often marginalised, face constant battles to secure funding [27] and have limited access to research expertise, those services that do carry out service evaluations deserve con- gratulations. Nonetheless, evaluations of NHS primary care complementary therapy services need greater rigour to provide better understanding of the impact these serv- ices can make on health outcomes and NHS costs. An ear- lier attempt to address this was the BESTCAM Delphi exercise which aimed to improve the *content* of comple- mentary therapy service evaluations by identifying useful data collection items [28]. Our intention is to focus on improvements in the *process* of data collection and report- ing.

The following figure illustrates a suggested scale of quality markers for evaluations of complementary therapy serv- ices. (Figure 1) At a basic level, those evaluating comple- mentary therapy services could collect data on health outcomes with standardised outcome tools such as MYMOP and SF36, rather than designing their own ques- tionnaires. Although there are many such tools available, we found that MYMOP and SF36 were most commonly used in complementary therapy service evaluations. In comparing SF36 to MYMOP, the SF36 allows for better identification of the domains where complementary ther- apy services may score the largest improvement, but MYMOP is more patient oriented. Both of these are avail- able without charge on the Internet (see http://www.sf- 36.org and http://www.pms.ac.uk/mymop).

A further step in improving the quality of evaluations of NHS complementary therapy services would be the inclu- sion of confidence intervals around estimates. Confidence intervals provide valuable information on the range of values that might occur and give an indication of the strength of the impact of an intervention (in this case, a complementary therapy service). So, for example, for the first symptom for the CHIPs service [29] there was an average improvement of 1.9 for service users between baseline and follow up MYMOP scores on a six point scale. Using confidence intervals, we can say that we are 95% confident that the value of that difference within this population will fall somewhere between 1.5 and 2.3, which suggests a moderately strong impact. If a confi- dence interval crosses zero, this suggests that the service does not have an impact on improving the score for that domain. Although potentially daunting, confidence inter- vals are not difficult to calculate and instructions can be found in Additional file 6.

A further improvement in the quality of evaluations would be the collection of NHS cost data from GP medi- cal records. This is a significant undertaking, as it requires

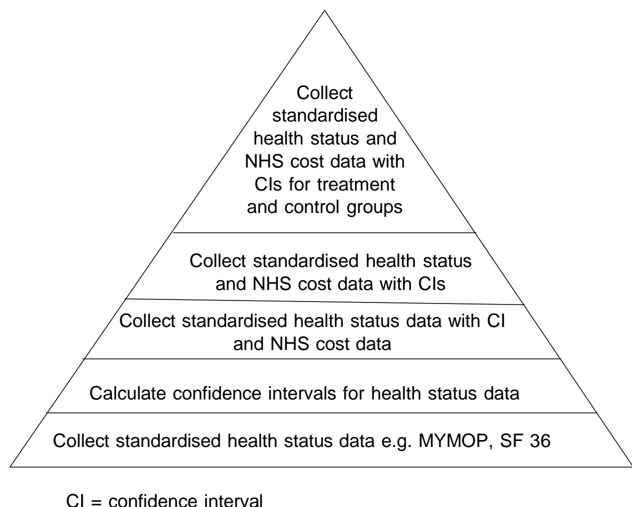

Figure 1
Quality markers for evaluations of NHS primary care complementary therapy services.

obtaining permission to access medical records from GP surgeries (and possibly ethics approval see http:// www.nres.npsa.nhs.uk), an understanding of medical ter- minology and extensive time. Furthermore, there is great variety in the way NHS cost data are collected as, unlike health status data, there are not standardised tools. How- ever, the evaluations in this review showed a trend towards the calculation of GP consultation rates as aver- age rates per patient over six or twelve months. Further research is needed into the optimum way of collecting and calculating prescription and secondary care data.

Once NHS cost data are collected, a further rung on the quality marker scale would be to calculate confidence intervals for cost data in addition to health status data.

Each of the first four stages on the quality marker triangle would require increasing confidence with research lan- guage and skills, although all of them could conceivably be undertaken with little or no academic involvement. However, the final step on the quality marker scale, to col- lect standardised health status and NHS cost data with confidence intervals for treatment and control groups, i.e. complementary therapy service users and non-users, would require significant engagement with academic researchers, possibly from a registered clinical trial unit (see http://www.ukcrn.org.uk). But such an endeavour would also necessitate substantial outside funding. This could help explain why so few randomised controlled tri- als of complementary therapy services have taken place. Moreover, even if conducting randomised

which randomised controlled trials actually influence cli- nicians and NHS commissioners' decisions around com- plementary therapy service provision [10].

controlled tri- als were less challenging, we do not know the extent to

Conclusion

In reviewing complementary therapy service evaluations, we found that uncontrolled health status data suggest that such services improve health outcome scores, but the data on the impact of these services on NHS costs are scarcer and inconclusive. Moreover, the overall quality of these evaluations was poor. To improve the quality of evalua- tions and increase understanding of the impact these serv- ices may have, we urge those evaluating complementary therapy services to use standardised health outcome tools, calculate confidence intervals and consider the collection of NHS cost data from GP medical records. Furthermore, discussion with the wider NHS healthcare community is needed on the optimum ways to standardise the collec- tion and reporting of NHS cost data in evaluations of complementary therapy services.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

Funding for the study was obtained by AS and DS. The study was conceived by LW. The majority of the data were collected and analysed by LW, with assistance from AS and DS especially at the interpretative stages. LW drafted the manuscript and DS made substantive revisions.

Additional material

Additional file 1

Supplementary table one. *Evaluations of NHS based primary care complementary therapy services with standardised health outcome and NHS cost data*
Click here for file
[http://www.biomedcentral.com/content/supplementary/1472-6882-9-5-S1.doc]

Additional file 2

Supplementary table two. *SF36 scores from six complementary therapy service evaluations without control groups*
Click here for file
[http://www.biomedcentral.com/content/supplementary/1472-6882-9-5-S2.doc]

Additional file 3

Supplementary table three. *MYMOP scores for seven service evaluations without control groups*
Click here for file
[http://www.biomedcentral.com/content/supplementary/1472-6882-9-5-S3.doc]

Additional file 4

Supplementary table four. *Changes in prescriptions identified in six service evaluations without control groups*
Click here for file
[http://www.biomedcentral.com/content/supplementary/1472-6882-9-5-S4.doc]

Additional file 5

Supplementary table five. *Changes in GP consultation rates identified in service evaluations without control groups*
Click here for file
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Additional file 6

How to calculate confidence intervals
Click here for file
[http://www.biomedcentral.com/content/supplementary/1472-6882-9-5-S6.doc]

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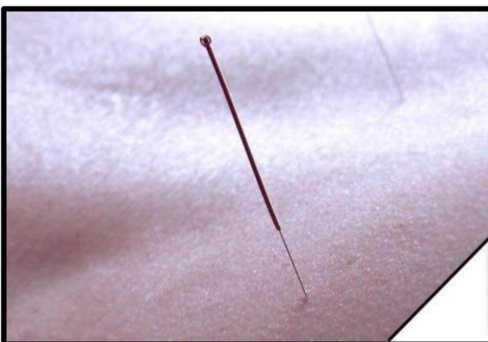
Impact

Integrated Medicine Partnership

Effective Integration

Acupuncture, Chiropractic and Homeopathy in Primary Care: Outcomes from the NHS Funded Service at Radford Medical Practice, Nottingham 2008 – 2010

"A good alternative when conventional medicine is not working"



Summary

Since February 2004, Impact Integrated Medicine Partnership has provided an integrated service offering acupuncture, chiropractic and homeopathy to residents and GP practices in Nottingham. A comprehensive evaluation of our service conducted in 2006 demonstrated the effectiveness of these interventions in treating a range of short and long term conditions, particularly back pain, mental health conditions, musculoskeletal disorders and chronic pain.

In 2008, Impact was commissioned via practice-based commissioning to provide a service for Radford Medical Practice. The service has been used by more than 40 patients, who have been treated at their local surgery, following a referral by their GP. Nearly all (90%) of the patients referred have completed a course of six sessions, and nearly all have reported an improvement in their symptoms. Just under half the patients treated by the Impact team have had their symptoms or conditions for more than five years, and have not been successfully treated by conventional means. As one of the GP partners comments[1], "A good alternative when conventional medicine *is+ not working." The GPs report being satisfied with the service that Impact has provided, and they feel that, at a cost of £260 for six sessions, it is good value for money compared to mainstream options. The partners state that a referral to Impact has benefited their patients, and one partner describes it as a "very good service."

Our work over the last six years has demonstrated repeatedly that patients who complete treatment with Impact subsequently visit their GP less often, report taking less medication, and have less need for referral to secondary care, thus saving NHS resources. Impact is also a very popular choice with patients. In 2007, *nine hundred* residents of Radford and Hyson Green signed a petition presented to the Chief Executive of Nottingham City PCT, requesting continuing access to Impact's services. A number of case histories have been included in this report, with changed forenames to protect patients' anonymity.

Nationally, the Impact team are recognised as skilled and experienced providers of integrated and complementary medicine, who have worked with a range of local and national organisations, including NHS Live, the General Chiropractic Council, Trent Improvement Network, and the Parliamentary Group for Integrated and Complementary Healthcare.

The new NHS commissioning process now gives GP commissioners the opportunity to make bold, patient-focussed commissioning decisions that introduce innovative and cost-effective ways of working, extend choice and access to patients, and forge new partnerships between traditional NHS providers and other organisations such as social enterprises. It is clear that commissioning Impact's services can lead to a better use of resources, as patients reduce their reliance on conventional primary care. We look forward to extending and developing our work with patients and practices throughout Nottingham.

[1] In the Service Evaluation form completed in August 2010

Background

Impact Integrated Medicine Partnership is a social enterprise which provides acupuncture, chiropractic and homeopathy in primary care settings. Between 2004 and 2007 Impact ran a very successful clinic at the Waverley Health Centre for residents of Radford and Hyson Green. Funded by New Deal for Communities, the team treated more than 300 patients and, in November 2006, won the national NHS Alliance Acorn Award for Integrated and Complementary Healthcare. In 2008, Impact was commissioned by Radford Medical Practice to provide a service to their patients, and this report describes the outcomes from this service.

Radford Medical Practice: The Decision to Commission Impact

Radford Medical Practice was established in the early 1960s and has three partners: Drs Liau, Kaur and Lonsdale. One of the practices serving the diverse and deprived inner-city communities of Radford, it has an excellent reputation amongst the local population. Having referred patients to the Impact service at the Waverley Health Centre, in 2008 Radford Medical Practice approached the team to run a service specifically for their patients. Commissioned via practice-based commissioning (PbC), the service has treated 42 patients, at a total cost of £12,000. This equates to £260 per patient, on the basis of £60 for the first consultation and £40 for each subsequent session (an average cost of £43 per session). Each patient has been allocated a maximum of six sessions, and all patients have been referred by the GPs.

In the PbC submission to the cluster board, the practice described their reasons for deciding to commission Impact, as follows:

- *Our doctors were very impressed with the range of services offered*
- *Referrals to Impact proved very popular with our patients*
- *They have demonstrated the effectiveness of interventions in treating a range of long-term conditions, particularly back pain, musculoskeletal disorders, chronic pain, mental health conditions and gynaecological disorders*
- *PbC allows us to introduce new ways of working – as a local social enterprise, Impact is uniquely placed to deliver flexible, whole person care, especially in deprived communities*
- *Their work over the last few years has demonstrated that patients who complete treatment at Impact subsequently visit their GP less often, report taking less medication and have less need for referral to secondary care*

- *In this way, capacity can be freed up for our GPs and nursing staff to concentrate on priority areas*

- *Provision of acupuncture, chiropractic and homeopathy is a cost-effective way of managing patients with long term conditions, including mental health conditions*

- *Impact may be accessed by all sections of the community including 'hard to reach' groups. It makes a significant contribution to tackling health inequalities.*

The Patients

Based on feedback from the Impact practitioners, the referred patients have been a very diverse group, in terms of ethnicity, disability and age. In addition, just under half (44%) completed an equal opportunities questionnaire before treatment began, and of these, 57% are from Black and Minority Ethnic communities. More than a third (37%) considered themselves to have a disability, including mobility problems or multiple disabilities. Each adult age group was well represented, although no children were referred. Only four patients have discontinued treatment – an excellent compliance rate of 90%.

Building on Impact's previous experience, and in consultation with the GPs, nearly all referrals fell into four categories; back pain, musculoskeletal disorders, chronic pain, and mental health conditions. Just under half (43%) of the patients referred had suffered their conditions for over five years. Some 36% reported having their conditions for more than a year, leaving less than a fifth (16%) who were referred within a year of the start of their symptoms.

Evaluation and Outcomes

A comprehensive evaluation framework has been used to analyse clinical outcomes. Areas of evaluation have included improvements in patients' health and reductions in GP attendance rates, medication and referrals to secondary care. Pre- and post-treatment measures SF36[2] and MYMOP[3] have been used with each patient. Improvement is demonstrated by an increase in SF36 score and a reduction in MYMOP score. Any forms not completed correctly have been discounted for evaluation purposes.

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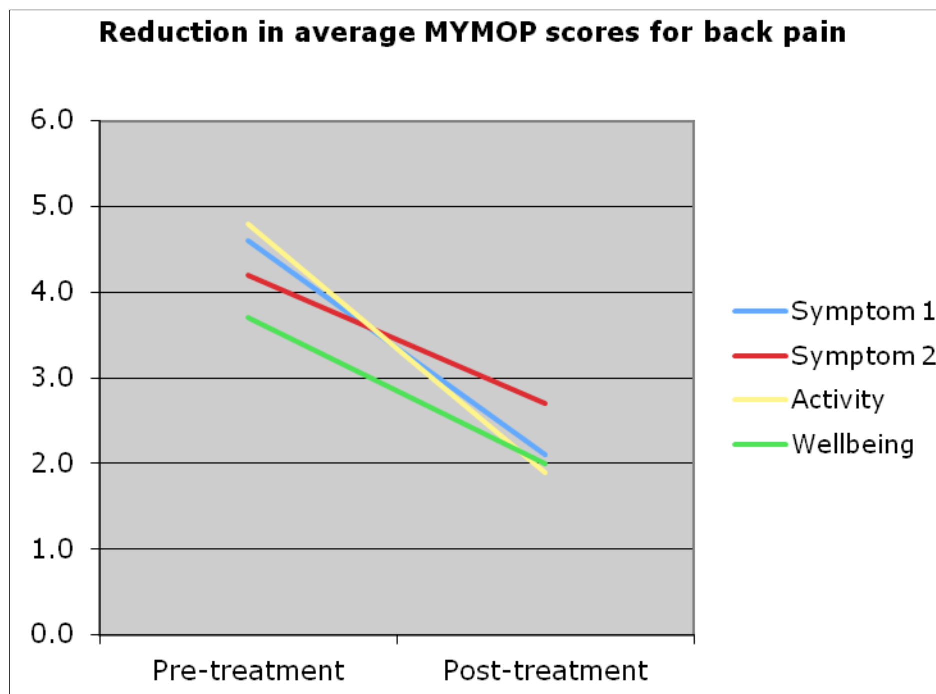
[2] The SF-36 Health Survey was designed for use in clinical practice and research, health policy evaluations and general population surveys. It assesses eight health concepts, including limitations in physical, social and usual role activities, bodily pain, general mental health, vitality and general health perceptions. An overall percentage score can be calculated for each patient, with 100% representing perfect health.

[3] MYMOP aims to measure the outcomes that the patient considers the most important. Using a 7 point score (0-6), patients score their two most troublesome symptoms, an activity that is limited by one or both symptoms, and their overall feeling of wellbeing. It is considered that the smallest difference that patients consider important is approximately 0.5. A moderate difference corresponds to a change of approximately 1.0, with changes of more than 1.5 considered large.

Back Pain

"Treatment has made a massive difference to my back pain. The severity of the pain has disappeared. Feel almost cured!"[4]

A total of 15 patients have been referred to the Impact service for back pain, and all received chiropractic treatment. The results for this group show that there has been significant improvement: an average reduction of 2.68 in MYMOP scores (varying from 0.5 to 4.5) and an average increase in SF36 scores of 29.62% (varying from 5.33% to 67.78%). These results were achieved within the six session maximum – however, the clinical guidance on low back pain issued by the National Institute for Health and Clinical Excellence (NICE) in May 2009 states that doctors should 'consider offering a course of manual therapy, including spinal manipulation, comprising up to a maximum of 9 sessions over a period of up to 12 weeks…manipulation can be performed by chiropractors and osteopaths'. The guidance also instructs doctors to 'consider offering a course of acupuncture needling comprising up to a maximum of 10 sessions over a period of up to 12 weeks'. In Nottingham, no chiropractic is currently available to patients with low back pain through the NHS. Some patients in Nottingham have submitted requests for access to chiropractic to LINKs (the patient involvement organisation), and the latter has begun dialogue on this issue with local primary care trusts.



[4] All patients' quotations are verbatim from patient satisfaction questionnaires.

"The treatment has been brilliant. The pain in my back was really severe and has been changed to very mild pain after treatment. I think a few more treatments could eliminate the pain altogether. Overall, brilliant results, life changing, very satisfied with the results."

39 year old Debbie presented with bilateral low back pain of 6 years duration. Her symptoms were stiffness and aching made worse by standing for any duration and she reported that it caused her to reduce her activities. A lumbar spine x-ray was not remarkable with some slight deterioration. She had previously had physiotherapy which had not helped and had 6 monthly facet injections to manage the pain.

On examination, Debbie was found to have an extra lumbar vertebra (L6) and the vertebral complex of L5 – L6 was fixed with local muscle spasm and associated trigger points in piriformis and quadratus lumborum with range of motion restricted in left lateral flexion. Trigger point therapy and manipulation of the affected vertebrae was administered weekly for 6 sessions with the final session occurring after 2 weeks.

Her MYMOP score reduced from 3.25 to 1.50 and her SF36 increased from 60.55% to 83.33%. She stopped having facet joint injections to her lumbar spine and stated that 'the chiropractor has helped significantly.'

Mental Health

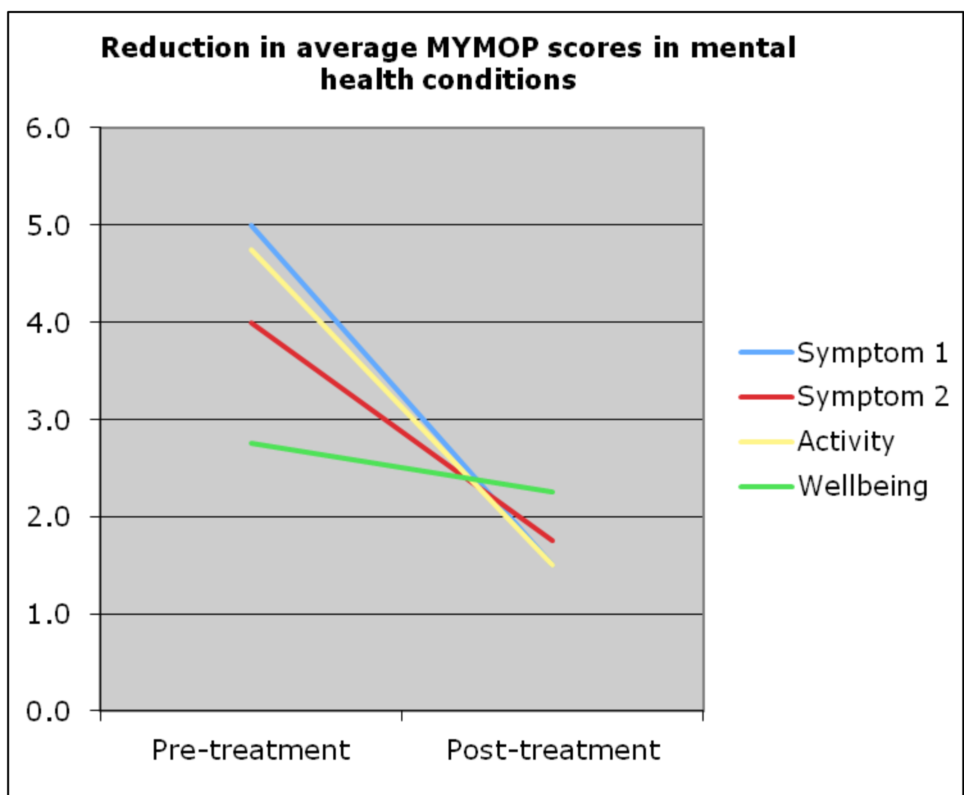
The homeopathy, and yourself, proved helpful and I feel more settled now."

Five patients have been referred to homeopathy for mental health conditions, significantly fewer than expected, albeit that studies have consistently shown that a significant proportion of GP consultations contain a mental health component, and there was no evidence to suggest that the full cohort of patients referred to Impact was any different. (At Impact's Radford and Hyson Green clinic, more than a third of the patients presented with mental health conditions, and outcomes for this group were the most positive. Patients with a range of chronic mental health problems, including anxiety, depression and stress-related disorders, reported experiencing improvement following homeopathic treatment at the Impact clinic between 2004 and 2006.)

The outcomes for patients from Radford Medical Practice have also shown significant improvements - an average reduction in MYMOP scores of 2.52 (varying between 1.75 and 3.5) and an average increase in SF36 scores of 36.89%, (varying from 23.33% to 50.45%).

58 year old Sarah was referred for homeopathic treatment because of difficulty sleeping, with associated feelings of exhaustion, low mood and headaches. She felt that these symptoms began in the menopause four years earlier and that a brief spell of trying HRT had only made the symptoms worse. Additionally, a recent eye test had revealed a very high intraocular pressure of 31 and 33 Hg (normal range 10-21Hg).

After four months of homeopathic treatment alone, a retest revealed a considerable improvement in the eye pressure scores to 23Hg in each eye. Her headaches and sleep pattern were improving also, and at the end of six months' treatment Sarah was feeling much better in herself. Consultations had revealed some long-standing emotional stress which she had felt unable to talk about before. Her overall MYMOP score reduced from 4.33 to 2.0.

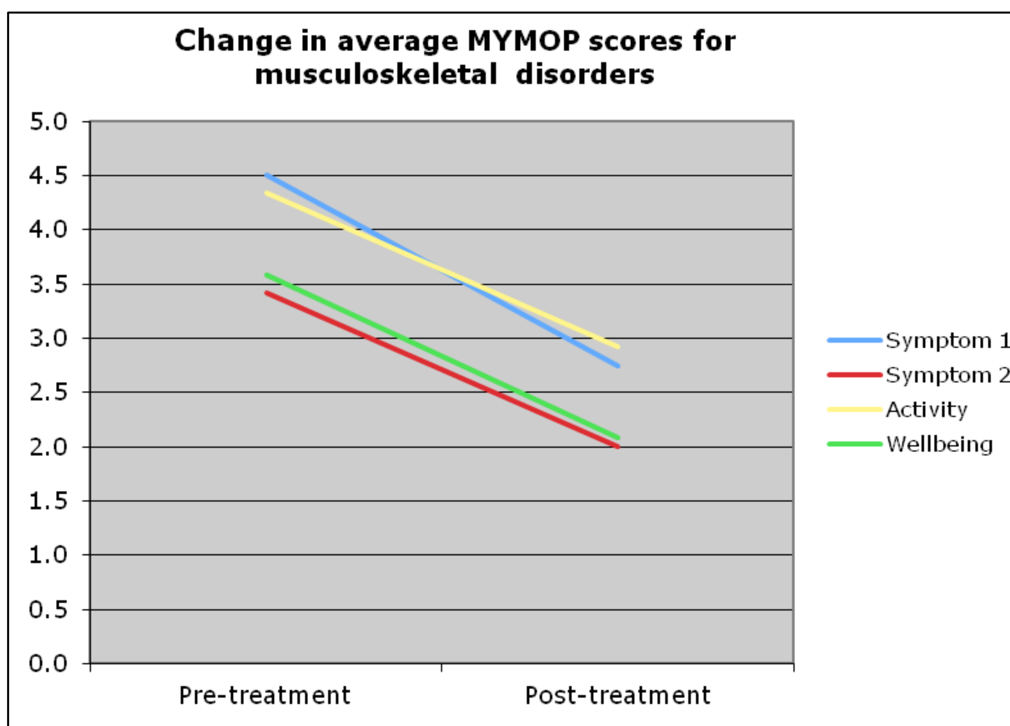


"Deep down, I feel a bit more steady and solid. I don't feel so tired, not dragging through the day. I was depressed, but I'm not now."

Musculoskeletal Disorders

"I do not need physio from work any more."

Sixteen patients were referred for musculoskeletal disorders, and the outcomes for this group also showed significant improvement, following either chiropractic or acupuncture. The average reduction in MYMOP scores was 1.6, and the average increase in SF36 scores was 10.36%. The Department of Health document '*Musculoskeletal Services Framework – A Joint Responsibility – Doing it Differently',* published in 2006, recommended the development of a wide range of non-surgical alternatives, including chiropractic and acupuncture. It also suggested that clinical assessment and treatment services should be established and should include chiropractic.



Sameena, 20 years old, presented with neck pain and accompanying headaches of over two years' duration. Her symptoms included a dull aching at the base of the neck and a sharp, right anterior headache, made worse by writing and studying.

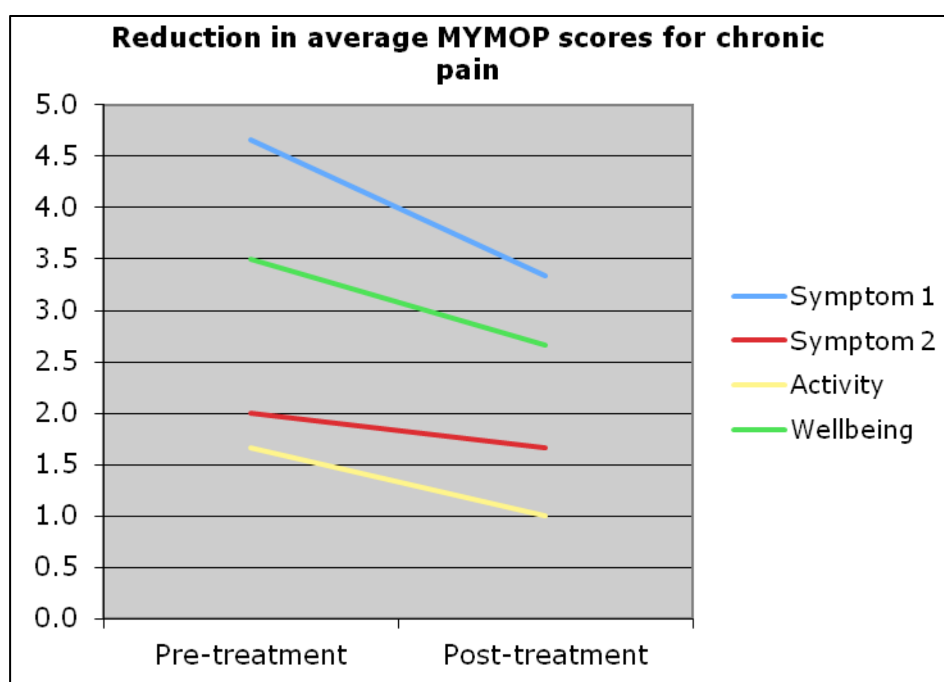
She had visited her GP on numerous occasions and had been referred for physiotherapy which had not helped. She had also been prescribed NSAIDs. On examination, she was found to have hyper tonicity in levatae scapulae and upper trapezius. Cervical vertebrae 5 and upper thoracic vertebrae 1 and 2 appeared fixed and inflexible.

Sameena received five weekly sessions of manipulation, soft tissue work and ergonomic advice, with a final sixth session 2 weeks later. Her MYMOP scores reduced from 4.75 to 2.0 and her SF36 scores increased from 46.44% to 72.22%. She stated that she attends her GP less often as a result of her treatment with Impact and that she needed less treatment elsewhere now. She was very satisfied with Impact's service and would recommend it to others.

Chronic Pain

"Generally sleeping more after a bad stretch, more energy than expected at times, some periods of extreme pain but generally able to cope, sometimes without medication."

Five patients with chronic pain have been referred to Impact for acupuncture treatment. Again, the results showed significant improvement - an average reduction in MYMOP scores of 1.36 and an average increase in SF36 scores of 13.45%. Acupuncture is now generally available in NHS pain management services, both in primary and secondary care, although it seems that access for patients is often limited. In 2006, Nottingham City PCT reviewed GP referrals to hospital-based chronic pain services and concluded that 'up to 50% of these referrals could be managed in primary care using interventions such as acupuncture, manipulation, algorithms, further GP education and promoting self-care.'[5]



29 year old John was referred for acupuncture as he was suffering from constant headaches. There was a history of migraines in his family and he remembered suffering from migraines from the age of three. He had also suffered a bad fall three years previously, which had left him with a constant headache and a desire to sleep a lot. A CT scan had not revealed any damage. He took a variety of painkillers which would take the edge off but not remove the pain.

After his second treatment John reported that he had avoided taking any painkillers and whilst he was still waking up in pain he was suffering much less through the day. During the course of treatment John reported that the severity, duration and frequency of his headaches had decreased. When he did have headaches, he found that taking two painkillers would usually remove them. He had no migraines at all whilst having treatment.

[5] The Primary Care Chronic Pain Pathway Proposal, Anita Dixon and Lucy Davidson, Broxtowe and Hucknall PCT

Practice-Based Evidence of Effectiveness

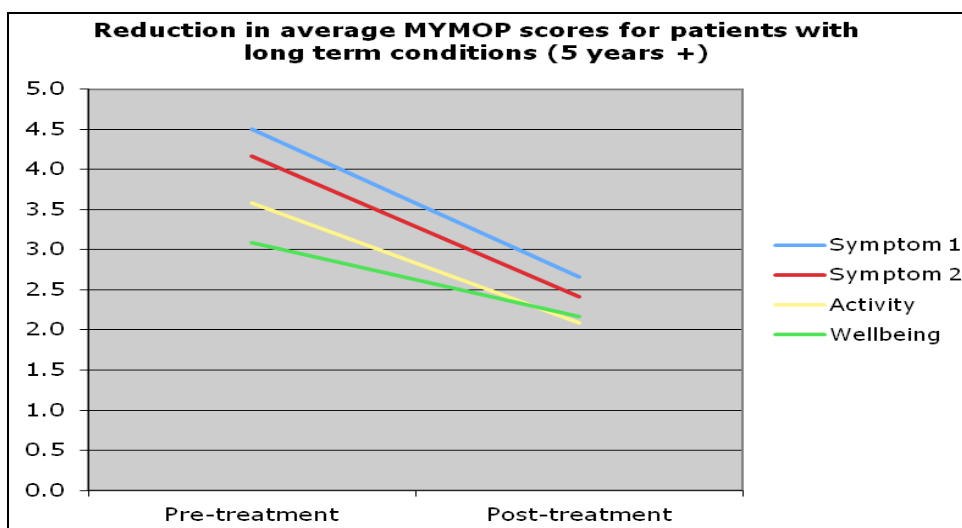
The clinical outcomes from this service tally very closely with the outcomes from Impact's previous clinic. This is particularly encouraging, because the patients from Radford Medical Practice had a maximum of six treatment sessions, whereas patients at the Waverley Health Centre were not restricted to a maximum number of sessions.

These results are also very similar to those obtained in the UK's first government funded trial into the use of complementary therapies in primary care, conducted in Northern Ireland in 2007 – 2008. In that trial (see www.getwelluk.com), the GPs involved were almost unanimously in favour of referrals to complementary services, in the light of such tangible results. In 99% of patient cases GPs said they would refer the patient, or a different patient, to the scheme again and in 98% of cases GPs said they would recommend the service to other GPs. Impact has considerable expertise in this area and is keen to extend the benefits of integrated medicine to other areas of Nottingham.

Tackling Chronic and Long Term Conditions

Just under half the patients referred had suffered their conditions for more than five years and some for many years longer. In nearly every case, therefore, the patient had already received all possible conventional treatment, with very limited results. The MYMOP outcomes graph below shows that, even for this group of patients, the outcomes have been positive. An average reduction in MYMOP scores of 1.75 (varying from 0.5 to 3.0) indicates significant improvement, as does an average increase in SF36 scores of 16.01%.

We suggest, therefore, that serious consideration be given to the commissioning of Impact's service for patients with long term conditions, including mental health conditions, particularly those who have not benefited from other treatment. As one of the GP partners comments[6], *"a good alternative when conventional medicine is not working".*



[6] On the Impact Service Evaluation form August 2010

Reduced Demand on Mainstream NHS Services

The evaluation shows that a referral to Impact subsequently reduces the take up of other primary and secondary care services. These findings are consistent with our previous work, which was evaluated by an independent academic, who found that patients went to see their GP less often following treatment: "Many of Impact's patients were frequent attenders to GP practices; some because they had many chronic physical conditions and others because of mental health issues…many frequent attenders decreased their burden on GP services".[7]

"At the start of treatment, anti-inflammatories and pain killers every day x 3 – now anti-inflammatories only once a week, if that, and painkillers once a week or less, depending on work load".

Following treatment, 75% of patients (31 out of 42) completed a questionnaire on changes in their usage of medication and the frequency of visits to their GP.

- 71% (22) of those who completed the questionnaire were on medication before starting treatment with Impact.
- 69% (21) of those who completed the questionnaire said they wanted to reduce or stop medication.
- 63% (14) of the patients who were on medication before starting treatment with Impact reported reducing or stopping their medication since it was no longer required after treatment with Impact.
- 46% (14) of those patients who completed the questionnaire reported going to see their GP less after treatment with Impact.
- 56% (5 out of 9) of those patients who were receiving treatment in secondary care no longer needed it after treatment with Impact.

"I visited my GP twice with back problems – I have not been since [treatment]".

"I stopped having facet joint injections for back pain as I was not having positive results – the chiropractor has helped significantly".

Several patients referred to the preventative aspects of the Impact treatment, one commenting that the referral to Impact had prevented her needing stronger medication. Another patient commented on the way in which treatment had prompted her to consider lifestyle changes:

"Did make me think more about my general health in relation to headache e.g. links to body – back pain, diet, exercise etc. Thank you".

[7] Dr Shona Kelly, available for download at www.impact-imp.co.uk

Patient Choice and Satisfaction

"Very happy with the service provided. It has changed my life for the better".

Just over half the patients (24) completed a patient satisfaction questionnaire once they had finished treatment with Impact. 100% agreed that they have been appropriately referred by their GP, and all of them said they would recommend Impact to others. Nearly 90% were very satisfied with the service they received; with the remaining patients saying they were satisfied.

"I received effective and positive treatment. Thank you!"

Several patients commented that, whilst they were happy with the treatment, six sessions were not sufficient. This was particularly true for acupuncture patients; normal clinical practice in acupuncture is to offer a course of ten sessions.

"If I could continue treatment I would do so. But the medical practice only allows 6 sessions which isn't enough".

In March 2007, in front of BBC TV cameras, the Impact Patients' Forum presented a petition to the Nottingham City Primary Care Trust Chief Executive, signed by approximately nine hundred local people. It is clear, therefore, that this service is extremely popular with patients, when it is made available as part of NHS primary care.

Health Inequalities

As is evident from recent studies, health inequalities continue to persist, with the gap between rich and poor being wider than ever. Impact's previous work in Radford and Hyson Green was recognised by Nottingham City Primary Care Trust as a valuable way of tackling health inequalities; in March 2007 Dr Chris Packham (Director of Public Health) referred to it as a 'gold standard service'.[8]

In 2004, Impact partner Julie McKay carried out a study which compared patients in her West Bridgford (NG2) private chiropractic practice with those at Impact's funded clinic (NG7).[9] Those from NG7 were nearly ten times more likely to have psychosocial difficulties than those from NG2. Their condition was also twice as likely to be chronic, and almost three times the number of consultations were required for treatment to be completed. This demonstrates that there is a much greater need for the kind of services provided by Impact in deprived areas, to address the higher incidence of chronic and complex conditions. Furthermore, since a significant proportion of GP consultations have a mental health component, the Impact team considers that the provision of integrated care, which can offer patients several interventions tailored to their individual physical and emotional needs, is an effective way to support and complement existing services.

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[8] BBC East Midlands local news story

[9] Impact Annual Report 2005 pp20 - 21

The Impact service at the Waverley Health Centre took referrals from local GPs and practice nurses, as well as other health and social care practitioners and patient self referral. This service was disproportionately popular with patients from black and minority ethnic (BME) communities; 48% of Impact's patients at the Waverley Health Centre were from BME groups, in an area where the resident BME population is 28%. For Impact, this illustrates a wider trend of the attraction of its services for groups traditionally considered 'hard to reach'.

Costs and Savings

As described above, the cost of the Impact service to the Radford Medical Practice has been £260 per patient, or an average of £43 per consultation. Whilst there are no reliable estimates of the cost of a GP consultation, it is clear that a reduction in GP visits equates with savings for the practice. Likewise, reductions in prescribed medication also result in savings for the practice. Nearly all of the costs charged by Impact for the service covered the practitioners' time; negligible amounts were required to cover materials, such as acupuncture needles, treatment couch roll or homeopathic remedies.

A reduction in referrals to secondary care certainly saves GP practices money. For example, the current Payment by Results Outpatient Attendance Tariff for pain management is either £160 or £231 for the first consultation (depending on whether the patient is seen by a single practitioner or a team), and £84 or £95 for follow up attendances. Referrals to other outpatient clinics are similarly more expensive than referrals to Impact; a referral to rheumatology is £238 for a first appointment and £98 for follow up attendances; a referral to orthopaedics is £134 with a tariff of £74 for follow up appointments. A referral to Impact for six sessions is, therefore, cheaper than a referral to secondary care, especially where a number of attendances may be required.

Analysis by North East Essex Primary Care Trust of a manual therapies back and neck service provided by chiropractors and osteopaths in 2009/10 concluded that:-

- Referrals to a spinal consultant had reduced by almost 30% since the introduction of the service.
- 74% of the 2,810 patients had their condition much improved or very much improved.
- 97% of the patients referred to the service were kept out of secondary care.
- 70% of patients taking medication for their condition reported either stopping or significantly reducing their use of medication post treatment.
- The PCT estimated the service as cost neutral.

It is notable that this service, like Impact's, also provides patients with a maximum of six sessions.

The potential to save money by diverting referrals from secondary care to community based services is illustrated in the Department of Health (DH) document, '*Exercising Outcomes: A Guide for Commissioners to Developing Musculoskeletal and Exercise Medicine Services'.* The DH states that diverting referrals from secondary care to community based services can generate cost savings of around £44 per appointment. With the average cost of an appointment with Impact currently at £43 per appointment, it is possible that the savings generated could cover the cost of providing the service.

Conclusion

Since 2004, the Impact team has repeatedly demonstrated the effectiveness of integrating holistic, complementary approaches into primary care. When Radford Medical Practice approached Impact in 2008 to deliver a service for their patients, the team was delighted to take another opportunity to make its service accessible to patients living in one of the most deprived areas of the city. Once again, by carefully evaluating the progress and outcomes for the patients, Impact has demonstrated that acupuncture, chiropractic and homeopathy are both clinically and economically effective ways of treating patients with short and long term conditions, including those who have not experienced improvement with conventional treatment. The Impact team is at the forefront of developing integrated care that reduces both the burden on GP and practice staff and prescribing costs, whilst also providing a service which offers an innovative approach to reducing health inequalities. The Impact team looks forward to being able to further develop this integrated approach for patients and practices in Nottingham and elsewhere.

Acknowledgements

The Impact team would like to thank the following people: Dr Liau, Dr Kaur and Dr Lonsdale
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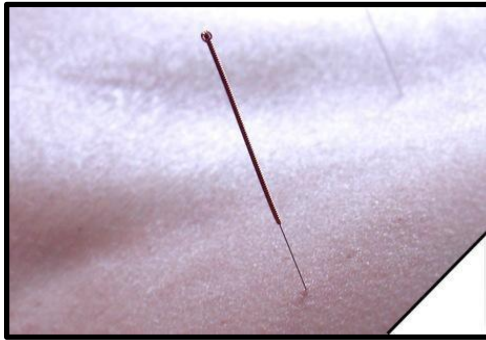
Many thanks go to all the patients who have participated so willingly and patiently in our evaluation.

Julie McKay BSc DC
Fiona Robertson BA DSSH Matt McGuire BA MBAcC
Shirley Thompson BSc MNWCH RSHom

"Very happy with the service provided. It has changed my life for the better"

"I received effective and positive treatment. Thank you."



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Next page

Evaluation

**Complementary And Alternative Medicines
Pilot Project**

May 2008

**Report Written By:
Donal McDade**

CONTENTS

EXECUTIVE SUMMARY 6
1. INTRODUCTION 11
1.1 PROJECT OBJECTIVES 11
1.2 THE GET WELL UK SERVICE 11
1.2.1 IDENTIFYING PATIENTS 12
1.2.2 COLLECTION OF PATIENT DATA 12
1.2.3 SUPPORTING PATIENTS WITH ACCESSING SERVICES 13
1.2.4 IDENTIFIYING CAM PRACTITIONERS TO SUPPORT THE PROJECT ... 13
1.2.5 IDENTIFIYING GPs TO SUPPORT THE PROJECT 13
1.3 EVALUTION TERMS OF REFERENCE 14
1.3.1 KEY EVALUATION TASKS 14
1.3.2 EVALUATION METHODOLOGY 14
1.3.3 INDEPENDENT SURVEYS OF PATIENTS, GPs AND PRACTITIONERS 15
1.4 NOTES ON TABLES 15
1.5 STATISTICAL SIGNFICANCE 15
2 PATIENTS REFERRED TO THE SERVICE 16
2.1 PATIENT PROFILE 16
2.2 COMPLETION OF MYMOP 1 FORM 17
2.3 HEALTH PROBLEMS IDENTIFIED BY PATIENTS 18
2.3.1 SEVERITY OF SYMPTOM 1 19
2.3.2 DIFFERENCES IN SEVERITY OF SYMPTOM 1 BY PATIENT GROUPS . 19
2.3.3 SEVERITY OF SYMPTOM 2 21
2.3.4 DIFFERENCES IN SEVERITY OF SYMPTOM 2 BY PATIENT GROUPS . 21
2.3.5 RESTRICTED ACTIVITY ASSOCIATED WITH SYMPTOMS 21
2.3.6 LEVEL OF RESTRICTED ACTIVITY ASSOCIATED WITH SYMPTOMS .. 22
2.3.7 LEVELS OF RESTRICTED ACTIVITY BY PATIENT GROUPS 23
2.3.8 LEVEL OF WELLBEING 23
2.3.9 DIFFERENCES IN LEVEL OF WELLBEING BY PATIENT GROUPS 24
2.3.10 DURATION OF SYMPTOM 1 25
2.3.11 DIFFERENCES IN LEVEL OF WELLBING BY PATIENT GROUPS 25
2.4 MEDICATION LEVELS PRIOR TO TREATMENT 26
2.4.1 CUTTING DOWN ON MEDICATION 26
2.5 WORRYING ABOUT SYMPTOMS 27
3 IMPACT OF TREATMENTS 28
3.1 CHANGES IN MYMOP SCORES BEFORE AND AFTER TREATMENT 28
3.1.1 CHANGES IN MYMOP SCORES BY THERAPY 29
3.1.2 CHANGES IN MYMOP SCORES BY HEALTH CONDITION 30
3.1.3 CHANGE IN PATIENTS REPORING HIGHEST SEVERITY LEVEL 30
3.1.4 PATIENTS REPORTING AN IMPROVEMENT IN MYMOP SCORES 31
3.1.5 REPORTED IMPROVEMENTS IN MYMOPS BY PATIENT GROUPS 31
3.2 LEVEL OF PATIENT WORRY POST-TREATMENT 32
3.3 PATIENT PERCEIVED CHANGE IN GENERAL HEALTH POST-TREATMENT 32
3.4 PATIENT USE OF MEDICATION POST-TREATMENT 32
3.5 PATIENT FEEDBACK 32
3.6 PRACTITIONER VIEWS ON EFFECTIVENESS OF TREATMENTS 33
3.6.1 PRACTITIONER VIEWS ON OUTCOMES BY TREATMENTS 35
3.6.2 RELATIONSHIP BETWEEN PRACTITIONER AND PATIENT VIEWS 36
3.7 GPs VIEWS ON HEALTH IMPROVEMENT AMONG PATIENTS 36
3.8 GP AND PATIENT VIEWS ON HEALTH IMPROVEMENT 37
3.9 PATIENT CONTACT WITH GP FOLLOWING TREATMENT 37

3.10 GP VIEWS ON IMPACT OF PROJECT ON WORKLOAD 37
3.11 NORMAL COURSE OF TREATMENT IF NO ACCESS TO CAM 38
3.12 GP VIEWS ON THE REFERRAL PROCESS OPERATED BY GET WELL UK .. 38
4 FOCUS GROUPS WITH PATIENTS 39
4.1 PATIENT AWARENESS OF CAM 39
4.2 REASONS FOR REFERRAL AND THERAPIES RECEIVED 39
4.3 PATIENT EXPECTATIONS 39
4.4 PATIENT REACTION TO A FREE SERVICE 40
4.5 GP SUPPORT FOR CAM 40
4.6 WAITING TIMES FOR TREATMENTS 41
4.7 AVAILING OF TREATMENTS 41
4.8 PATIENTS BEING PROVIDED WITH ADVICE BY PRACTITIONERS 42
4.9 PATIENT COMMENTS ON QUALITY OF PRACTITIONERS 42
4.10 PATIENT UNDERSTANDING OF TREATMENTS 42
4.11 IMPACT OF TREATMENTS 43
4.12 IMPROVEMENTS IN SOCIAL AND EMOTIONAL WELLBEING 45
4.13 CONTROL OVER PAIN 45
4.14 RESPONSIVENESS OF THERAPIES 45
4.15 LEVEL OF PATIENT WORRY FOLLOWING TREATMENT 45
4.16 OTHER IMPACTS OF TREATMENTS 45
4.17 COMPLEMENTARY TREATMENTS 45
4.18 COMPLETION OF MYMOP QUESTIONNAIRES 46
4.19 SUGGESTED IMPROVEMENTS 46
4.20 PATIENT PERCEIVED BENEFITS 46
4.21 PATIENT PERCEIVED WEAKNESSES OF THE PROJECT 47
4.22 CONCLUDING COMMENTS 47
5 FOCUS GROUPS WITH GPs AND CAM PRACTITIONERS 49
5.1 AWARENESS AND ATTITUDES TO CAM 49
5.2 GP AND PRACTITIONER EXPECTATIONS FROM THE PROJECT 49
5.3 INITIAL CONCERNS ABOUT THE PROJECT 49
5.4 GP AND PRACTITIONER VIEWS ON PATIENT AWARENESS OF CAM 50
5.5 PATIENT COMPLIANCE AND EXPECTATIONS 50
5.6 SUPPORTING GPS TO BETTER UNDERSTAND CAM 51
5.7 TREATING PATIENTS 51
5.8 INCREASED CONTACT WITH GPS 52
5.9 PRACTITIONER CONCERNS ABOUT MYMOP FORMS 52
5.10 GP AND PRACTITIONER VIEWS ON HEALTH OUTCOMES 52
5.11 OTHER IMPACTS ON PATIENT HEALTH 54
5.12 IMPACT OF PROJECT ON WAITING LISTS FOR OTHER SERVICES 54
5.13 IMPACT OF PROJECT ON WORKLOAD / GENERAL PRACTICE 54
5.14 IMPACT OF PROJECT ON OTHER SERVICES 54
5.15 GP AND PRACTITIONER VIEWS ON PATIENT AFFORDABILITY 55
5.16 GP AND PRACTITIONER VIEWS ON PROJECT STRENGTHS 55
5.17 GP AND PRACTITIONER VIEWS ON PROJECT WEAKNESSES 56
5.18 GP AND PRACTITIONER CONCLUDING COMMENTS 56
6. SURVEY OF PATIENTS 57
6.1 PROFILE OF THE PATIENT SAMPLE 57
6.2 FINDING OUT ABOUT THE PROJECT AND AWARENESS OF CAM 58
6.2.1 AWARENESS OF CAM BY PATIENT CHARACTERISTICS 58
6.2.2 REASONS WHY PATIENTS AVAILED OF THE TREATMENTS 58
6.3 REFERRAL TO THE PROJECT 60
6.4 PATIENTS BEING SUPPORTED BY GPS 60
6.5 PATIENT INFORMATION LEAFLET 61

6.6 COMPLEMENTARY NATURE OF TREATMENTS 61
6.7 PATIENT VIEWS ON GP MATCHING OF CONDITIONS WITH THERAPIES ... 61
6.8 PATIENT CONCERNS OR ANXIETIES 62
6.9 PATIENT SATISFACTION WITH REFERRAL PROCESS 62
6.10 RECEIVING TREATMENTS 63
4.11 NUMBER OF TREATMENT SESSIONS 63
6.12 PATIENT INTERACTION WITH TREATMENT PRACTITIONERS 63
6.13 PRACTITIONERS PROVIDING PATIENTS WITH HEALTH ADVICE 63
6.14 OVERALL SATISFACTION WITH TREATMENTS RECEIVED 64
6.15 IMPROVEMENTS IN PATIENT EXPERIENCE OF GETTING TREATMENTS .. 65
6.16 IMPACT OF TREATMENTS ON PHYSICAL AND MENTAL HEALTH 65
6.17 IMPACT OF TREATMENTS BY PATIENT GROUPS 66
6.18 PATIENT PERCEIVED IMPACT OF TREATMENTS ON QUALITY OF LIFE 66
6.19 LEVEL OF PATIENT WORRY POST-TREATMENT 67
6.20 PATIENT PERCEIVED OUTCOMES FOLLOWING TREATMENTS 68
6.20.1 PATIENT PERCEIVED HEALTH OUTCOMES BY PATIENT GROUP....... 68
6.21 PATIENT PERCEPTION OF WELLBEING FOLLOWING TREATMENT 69
6.22 USE OF MEDICATION 69
6.23 USE OF PAIN KILLERS 70
6.24 PATIENT PERCEPTION OF THE APPROPRIATENESS OF TREATMENTS ... 70
6.25 IMPACT OF TREATMENTS ON EMPLOYMENT 71
6.26 USING COMLPEMENTARY THERAPIES IN THE FUTURE 72
6.27 PATIENT INTERACTION WITH GPS 72
6.28 IMPACT OF TREATMENTS ON USE OF GP SERVICES 73
6.29 IMPACT OF TREATMENTS ON USE OF OTHER HEALTH SERVICES 73
6.30 PATIENT PERCEPTION OF MOST IMPORTANT BENEFIT OF CAM 74
6.31 PATIENT PERCEIVED IMPROVEMENT IN HEALTH AND WELLBEING 75
6.32 IMPROVEMENTS IN PATIENT EXPERIENCE OF PROJECT 75
7 SURVEY OF GPS 76
7.1 GP UNDERSTANDING OF CAM 76
7.2 GPS GETTING INVOLVED IN THE PROJECT 76
7.3 GP CONCERNS OR ANXIETIES ABOUT GETTING INVOLVED 76
7.4 GPS MATCHING PATIENT CONDITIONS WITH THERAPIES 77
7.5 SUPPORT FOR GPS 77
7.6 PATIENT RECEPTIVENESS TO CAM 77
7.7 GP SATISFACTION WITH THE REFERRAL PROCESS 78
7.8 GP PERCEIVED IMPACT OF CAM ON PATIENTS 78
7.9 GP PERCEPTION OF PATIENT COMPLIANCE WITH TREATMENTS 79
7.10 SEEING PATIENTS FOLLOWING THEIR CAM TREATMENTS 79
7.11 PATIENT BENEFITS FROM THE TREATMENT 80
7.12 PATIENT USE OF MEDICATION 80
7.13 PATIENT REACTION TO THE PROJECT 81
7.14 PATIENTS CONTINUING WITH TREATMENTS 81
7.15 IMPACT ON PROJECT ON GENERAL PRACTICE 81
7.16 GP's VIEWS ON USE OF SERVICES BY PATIENTS 82
7.17 CHANGE IN GP PERCEPTION OF CAM 82
7.18 GPS VIEWS ON INTEGRATING CAM INTO PRIMARY CARE 82
7.19 GP VIEWS ON PROJECT STRENGTHS 82
7.20 GP VIEWS ON PROJECT WEAKNESSES 83
7.21 GP SUPPORT FOR CAM IN THE FUTURE 83
8. SURVEY OF PRACTITIONERS 84
8.1 GETTING INVOLVED IN THE PROJECT 84
8.2 CONCERNS OR ANXIETIES ABOUT GETTING INVOLVED 84

8.3 REFERRAL OF PATIENTS 84
8.3.1 PRACTITIONER VIEWS ON MATCHING PATIENTS WITH THERAPIES. 84
8.3.2 PRACTITIONERS BEING PROVIDED WITH PATIENT INFORMATION ... 85
8.3.3 PATIENTS BEING GIVEN SUFFICIENT INFORMATION BY GPS 85
8.4 PRACTITIONER VIEWS ON COMMUNICATION WITH GPS 85
8.5 PRACTITIONER SATISFACTION WITH THE REFERRAL PROCESS 86
8.6 PRACTITIONER PERCEPTION OF PROJECT IMPACT ON PATIENTS 86
8.7 PRACTITIONER PERCEIVED BENEFITS TO PATIENTS 87
8.8 MEDICATION 87
8.9 PATIENT REACTION 87
8.10 PATIENTS USING CAM BEYOND THE PILOT PROJECT 88
8.11 PRACTITIONER VIEWS ON IMPACT OF PROJECT ON GPS 88
8.12 PRACTITIONER VIEWS ON USE OF SERVICES BY PATIENTS 89
8.13 INTEGRATION OF CAM WITHIN PRIMARY CARE 89
8.14 PRACTITIONER PERCEPTION OF CHANGE IN GP ATTITUDES 89
8.15 PROJECT STRENGTHS 90
8.16 PROJECT WEAKNESSES 90
8.17 MOVING FORWARD 90
9. DISCUSSION 92
9.1 GET WELL UK DATA 92
9.2 INDEPENDENT SURVEYS 93
9.2.1 PATIENT SURVEY 93
9.2.2 PRACTITIONER SURVEY 94
9.2.3 GP SURVEY 95
9.3 FOCUS GROUPS 97
9.3.1 PATIENT FOCUS GROUPS 97
9.3.2 GP AND CAM PRACTITIONER FOCUS GROUPS 98
9.4 MEETING THE PROJECT OBJECTIVES 100
APPENDICES 101
APPENDIX 1: PATIENT QUESTIONNAIRE 102
APPENDIX 2: GP QUESTIONNAIRE 119
APPENDIX 3: CAM PRACTITIONER QUESTIONNAIRE 130
APPENDIX 4: DISCUSSION SCHEDULE – FOCUS GROUPS 141

EXECUTIVE SUMMARY

This report presents the findings from an evaluation of a pilot project which provided patients with access to a range of Complementary and Alternative Medicine (CAM) through their GP practice. Overall 713 patients were referred to the project by their GP. Patients presenting to their health centre with musculoskeletal and mental health conditions, were referred for a range of CAM therapies including acupuncture, chiropractic, osteopathy, homeopathy, reflexology, aromatherapy and massage. The project was commissioned by the Department of Health, Social Services and Public Safety with a view to exploring the potential for CAM within existing primary care services in Northern Ireland. The project was implemented by Get Well UK in two primary care centres in Northern Ireland: Shantallow Health Centre in Londonderry and The Arches Centre in Belfast. The evaluation, conducted independently by Social & Market Research (SMR), is based on an analysis of project monitoring data provided by Get Well UK; and focus groups and surveys of patients, CAM practitioners and GPs from the two participating health centres.

Key Findings: The Patient Experience

Using the various data sources, the evaluation has found a significant level of health gain for the vast majority of patients who have received complementary and alternative medicine as part of the pilot project. This is evidenced by the following:

- Analysis of MYMOP (Measure Yourself Medical Outcome Profile) data, which was generated using a validated health instrument used for measuring patient health gain in general practice, found statistically significant improvements on each of the health outcome indicators measured i.e. the severity of patient symptoms; the level of patient activity associated with their symptoms; and, overall patient wellbeing (source, MYMOP);

- The proportion of patients reporting that the severity of their symptoms were 'as bad as it could be', fell from 31% prior to treatment to 5% following treatment (source, MYMOP);

- 80% of patients recorded an improvement in the severity of their main symptom, with 73% recording an improvement in their level of activity associated with their main symptom (source, MYMOP);

- 67% of patients recorded an improvement in their wellbeing (source, MYMOP);

- 81% of patients said that their general health had improved, with a similarly high proportion of patients (82%) reporting to be less worried about their symptoms following treatment (source, MYMOP);

- 81% of patients reported an improvement in their physical health, with 79% reporting an improvement in their mental health (source, patient survey);

- 84% of patients directly linked the CAM treatments to an improvement in their overall wellbeing (source, patient survey);

- 62% of patients were suffering less pain, with 60% having more control over pain (source, patient survey);

- There was a 14 percentage point reduction in the proportion of patients using medication between the pre and post-treatment stages (i.e. down from 75% to 61%) (source, project monitoring data);

- 44% of patients who were taking medication prior to their treatment, had reduced their use of medication (source, patient survey);

- Among patients using pain killers prior to treatment, 55% said that they use fewer pain killers following treatment (source, patient survey);

- In the majority of patient cases, CAM practitioners reported an improvement in: patient quality of life; relief of presenting symptoms; relief of chronic conditions; increased mobility; increased emotional stability; and, a reduction in patient worry (source, project monitoring data);

- 24% of patients who used other health services prior to treatment (e.g. other primary care services, secondary care services and Accident and Emergency), said they now use these services less often (source, patient survey);

- 64% of patients in employment said that following treatment they now take less time off work. Among patients not in employment, 16% said that having the CAM treatments had encouraged them to think about going back into employment (source, patient survey);

- 94% of patients would recommend CAM to other patients with similar health conditions (source, patient survey);

- 89% of patients expressed an interest in continuing with CAM, with just 30% saying they would be able to afford to continue with CAM treatments (source, patient survey);

- Patients were supportive of CAM being integrated into primary health care, with a call for increased public awareness of the potential of CAM for health gain (source, patient focus groups);

- Patients identified a need for CAM to be promoted among GPs in Northern Ireland, and for initiatives to be taken to help reduce the level of scepticism held by some GPs towards CAM (source, patient focus groups);

Key Findings: The GP Experience

- In 65% of patient cases, GPs documented a health improvement, with a high degree of correlation between GP and patient assessment of health improvement (source, project monitoring data);

- In 65% of patient cases, GPs said they had seen the patient less often following the patient's referral to CAM (source, project monitoring data);

- Improving patient health was found to be the main motivation for GPs getting involved in the pilot project (source, GP survey and focus groups);

- Most GPs said that their understanding and knowledge of CAM had improved by participating in the pilot project, with most conceding that their knowledge was limited at the initial stages. Some GPs had experienced difficulty initially in matching their patients with appropriate therapies, with most of the GPs supporting the need for further educational interventions such as seminars, talks with practitioners and having more written information on CAM (source, GP survey and focus groups);

- Half of GPs reported prescribing less medication for chronic or acute patients (source, GP survey);

- Half of GPs reported that the option to refer their patients to CAM had reduced their workload, with two GPs pointing to a financial saving for their practice. All but one of the GPs had seen the project as a positive development for their practice, with all agreeing that it provided them with more referral options (source, GP survey);

- Most GPs reported that their patients were using Allied Health Professionals less often, with half saying that their patients were using secondary care services less often (source, GP survey);

- Ten out of the 12 GPs surveyed had a more positive view of the potential for CAM within primary care, with all wishing to continue with the option of referring their patients to CAM (source, GP survey);

- In 99% of patient cases, the GP said that they would be willing to refer the same patient, or another patient, to the Get Well UK service. Also in 98% of patient cases, the GP said they would be willing to recommend the service to another GP (source, project monitoring data);

Key Findings: The CAM Practitioner Experience

- CAM practitioners reported a health improvement in 77% of their patients on average, with health gains including: pain relief; improved quality of life; improved mobility, stress relief and improved emotional wellbeing (source, practitioner survey);

- CAM practitioners identified a need for a series of educational interventions targeted at GPs to improve their understanding of CAM and to better support them with matching health conditions with appropriate therapies (source, practitioner survey and focus groups);

- CAM practitioners called for GPs to supply more information on patient medical condition as part of the referral process (source, practitioner survey and focus groups);

- CAM practitioners identified a tendency for GPs to refer patients with chronic medical conditions to the project, with practitioners concerned that the therapies may not be as responsive to this type of patient compared to, for

example, patients with acute medical conditions (source, practitioner survey and focus groups);

- Affordability was identified as the main barrier for patients wishing to continue with CAM (source, practitioner survey and focus groups);

- All CAM practitioners supported the integration of CAM within primary health care, with patient health gain cited as the key benefit (source, practitioner survey and focus groups);

- CAM practitioners reported a more positive attitude to CAM among GPs who had participated in the project, with ongoing contact and communication between GPs and CAM practitioners identified as a key requisite if CAM is to be rolled out more extensively across Northern Ireland (source, practitioner survey and focus groups);

Recommendations

(i) Given the evidence of health gain documented by patients, GPs and CAM practitioners, it is recommended that DHSSPS and the project partners explore the potential for making CAM more widely available to patients across Northern Ireland. Not only has this project documented significant health gains for patients, but it has also highlighted the potential economic savings likely to accrue from a reduction in patient use of primary and other health care services, a reduction in prescribing levels and reduced absenteeism from work due to ill health.

(ii) This pilot project has clearly demonstrated that CAM fits well within a primary health care context, with patients valuing the support and judgement of their GPs in accessing treatments. It is recommended that DHSSPS and the project partners examine ways of integrating CAM within primary care, taking on board the need for a strategy to promote GP knowledge and understanding of CAM to ensure that health conditions are matched appropriately with CAM therapies. A strategy to promote awareness and understanding of CAM among GPs, as well as the positive health gains for patients, should also go some way to addressing issues around scepticism held by some GPs.

(iii) To further assist the process of integrating CAM with primary health care, it is recommended that consideration be given to exploring the potential for sharing medical records with CAM practitioners. Furthermore, consideration should be given to exploring the potential for CAM practitioners to be involved in clinical meetings and case conferences, which may provide patients, particularly those with chronic health problems, with more treatment options. This may also lead to significant cost savings for the health service.

(iv) The project has highlighted a number of areas where the operation of a CAM service can be further improved. In particular, it is recommended that DHSSPS and the project partners explore ways of ensuring that patients are provided with accurate and up to date information at all points of the referral process, as well as at the point of receiving treatments. In addition, the evaluation has found that patients may benefit from a ‘triage’ system to ensure appropriate matching of health conditions and CAM treatments;

(v) Given that the pilot project has raised expectations among patients, DHSSPS and its partners should consider a mechanism for ensuring that patients who presented with long-term illnesses, and in particular those who experience pain, be offered booster or maintenance sessions beyond the life of the project.

(vi) Given the limited number of CAM practitioners in Northern Ireland, and the difficulties in identifying practitioners to participate in the pilot project, it is recommended that DHSSPS and the project partners consider ways of retaining this resource within a model for wider service delivery.

(vii) Given that the health outcomes for patients have been significant, it is recommended that DHSSPS and the project partners consider the development of a public health information campaign aimed at promoting the potential benefits of CAM. Allied to this point, it is recommended that DHSSPS and its partners examine the role of CAM in supporting health prevention and health promotion strategies, given the evidence that patients are likely to adhere strongly to the advice provided by CAM practitioners.

(viii) The evaluation has documented the positive impact of CAM on patients who are economically active, particularly in the context of helping people back into work following illness. It is recommended that the outcomes from this project be shared with colleagues in other departments (e.g. Department for Employment and Learning), to allow them to examine the potential for CAM within their own operational areas.,

(ix) Given that the evaluation outcomes are based on the perception of the various stakeholder groups (i.e. patients, CAM practitioners and GPs), it is recommended that DHSSPS and the project partners give consideration to integrating other approaches to measuring health impact (e.g. a formal case control study) on an ongoing basis.

1. INTRODUCTION

This report presents the findings from an evaluation of a pilot project aimed at integrating complementary and alternative medicine (CAM) into existing primary care services in Northern Ireland. The project was available to patients registered with two primary care centres: The Arches Centre in East Belfast and Shantallow Health Centre in Londonderry. The Arches Centre has seven GP practices and Shantallow health Centre has two GP practices. Between February 2007 and February 2008, 713 patients presented with a variety of musculoskeletal and mental health problems and were referred to a range of therapies including: chiropractic; osteopathy; reflexology; massage; aromatherapy; acupuncture; and, homeopathy. The pilot project was funded by the Department of Health, Social Services and Public Safety Northern Ireland (DHSSPSNI) and administered by Get Well UK. The evaluation was conducted independently by Social & Market Research (SMR).

1.1 PROJECT OBJECTIVES

The pilot objectives were:

- To measure the health outcomes of the service and monitor health improvements;

- To redress inequalities in access to complementary medicine by providing therapies through the Health Service, allowing access for all;

- To contribute to best practice in the field of delivering complementary therapies through primary care;

- To increase patient satisfaction with quick access to expert care;

- To help patients learn self management strategies to manage / improve their health;

- To free up GP time to work with other patients;

- To identify any other relevant cost efficiencies; and,

- To deliver the programme to 700 patients within a budget.

1.2 THE GET WELL UK SERVICE

In December 2006, DHSSPI appointed Get Well UK to oversee the roll out of a pilot project within the identified health centres. Get Well UK is a not-for-profit organisation with a high level of expertise and experience in developing and implementing complementary health initiatives, with previous projects developed in London.

Get Well UK proposed to develop a service targeted at two challenging areas within general practice: musculoskeletal problems; and, depression, stress and anxiety. Patients with musculoskeletal conditions were referred to an osteopath, chiropractor or acupuncturist for assessment and treatment. The practitioner could refer patients on for massage, aromatherapy or reflexology treatments, if

appropriate. Patients with stress, depression or anxiety were referred to a homeopath for a full assessment and monthly treatments or to an acupuncturist who would typically offer weekly treatments. . If appropriate, homeopaths and acupuncturists were also able to refer patients for supporting 'complementary' treatments such as aromatherapy, massage or reflexology.

In developing the pilot project in Northern Ireland, Get Well UK worked closely with the health centres to agree appropriate referral criteria for the service. As part of this process Get Well UK developed GP Handbooks which included information about care pathways, the clinical team, liabilities and background information on Get Well UK. Referrals to the project were co-ordinated by Get Well UK's Central Customer Services Team, who on receiving a referral contacted the patient to discuss the most suitable time and location for their assessment, and to arrange any special facilities such as a female practitioner or language support. The patient was mailed a letter confirming their appointment details, the name of the assessing clinician, a map of the location, information about what to expect at the assessment and details of complaints and non-attendance policies. Patients agreed to a course of treatment at their first appointment, with each subsequent appointment booked with their practitioner and recorded on the Get Well UK appointment system.

At the point of patient discharge from the service Get Well UK provided the patient's GP with a report detailing diagnosis, treatment received, outcomes and recommendations. This report was appended to the patient's medical records, with a copy also forwarded to the patient themselves.

1.2.1 IDENTIFYING PATIENTS

A number of criteria were applied for the purposes of selecting patients to participate in the project, namely: be resident in the area covered by the GP practice; be aged 18 or over; have a musculoskeletal problem and / or have presented to their GP with depression, stress or anxiety; and, be willing to participate in the pilot project.

1.2.2 COLLECTION OF PATIENT DATA

A central element of Get Well UK's approach to this project was to ensure that stakeholder feedback was regularly collected and collated to allow for an independent assessment of project impact. Table 1.1 shows the data that were collected throughout the pilot project.

Table 1.1 Data Collected

Data	**Collection**	**Collection Agent**
Patient Demographics	1st Treatment	Practitioner
MYMOP 1 Data	1st Treatment	Practitioner
Patient Service Evaluation	Last Treatment	Patient
Practitioner Evaluation	Last Treatment	Practitioner
GP Evaluation	Last Treatment	GP
MYMOP 2 Data	Last Treatment	Practitioner
Supervision Feedback	Monthly	Supervision Led
Patient Complaints	On Demand	Customer Service
GP / DHSSPSNI Feedback	On Demand	Managing Director
Customer Services Feedback	On Demand	Customer Service

Patient Demographic Data: A range of data was collected on each patient including gender, ethnicity, educational attainment, housing status, occupation, religion and receipt of state benefits. This data allows an assessment of who has accessed the service.

Measure Yourself Medical Outcome Profile (MYMOP): With their consent, each patient was asked to complete Measure Yourself Medical Outcome Profile (MYMOP)[1] forms immediately prior to treatment and post treatment. This is a patient-generated validated instrument, developed by Somerset GP Dr Charlotte Patterson, which is used as a primary care research tool to capture a patient's self-reported health change. The patient identifies and grades on a seven point scale their most important symptom, an optional second symptom, a daily living activity which symptoms one and two prevent or interfere with, and their wellbeing. These four dimensions are used to monitor health outcomes.

Evaluation Forms: At the end of every package of care, patient satisfaction is surveyed. The treatment practitioner and referring GP also complete evaluation forms.

1.2.3 SUPPORTING PATIENTS WITH ACCESSING SERVICES

The musculoskeletal service was provided in the form of a six to eight week programme. Services directed at alleviating depression, stress and anxiety were provided via a six month treatment programme, due to homeopathic treatments being provided on a monthly basis. After a slow start to referrals in the early months of the project (February, March and April 2007) the number of referrals gradually increased. Patients were supported by Get Well UK throughout the referral process and in particular through the process of accessing the required services for their package of care (e.g. provision of a helpline number by Get Well UK which was accessible from 9am to 6pm). Get Well UK's Customer Services Team provided ongoing support to patients, GPs, practice managers and practitioners throughout the life of the project.

1.2.4 IDENTIFIYING CAM PRACTITIONERS TO SUPPORT THE PROJECT

A key challenge presented by the pilot project was the need to identify CAM practitioners to provide the necessary range of treatments to presenting patients. To address this need, Get Well UK applied a two stage recruitment process: a written application; and, a face-to-face interview. A total of 16 practitioners were recruited to the project.

1.2.5 IDENTIFIYING GPs TO SUPPORT THE PROJECT

Within the Belfast practices, 30 GPs were encouraged to refer their patients to the pilot project, with 5 GPs and a prescribing nurse in the Londonderry practices referring their patients.

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[1] Patterson C. Measuring outcome in primary care: a patient-generated measure, MYMOP, compared to the SF-36 health survey. British Medical Journal 1996; 312: 1016-20.
Patterson C,. Britten N. In pursuit of patient-cantered outcomes: a qualitative evaluation of MYMOP, Measure Yourself Medical Outcome Profile. Jour Health Services Res Policy 2000; 5:27-36.

1.3 EVALUTION TERMS OF REFERENCE

The key focus for the evaluation was to conduct an analysis of data received as part of the pilot project and to produce a report describing in detail the effect the pilot has had on a number of key areas, to include:

- Health benefits to the patient;
- Health economics / cost analysis;
- Patient satisfaction with the services offered;
- GP satisfaction with the services offered;
- Effect on medication usage; and,
- Reduction in GP workload

1.3.1 KEY EVALUATION TASKS

In accordance with the Terms of Reference, the evaluation focused on:

- Examining and evaluating data collected by Get Well UK, for example using the MYMOP information and interpreting the findings;

- Carrying out five focus groups during the pilot year to ascertain satisfaction levels and get qualitative feedback from patients, GP's and practitioners;

- Preparing for and presenting an interim report at the formal steering group meeting in August 2007, and also giving an overview of the initial findings from the pilot at the final steering group meeting in March 2008;

- Preparing and presenting a final report for approval by the steering group by the end of March 2008.

1.3.2 EVALUATION METHODOLOGY

The evaluation is based on an analysis of data from the following sources:

- Referral forms: one part completed for the GPs and one part by the patient (n=713);

- Patient Monitoring Form: completed by patients at their first appointment and recording basic patient demographic information (n=419);

- MYMOP Forms: used as a tool for recording a patient's own assessment of changes in a symptom of their choice, any related functional impairment and their general wellbeing. A MYMOP form was completed at the first and last appointment in order to track any changes in these parameters (and in any variation in medication) made during the course of their treatment (n=339)[2];

- Patient Evaluation Form: completed at the final appointment (n=300);

[2] Note that 339 patients completed a MYMOP assessment before the commencement of their first treatment period and at the conclusion of their first treatment period.

- Practitioner's Evaluation Form: sought information on the patient's progress and some details of treatment provided and was completed at the end of a course of treatment (n=394);

- GP Evaluation form: sought views on the effect of complementary treatment on each patient, and any impressions GPs had of the way the service had affected the practice's use of resources in each case (n=231).

It should be noted that not all of the above forms were completed for all patients, and that the data presented in this report reflects the changing base figures for each of the above elements. Where changes in base figures occur, this will be reported in the commentary of the report. The main reason for an incomplete dataset is that the audit data was collected until the end of January, whereas the service continued to run until the end of March.

1.3.3 INDEPENDENT SURVEYS OF PATIENTS, GPs AND PRACTITIONERS

In addition to the above data, which was supplied by Get Well UK, the steering group also agreed to conduct independent surveys of patients, GPs and practitioners. Each of the three groups was mailed a self-completion questionnaire (see Appendix) seeking their views on different aspects of the project. This was followed up with reminder letters which were mailed two weeks after the initial mailing. Fieldwork for the surveys was conducted in February and March 2008.

Overall, 227 patients had returned their questionnaires by 20 March 2008, which equates to a response rate of 45%. Of the 16 practitioners contributing to the pilot project, 12 completed and returned a questionnaire, representing a response rate of 75%. Finally, among the 35 GPs surveyed, 12 completed and returned their questionnaire by the cut off date of 20 March 2008, representing a response rate of 34%.

1.4 NOTES ON TABLES

Due to the rounding of row and column percentages within tables and figures, sums may not always total to 100. Note that base totals may also change in tables. It should be noted that dash marks [-] are used in some tables to indicate that the figure is less than 1%.

1.5 STATISTICAL SIGNFICANCE

It should be noted that in this report, the following symbols have been used to denote statistical significance: * statistically significant at the 95% confidence interval; ** statistically significant at the 99% confidence interval; and, *** statistically significant at the 99.9% confidence level. Note also that differences alluded to in the text are statistically significant at the 95% level.

2 PATIENTS REFERRED TO THE SERVICE

This section of the report presents an overview of the profile of patients referred to the project, both in terms of their socio-demographic characteristics as well as their health status at the time of referral. Differences in health status and behaviour between different patient groups are also highlighted.

2.1 PATIENT PROFILE

A total of 713 patients were referred to the project between 6 February 2007 and 30 November 2007, with 147 patients referred for a second treatment. In terms of practice location, the Belfast practices referred the majority of patients to the project (n=389 or 55%) compared with the Derry practice (324 or 45% of all patients.

Table 2.1 Profile of Patients Referred to Pilot Project (n=713)

		%	N
Sex	Male	30	214
	Female	69	494
	Missing	1	5
Age	<40 years	28	202
	40 – 59 years	42	296
	60+ years	26	183
	Missing	5	32
Location	Belfast	55	389
	Londonderry	45	324
Health Condition	Depression, stress or anxiety	36	257
	Musculoskeletal	62	440
	Both	1	10
	Missing	1	6
Treatment (First)	Acupuncture	37	262
	Aromatherapy	2	14
	Chiropractic	20	145
	Homeopathy	13	92
	Massage	0.1	1
	Osteopathy	19	133
	Reflexology	0.4	3
	Missing	9	63

The majority of patients were female (69%) rather than male (30%), with 28% aged under 40, 42% aged between 40 and 59 and 26% aged 60+ years. Patients with musculoskeletal conditions accounted for most of the referrals (62%), with patients with depression, stress and anxiety accounting for 36% of referrals. Finally, 37% of first treatment referrals[3] were for acupuncture, with 20% for chiropractor and 19% for osteopathy. Thirteen percent of referrals were for homeopathy, 2% aromatherapy, 0.4% for reflexology and 0.1% for massage.

[3] Some patients were referred for more than once course of treatment.

2.2 COMPLETION OF MYMOP 1 FORM

The analysis of the MYMOP 1 data is restricted to only those patients where data was collected and recorded (n=419), and not all patients referred as part of the project (n=713). Table 2.2 presents a profile of those patients who completed MYMOP 1 forms, with a number of statistically significant differences. For example, a greater proportion of Derry patients completing MYMOP 1 forms were aged under 40 (35%) compared with Belfast patients (19%). There was also a highly significant difference in the religious profile of patients who completed MYMOP 1 forms, with almost all of the Belfast sample describing their religion as Protestant (94%) compared with the Derry sample of whom 98% described their religious tradition as Catholic. This reflects the criteria applied for selecting the practices to participate in the project, which was delivered in line with the equality framework of Section 75 of the Northern Ireland Act 1998.

Table 2.2 Profile of Patients Completing MYMOP Forms (n=419)

		All	Belfast	L'Derry
		%	%	%
Sex	Male	33	33	32
	Female	67	67	68
Age***	<40 years	27	19	35
	40 – 59 years	42	37	47
	60+ years	31	43	18
Social Class	ABC1	35	34	35
	C2DE	66	66	65
Education	Qualifications	62	63	62
	No Formal Education	38	37	38
Social Benefits	Yes	54	43	64
	No	46	57	36
Religion***	Protestant	45	94	2
	Catholic	55	6	98
Health Condition***	Depression, stress or anxiety	34	19	49
	Musculoskeletal	66	81	51
Treatment (First)***	Acupuncture	44	30	58
	Chiropractic	22	44	0
	Homeopathy	10	8	11
	Osteopathy	23	14	32
	Other	1	3	0
Duration of Symptoms***	Less than 1 Year	25	34	17
	1-5 Years	29	34	24
	More than 5 Years	46	32	59

* p<=0.05; ** p<=0.01; *** p<=0.001

Belfast patients were more likely to present for musculoskeletal conditions (81% vs. 51%), whereas the Derry patients were more likely to have presented for depression, stress or anxiety (49% vs. 19%). In relation to treatments, Belfast patients were more likely to have availed of the services provided by a chiropractor (44%), whereas Derry patients were more likely to have availed of acupuncture and osteopathy (58% and 32% respectively). Table 2.2 shows that although nearly half

(46%) of all patients who had completed MYMOP 1 forms had their symptoms for more than five years, proportionately more of the Derry patients (59%) had their symptoms for more than five years compared with the Belfast patients (32%).

2.3 HEALTH PROBLEMS IDENTIFIED BY PATIENTS

Table 2.3 presents a list of the conditions (main symptom) cited by patients when completing their first MYMOP form. The most common conditions were back pain (30%), neck pain (15%) and anxiety / panic attacks (9%). Of the 418 patients that listed a key symptom in their first MYMOP form, 89% listed a second symptom and in many cases this related to the key symptom (e.g. neck pain and headaches, lower back pain and stiffness, tiredness / lack of energy and depression etc.). In other cases the symptoms were quite distinct (e.g. pain and Irritable Bowel Syndrome, panic attacks and depression, depressive mood and back pain etc.).

Table 2.3 Conditions Identified by Patients on First MYMOP - Symptom 1 (n=418)

		%	N
Musculoskeletal	Back Pain	30.1	126
	Neck Pain	14.8	62
	Shoulder Pain	7.9	33
	General Pain	5.5	23
	Hip Pain	2.9	12
	Leg Pain	2.6	11
	Knee Pain	2.6	11
	Arm Pain	1.7	7
	Hand Pain	1.7	7
	Feet Pain	1.4	6
	Arthritis Pain	1.0	4
	Chest Pain	.5	2
Psycho Social	Anxiety / Panic Attacks	8.6	36
	Stress	4.1	17
	Fatigue	4.1	17
	Insomnia	2.4	10
	Depression	1.9	8
	Anger - Aggressiveness	1.4	6
	Emotional	.5	2
	Tension	.2	1
	Loneliness	.2	1
Other	Headaches Migraines	1.9	8
	Shakes	.5	2
	Abdominal	.5	2
	Chest Infection	.2	1
	Blood Pressure	.2	1
	Overweight	.2	1
	Psoriasis	.2	1
Total		100.0	418

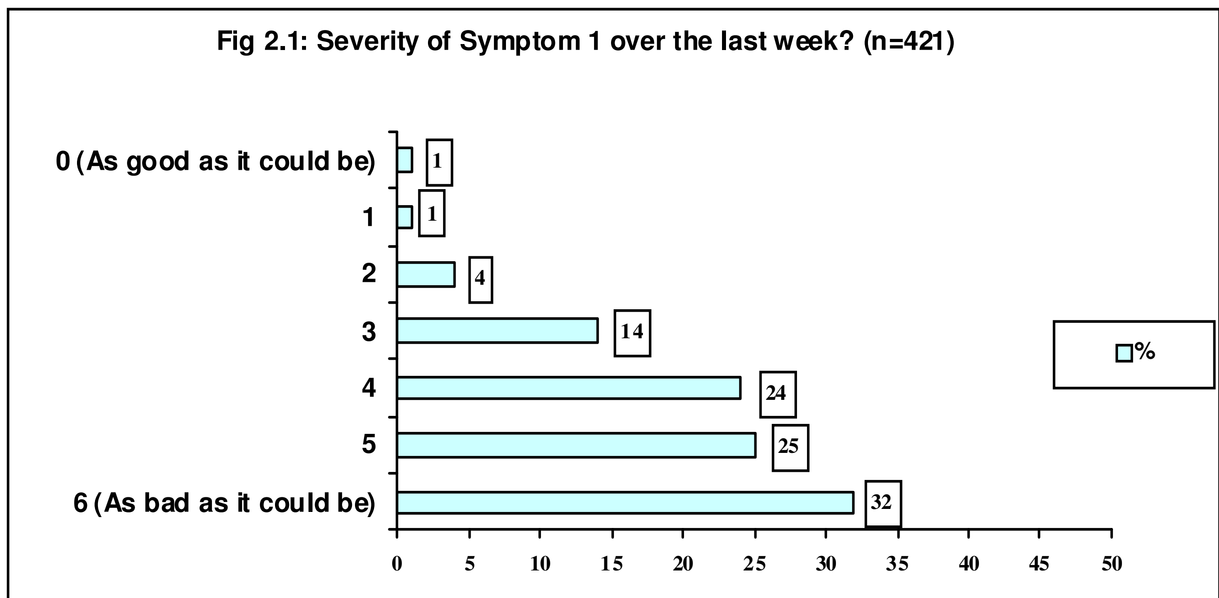
Patients with musculoskeletal conditions who represented the largest group of patients were mainly referred to an acupuncturist, a chiropractor or an osteopath, whereas patients presenting with anxiety, depression or tension were more likely to be referred to an acupuncturist or homeopath.

Table 2.4 Patient Conditions by First Treatment

	Acupu'e	Chiro	Homeo'thy	Osteo'thy	Aromatherapy, Massage, Reflexology	N
	%	%	%	%	%	
Pain: Back, neck, shoulder, hip, arm, feet, chest, leg, hand, knee	33	32	1	34	-	277
Anxiety, depression, tension	67	-	24	1	7	70
General Pain	68	9	23	-	-	22
Headaches, migraine	63	13	12	12	-	8
Fatigue	65	-	35	-	-	17
Insomnia	60	-	40	-	-	10
Other	75	-	25	-	-	12

2.3.1 SEVERITY OF SYMPTOM 1

Patients were asked to rate the severity of their main symptom (physical or mental) i.e. to say how bad they felt it had been over the previous week, and to score it on a 7 point scale from 0 to 6 where 0 is *'as good as it could be'* and 6 is *'as bad as it could be'*. Figure 2.1 shows that almost one in three (32%) patients rated the limitations that their main symptom imposed on them, *'as bad as could be'*.



2.3.2 DIFFERENCES IN SEVERITY OF SYMPTOM 1 BY PATIENT GROUPS

The analysis also examined whether or not there were differences in the level of severity of patient's key symptom by different patient groups. For example, women compared with men recorded a higher mean level of severity for their main symptom (4.7 vs. 4.4), as did those in the lower social classes (C2DE, 4.7) compared with those in the higher social classes (ABC1, 4.4). Patients in receipt of social benefits were also significantly more likely to rate their main symptom as severe (4.9 vs. 4.3).

Table 2.5 Mean Level of Severity of Patient Symptoms by Patient Groups

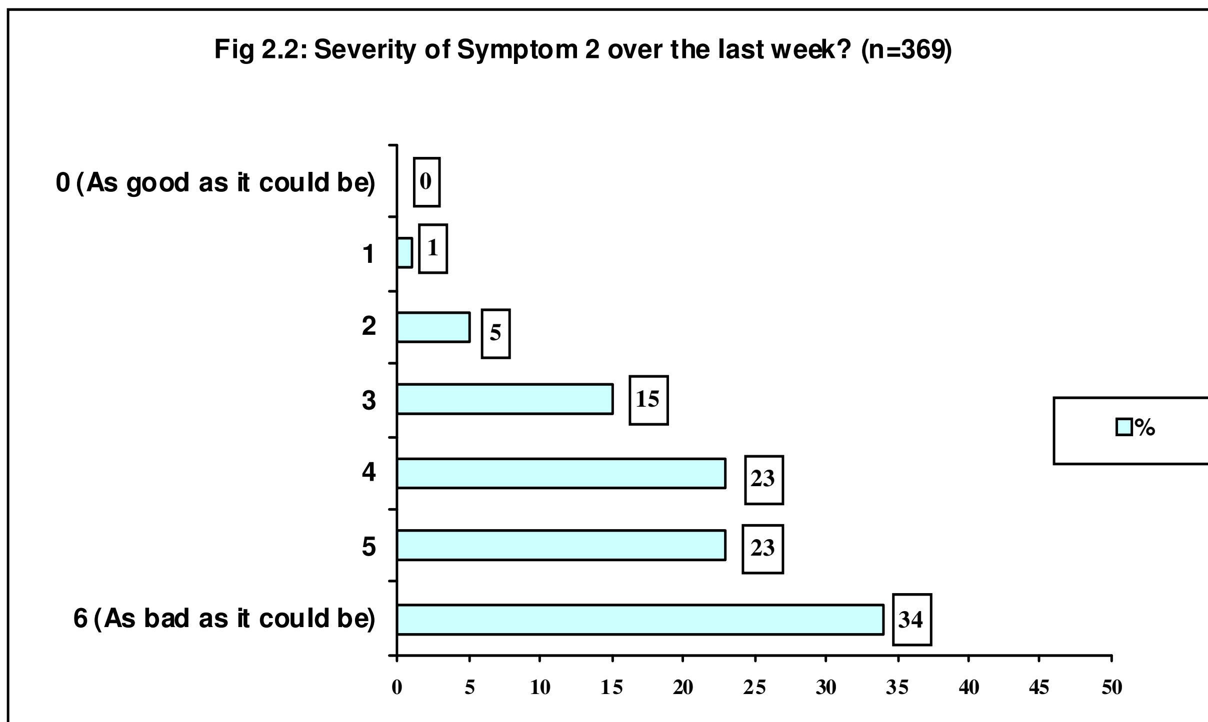
		Mean Severity	n
Sex*	Male	4.4	136
	Female	4.7	279
Social Class*	ABC1	4.4	120
	C2DE	4.7	231
Social Benefits***	Yes	4.9	218
	No	4.3	187
Religion***	Protestant	4.2	172
	Catholic	5.0	208
Duration of Symptoms***	Less than 1 Year	4.2	102
	1-5 Years	4.6	119
	More than 5 Years	4.8	190
Practice***	Belfast	4.2	205
	L'Derry	5.0	212

* p<=0.05; ** p<=0.01; *** p<=0.001

Patients who had experienced their symptoms for more than five years (4.8) also recorded a higher level of severity compared with patients who had experienced their symptoms for between 1 and 5 years (4.6), and those who had experienced their symptoms for less than one year (4.2). Patients attending the Derry practice (5.0), compared with patients attending the Belfast practice (4.2), recorded a higher mean level of severity with their main symptom. This was also reflected when patient religion was analysed, with the Derry patients who are predominantly Catholic (5.0) also recording a higher mean level of severity with their main symptom compared with Protestant patients who were predominantly from the Belfast practice (4.2).

2.3.3 SEVERITY OF SYMPTOM 2

Among those patients who listed a main symptom, 88% (n=369) listed a second symptom (mental or physical) which bothered them. Figure 2.2 shows that approximately one in three patients (34%) rated their secondary symptom as 'as bad as it could be'.



2.3.4 DIFFERENCES IN SEVERITY OF SYMPTOM 2 BY PATIENT GROUPS

In line with the main symptom, the level of severity of the second symptom was consistent across the various patient groups, with those reporting a statistically significant higher mean level of severity being: women (4.7 vs. 4.4); in the lower social classes (4.8 vs. 4.4); be in receipt of benefits (4.9 vs. 4.3); Catholic (4.9 vs. 4.3); and, be a patient of the Derry practice (4.9 vs. 4.2).

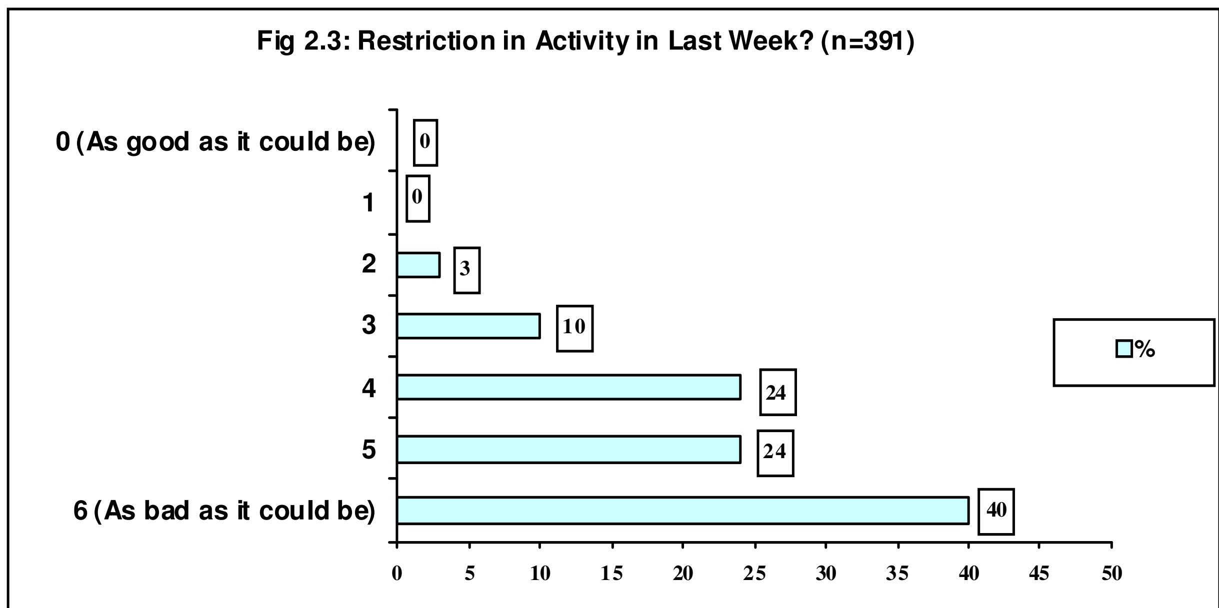
2.3.5 RESTRICTED ACTIVITY ASSOCIATED WITH SYMPTOMS

Patients were also asked to indicate if their symptoms prevented them, or made it difficult for them, to undertake one activity. The responses are presented in Table 2.6 and show that more than a quarter (28%) of patients said that their condition made it difficult for them to walk, with 13% saying that their symptoms made it difficult for them, or prevented them, from engaging in sport and physical activity.

Table 2.6 Activities Patients Find Difficult to Perform (n=388)		
	%	n
Walking	28.4	110
Sport / Physical Activity	12.6	49
Going out / Socialising	10.3	40
Relaxing / Reading	9.0	35
Everyday Living	6.2	24
Housework	5.9	23
Work	4.9	19
Sleeping	3.6	14
Sitting	3.4	13
Driving	3.1	12
Standing	2.8	11
Lifting	2.6	10
Gardening	2.3	9
Concentrating	2.1	8
Bending	1.5	6
Cooking	.5	2
Eating	.5	2
Shopping	.3	1

2.3.6 LEVEL OF RESTRICTED ACTIVITY ASSOCIATED WITH SYMPTOMS

After listing one activity which their condition restricted them from engaging in, patients were then asked to score on a 7 point scale (0 to 6) how bad this had been in the last week. Figure 2.3 shows that 40% of patients reported that their restricted activity in the previous week was 'as bad as it could be'.



2.3.7 LEVELS OF RESTRICTED ACTIVITY BY PATIENT GROUPS

The mean level of 'restricted activity' for the whole sample was 4.8, with those more restricted being: women (4.9); in the lower social classes (5.0); be in receipt of benefits (5.0); Catholic (5.2); and, be attending the Derry practice (Table 2.7).

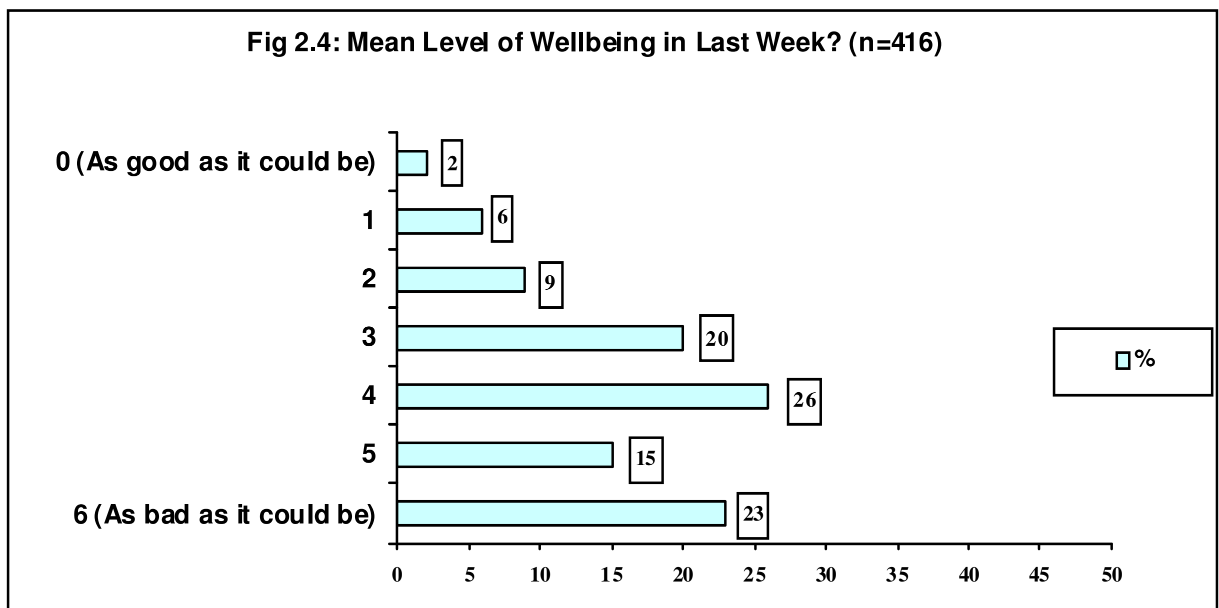
Table 2.7 Mean Level of Restriction in Activity by Patient Groups

		Mean Severity	N
Sex*	Male	4.6	126
	Female	4.9	259
Social Class**	ABC1	4.6	109
	C2DE	5.0	220
Social Benefits***	Yes	5.0	206
	No	4.6	171
Religion***	Protestant	4.4	168
	Catholic	5.2	185
Practice***	Belfast	4.5	184
	L'Derry	5.2	203

* p<=0.05; ** p<=0.01; *** p<=0.001

2.3.8 LEVEL OF WELLBEING

As with severity of symptoms and restriction in activity, patients were asked to rate their level of wellbeing on a scale from 0 to 6 where 0 is *'as good as it could be'* and 6 is *'as bad as it could be'*. Using this approach found that almost one quarter of patients (23%) rated their mean level of wellbeing *'as bad as it could be'*.



2.3.9 DIFFERENCES IN LEVEL OF WELLBEING BY PATIENT GROUPS

Analysis by patient background characteristics found a number of statistically significant differences, with those more likely to report a poorer level of wellbeing in the previous week including: women; those in the lower social classes; those with no formal educational qualifications; those in receipt of benefits; Catholic patients; those availing of homeopathic treatments; those presenting with mental health problems; those who have experienced their symptoms for longer; and, those attending the Derry practice.

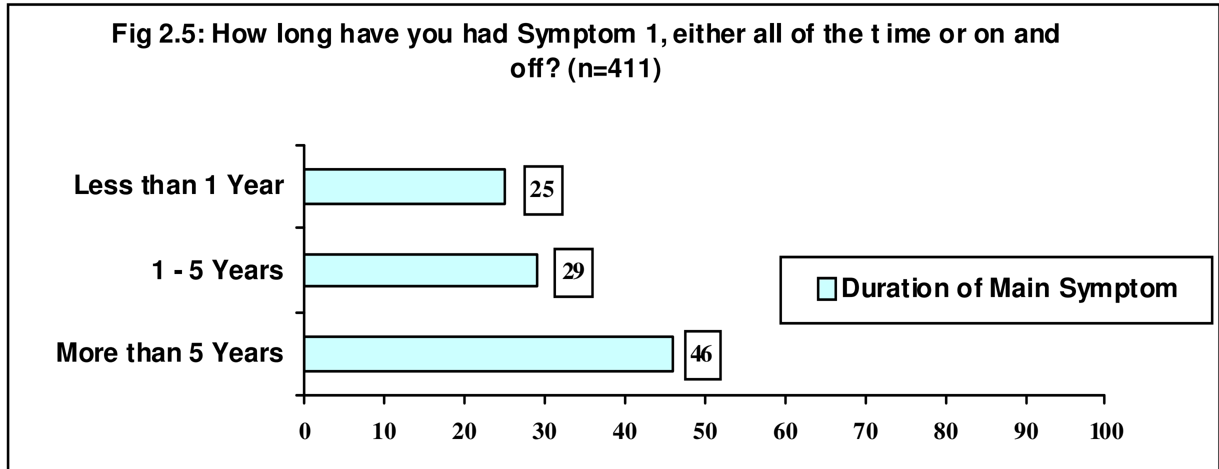
Table 2.8 Mean Level of Wellbeing in Last Week by Patient Groups

		Mean Severity	N
Sex*	Male	3.6	133
	Female	4.1	278
Social Class*	ABC1	3.7	120
	C2DE	4.0	229
Education*	Qualifications	3.8	226
	No Qualifications	4.1	140
Social Benefits***	Yes	4.3	216
	No	3.5	186
Religion*	Protestant	3.7	171
	Catholic	4.1	206
Treatment***	Acupuncture	4.2	185
	Chiropractic / Osteopathy	3.6	185
	Homeopathy	4.5	40
Condition***	Mental Health	4.4	138
	Musculoskeletal	3.7	264
Duration of Symptoms*	Less than 1 Year	3.7	102
	1-5 Years	3.8	118
	More than 5 Years	4.2	187
Practice**	Belfast	3.7	203
	L'Derry	4.2	210

* p<=0.05; ** p<=0.01; *** p<=0.001

2.3.10 DURATION OF SYMPTOM 1

One in four (25%) patients reported having had their main symptom for less than a year, with 29% having had their main symptom for between 1 and 5 years. Quite a significant proportion (46%) of patients had their symptoms long-term (i.e. more than 5 years).



2.3.11 DIFFERENCES IN LEVEL OF WELLBING BY PATIENT GROUPS

Patients who had experienced their main symptom for longer (i.e. more than 5 years) were more likely to be from the lower social classes, be in receipt of benefits, describe their religious affiliation as Catholic and be attending the Derry practice.

Table 2.9 Duration of Symptom 1 by Patient Groups

		Less than 1 Year	1-5 Years	More than 5 Years	N
		%	%	%	
Social Class**	ABC1	36	29	35	116
	C2DE	19	30	51	226
Social Benefits***	Yes	17	26	57	215
	No	35	33	32	181
Religion***	Protestant	31	37	32	167
	Catholic	19	23	58	205
Practice***	Belfast	34	34	32	199
	L'Derry	17	24	59	208

* p<=0.05; ** p<=0.01; *** p<=0.001

2.4 MEDICATION LEVELS PRIOR TO TREATMENT

At their first appointment to see a CAM practitioner, three out of four patients (75%) said that they were taking medication for their problem. Among this patient group, those aged under 40 were significantly less likely to be taking medication for their condition (61%), whereas those more likely to be taking medication for their problem were: from the lower social classes (81%); have no formal educational qualifications (83%); be in receipt of benefits (84%); and, have had their main symptom for longer (81%).

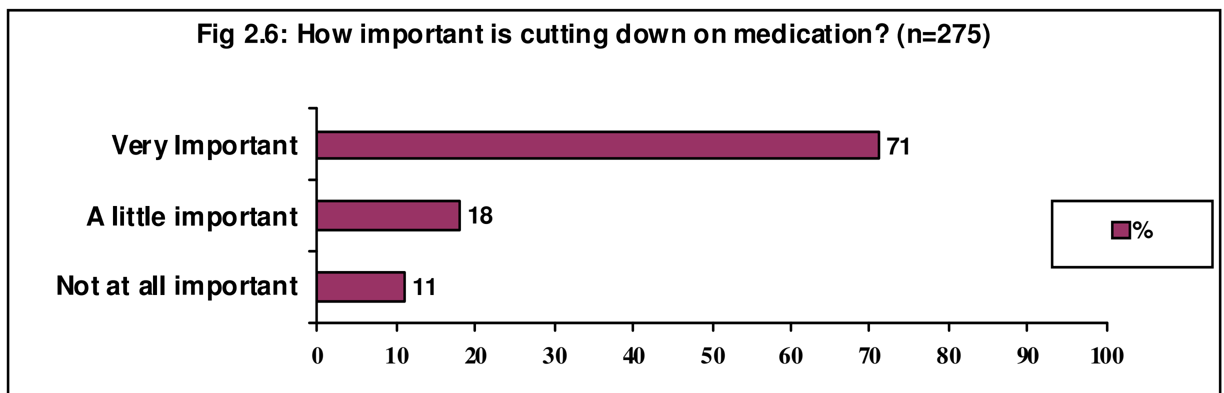
Table 2.10 Medication Use By Patient Groups

		Taking Medication %	N
All Patients		75	400
Age**	<40	61	103
	40-59	80	163
	60+	78	119
Social Class***	ABC1	58	113
	C2DE	81	222
Education**	Qualifications	69	216
	No Qualifications	83	138
Social Benefits***	Yes	84	211
	No	63	175
Duration of Symptoms**	Less than 1 Year	63	95
	1-5 Years	75	113
	More than 5 Years	81	185

* p<=0.05; ** p<=0.01; *** p<=0.001

2.4.1 CUTTING DOWN ON MEDICATION

Almost nine out of ten (89%) patients who were taking medication, said that cutting down on their medication was important to them, with those in the 40-59 age group (94%) more likely to say that cutting down on their medication is important to them, compared with patients in other age groups (under 40, 83%; aged 60+, 84%).



2.5 WORRYING ABOUT SYMPTOMS

On presenting for their first appointment with a practitioner, approximately one third (35%) of patients said they were extremely worried about their symptoms.

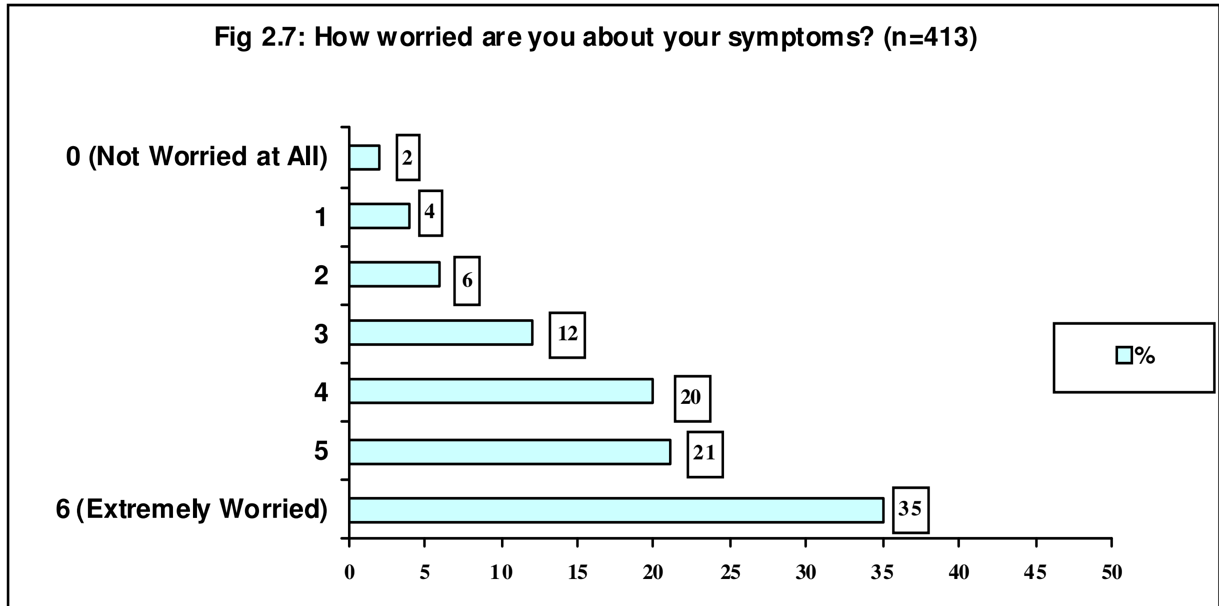


Table 2.11 shows that patients in the 40-59 age group were more likely to be worried about their symptoms (4.8), compared with patients in other age groups. Similarly, a higher mean level of worry was recorded by patients in receipt of benefits (4.8), Catholic patients (4.9), those with symptoms for more than 5 years (4.7) and those attending the Derry practice (4.9). Conversely, patients availing of chiropractic / osteopathy treatments were less likely to be worried about their symptoms, compared with other treatment groups.

Table 2.11 Mean Level of Worry About Symptoms by Patient Groups

		Mean Worry Level	N
All Patients		4.4	413
Age**	<40	4.5	109
	40-59	4.8	166
	60+	4.0	120
Social Benefits***	Yes	4.8	217
	No	4.0	182
Religion*	Protestant	4.0	166
	Catholic	4.9	207
Treatment*	Acupuncture	4.6	182
	Chiropractic / Osteopathy	4.2	185
	Homeopathy	4.7	41
Duration of Symptoms*	Less than 1 Year	4.1	100
	1-5 Years	4.3	115
	More than 5 Years	4.7	190
Practice***	Belfast	4.0	200
	L'Derry	4.9	210

* p<=0.05; ** p<=0.01; *** p<=0.001

3 IMPACT OF TREATMENTS

This section of the report details the impact of the treatments on the health status of patients, from the perspectives of the patients themselves, as well as from the perspectives of the GPs and CAM practitioners who participated in the project. The analysis is based on:

- a comparison of MYMOP (completed by patients) data before and after treatment;
- practitioner assessments of the impact of treatments;
- GP assessments of the impact of the treatments on patient health gain; and,
- an assessment of project impact from surveys of patients, GPs and practitioners.

3.1 CHANGES IN MYMOP SCORES BEFORE AND AFTER TREATMENT

As noted in Section 1 each patient was asked to complete a MYMOP (Measure Yourself Medical Outcome Profile) form prior to being treated with CAM as well as at the point the treatment programme was completed. MYMOP is used to identify changes, if any, in how patients perceive their symptoms, their activity levels and their general wellbeing.

The comparison of patient MYMOP scores between pre and post treatment was restricted to those patients (n=337) who had completed both a MYMOP form at the first appointment, and a MYMOP form on completion of their treatment programme.

Using a Paired-Samples T-Test found that the mean MYMOP severity scores for the whole sample had fallen significantly ($p<=0.001$) between pre and post treatment for each of the areas measured i.e. the severity of symptoms 1 and 2, patient activity and patient wellbeing. This indicates that the whole sample of patients had reported health improvement on each of the specific indicators. Indeed, the overall mean aggregate score (based on an index of the 4 individual MYMOP elements) for the whole sample, had also fallen significantly ($p<=0.001$) between the pre and post treatment stages, indicating that the sample of patients had reported a significant improvement in their health status.

Table 3.1 Changes in MYMOP Scores Before and After Treatment

	Before Treatment		After Treatment		Change	
MYMOP Score	Mean	Median	Mean	Median	Mean	Median
Symptom 1	4.61	5	2.74	3	1.87***	2***
Symptom 2	4.60	5	2.81	3	1.79***	2***
Activity	4.85	5	3.09	3	1.76***	2***
Wellbeing	4.00	4	2.68	3	1.32***	1***
Aggregate Score	4.50	4.5	2.82	3.0	1.68***	1.5***

* $p<=0.05$; ** $p<=0.01$; *** $p<=0.001$

In addition to a comparison of the mean MYMOP scores pre and post treatment, the analysis (using the Wilcoxon Signed Rank Test) also found a highly significant ($p<=0.001$) reduction in the median severity scores reported by patients. The

reduction in aggregate median score (i.e. based on all 4 elements) between pre and post treatment (1.5) was also found to be highly significant (p<=0.001), which again indicates a significant improvement in patients' self perceived health status between the two periods.

3.1.1 CHANGES IN MYMOP SCORES BY THERAPY

A similar analysis to that applied for all patients was applied to patients availing of specific treatments, and Tables 3.2 to 3.4 show that patients recorded highly significant reductions (p<=0.001) in the severity scores for each treatment. On each specific indicator, patients in the period between pre and post treatment recorded significant improvements in their health status regardless of treatment / therapy.

Table 3.2 Changes in MYMOP Scores Before and After Treatment (Acupuncture)

	Before Treatment		After Treatment		Change	
MYMOP Score	Mean	Median	Mean	Median	Mean	Median
Symptom 1	4.85	5	3.00	3	1.79***	2***
Symptom 2	4.88	5	3.24	3	1.63***	2***
Activity	5.00	5	3.48	4	1.53***	1***
Wellbeing	4.41	4	2.98	3	1.42***	1***
Aggregate Score	4.76	5	3.18	3.25	1.58***	1.75***

* p<=0.05; ** p<=0.01; *** p<=0.001

Table 3.3 Changes in MYMOP Scores Before and After Treatment (Chiropractor / Osteopathy)

	Before Treatment		After Treatment		Change	
MYMOP Score	Mean	Median	Mean	Median	Mean	Median
Symptom 1	4.46	5	2.62	3	1.84***	2***
Symptom 2	4.39	4	2.57	3	1.82***	1***
Activity	4.76	5	3.01	3	1.75***	2***
Wellbeing	3.56	4	2.53	3	1.02***	1***
Aggregate Score	4.28	4.25	2.66	2.75	1.61***	1.5***

* p<=0.05; ** p<=0.01; *** p<=0.001

Table 3.4 Changes in MYMOP Scores Before and After Treatment (Homeopathy)

	Before Treatment		After Treatment		Change	
MYMOP Score	Mean	Median	Mean	Median	Mean	Median
Symptom 1	4.33	4	2.06	2	2.27***	2***
Symptom 2	4.39	5	2.12	2	2.27***	3***
Activity	4.57	5	1.90	2	2.66***	3***
Wellbeing	4.40	4	2.12	2	2.28***	2***
Aggregate Score	4.42	4.5	2.05	2	2.37***	2.5***

* p<=0.05; ** p<=0.01; *** p<=0.001

3.1.2 CHANGES IN MYMOP SCORES BY HEALTH CONDITION

MYMOP scores were also compared pre and post treatment for patients presenting with mental health and musculoskeletal conditions. Tables 3.5 and 3.6 show that for both types of condition, the improvements in severity scores were highly significant (p<=0.001). Again on each specific indicator, patients in the period between pre and post treatment recorded significant improvements in their health status regardless of whether they presented with musculoskeletal conditions or mental health related conditions.

Table 3.5 Changes in MYMOP Scores Before and After Treatment (Mental Health)

	Before Treatment		After Treatment		Change	
MYMOP Score	Mean	Median	Mean	Median	Mean	Median
Symptom 1	4.69	5	2.68	3	2.00***	2***
Symptom 2	4.77	5	2.90	3	1.87***	2***
Activity	4.91	5	2.92	3	1.98***	2***
Wellbeing	4.42	4	2.61	3	1.80***	1***
Aggregate Score	4.68	4.75	2.78	2.75	1.90***	2***

* p<=0.05; ** p<=0.01; *** p<=0.001

Table 3.6 Changes in MYMOP Scores Before and After Treatment (Musculoskeletal)

	Before Treatment		After Treatment		Change	
MYMOP Score	Mean	Median	Mean	Median	Mean	Median
Symptom 1	4.57	5	2.76	3	1.81***	2
Symptom 2	4.52	5	2.78	3	1.74***	2
Activity	4.80	5	3.14	3	1.65***	2
Wellbeing	3.78	4	2.68	3	1.10***	1
Aggregate Score	4.40	4.5	2.83	3	1.57***	1.5

* p<=0.05; ** p<=0.01; *** p<=0.001

3.1.3 CHANGE IN PATIENTS REPORING HIGHEST SEVERITY LEVEL

On all of the MYMOP indicators, the proportion of patients scoring level 6 on the severity scale *('as bad good be')* fell, with the largest reduction in relation to the severity of their main symptom (i.e. a drop of 26 percentage points in the proportion of the sample rating the severity of their main symptom *'as bad as it could be,* down from 31% pre treatment to 5% post treatment).

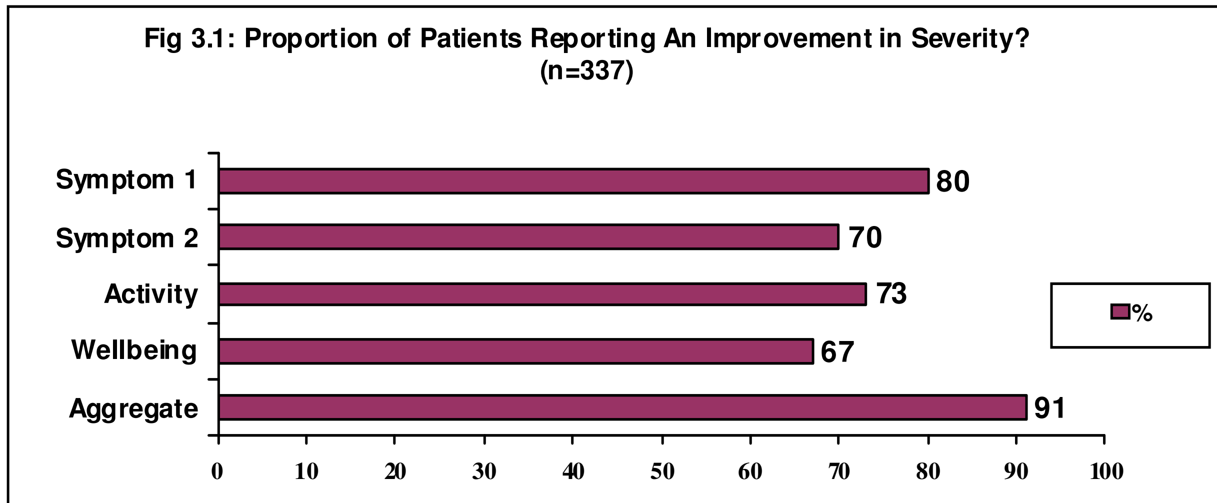
Table 3.7 % of Patients Scoring Level 6 on MYMOP Before and After Treatment (n=337)

MYMOP Score	Scoring Level 6	
	Before Treatment	After Treatment
	%	%
Symptom 1	31	5
Symptom 2	33	8
Activity	38	11
Wellbeing	22	7

* p<=0.05; ** p<=0.01; *** p<=0.001

3.1.4 PATIENTS REPORTING AN IMPROVEMENT IN MYMOP SCORES

Figure 3.1 shows that 80% of patients reported an improvement in the severity of their main symptom, with 70% reporting an improvement in the severity of secondary symptoms. More than seven out of ten (73%) patients said that their level of activity had improved between pre and post treatment, with 67% saying that their overall level of wellbeing had improved following treatment. Overall, 91% of patients recorded an increase in their overall MYMOP score (i.e. a health improvement).



3.1.5 REPORTED IMPROVEMENTS IN MYMOPS BY PATIENT GROUPS

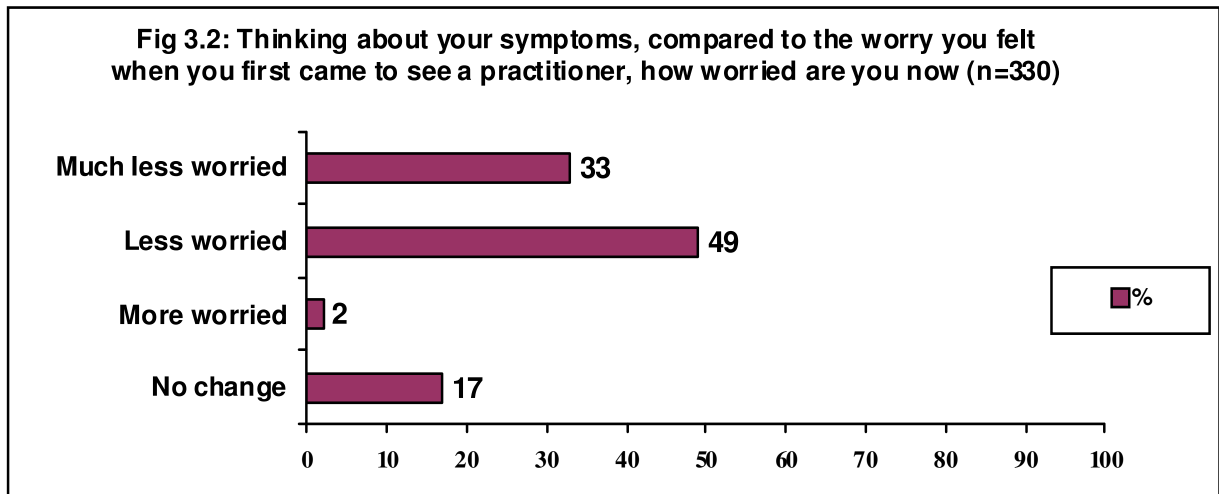
There were some differences in improvement levels by patient background characteristics, with those patients on benefits more likely to report an improvement in their secondary symptom (74% vs. 65%). Patients with no formal educational qualifications were also more likely to point to an improvement in the severity of their secondary symptom (76% vs. 66%).

In relation to treatment programme, patients who availed of chiropractic and osteopathy treatments (56%) were less likely to record an improvement in their level of wellbeing, compared with patients availing of acupuncture (77%) and homeopathic treatments (79%).

Finally, a greater proportion of patients presenting with mental health problems, compared with musculoskeletal problems, recorded an improvement in their wellbeing between pre and post treatment (80% vs. 62%).

3.2 LEVEL OF PATIENT WORRY POST-TREATMENT

The vast majority (82%) of patients said that following their treatments they were less worried about their symptoms, with 33% saying they were 'much less worried' and almost half (49%) saying they were 'less worried'. Just 1% of patients said they were 'more worried', with 17% of patients saying that their level of worry had remained unchanged.



3.3 PATIENT PERCEIVED CHANGE IN GENERAL HEALTH POST-TREATMENT

On a very positive note, more than eight out of ten (81%) patients said that their general health had improved as a result of their treatments, with a greater proportion of those in the higher social classes (ABC1, 86%; C2DE, 77%), and those not in receipt of benefits (86% vs. 76%), reporting a health improvement. Also of note is the finding that patients presenting with mental health related conditions were also more likely to report a health improvement compared with patients presenting with musculoskeletal conditions (86% vs. 78%).

3.4 PATIENT USE OF MEDICATION POST-TREATMENT

The analysis also found a reduction of 14 percentage points in the proportion of patients who said they were taking medication following their treatments (a drop from 75% at the first appointment to 61% following treatment). Specifically among those patients who were taking medication at the pre treatment stage, 20% said that they had stopped using medication following treatment, whereas among those patients who were not taking medication at the pre-treatment stage, 9% were taking medication at the post-treatment stage.

3.5 PATIENT FEEDBACK

Patients were also given an opportunity to rate a number of other aspects of the service received, with all patients rating as excellent or good the friendliness and courtesy of the practitioner, as well at the level of respect shown to them by practitioners and the practitioner's attention to their privacy. Almost nine out of ten (89%) patients rated the effectiveness of the treatments in managing their health problem as either 'excellent' or 'very / good'.

Table 3.8 Patient Views on CAM Practitioners

	Excellent	Very Good	Good	Fair	Poor	n
	%	%	%	%	%	
Effectiveness of the treatment for managing your health problem	35	35	20	10	1	293
Explanations of Treatment	63	31	4	1	-	293
Attention given to what you had to say	78	18	4	-	-	294
Advice given about ways of avoiding illness and staying healthy	57	32	9	1	1	288
Friendliness and courtesy shown to you by your practitioner	92	8	-			295
Respect shown to you, or attention to your privacy	88	12	-	-	-	294
Amount of time you had with the practitioner during each visit	61	29	8	1	-	293

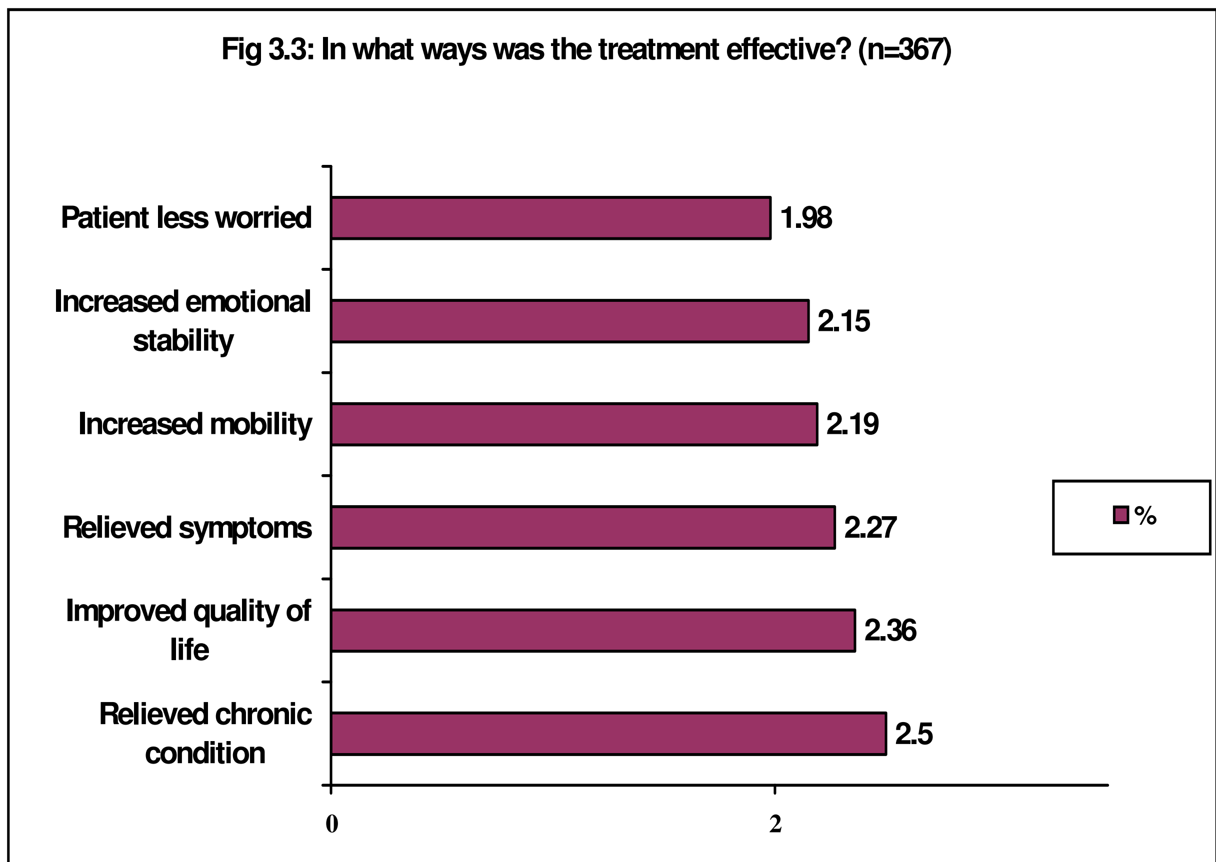
3.6 PRACTITIONER VIEWS ON EFFECTIVENESS OF TREATMENTS

Practitioner evaluation forms were completed for 367 patients, with practitioners asked to rate how effective the treatment had been in relation to a number of indicators. Assuming that scores from 0 to 2 indicate ‘effective’, practitioners reported that the treatments had been effective in reducing patient worry in 71% of cases, with increased mobility deemed to be an effective outcome in 66% of patient cases.

Table 3.9 Practitioner Views on Effectiveness of Treatments

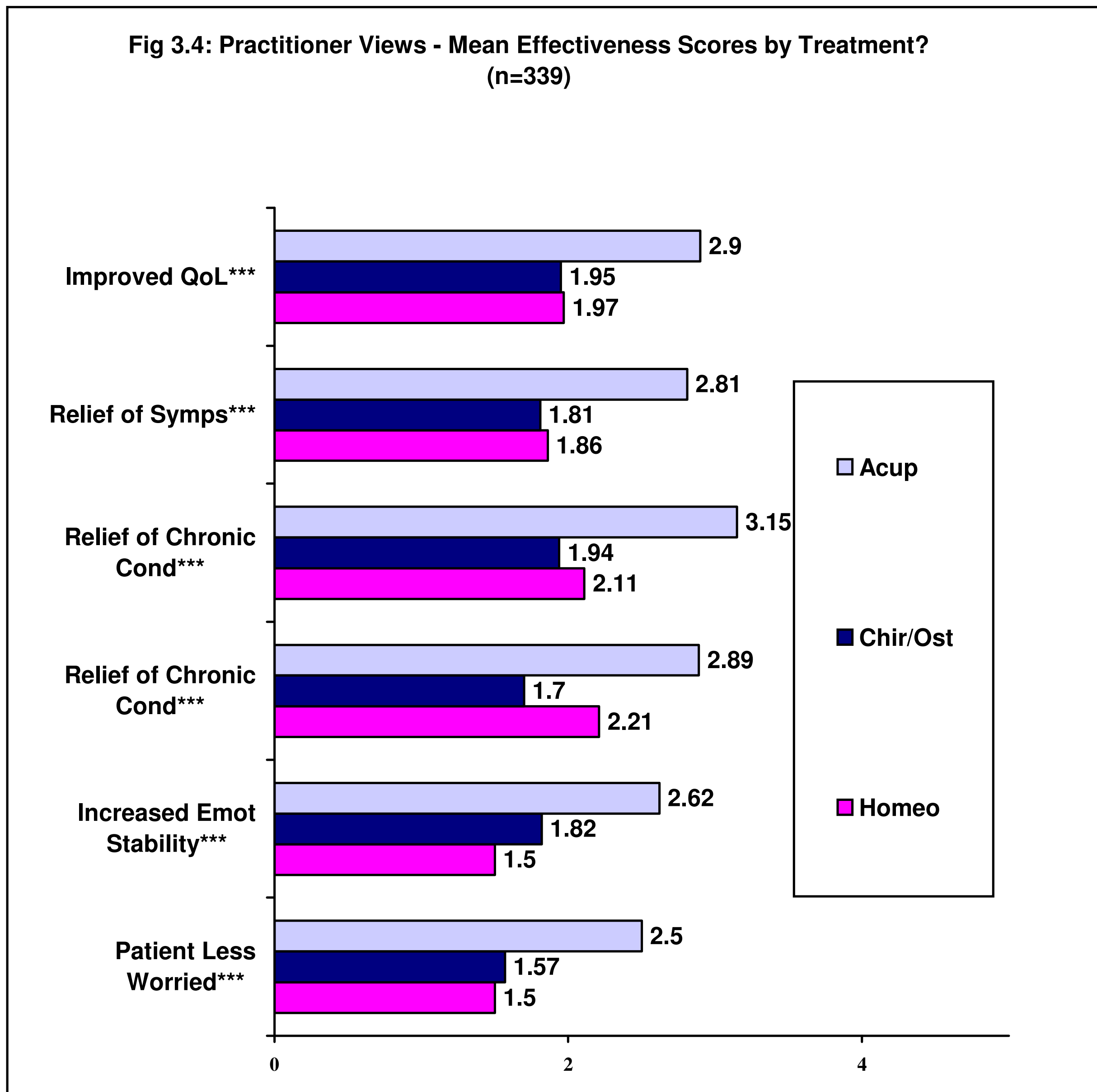
Outcomes	As good as it could be						As bad as it could be	n
	0	1	2	3	4	5	6	
	%	%	%	%	%	%	%	
Improved Quality of Life	8	20	30	24	9	5	4	367
Relief of presenting symptoms	9	23	29	21	8	6	3	367
Relieved chronic condition	8	20	28	22	10	7	6	355
Increased mobility	9	25	32	18	9	5	3	314
Increased emotional stability	10	23	31	22	8	3	3	362
Patient less worried	13	25	33	17	5	3	3	354

Figure 3.3 presents practitioners views on the effectiveness of the treatments in the form of mean scores, where the lower the score the more effective the treatment. Using this approach shows that practitioners judged the treatments to be most effective in reducing worry among patients, and least effective (relative to the other items) at relieving chronic conditions.



3.6.1 PRACTITIONER VIEWS ON OUTCOMES BY TREATMENTS

Figure 3.4 presents practitioners' views on the patient outcomes by therapy, with lower mean scores indicating that the practitioner perceives a better outcome. Using this approach shows that practitioners were more likely to perceive better patient outcomes for chiropractic / osteopathy and homeopathic treatments, compared with acupuncture. Note that there were no significant differences in practitioner perceived outcomes by patient health condition (i.e. musculoskeletal or mental health).



3.6.2 RELATIONSHIP BETWEEN PRACTITIONER AND PATIENT VIEWS

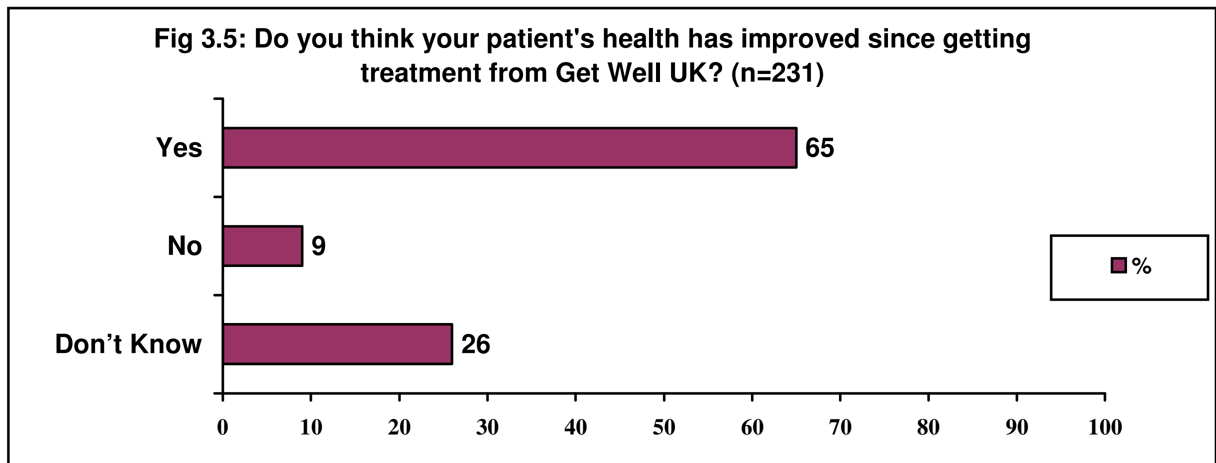
The relationship between practitioner and patient perception of treatment outcomes was assessed by correlating pre / post changes in (i) patient's mean MYMOP scores and (ii) patient's post treatment retrospective worry reduction scores, with the six perceived outcome scores from the practitioner post-treatment evaluation forms. This analysis found that the MYMOP symptom reduction scores were positively correlated with practitioner perceptions of patient reduction in worry, improved quality of life, relief of chronic conditions, increased mobility and increased emotional stability. This suggests that the patient's perception of treatment outcome is consistent with that of the practitioner.

Table 3.10 Correlation Between Patient MYMOP Symptom Reduction Scores and Practitioners Perceptions of Change in Patient Condition

	r	p	r^2
Improved quality of life	0.53	P<=0.01	0.28
Relief of presenting symptoms	0.52	P<=0.01	0.27
Relief of chronic conditions	0.49	P<=0.01	0.24
Increased mobility	0.46	P<=0.01	0.21
Increased emotional stability	0.50	P<=0.01	0.25
Patient less worried	0.48	P<=0.01	0.23

3.7 GPs VIEWS ON HEALTH IMPROVEMENT AMONG PATIENTS

In almost two out of three patient cases (65%), GPs said that the patient's health had improved since receiving CAM treatments, with 9% saying there had been no improvement, and 26% recording 'don't know'.



Although just outside the level of statistical significance (p=0.06), GPs in Derry were more likely to say that a patient's health had improved (in 71% of cases), compared with their Belfast counterparts who recorded such an outcome in 58% of cases.

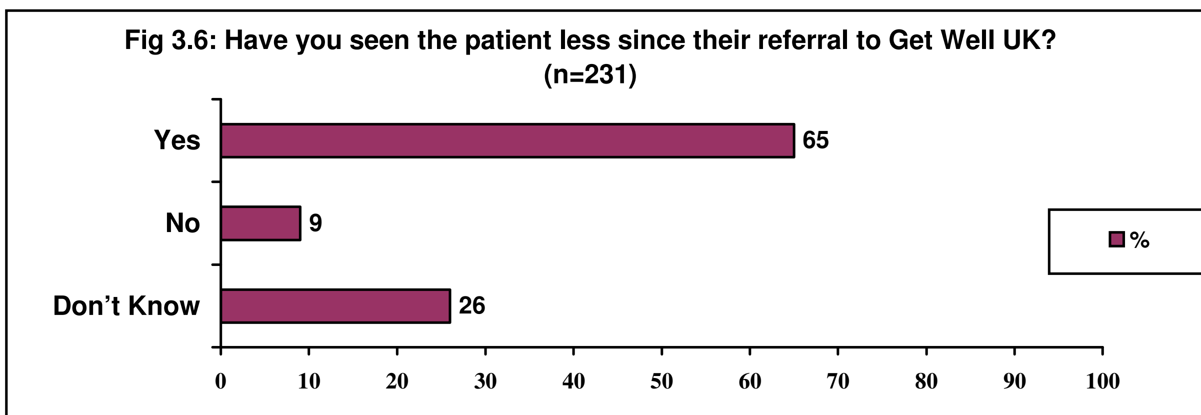
GPs were more likely to report a positive health improvement for patients in the higher social classes (ABC1, 76% vs. C2DE, 58%). The analysis found no statistically significant difference in GP view on outcome by either patient condition (mental health, 69% vs. Musculoskeletal, 64%) or therapy (acupuncture, 72%; Chiropractic / Osteopathy, 57%; and, Homeopathy, 64%).

3.8 GP AND PATIENT VIEWS ON HEALTH IMPROVEMENT

There was a high level of correlation between both GP and patient views with regard to perception of a health improvement. Among those patients who reported a health improvement, this was supported by GPs in 73% of cases. Among all cases where a GP recorded a health improvement, this was supported by 86% of patients. The only patient demographic characteristic showing a significant difference in relation to GP perception of health outcome was social class, with GPs more likely to record a health improvement for patients in the higher social classes (ABC1, 76%) compared with patients in the lower social classes (C2DE, 58%).

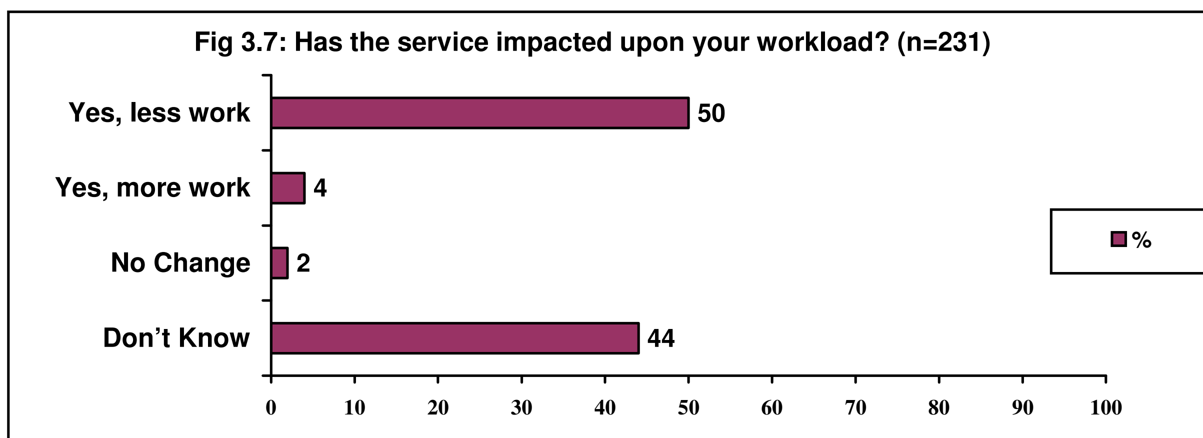
3.9 PATIENT CONTACT WITH GP FOLLOWING TREATMENT

In the majority of cases (65%), the GP said that they had seen the patient less since their referral to Get Well UK, with 34% saying there had been no change in the frequency of seeing patients. GPs were more likely to say that they had seen less of patients who had their symptoms for between 1 and 5 years (69%), compared with patients who had their symptoms for less than one year (50%), and more than 5 years (48%).



3.10 GP VIEWS ON IMPACT OF PROJECT ON WORKLOAD

In half of cases where a GP assessment form had been completed, the GP said that the pilot project had meant 'less work' for them, with 4% saying that the project had meant 'more work for them' and 2% recording no change in their workload.

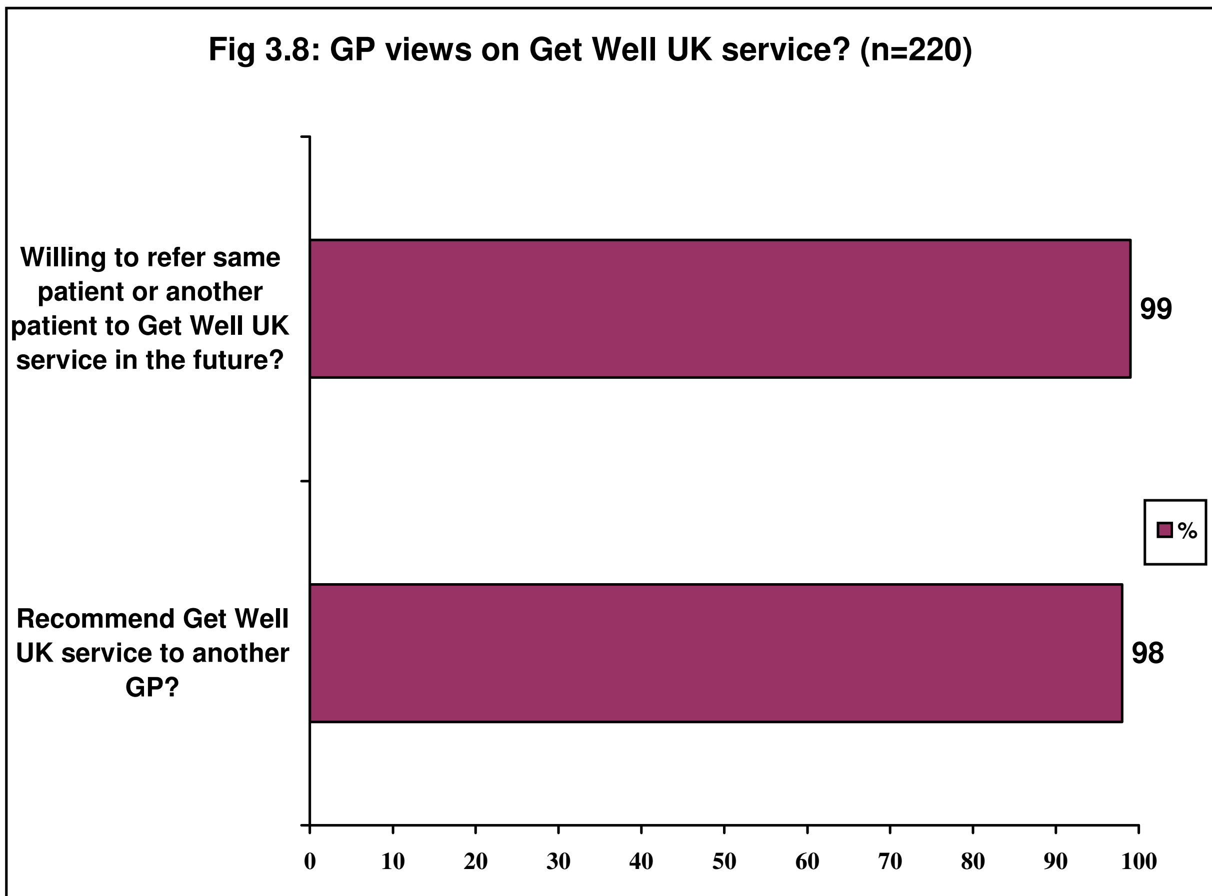


3.11 NORMAL COURSE OF TREATMENT IF NO ACCESS TO CAM

GPs were asked to say what their normal course of treatment would be if they had no access to CAM via the project. In almost half of patient cases (49%), GPs said that they would refer the patient for treatment, with 45% saying they would spend time with the patient. Just over one third of GPs (37%) said they would prescribe medication, with 10% conducting further investigation and 12% saying they would do nothing.

3.12 GP VIEWS ON THE REFERRAL PROCESS OPERATED BY GET WELL UK

In all patient cases, the GP said that they had found the Get Well UK referral process easy and straightforward, with GPs in only two patient cases finding it time-consuming. Finally, in 99% of patient cases the GP said that they would be willing to refer the same patient or another patient to the Get Well UK service in the future. Finally, in 98% of patient cases GPs said that they would recommend the Get Well UK service to another GP.



4 FOCUS GROUPS WITH PATIENTS

To provide a qualitative dimension to the evaluation, five focus groups were conducted with patients, GPs and CAM practitioners. This section of the report presents the outcomes from the three focus groups with patients.

4.1 PATIENT AWARENESS OF CAM

Most of the patients in the groups had been referred to CAM by their GP, some becoming aware of the project through local media coverage as well as via their practice nurse. In the Derry group most of the patients had heard of the various treatments but lacked any detailed understanding beyond recognition of the various treatment terms.

In contrast, the Belfast group appeared to have a better understanding of CAM, but not about the availability of treatments at the Health Centre; 'I knew about acupuncture and reflexology….but not that it was available here', 'I was aware of them and the range….but I didn't know they were available here'.

In Belfast four of the patients had previous experience of using acupuncture and reflexology services privately; 'I had a fall 9 years ago and had physio and acupuncture, it was very successful. I asked my GP for it then but was told that it wasn't available on the NHS'. Other sources of information about CAM included previous nursing job in the NHS, talking to friends who had used CAM services and TV and newspapers.

4.2 REASONS FOR REFERRAL AND THERAPIES RECEIVED

Patients within the groups listed a range of health conditions including; arthritis; anxiety; back pain; neck pain; neck pain; shoulder pain; spinal injuries, with back, neck ,head, shoulder and arm pain; ME; stress; and, depression. In response to these conditions patients had been referred for chiropractor, acupuncture, homeopathy, aromatherapy, osteopathy and reflexology, with most having had 12 treatment sessions, with 6 sessions per treatment.

4.3 PATIENT EXPECTATIONS

Patients had differing perceptions of CAM prior to treatment, although these were generally positive. In the Belfast groups 4 of the 15 patients felt that CAM treatments would offer an alternative to their GP; 'better than going to the GP', 'rather that (CAM) than going to my GP'.

Some of the group felt that CAM might help them reduce or cut out completely their intake of painkillers with comments such as: 'better than taking painkillers'; 'instead of the GP saying here take these pills again'; and, 'I hate taking painkillers'.

Two of the Belfast patients expressed strong feeling that CAM should be viewed as just another treatment option; 'I always though that CAM should go hand in hand with normal medical practice', 'alternative medicine should always be explored if you're getting nowhere with the normal channels'.

The patient expectations of using the CAM services were overwhelmingly positive. Many of the patients described their feelings at this time as hopeful. They looked

forward to being referred to the CAM services hoping to 'be cured', to become 'free of pain', or 'to get better'. Not all of the expectations were so high, with some patients having more modest expectations; 'slow relief from my ME symptoms but not a miracle cure', 'relief from pain to some extent, but not total relief', and 'to get some relief from pain', 'not to be so depressed'.

4.4 PATIENT REACTION TO A FREE SERVICE

The fact that the service was free was a major attraction for most of the patients in the groups, with all of those in the Derry group saying that they would have been unable to avail of the treatments if there had been a cost. This was also the view among the majority of Belfast patients, although some patients thought that they may be able to 'manage 2 or 3 treatments occasionally', but 'not a full course of treatments'. All of the Belfast patients felt that they would need to know the cost of a full course of treatment and that they were all unlikely to be able to afford regular CAM.

4.5 GP SUPPORT FOR CAM

The support of the GP was important for some of the Derry patients in that it accorded a degree of credibility to the project and encouraged patients to go forward for treatment. One patient had seen a leaflet about the project while waiting to see their GP:

> 'I seen it on the table [the leaflet] …still reading it when I went into the Doctors office and he asked me if I would like to go further into that. I jumped at the chance …great opportunity as part of a pilot project'.

Other patients made comments such as 'I'd rather have so many doses of therapy and cut down on my medication…..I've cut down using painkillers', with another patient saying that CAM is '….something that has worked for 4000 years, there is a fair chance it will work over her too'.

A few of the Belfast patients had suggested CAM to their GP's themselves; 'I saw a programme on TV about osteoarthritis and acupuncture. I asked my GP and this project was just starting', 'I suggested it to my GP, I was going to go privately'. The majority of patients in all of the groups had been told about the CAM project by their GP. One patient had been told about CAM by her diabetic nurse and then referred by her GP.

The Belfast patients were overwhelmingly positive and hopeful about being referred for CAM. None of these groups expressed any anxiety or apprehensions about the referral with some describing their feelings as being; 'excited', 'privileged', 'hopeful', 'relief', 'I felt great', 'hoping it would work'. One of the group summed up his feelings on referral as; 'when you're in pain you'll try anything' and the rest of the group agreed.

In general the Belfast patients did not find their GP's either enthusiastic or particularly positive about the CAM project, with these patients provided with limited information by their GP including information on the range of treatments and possible side-effects. Commenting on the information provided, patients said they were given 'basically nothing', 'very little information' or 'no great explanation'.

Some of the patients in Belfast said that their GPs attitudes towards CAM were seen as non committal and verging on the negative; 'my GP said he had nothing against acupuncture, it might help and it might not', '…..you might find it will work, you might find it won't', 'he made me feel he could do no more for me and this was a last resort'.

Only one of the Belfast patients found her GP positive about CAM; 'my GP said there's a pilot scheme and you might benefit, she was very positive about it'. The majority of patients felt that their GPs did not indicate to them that the treatments were complementary and not alternative. Only four of the Belfast patients had been told that the CAM treatments were complementary to their other medical treatment.

A few of the patients had received a leaflet about the CAM services from their GP. The majority of the patient group did not receive any written information from their GP, although all would have liked to have received a leaflet or some further information in writing. There were also suggestions in relation to further information about the full range of treatments available, what to expect, 'to give you an idea what you'll be facing' and 'a triage meeting to hand over detailed information'.

In Derry some of the patients said that their GPs explanation of the various treatments was limited, with a better explanation given at their first appointment with the practitioner. One of the patients felt that he had been inappropriately matched with a therapy, and felt that 'there needed to be a more accurate assessment rather than filling in a form...I would try acupuncture again though even though I had a bad experience'. This same patient made the point that the referral process may benefit from a triage system, where patients are assessed 'in between the GP and practitioner' before being referred for treatment. This patient however did recognise that GPs 'were finding their way', with the suggestion that more reading material for patients would have been helpful.

4.6 WAITING TIMES FOR TREATMENTS

Across all of the groups the waiting times from referral to first appointment with a therapist ranged from two weeks to three months, with the majority being seen within one month. There was general satisfaction with the waiting times; 'I was pleasantly surprised….only a few weeks'. There was an acknowledgement in both the Belfast focus groups that people who are in constant pain can be impatient; 'it seems longer than it really is when you're in pain'. Although it was agreed that waiting for two months or more was not acceptable; 'two months is too long when you're in pain.'

4.7 AVAILING OF TREATMENTS

The range of treatments utilised by patients were acupuncture, homeopathy, reflexology, chiropractic and osteopathy. Many of the patients received more than one type of treatment e.g. chiropractor and acupuncture, reflexology and acupuncture, acupuncture and homeopathy, homeopathy and acupuncture, homeopathy and chiropractic and osteopathy and acupuncture.

The locations where patients were treated were seen as suitable by everyone. The patients enjoyed the flexible approach to the timings of the treatments; 'we were asked when suited and we chose', 'we negotiated the times with the therapists'. The majority of patients had received or were just about to complete 12 treatment

sessions; often six of one type of treatment, followed by another six of a different type.

4.8 PATIENTS BEING PROVIDED WITH ADVICE BY PRACTITIONERS

Across the groups almost all patients reported being given some advice or information on managing their conditions. All of the patients welcomed this advice, with almost all saying that they were adhering to the treatment plan developed by their practitioner. In most cases this consisted of tailored exercises and advice about posture. The therapists also took time to explain in detail the reasons why some of the patients experienced severe pain. This advice was viewed as extremely helpful by all of the patients and was described as; 'wonderful advice', 'great advice', '…..it relieved my anxiety', 'she explained why the pain travelled and all about my condition…she was so very good', 'the not knowing why (you have pain) is awful, once she explained it, it was a great relief'.

All of the patients had acted upon the advice given to them by the therapists, resulting in a number of small but significant lifestyle changes. One patient who had stopped reading in bed because of her pain, now put a pillow on her knee to hold the book. One patient now sleeps with a pillow under her knee and is sleeping better, with another patient now able to sit up straight without any pain. Other patients said that they are now conscious about their posture; 'if I'm not sitting right now I'm trying to correct it'. None of the patients felt that the therapists could have provided them with anything additional; 'no; they were very informative'.

4.9 PATIENT COMMENTS ON QUALITY OF PRACTITIONERS

All of the patients in the groups had completed their treatments or were about to complete their course of treatments. They were all delighted with the therapists themselves, their pleasant, friendly, patient approach and particularly the skilled and professional way that they communicated with the patients. What stood out the most in the Belfast patient groups was how much each patient had benefited from and enjoyed talking and being genuinely listened to by the therapists. The therapists were described as being; 'excellent', 'listened so well', 'very relaxing', 'so lovely', 'very friendly', 'first class', 'putting you at your ease'. One very satisfied patient described the way she was treated by the homoeopath; 'he was excellent, he listens, he thinks, and then he sorts it out'.

The therapists were praised by the patients for their respectful way that they treated the patients; 'they showed us the highest respect', 'they were very respectful'. The genuine interest shown in the patients as people, the attention shown towards them though the quality of the listening and the friendly manner of the therapists were all commented on throughout the focus groups.

In general there was satisfaction with the amount of time given by the therapists, which ranged from half an hour to one and a half hours, with the average length of therapy session being one hour. However, most of the patients would have liked longer sessions if it were possible; 'very satisfied but would have taken more if offered'.

4.10 PATIENT UNDERSTANDING OF TREATMENTS

All the patients felt that they had an understanding of the treatments that they received. The majority of the patients had no problems in sharing their medical history with someone other than their GP. They generally had a pragmatic approach to this; 'no problem, they've heard it all before', 'it's a qualified person whose helping you out, so it's fine', 'they're trying to help you' and 'with one patient saying that 'having a good rapport is a strong aspect of it', and '…she [practitioner] knows more about my health than my own doctor does…'. There was just one patient who found it; 'a wee bit embarrassing'. The general experience of patients was that any anxieties or concerns they had were quickly addressed by practitioners providing them with reassurance and 'putting them at ease'.

4.11 IMPACT OF TREATMENTS

For many of the Derry patients their key motivation was to achieve pain relief, with one particular patient seeing a significant change to his condition:

> 'Prior to getting the acupuncture I was on 44 tablets a day and it was a waste of time going near my GP…there was nothing else he could give me…which was true…now after 6 sessions of acupuncture I am down to 17 tablets a day and I hope that continues…the only way I can see that continuing is to get a booster every 2 weeks or every 4 weeks. I have had ulcerated colitis for the last 15-20 years which means that I have diarrhoea 7 or 8 times a day…after the second session of acupuncture I haven't had diarrhoea since…acupuncture…absolutely fantastic…the practitioner explained everything to me…I was involved in a car accident and had my spleen removed…but the practitioner was working on the spleen, the nerve ends of the spleen and after the second treatment the symptoms had gone…unbelievable. People are coming up to me and asking what have you been doing? …what are you taking…what is making you so lively'.

For most of the patients in the focus groups their experience of the various treatments had been extremely positive, with the following comments made by patients in Derry:

'I'm finding that after my second session that my pain is not as bad… a reduction in pain and I'm able to get around more and I feel its brightened me up…maybe I shouldn't be saying that';

'It has been 100% positive…I have increased mobility and I'm in a better mood because I can do more and the pain has eased';

'I'm worrying less about my health and I'm taking fewer anti-inflammatory drugs now…it's positive'

'It has cancelled out the medication, stopped me from going on medication…I'm more confident and better able to cope with life…they got me through a situation';

'…brilliant…no mood swings…feel far better as a result of it';
In one of the groups, 7 out of 8 patients said that their symptoms had improved following treatment, with some patients saying that they no longer 'feel the need to take as much medication' and have 'more control over pain'.

One of the patients did comment on what they believed to be an inappropriate referral for their condition, with a breakdown in communication between their GP and therapist resulting in the patient incorrectly cutting down on their use of pain killers with the patient saying that

> '…my doctor cut the pain killers and the pain got worse…it was difficult to tell her and she should have let me stay on the tablets…I was in pain but didn't want to say…she was on a beaten docket and so was I!'

Although this patient's experience had been negative, he did say that 'maybe you have to try a number of different treatments before you find one that is effective'. In hearing this patient's testimony the group felt that it is important that the referral process from GP to practitioner is brought to closure with a meeting between the GP and patient to assess the impact the treatment has had, and to review medication use if appropriate.

Overall patients expressed very positive and favourable views on the impact of their treatments, with almost all experiencing relief of or an improvement in their symptoms, ranging from a slight improvement to a great improvement. The greatest reported improvement was in the reduction of pain.

Patients reported decreases in pain, 'easing of pain' and 'pain completely gone'. The impact of the pain relief on the patients' lives has been quite profound and wide spread, with shoulder, neck, head, back, knee and arm pain symptoms all reported as being affected; 'my back pain has practically cleared up now', 'I had chronic back pain and pain in my shoulder and arm, which I would say is nearly completely gone'.

Patients' quality of life, in terms of independence in everyday living tasks and ability to enjoy life more, had been improved in a number of different ways; 'able to sleep at night', 'move my neck for the first time in a long time', 'I can now sit in a chair and relax, my restless legs never move now…that's a big change', 'getting in and out of bed more easily', 'able to read a book in bed', 'I can hold the hairdryer now and do my own hair'. There were some graphic and moving descriptions of the impact of the treatment upon people's lives;

> 'I was in really severe pain, like being grabbed really tight…..the treatment has lessened the pain. The pain relief is fantastic. I'm not in anywhere near the pain I was in.'

> 'I couldn't sleep…..it's made a tremendous difference to my attitude and the way I'm treated.'

> 'I now get a better night's sleep…I can tolerate the pain much better, it's eased quite a bit'.

4.12 IMPROVEMENTS IN SOCIAL AND EMOTIONAL WELLBEING

In terms of the impact on social and emotional well being, some of the patients reported a positive impact on their mental health, their anxiety levels, their attitude to others and their relationships; 'I now have a good mental attitude', 'It's definitely helped me…they're teaching me techniques to relax. It's all about changing your way of thinking…it's slow, you don't just change over night', 'seemingly the wife's telling me that I was cross, because I was in pain all the time…I couldn't sleep. It's made me into a better person', 'it was so demoralising, I couldn't shower or wash myself…now I can do it all myself'.

4.13 CONTROL OVER PAIN

The majority of the patients felt that they had gained some more control over the pain associated with their condition; however the greater sense of control experienced came from having some choice over the kind of treatments they received and the good communication between themselves and the therapists.

Approximately one third of patients across all of the groups said that they had reduced their intake of painkillers in direct response to the success of the CAM treatments; 'I had chronic…pain…I've gone from 7 painkillers a day down to one'. 'I stopped taking them just before starting the therapies…I had had enough of them…I manage without them now', 'the doctor wanted to give me antidepressants and I didn't want them. That's why I went for the alternative therapy'.

4.14 RESPONSIVENESS OF THERAPIES

According to patients those symptoms that were the most responsive to the treatments were neck, back and shoulder pain and anxiety. Where treatments were less responsive, the therapists referred patients to other CAM treatments, always offering alternatives. This was greatly appreciated by those patients who were cross referred i.e. referred to another CAM therapist.

4.15 LEVEL OF PATIENT WORRY FOLLOWING TREATMENT

All of the patients felt less worried about their health conditions as a result of the treatments. This was felt to be the result of being listened to, the relief of symptoms, being able to talk to someone about their conditions on a regular basis as well as having a greater understanding of their conditions: 'I know I can get relief by the acupuncture', 'I have a better understanding of my own body now and my own life'.

4.16 OTHER IMPACTS OF TREATMENTS

Other changes in circumstance reported as a result of the project were being able to drive again, being able to work; 'I'm restricted in my movements but I can work' and giving up work; 'I resigned from my job….I'm unemployed and very happy…it's a positive change…I was so stressed'.

4.17 COMPLEMENTARY TREATMENTS

The majority of the patients viewed their therapies as being complementary to their existing treatments rather than alternatives; 'it (CAM) should be hand in hand with

mainstream GP services….should all be one service, under the umbrella of the NHS'.

4.18 COMPLETION OF MYMOP QUESTIONNAIRES

Only half of the Belfast patients completed the MYMOP questionnaires unaided, with patients needing help to complete these questionnaires because of poor eye-sight and concentration problems. There was some discussion among the patients about the accuracy of these forms, with a number of patients expressing views about the 'subjectivity of pain', 'everyone's idea of pain is so different'. Other criticisms of the MYMOPS were that they were not specific enough, had too many open ended questions and relied heavily on 'comparing present pain with previous levels of pain, expressed on the last form completed, which is sometimes hard to remember'.

4.19 SUGGESTED IMPROVEMENTS

Patients identified a number of changes/improvements to the CAM project. The most common issue highlighted was the lack of information given to patients by GPs. Patients wanted to see more information about the range of CAM services available, descriptions of each individual therapy and how many treatment sessions are available per patient; 'people don't know what the individual therapies are and what are the differences'. They also felt that the public in general, and GPs in particular, should be made more aware of the benefits of CAM. Other service developments suggested were; improved waiting times for referral to treatment, treatments available more often; 'once a week isn't enough', a triage meeting between the therapist, patient and the GP at the commencement of the course of therapy. There were also issues about having to go back to the GP to be referred again for additional CAM sessions or a different therapy; 'the amount of treatments should be determined by the therapists and not the GPs'. Patients also had concerns about the costs of continuing with the therapies, particularly those with chronic conditions who felt that they would require booster treatments. According to patients the key benefits of the therapies were that they were better able to engage with life with one patient saying that before the therapies 'I hadn't the energy to get out of bed'.

4.20 PATIENT PERCEIVED BENEFITS

The following is a list of what patients felt were the key benefits of the project:

- being listened to and being treated with respect and not being judged;
- health improvement and particularly relief of pain;
- availability of CAM on the NHS, and having an alternative to conventional medications;
- greater energy levels and more motivated to interact and engage with every day life, 'I feel alive again, instead of being dead'; 'I now have hope'
- avoiding or reducing reliance on medication;

- enjoyment of the treatment sessions, the quality of the therapists and high levels of compliance reported by patients;

- patients becoming advocates for the therapies and the project, with each saying that they had spoken with other family and friends about the benefits; and,

- an increased level of confidence in interacting with GPs.

4.21 PATIENT PERCEIVED WEAKNESSES OF THE PROJECT

Conversely, patients felt that the project could have been improved in the following areas:

- better promotion and profiling of the project;

- lack of support for CAM by some GPs / lack of recognition of CAM by the medical profession;

- more treatment sessions;

- more information for patients on the various treatments, and particularly in matching health conditions with therapies;

- more detailed assessment of patients' conditions, with a need for some form of triage system to ensure appropriate matching of health conditions with therapies;

- lack of a detailed briefing / meeting with their GP following treatment. A review of medication should be an essential element of this process;

- more information / education for GPs to ensure more effective matching of patient health conditions with treatments;

- a lack of a maintenance program of treatments to sustain improved levels of wellbeing among patients;

- GP scepticism of CAM, with a call for the service to be offered on a consistent basis rather than access being determined by the attitude of the GP towards CAM;

- a lack of integration of CAM within primary care, with some patients pointing to examples in other countries (e.g. USA) where CAM is fully integrated with primary care.

4.22 CONCLUDING COMMENTS

Finally, all of the patients said they would recommend CAM treatments to other people. They were unanimously distressed and disappointed at the end of the project with the majority of patients wishing that they could continue with the treatments privately but felt that they would not be able to afford it. Some said that they would try to manage a treatments every so often with four patients willing to forego their annual holiday in order to pay for CAM treatments. The lack of general

access to these treatments because of inability to afford private treatment was a recurring concern throughout the focus groups.

The concluding comments from the patient groups were that the project been a very positive experience; 'I really enjoyed myself even the pain was worth it' and that it should be funded and continued in the long term 'the project should continue beyond March', 'there should be more funding for CAM on the NHS'.

5 FOCUS GROUPS WITH GPs AND CAM PRACTITIONERS

This section of the report in based on the outcomes of two focus groups with practitioners and GP. The groups were convened in Derry and Belfast.

5.1 AWARENESS AND ATTITUDES TO CAM

The focus group discussion was initiated by asking GPs to comment on their perception and general awareness of CAM prior to participating in the project. The view from all of the GPs that their awareness was limited, having had little exposure to any of the therapies with the exception of acupuncture which one of the GPs had some exposure to within a hospital setting.

In one of the groups there was some negativity directed at the project from one of the GPs who felt that the 'project was foisted upon us', with this same GP of the view that 'it doesn't belong in the NHS'.

5.2 GP AND PRACTITIONER EXPECTATIONS FROM THE PROJECT

Commenting on expectations from the project, the practitioners wanted to see a high level of referral to the project and 'for GPs to see value in the treatments' being provided to their patients. For both the GPs and practitioners the project offered the possibility of 'a measurable trial', with the project outcomes supporting the integration of CAM into primary care in Northern Ireland. The project was also seen as offering alternative referral options for GPs, as well as improving their understanding of CAM.

The Derry practice is located within an area of high social and economic deprivation, lower levels of educational attainment and high levels of long-term unemployment. For some of the practitioners the project was an opportunity for them to work with a patient profile characterised by trauma and violence, which was fundamentally different from their normal patient profile in private practice 'with many of these patients presenting with mental health problems…with many for the first time getting an opportunity to talk about it'.

One of the practitioners providing services to the Derry patients felt that the patient profile was very different from their normal private practice with 'a lot of patients are very complex cases…not just one condition…but could be psychological, physical…good to have the option of referring on to other treatments…works well…leaves the door open to deal with these complex cases…'.

One GP said that 'we are at the end of our tether with some patients…some have back trouble and have been on countless medications …been to physio and been everywhere and nothing seems to work …give this a go and see what happens'. One of the GPs in Derry also said that initially 'there was a temptation to focus on the chronic patients, but these may not be the best people to refer…should maybe have focused on people with more acute problems but initially didn't really know to select patients appropriately because you didn't know what was possible'.

5.3 INITIAL CONCERNS ABOUT THE PROJECT

Some of the GPs expressed concern about what they felt was a lack of organisation at the initial phase of the project, which they felt led to some

uncertainty on their part with regard matching patient health conditions with the various treatments. Although all of the GPs appreciated the time pressures in getting the project established, it was felt that many of the initial problems could have been resolved by having meetings with the practitioners to discuss the services they provided, the treatments available and the general referral procedures which would operate throughout the life of the project.

Both the GPs and the practitioners said that the referral process was quite slow, with some contact between practitioners and patients to ensure appropriate matching of therapies with patient conditions. Indeed the GPs that took part in the focus groups underscored the importance of matching conditions with therapies, and the need for information / education to support them with this process. It should be noted however, that both the GPs and practitioners felt that GPs matching conditions with therapies became less of a problem as the project progressed.

It was also felt by some of the practitioners that the referral form itself could be redesigned to provide more room for GPs to list patients' medical conditions as well as providing more information on prescribed medications.

At the initial stages of the project, both practitioners and GPs agreed that it was mostly patients with chronic conditions rather than acute conditions who were being referred for CAM but that this became more balanced as the project progressed. However, the point was made by practitioners that the potential for patient benefit is greater if the patient is referred before their condition becomes chronic:

> *'there is an opportunity to treat just before they start on medication…ask them if they would be willing to try something, an alternative…give them the option which is free from medication initially and maybe prevent medication…in other cases you can complement the medication with the GPs help…'*

5.4 GP AND PRACTITIONER VIEWS ON PATIENT AWARENESS OF CAM

According to both GPs and practitioners, patient awareness of CAM was low, with some of the GPs mentioning that they had patients who had enquired about CAM but their own limited knowledge made it difficult to respond to such requests effectively. As the project progressed however, GPs were provided with an information leaflet which they were able to pass on to patients who found it very helpful. Nevertheless, although patient knowledge of CAM was limited, their reaction to being offered the therapies was very receptive, with GP concerns about a low take-up of a 'free service' proving unfounded. One GP said that 'patients were very receptive particularly if you are offering them an alternative to medication …patients with stress…acupuncture…very beneficial rather than medication…post natal depression is also another area where the therapies have proved effective'.

5.5 PATIENT COMPLIANCE AND EXPECTATIONS

Both the GPs and practitioners reported a high level of compliance with treatment programmes with a non compliance level of 'between 1 and 2%' estimated by practitioners and GPs. There was general agreement in the groups that waiting times for treatments was not a problem, with patient compliance with treatment programs very high and 'on a par with private practice'. One GP made the

comment that '…sometimes your experience of compliance with treatment in the NHS taints your view…you expect low compliance…in private practice…they are paying for your advice and maybe they value it more…one worry about this was that its free…but this hasn't been the case…most of the patients have been committed to the treatments'.

The GPs felt that the patients themselves did not have a high expectation of the potential for CAM, with one GP saying:

'…quite a lot of patients didn't have very high expectations of the treatments….they were just thrilled at the outcome….the problem is now most of the patients cannot afford to continue with their treatments…now at a low…knows what has happened but can't continue…', with another GP concerned about the '…problem is that once it goes it will create a vacuum…I feel there will be a gap'.

5.6 SUPPORTING GPS TO BETTER UNDERSTAND CAM

Some of the practitioners made the point that there can be a variety of reasons why a patient is suffering from stress with a call for GPs to widen their definition of depression which in turn broadens out the referral potential for patients. It was suggested that more communication between GPs and practitioners would help GPs to better understand the range of treatment options for this condition. One GP commented that:

> 'in future GPs would need to be educated on the range of treatments, nature, suitability before they start …with conventional medicines I know what the different specialties do…and I need this information for alternative therapies…what they are about and what they can achieve..'

In supporting GPs to better understand the work of CAM it was suggested by both GPs and practitioners that consideration be given to providing GPs with some or all of the following:

- a half day seminar on CAM;
- talks by CAM practitioners;
- what types of patients they expect and what will lead to the best outcomes;
- GPs to observe treatments;
- an induction for GPs '…you just couldn't drop this in on the NHS…would get a lot of inappropriate referrals…GPs need to know which patients to refer…wouldn't take long'; and,
- information leaflets for GPs.

5.7 TREATING PATIENTS

GPs said there was a small number of refusals with the main reasons being patient scepticism with others 'simply preferring a tablet'. Practitioners also offered advice on general lifestyle and maintenance which according to all of the practitioners was well received. There was a general view expressed by practitioners that patients with chronic conditions need more that six treatment sessions and also require more longer term maintenance, whereas six sessions were felt to be sufficient for patients presenting with acute conditions.

Being able to give patients enough time was seen to be of great benefit to patients, with the practitioners saying that this provides an opportunity to explore the patient's condition using a holistic approach. In contrast with general practice, GPs in the group said that usually their time is limited to around 10 minutes with one GP saying that it can be like '…opening a can of worms, and its difficult to get the lid back on'.

The therapists gave advice and information to all their patients on how to manage their condition and felt strongly that patient education was a significant and vital part of the service. The therapists agreed that patients were; 'slow at first to follow the advice' but 'once they could see the benefits, that they could help themselves', then there was almost total compliance. Patients reported to the therapists that they were regularly carrying out the individual exercise programmes that the therapists designed for them and making changes to their diet as advised. The therapists reported a number of lifestyle changes, some life changing; 'one of my patients says that now she can start planning her future'. Many of the changes were seemingly more mundane, yet significant for patients, involving the ability to carry out essential everyday living tasks; 'one of my patients can now change her own baby's nappy', another can 'brush her hair herself', 'is no longer incontinent'.

The therapists did not perceive any problems with the patients sharing their medical history with them. They agreed that they had much greater time to spend with their patients, put them at their ease and really 'get to know them'.

5.8 INCREASED CONTACT WITH GPS

The therapists felt strongly that there should be more contact between themselves and the GPs, that the project should 'be approached as an integrated health service'. They also would have liked to be provided with 'more information on patients medication' prior to treatment.

5.9 PRACTITIONER CONCERNS ABOUT MYMOP FORMS

The therapists had concerns about the MYMOP patient questionnaires and their patients' ability to accurately complete them; 'they are not easily completed by the average person'. The GPs had not seen the MYMOP forms. One of the therapists had; 'helped patients to complete the forms' as most of his patients couldn't complete it alone. He was concerned about the 'scope for manipulation with the forms', whilst making it clear that he was scrupulously careful not to sway his patients in any way.

5.10 GP AND PRACTITIONER VIEWS ON HEALTH OUTCOMES

In terms of impact on patient health, one practitioner felt that '80% to 90% of my patients have had a positive effect in relation to psychological wellbeing or musculoskeletal conditions…although its lower for chronic cases…better for acute…but very few patients where there has been no impact'. This was supported by the GPs in the group with one saying:

> 'I get very positive feedback from patients…there were a few patients who it didn't work for…mainly chronic…their expectations were low…most patients enjoyed the experience…patients are asking for the practitioners and they are getting great benefit from it…patients have multiple problems, for

example, chronic back pain makes them depressed…a holistic approach allows them to be helped in one sphere which can help in other spheres of their lives…better back, better mood…very positive feedback from patients'.

Another GP said that there were cases where the patients' medication had remained the same but that the patients had felt better even though their symptoms had persisted they experienced less pain and improved mood and better relationships with other family members.

In the Belfast group the GPs felt that they were not able to comment in detail on the impact of the treatments on their own patients, as none of the patients referred for CAM had been back to see their GPs, since commencing the therapies. They both agreed that this fact should speak for itself, as they had generally referred patients who were long term, regular attendees at their surgeries.

The therapists felt that in general their patients had experienced relief from pain and had benefited from 'the extra time we are able to spend with them'. The therapists had received small gifts of flowers and chocolates from grateful patients. There was some joking and mutual acknowledgement, that the GPs had never received any gifts in all the years of treating these patients.

The therapists agreed that the impact of the treatments on the patients' symptoms were individual and varied, however, chronic fatigue, relief or lessening of pain in the back, shoulder, arms and legs, were commonly reported effects. Feeling less anxious, less stressed and more able to enjoy life were other commonly reported outcomes. The symptoms most responsive to treatments were back pain, neck pain, chronic fatigue and irritable bowel syndrome. Individual patients reported that they were now able to brush their hair, change nappies, drive the car, move their neck from side to side and become continent after being incontinent. The therapists felt that their patients' general health had improved, with small improvements in some patients to great improvements in others.

Where therapies were less successful, the therapists referred on to other therapies within the project.

The therapists were aware that a significant number of their patients had been able to reduce or stop their intake of painkillers since commencing therapy. The GPs were not aware of any changes in use of medication as 'we aren't seeing these patients now, they rarely return to their GPs'.

Both the therapists and the GPs viewed the treatments as being complementary to their existing treatments and not alternative, although it was interesting to note that these patients had stopped regularly attending their GPs. One of the therapists said that she 'did not like the term alternative medicine…..as they are all appropriate treatments'.

The therapists found that the patients were all less worried about their health conditions as a result of the treatments. The therapists felt that they had built up good, warm and open relationships with their patients. The GPs felt that their relationships with their patients had changed in that they now 'see them less' or 'not at all'.

5.11 OTHER IMPACTS ON PATIENT HEALTH

A range of other impacts was also documented by GPs and practitioners including: a lower level of prescribing medication; patients themselves saying they need less medication; patients reporting a 'few extra pain free hours before they needed to use medication'; a reluctance by patients to say that their health was improving for fear of losing benefits such as the Disability Living Allowance (DLA); GPs seeing less of those patients who had attended with acute medical conditions (e.g. lower back pain); and, 'a dramatic reduction in the number of referrals to physio'.

5.12 IMPACT OF PROJECT ON WAITING LISTS FOR OTHER SERVICES

There was discussion in the groups about the lengthy waiting times for patients to access Community Mental Health services, with some of the GPs using the project as an opportunity to refer patients for CAM treatments. The point was made that using alternatives such as CAM removed the 'stigma' associated with Community Mental Health services. One GP said that the option of referral for CAM was very useful in 'depression borderline cases where the patient is maybe not that keen on antidepressants' and would like to try an alternative.

5.13 IMPACT OF PROJECT ON WORKLOAD / GENERAL PRACTICE

GPs were also asked to comment on what impact the project had had on their workload, with the general view from GPs that their workload had not changed significantly. One GP summed this up with the following comment:

> '…If I have a spare slot, someone will fill it up…patients are calling all the time…I'm in 4 hours today…my workload hasn't changed…yes the patients I see a little less…but the space or vacuum is filled by other patients…'.

One of the GPs felt that his work load had probably been reduced as he was seeing less of the patients referred for CAM; 'these patients are not returning regularly', 'only 2 or 3 of the patients that I have referred, have I seen back again'. The other Belfast GP had not experienced any reduction in his work load, although this same GP admitted referring fewer patients for CAM.

All the GPs and the therapists agreed that the impact of the project had been positive; 'all the feedback is good'. Neither of the GPs had noticed any changes in their levels of prescribing for these patients; 'no it doesn't stand out,' 'the study is too small for significant prescribing changes'.

5.14 IMPACT OF PROJECT ON OTHER SERVICES

Specifically on the issue of whether or not patients were using less of secondary care services, one GP stated:

> 'If you look at my physio referrals, they have gone way down…its not a service…patients don't actually get therapy (physio) anymore, they do very little manipulation or treatment…patients are getting more benefit from complementary therapists….and I'm now referring more to alternative practitioners…'.

'…one limitation is that you can't prove statistically that the patient is improving in say functional capacity, but the patient is coming back and feeling great...their quality of life has improved'.

5.15 GP AND PRACTITIONER VIEWS ON PATIENT AFFORDABILITY

Affordability was identified as a major barrier for patients wishing to continue with CAM treatments, with some of the GPs saying that they have had patients coming back to them 'in the hope that they get referred back again'. Some of the practitioners also said that some of their patients with chronic conditions will need 'to be kept at a certain level [in terms of treatment] for the benefits to be sustained'. Some of the focus group participants felt that the project in its current format was 'too short of a timescale to be able to properly assess the benefits to patients…and you might need something which is over a longer period like a clinical based case-control study'.

One of the Belfast GPs had strong views about the cost of this CAM pilot project; 'for £200,000 we could have 4 additional physios and cleared our physio waiting list', 'the therapies weren't a cheap option…they cost £200,000…..half of it is going on management and admin too'.

5.16 GP AND PRACTITIONER VIEWS ON PROJECT STRENGTHS

The participants identified the following as being the key strengths of the project:

- t was felt that the high quality of the therapists added significant value to the pilot project, with many of the GPs getting very positive feedback on practitioners from their patients;

- patients who would normally be able to access such treatments due to cost, have been given a new experience;

- the treatments have brought patients to 'a new level' in terms of an improvement in their overall health and wellbeing;

- the project has provided GPs with a greater number of referral options, and offered alternative therapies rather than conventional therapies;

- patients have had the benefit of more time with practitioners to talk about and explore their health conditions in a holistic way;

- the health improvement of patients evidenced by the views of both GPs and practitioners within the groups;

- the positive outcomes for patients have had a 'ripple effect' within the community, with other patients now presenting and asking to be referred for CAM;

5.17 GP AND PRACTITIONER VIEWS ON PROJECT WEAKNESSES

Practitioners and GPs were also asked to comment on areas where the project could be improved. Views expressed included:

- wishes for more educational input directed at GPs, particularly in improving their understanding of the various treatments and appropriately matching patient conditions with therapies;

- concern that some GPs were sceptical of CAM, which led to a lower level of referral by these GPs;

- concern at the initial stages of the project when it proved difficult to recruit therapists, as to whether there would be a sufficient number of trained therapists to respond to demand if the project were to be rolled out further;

- advice to revise and simplify the MYMOP forms;

- general acceptance among the therapists and GPs that there was not enough communication between them in terms of feedback on patients' progress.

- the issue of measuring outcomes accurately (as reported above, in connection with the homoeopath) in relation to patients' difficulties in completing the forms unaided.

5.18 GP AND PRACTITIONER CONCLUDING COMMENTS

Both the Belfast GPs would refer to other patients for CAM treatments, 'if the project continues'. One of the therapists felt that some of the patients from this pilot would continue with the treatments in a private capacity, whilst the other therapist was 'not aware' of the demand and had received no enquiries yet.

The GPs felt that their practices did support the CAM project. One of the GPs said he supported it because 'it was something for nothing'. The therapists and one of the GPs agreed that CAM should be available on the NHS, whereas the other GP felt strongly that 'it should not be funded by the NHS…..It has a place but not in the NHS….there's not enough evidence….show us the evidence first'. One of the therapists felt that if the CAM project were 'rolled out, expanded...…then the GPs would see greater results and a bigger impact'.

The use of chaperones was not an issue for this project as the project was limited to people over 18, however one of the therapists said that chaperones could be arranged for minors or patients with reduced autonomy. Finally, the cost of accessing CAM treatments privately ranged from £30 to £60. The therapists and one of the GPs thought that complementary therapies fitted well into general practice and the other GP agreed that it 'would in an ideal world'.

6. SURVEY OF PATIENTS

This section of the report presents the findings from a survey of patients who availed of the different therapies. The purpose of the survey was to elicit patient opinion on awareness of the service, the referral process, and the impact of the treatments on patient health. As noted in Section 1 of this report, 500 patients were surveyed, with 227 completing and returning a questionnaire within the fieldwork period. This represents a response rate of 45%.

6.1 PROFILE OF THE PATIENT SAMPLE

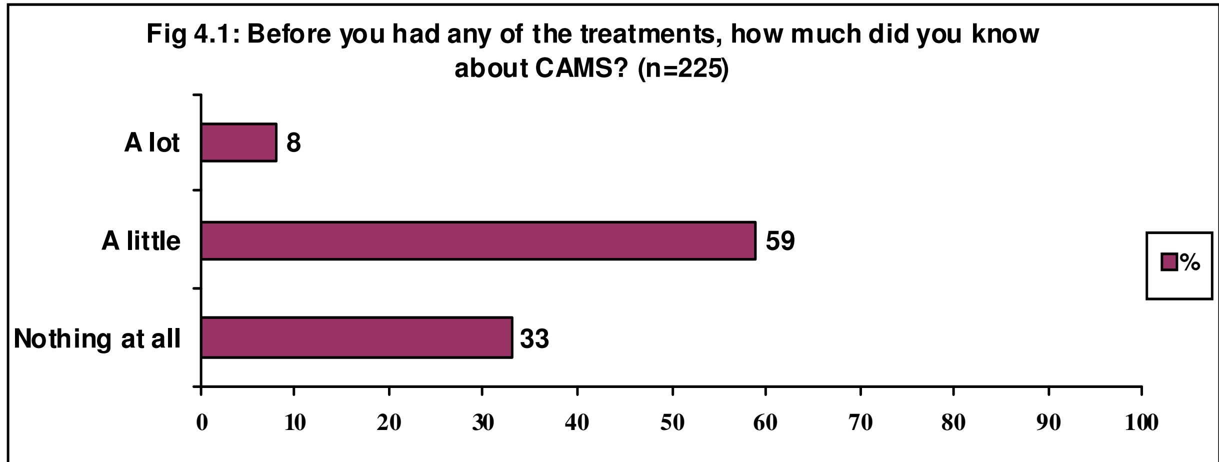
Table 6.1 presents a profile of the patient sample, and shows that the sample is largely consistent with the overall patient profile referred to the project.

Table 6.1 Profile of Patient Sample

		%	N
Sex	Male	28	63
	Female	72	163
Age	Under 30	5	11
	30-49	34	78
	50-69	44	99
	70+	17	39
Marital Status	Single	15	33
	Married	61	138
	Divorced / Separated	12	28
	Widowed	12	27
	Civil Partnership	.4	1
Employment Status	Self-employed	6	13
	Working Full-time	22	47
	Working Part-time	11	24
	Seeking work for the first time	-	-
	Unemployed	1	2
	Looking after home and family	12	25
	Unable to work due to permanent illness or disability	15	32
	Not actively seeking work but would like to work	1	3
	Not working and not seeking work	-	-
	On a government scheme	-	-
	Retired	32	68
	Student	-	-
	Other	1	2
Dependents	Yes	37	80
	No	63	139
Receive Benefits	Yes	47	97
	No	53	111
Education	Qualifications	62	133
	No Qualifications	38	80
Housing Tenure	Own Home / Mortgage	75	165
	N I Housing Executive	11	25
	Private Rented	9	19
	Other	5	11
Religion	Catholic	42	85
	Protestant	52	105
	Other	6	14
Area	Derry	38	84
	Belfast	62	138

6.2 FINDING OUT ABOUT THE PROJECT AND AWARENESS OF CAM

Most patients surveyed said that they had found out about the availability of CAM through their GP (77%), with 11% finding out through their practice nurse and 12% from other sources. Awareness of CAM among patients was found to be limited, with only a minority of patients (8%) indicating that they knew 'a lot' about complementary medicine, with the majority (59%) saying that they knew 'a little'. The remaining 33% of patients said they knew 'nothing at all' about CAM.



6.2.1 AWARENESS OF CAM BY PATIENT CHARACTERISTICS

There were some differences in reported awareness of CAM between different patient groups, with higher levels of awareness reported by patients who were: economically active (81% vs. 61%); not in receipt of state financial benefits (75% vs. 63%); have a household income based mainly on employment rather than benefits (76% vs. 56%); have formal educational qualifications (81% vs. 44%); and, be owner occupiers (73% vs. 52%).

6.2.2 REASONS WHY PATIENTS AVAILED OF THE TREATMENTS

The importance of the patient's GP in directing patients towards CAM was borne out in the survey, with the finding that 62% of patients availed of treatments because their 'GP thought it would be a good idea'. Also for the majority of patients surveyed (56%), a motivation to improve their health was a reason for availing of the treatments, with the free cost of treatments cited as a factor by 31% of patients. Taking the treatments as a last resort, was found to be a reason for almost one quarter of patients (24%). 44% of patients listed a number of other reasons why they took the treatments, with a willingness to stop taking medication, an expectation of health improvement and pain reduction, being the most common (Table 6.2).

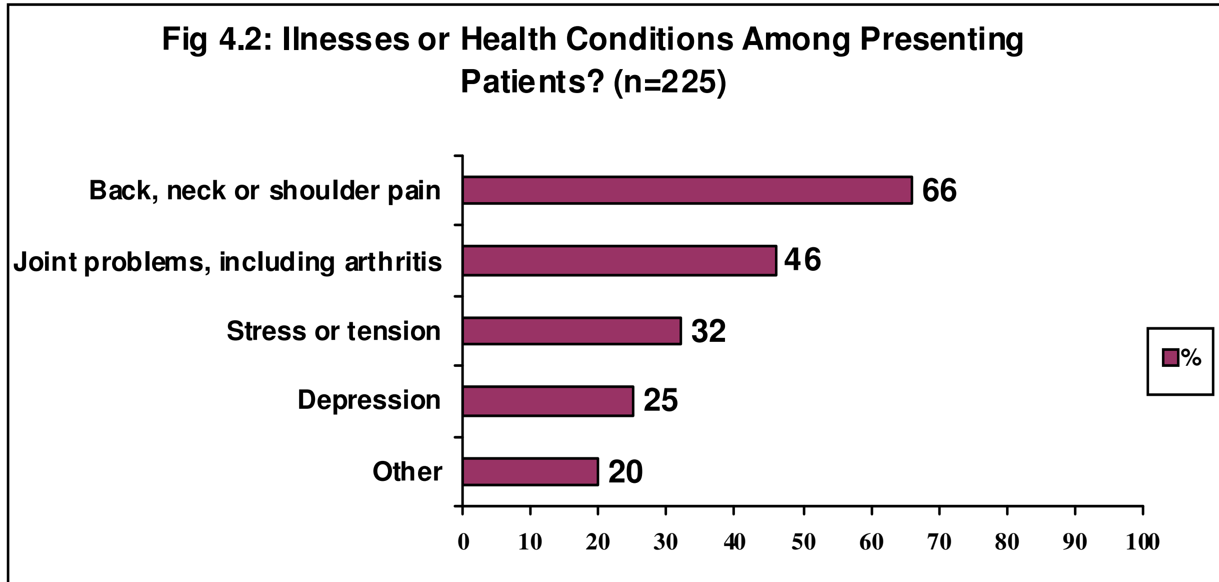
Table 6.2 Other Reasons Why Patients Took CAM		
	%	N
I Wanted To Stop Taking Tablets	20	18
Had Used CAM And Found It Helpful/Believed In CAM	20	18
I Was Suffering A Lot Of Pain/Pain Relief	18	16
Make Me Feel Better	9	8
Had Heard Good Reports About It	4	4
Curiosity	3	3
Recommended By A Friend	3	3
Saw A Programme On TV About Acupuncture	2	2
Medication Didn't Seem To Help	2	2
Advice From Practice Nurse	2	2
I Could Not Have Afforded It	2	2
It Was The Only Option Offered	1	1
Help Lift My Mind	1	1
Had Tried Other Things & Got Little Relief	1	1
I Did Not Want Any Type Of Surgery	1	1
Feeling Stressed	1	1
Always Been Interested In Alternative Medicines	1	1
To Avoid Radiological Intervention	1	1
Had No Faith In Drug Treatment	1	1
CAM Are Complementary With Traditional Medicines	1	1
Have Confidence In Complementary Medicine	1	1
Would Always Be Willing To Try Something New	1	1
	100	89

In most cases (83%) patients said that support for CAM by their GP practice influenced their decision to take the treatments offered. Three out of four patients listed comments on the support of their practice for CAM, with 44% of these patients happy to take the advice of either their GP or practice nurse.

Table 6.3 Why did support offered by your GP practice influence your decision to take treatments		
	%	n
Doctor / Nurse Knows Best / Advice	44	75
Had Already Tried It	11	19
Support From GP	11	18
I Could Not Have Afforded Such Treatment	8	13
Better Than / Want To Stop Taking Medication	6	10
Thought It Might Ease The Pain	5	9
Other Treatments Had Not Been Beneficial	3	5
Felt I Should Try It	2	4
Aware Of The Benefits	2	3
I Feel Complementary Medicine Has A Part To Play	1	2
Gave Credibility To The Treatment/Done Research Myself	1	2
Couldn't Travel Bad Mobility	1	2
It Was Good To Be In Your Own Health Centre	1	2
Reassuring That Conventional Medicine Was Incorporating CAM	1	2
Would Never Have Thought About It Had It Not Been Offered	1	1
Wanted The Treatment And This Was A Trial	1	1
Always Been Interested In Alternative Medicines	1	1
You Know It Is Safe	1	1
Nothing More Could Be Done Medically To Help Me	1	2
Leaflets Were Displayed	1	1
Access & Availability	1	1
		169

6.3 REFERRAL TO THE PROJECT

In most cases (90%) patients said that their GP had referred them for treatments, with a practice nurse making the referral in 10% of cases. As was the case with the analysis of the Get Well UK data, musculoskeletal conditions were the main reason why patients had been referred for treatment, with 66% being referred for back, neck or should pain, and 46% being referred for joint problems including arthritis. Similar numbers were referred for conditions associated with stress / tension (32%) and depression (25%).



6.4 PATIENTS BEING SUPPORTED BY GPS

In the majority of cases (89%), patients said that their GP fully supported them getting the treatments, with a similarly high proportion (81%) saying that the reasons for the referral were well explained to them. On the issue of whether or not patients felt that their GP had a good understanding of the treatments, most patients agreed (68%), with 19% recording 'don't know'.

Table 6.4 Patients' Views on Aspects of the Referral Process

	Agree	Neither	Disagree	Don't Know	N
	%	%	%	%	
My GP fully supported me getting the treatments	89	5	1	5	217
The reasons for the referral were well explained to me	81	10	6	4	200
My GP had a good understanding of the treatments	68	9	3	19	205

6.5 PATIENT INFORMATION LEAFLET

In the vast majority of cases (76%) patients remembered receiving by post an information leaflet on the project, with almost all finding this leaflet helpful (99%). One in five (20%) patients felt that they should have been given more information about the treatments they were referred for, with male patients (29%) more likely to hold this view compared with female patients (17%).

6.6 COMPLEMENTARY NATURE OF TREATMENTS

In 59% of cases, patients reported that their GP had told them that the treatments were designed to complement their existing treatments and were not meant to be alternatives to their existing treatments. Twenty two percent of patients (22%) said that their GP had not informed them of the complementary nature of the treatments, with 19% unable to recall if their GP had provided this advice.

6.7 PATIENT VIEWS ON GP MATCHING OF CONDITIONS WITH THERAPIES

Most patients surveyed (64%) felt that their GP knew enough about the different treatments to appropriately match the therapies with their illness or condition, with 9% holding the opposite view and 27% recording 'don't know'. Patients were given the opportunity to explain their answer to this question and their responses are listed in Table 6.5 below.

Table 6.5 Did GP Know Enough About Different Treatments To Match Appropriately with Patient Illness or Condition?

	%	n
GP Agreed / Recommended I Should Try The Treatment	29	39
Explained Fully What Was Going To Be Happening	27	37
Practice Nurse Referral	8	11
Not A Lot Of Info Given/ Didn't Know What Would Be Offered	7	9
I Asked To Be Placed On A Waiting List/Referral	6	8
I Was Given The Most Appropriate Treatment	4	5
Complementary In General Was Suggested - Not The Specifics	3	4
Didn't Discuss It With Me	3	4
GP Had Stated Other Patients Had Benefited	2	3
I Needed To De-Stress	1	2
Little Is Known About Frozen Shoulders	1	1
Never Had Aromatherapy And It Was Wonderful	1	1
No More Treatment To Offer Me	1	2
Written And Diagrams To Do Exercises At Home	1	1
I Presumed He Had Read My Medical History	1	1
At The Time I Was Very Low	1	1
Some Treatments They Seemed To Be Puzzled	1	1
Didn't Need GP's Advice	1	1
GP Not Overly Keen On Referral	1	1
Didn't Think The GP Was Very Aware Of The Program	1	2
GP Keeps An Open Mind And Is Willing To Try Alternatives	1	1
		135

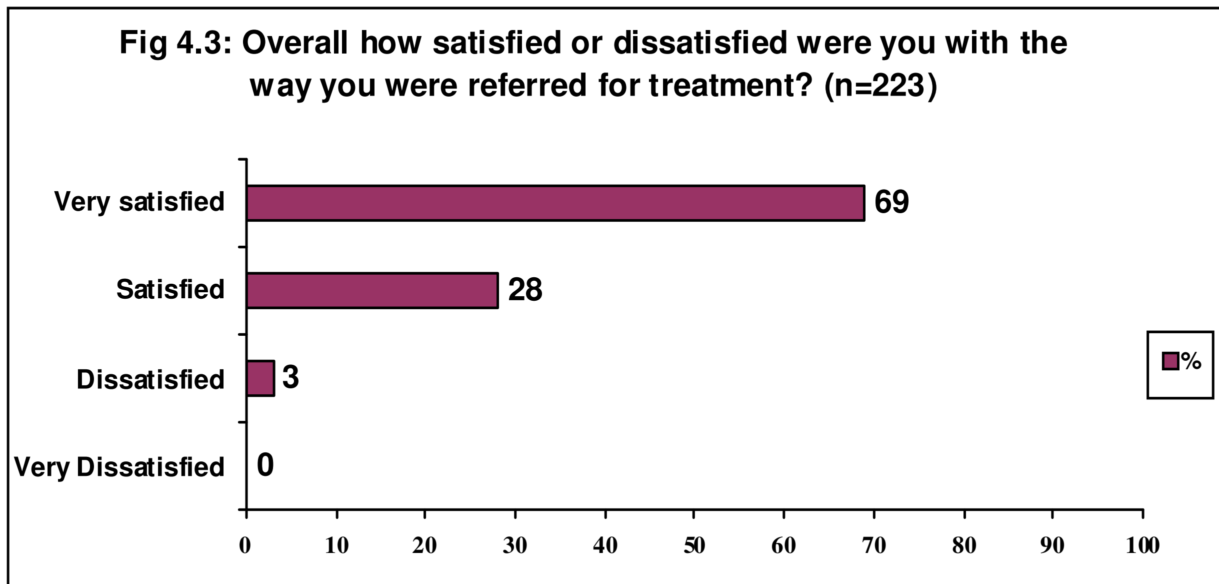
Generally patients were found to be satisfied that the treatments they received were appropriate to their medical condition, with 84% saying that their GP had appropriately matched their illness with a therapy. Just 4% of patients felt that their GP had inappropriately matched their condition with a therapy, with 12% recording 'don't know'.

6.8 PATIENT CONCERNS OR ANXIETIES

Just 8% of patients (n=18) said that they had concerns or anxieties about being referred for complementary therapies, with patients in the younger age groups (under 30, 18%; 30-49, 14%) more likely to have had concerns compared with patients in older age groups (50-69, 3%; 70+, 5%). The main concern, cited by nine patients, related to uncertainty about procedures used by therapists in the treatment of patients, with three patients concerned about how effective the treatment would be.

6.9 PATIENT SATISFACTION WITH REFERRAL PROCESS

Almost all patients (97%) were satisfied with the way they had been referred for treatment, with 69% 'very satisfied' and 28% 'satisfied'. Just 3% were 'dissatisfied'.

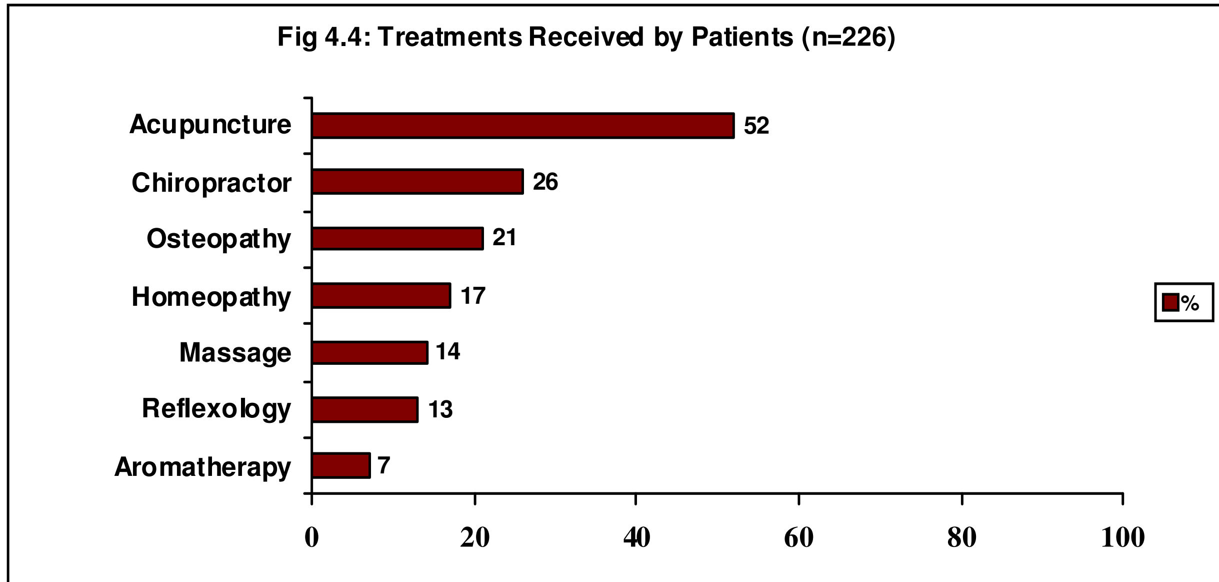


Among the six patients who were dissatisfied with the referral process, three alluded to the ineffectiveness of the treatments, with one saying that their referral had been lost. Other reasons for dissatisfaction included: no information given prior to attending (n=1); and, and not having been given a choice of treatments (n=1).

6.10 RECEIVING TREATMENTS

Following referral, the majority of patients (52%) received acupuncture treatments, with 26% receiving chiropractor treatments and 21% receiving osteopathy treatments.

Fig 4.4: Treatments Received by Patients (n=226)



4.11 NUMBER OF TREATMENT SESSIONS

On average, patients had eight treatment sessions in total, with 47% of patients having had six sessions and 17% having 12 sessions. The survey revealed that those presenting with mental health conditions reported having had a higher mean number of sessions (9 vs. 7), as did patients who had received acupuncture (10 vs. 6) and reflexology (11 vs. 8) treatments.

Most patients (56%) felt that they were offered enough treatment sessions, although a sizeable proportion held the opposite view (44%). There were no statistically significant variations in response to this question by any of the patient subgroups, including health condition or treatment given. In the majority of cases (66%), patients said that they were seen within one month of being referred for treatment.

6.12 PATIENT INTERACTION WITH TREATMENT PRACTITIONERS

Patients expressed an extremely positive assessment of their interaction with CAM practitioners throughout the duration of their treatments, with almost all saying that treatment practitioners: explained in detail what the treatment involved (96%); took sufficient time to find out about the patient's illness or condition (96%); and, that practitioners were courteous and professional (100%). Similarly high proportions of patients said that they were happy to share information on their medical condition with practitioners (99%), had trust and confidence in their practitioner (98%), and were given sufficient time by their practitioner (96%).

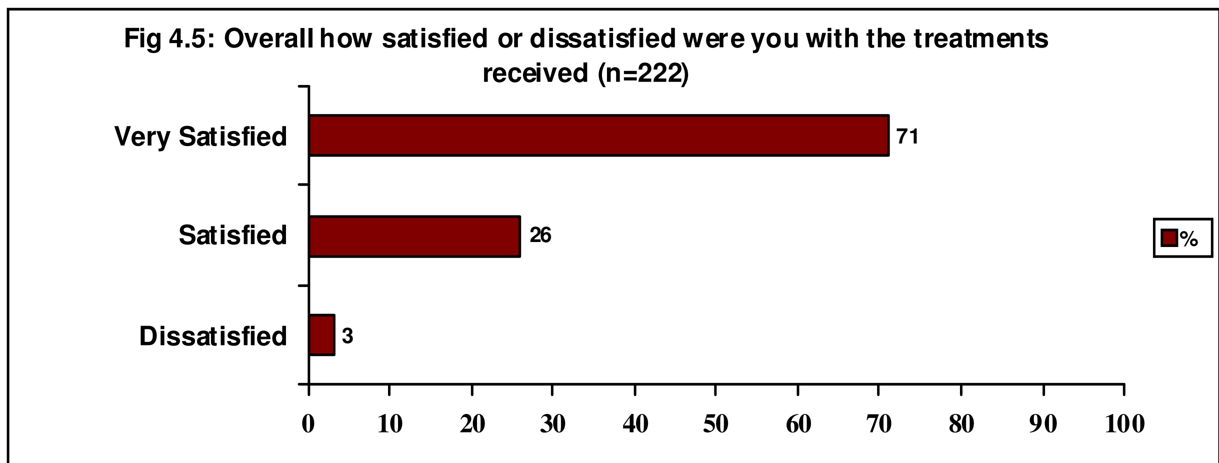
6.13 PRACTITIONERS PROVIDING PATIENTS WITH HEALTH ADVICE

The health promotion / preventative role of practitioners was borne out in the survey with the finding that 87% of patients said that the practitioner gave them

advice on how to manage their condition, with almost all (97%) patients finding the advice helpful and easy to follow (85%). Patients also reported a high level of compliance with their treatment programmes, with 85% saying that they completed all of the sessions / treatments that they were referred to. Among those who were unable to attend all of the sessions, sickness / illnesses was cited as the reason for failing to do so by five patients, with other reasons including: appointment date being unsuitable due to work commitments (n=2); health condition got worse (n=2); forgetting the appointment (n=2); practitioner was ill (n=2); the treatments were unsuccessful (n=2); and, not having the appointment date arrive in the post (n=2).

6.14 OVERALL SATISFACTION WITH TREATMENTS RECEIVED

Overall 97% of patients said that they were satisfied with the treatments they received, with 71% 'very satisfied' and 26% 'satisfied'. Just 3% of patients in the survey (6 patients) were 'dissatisfied' with the treatments they received, with the main reason for dissatisfaction being what they perceived as lack of effectiveness in treating their condition (n=3). One patient was dissatisfied because the treatment in their view was 'too painful', with another patient saying that they 'should have had an x-ray first'.



6.15 IMPROVEMENTS IN PATIENT EXPERIENCE OF GETTING TREATMENTS

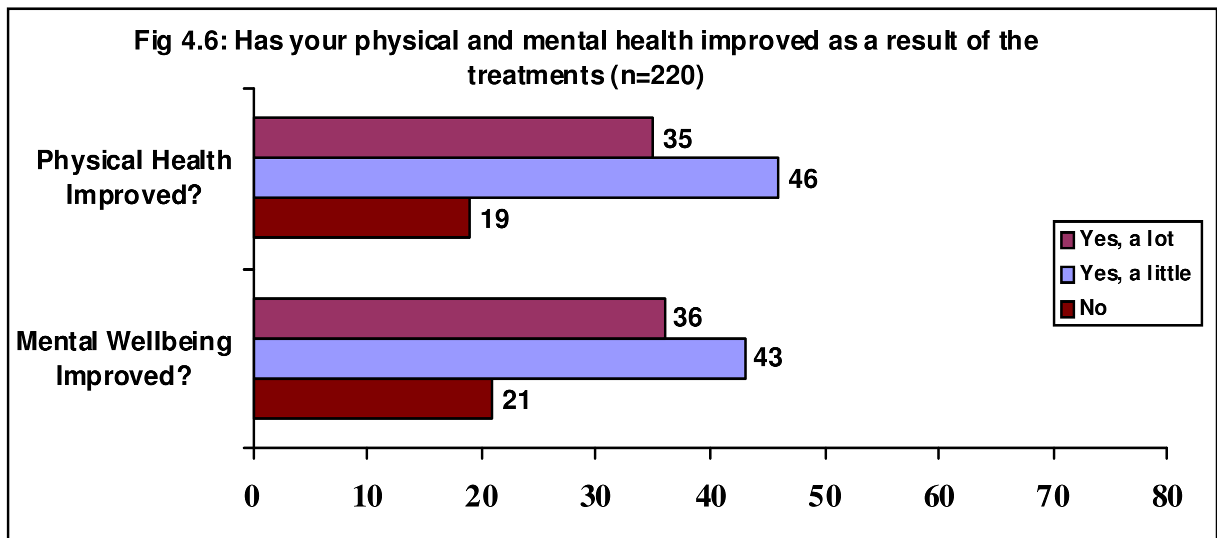
Approximately one in five (21%) patients felt that there were ways that their experience of getting the treatments could have been improved, with six patients calling for further treatments, four suggesting that more time should be allocated to the treatment sessions, and four saying that treatment should be made available as soon as the referral has been made by their GP. A number of other patient suggested improvements are listed in Table 6.6.

Table 6.6 How Could Your Experience Of The Treatments Have Been Improved?

	N
Further Treatments	6
More Time/Longer Sessions	4
Getting Treatment As Soon As Referral Has Been Made By GP	4
More Flexible Treatment Times	3
More Massage	3
Environment Too Noisy	2
Different Treatments Discussed	2
By Checking My Medical Notes	1
More Time To Consult With The Therapist Before And After Treatments	1
Care Taken When Handling Paperwork	1
The Room Was Always Cold	1
A Little Advice On What Suitable Clothing To Wear	1
By An Initial X-ray	1
Triage To Ascertain The More Appropriate Treatment	1
Fitness Class	1
	32

6.16 IMPACT OF TREATMENTS ON PHYSICAL AND MENTAL HEALTH

An important aspect of the patient survey was to get some indication of patient-perceived health outcomes as a result of the treatments received. Given this objective, it is encouraging to find that approximately four out of five patients who availed of the various treatments said that their physical (81%) or mental health (79%) had improved as a result of their treatments. Indeed 84% of all patients said that either their physical health or mental wellbeing had improved as a result of their treatments.



6.17 IMPACT OF TREATMENTS BY PATIENT GROUPS

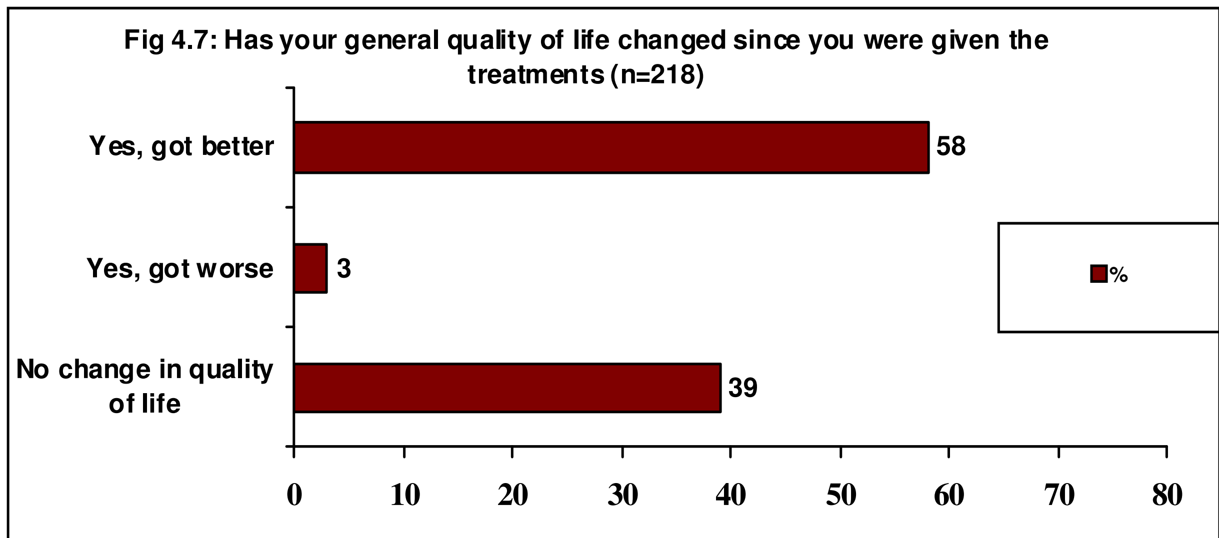
In relation to physical health, those who presented with musculoskeletal conditions were more likely to say that their physical health had improved as a result of the treatments (84% vs. 68%).

Among those patients who presented with mental health related conditions, those who were economically active were more likely to report an improvement in their mental wellbeing following treatment (89% vs. 72%), as were those with a higher level of educational attainment (85% vs. 71%) and owner occupiers (83% vs. 69%).

In relation to an improvement in either physical or mental wellbeing, health outcome was found to be significantly correlated with patient age, with all patients under the age of 30 reporting an improvement compared with 91% in the 30-49 age group, 80% in the 50-69 age group and 77% in the 70+ age group. Also economically active patients were also more likely to report an improvement in either their physical or mental wellbeing (94% vs. 79%), as were patients with a higher level of educational attainment (90% vs. 80%).

6.18 PATIENT PERCEIVED IMPACT OF TREATMENTS ON QUALITY OF LIFE

The survey also found that the majority of patients surveyed said that their general quality of life had improved (58%) since they were given the treatments, with just 3% saying that it had got worse, and 39% saying that their general quality of life has remained unchanged.



As with improved physical and mental wellbeing, economically active patients who availed of the treatments were more likely to say that their general quality of life had improved (75% vs. 50%), with better educated patients also more likely to report an improvement in their general quality of life (67% vs. 46%).

6.19 LEVEL OF PATIENT WORRY POST-TREATMENT

Almost three out of four (74%) patients said that they were less worried about their health as a result of their treatments, with one in four (24%) 'a lot less worried' and 50% 'a little less worried'. Note that there were no differences in response to this question by presenting health condition or treatment.

6.20 PATIENT PERCEIVED OUTCOMES FOLLOWING TREATMENTS

Patients were asked to consider whether a number of specific health outcomes applied to them following their treatments. Table 6.7 shows that the results are extremely positive, with almost seven out of ten (69%) patients reporting an improvement in their symptoms, with approximately six out of ten patients saying that they suffer less pain (62%) and feel as if they have more control over pain (60%). The majority of patients (57%) said that they feel that life is worth living, with 53% better able to get about. At the other end of the spectrum, 41% of patients reported having reduced mood swings, with 43% having improved relationships with other family members. Overall, 94% of all patients surveyed reported at least one of the health outcomes listed in Table 6.7.

Table 6.7 Patient Perceived Outcomes Following Treatments

Patient Perceived Outcomes	Yes	No	Don't Know	
	%	%	%	n
Have seen an improvement in your symptoms	69	23	8	196
Suffer less pain	62	33	5	190
Feel as if you have more control over pain	60	27	13	189
Feel more that life is worth living	57	26	17	172
Are better able to get about	53	36	11	176
Have a more positive outlook on life	50	32	18	182
Feel more in control of your life	50	34	16	175
Are more likely to get out and about	49	36	14	176
Feel more confident	48	38	14	189
Are less likely to worry or feel anxious	46	38	16	181
Have improved relationships with other family members	43	35	22	170
Have reduced mood swings	41	39	21	176
At Least One Of The Above	**94**	**6**	**-**	**227**

6.20.1 PATIENT PERCEIVED HEALTH OUTCOMES BY PATIENT GROUP

Analysis of patient perceived health outcomes by the different patient groupings found a number of statistically significant differences in response to the three most frequent outcomes reported by patients (i.e. improvement in symptoms, less pain; and, more control over pain):

- economically active patients (83% vs. 60%), and better educated patients (76% vs. 59%), were more likely to report an improvement in their symptoms;

- economically active patients (79% vs. 52%), and better educated patients (69% vs. 51%), were more likely to say that they suffered less pain following treatment;

- patients presenting with musculoskeletal conditions were more likely to report less pain compared with patients presenting with non-musculoskeletal conditions (64% vs. 53%);

- patients availing of chiropractor treatments were more likely to report less pain compared with other patients (79% vs. 56%); and,

- economically active patients (68% vs. 54%) were more likely to report having more control over pain following their treatments.

6.21 PATIENT PERCEPTION OF WELLBEING FOLLOWING TREATMENT

A number of additional questions were included in the survey to assess patients' general feelings at three specific points: before they took the treatments; immediately after they took the treatments; and, at the time of the survey (i.e. current level of wellbeing).

For each point in time, patients were asked to rate their responses on a 7 point scale from 0 to 6, with 0 indicating that their feeling of wellbeing was 'as good as it could be' and 6 indicating that their feeling of wellbeing was 'as bad as it could be'. Table 6.8 shows that the proportion of patients giving their general feeling of wellbeing a rating score of 6 ('as bad as it could be'), fell from 23% at the pre-treatment stage, to 4% immediately following treatment, and to 6% in the current survey. Similarly, there has been a significant reduction in the mean general wellbeing score (i.e. improved wellbeing) between the pre-treatment stage and each of the follow-up stages. This statistical pattern is also repeated when median scores are compared between the pre-treatment stage and each of the following up stages. This shows that the improvements in health had been sustained over time.

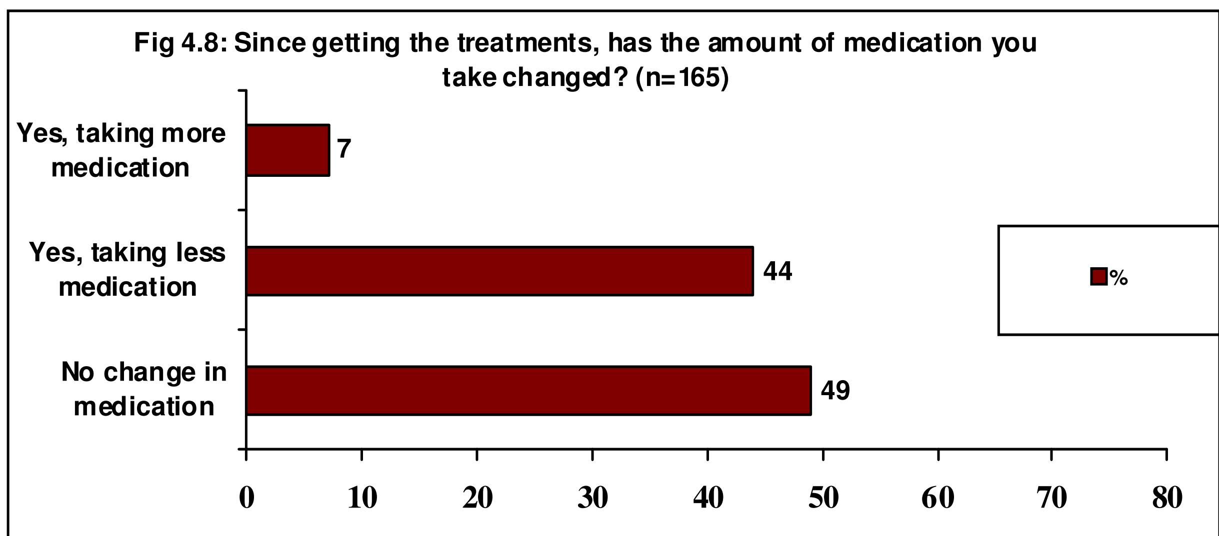
Table 6.8 Patient Rating of their General Wellbeing Before and After Treatment

	Before Treatment	After Treatment	Currently	n
% Scoring 6 'as bad as it could be' ***	23	4	6	213
Mean Scores***	4.36	2.57	2.71	213
Median***	5	3	3	213

* p<=0.05; ** p<=0.01; *** p<0.001

6.22 USE OF MEDICATION

Following treatment, 44% of those who were taking medication prior to their treatment said that they were now taking less medication, with 49% saying there had been no change in the amount of medication they take. Seven percent said that they now take more medication compared with the pre-treatment stage.

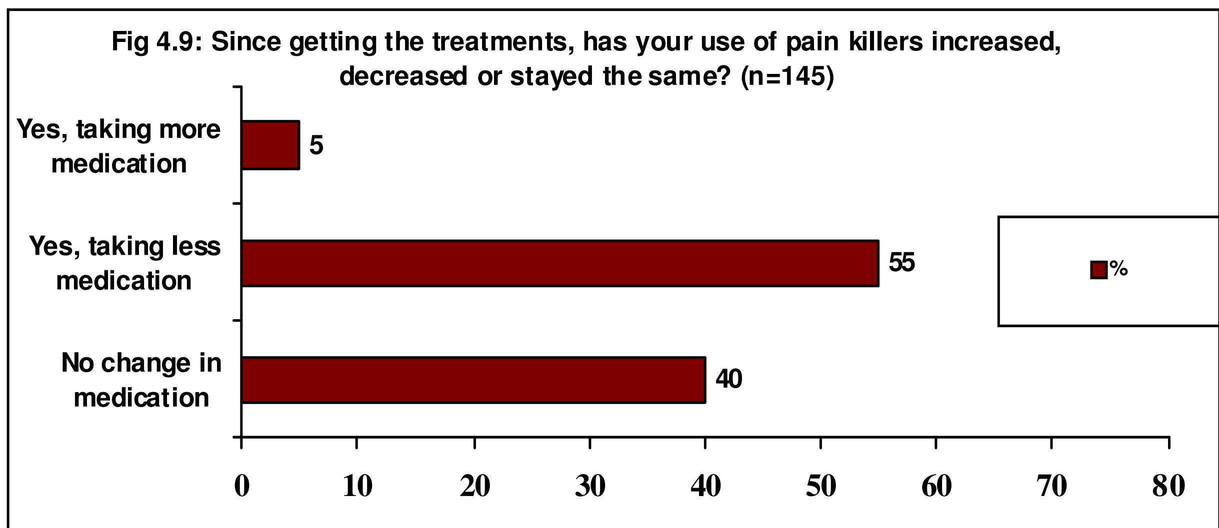


Among those who were using medication prior to their treatments, economically active patients were more likely to report taking less medication following treatment (66% vs. 36%).

6.23 USE OF PAIN KILLERS

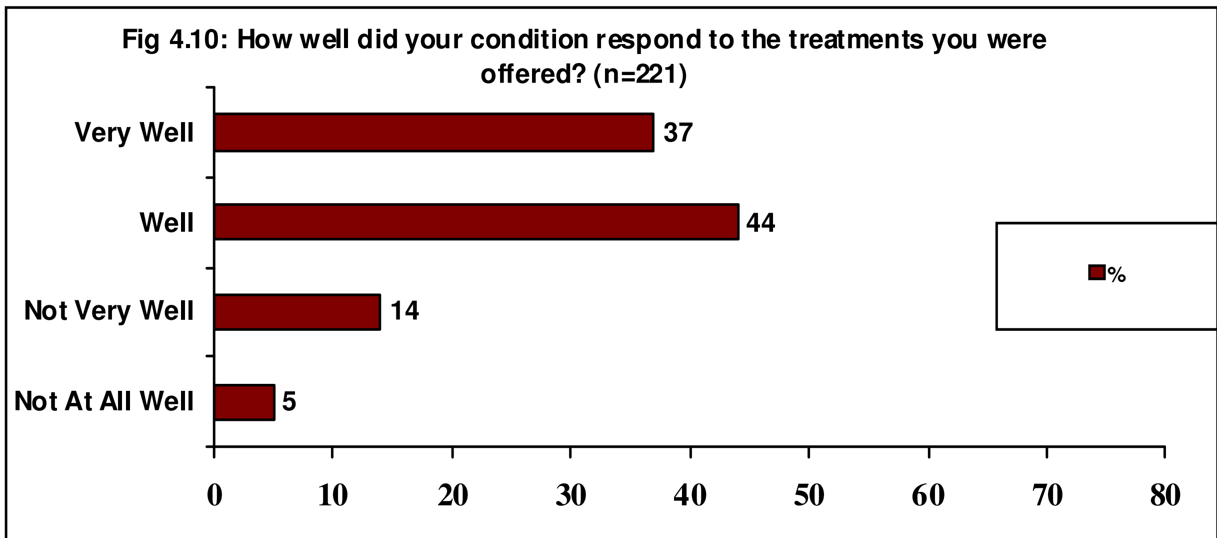
Prior to treatment, two out of three patients (66%) said that they were using pain killers on a regular basis, with a higher level of usage reported by economically inactive patients (74% vs. 54%), those in receipt of benefits (79% vs. 54%), those with no formal educational qualifications (83% vs. 57%), and those who presented with musculoskeletal conditions (71% vs. 46%).

Among patients who were using pain killers on a regular basis at the pre-treatment stage, most (55%) said that they had reduced their usage following treatment, with 44% saying that their use of pain killers had remained unchanged, and 5% saying that their use of pain killers had increased.



6.24 PATIENT PERCEPTION OF THE APPROPRIATENESS OF TREATMENTS

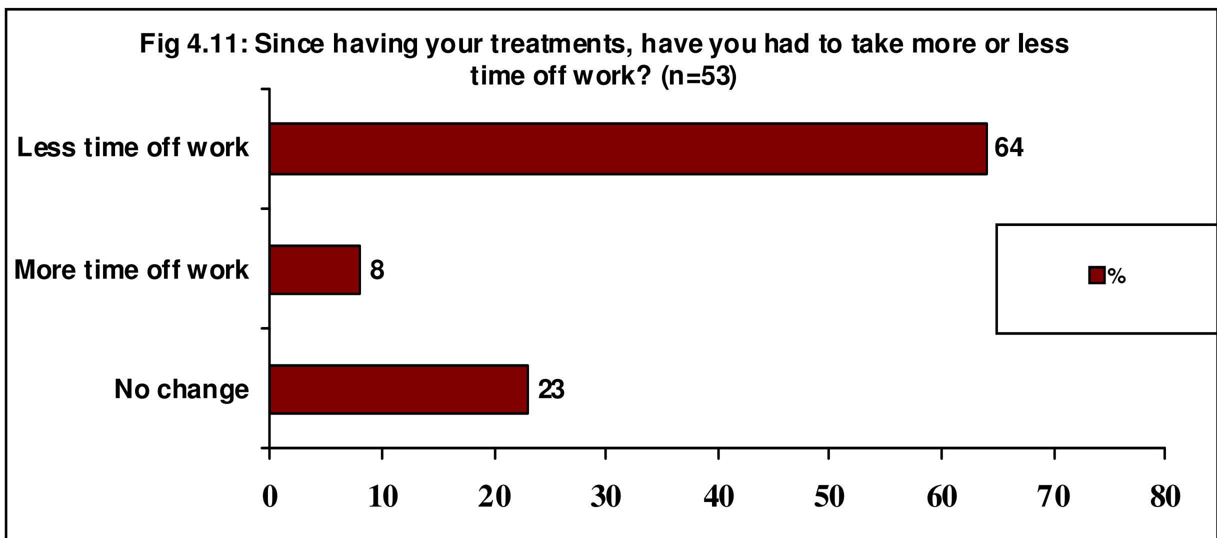
In the vast majority of cases (91%) patients felt that the treatments they were given were appropriate for their condition, with approximately eight out of ten (81%) patients saying that their condition had responded well to the treatments they were offered (‘very well’, 37%; ‘well’, 44%).



Again patients who were economically active were significantly more likely to indicate that their condition responded well to treatment (87% vs. 77%).

6.25 IMPACT OF TREATMENTS ON EMPLOYMENT

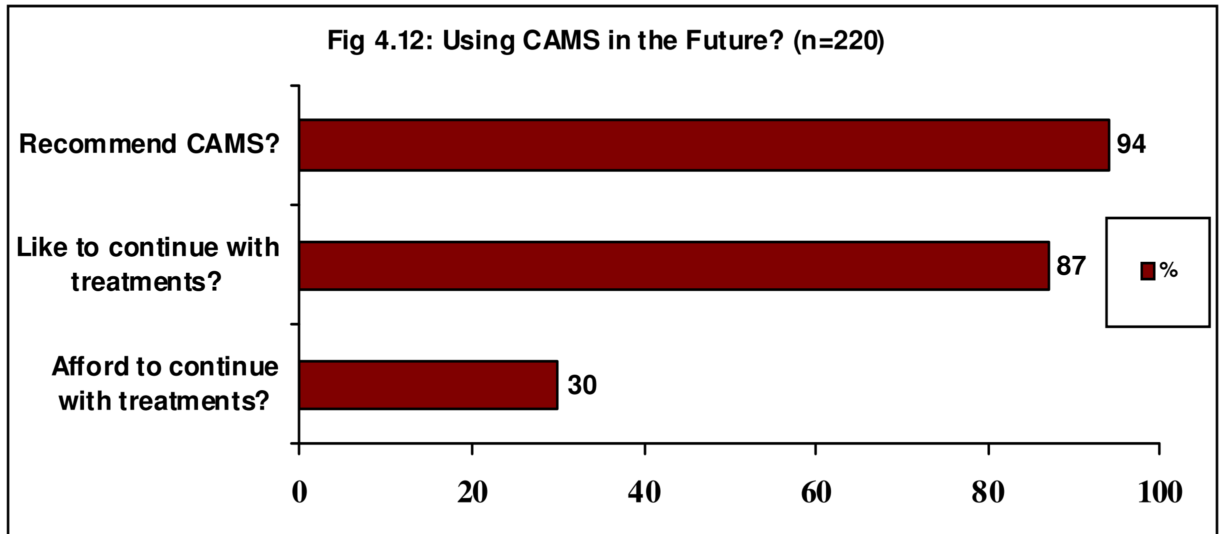
Most of those patients who had a paid job said that their illness or condition meant that they had to take time off work (64%). However following treatment, the majority of these patients (64%) said that they now take less time off work.



Among those not in employment, 16% said that having the treatments had encouraged them to think about going back into employment, with one in ten (10%) of these patients saying it was likely that they would get back into employment within the next 12 months.

6.26 USING COMLPEMENTARY THERAPIES IN THE FUTURE

Overall, 94% of patients said that they would recommend Complementary and Alternative Medicines (CAM) to other people with the same health problem as themselves. This response was consistent across all of the patient groups (i.e. age, sex, educational attainment level etc), and all health conditions and therapies.



Patient interest in continuing with CAM was high (87%), with patients presenting with musculoskeletal conditions more likely to express an interest in continuing with treatments (86% vs. 89%), as did patients who availed of reflexology (97%), compared with other treatments (81%).

Figure 6.12 also shows that just 30% of all patients said that they would be able to afford to continue with treatments, with those in receipt of state benefits less likely to say that they would be able to afford future treatments (22% vs. 39%).

6.27 PATIENT INTERACTION WITH GPS

The survey also sought to assess whether or not patients had discussed the impact of their treatments with their GP, with 40% of patients having done so. Patients presenting with mental health problems rather than musculoskeletal conditions (49% vs. 34%), were more likely to have discussed the impact of the treatments with their GP as were those registered with the Derry practice (48%) rather than the Belfast practice (35%).

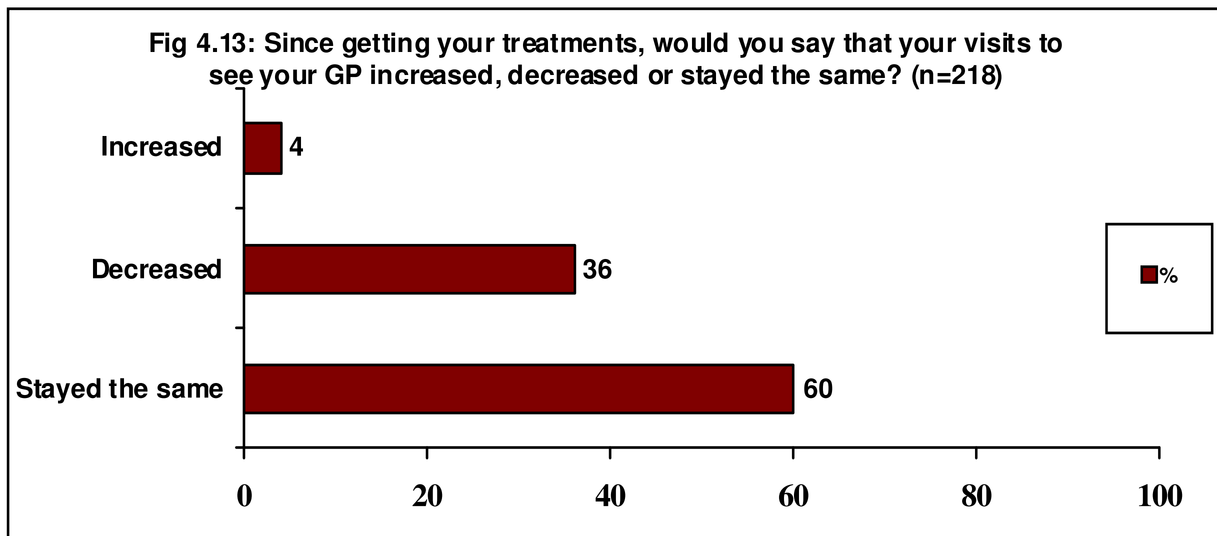
Patients were also asked to comment on their GPs' reactions to the treatments or general project. Excluding those patients who recorded 'don't know', 99% of patients said that their GP's reaction had been positive, with just 1 patient saying that their GP's reaction had been negative. A total of 23 patients listed comments on their GP's reaction to the project, with 13 saying that their GP had asked them how they felt, with 19 saying that their GP had been supportive of their treatments.

Table 6.9 Patient Views On The Reaction Of Their GP To The Treatments Or General Project		
	%	n
Been Asking Me How I Felt	22	13
GP Supported The Treatment	19	11
GP Encouraged/Referred Me To Go For More Treatment	7	4
The Amount Of Medication Would Reduce	5	3
During The Treatment I Felt Great	3	2
Getting Some Pain Relief	3	2
A General Impression	2	1
GP Has Recommended My Husband For Treatment	2	1
Pleased To See Me Trying More Things	2	1
Pleased The Treatment Worked/Benefit	40	23

Among those who had not discussed the impact of the treatments with their GP, most (55%) would have welcomed the opportunity to have done so.

6.28 IMPACT OF TREATMENTS ON USE OF GP SERVICES

Following treatment, more than a third (36%) of patients said that their visits to see their GP had decreased, with 4% saying that their frequency of visits had increased, and 60% recording no change. Note that there were no significant differences in frequency of patient visits to see their GP between patient groups.



6.29 IMPACT OF TREATMENTS ON USE OF OTHER HEALTH SERVICES

Among patients who previously used a range of other health services, approximately one in five (19%) reporting using other primary care services (e.g. practice nurse, pharmacy etc) less often, with 11% using hospital services less often, and 14% using A&E services less often.

Table 6.10 Patient Use of Services Since Getting Treatment					
Use of Services Since Getting Treatment	Less Often	More Often	No Change	Don't Know	n
	%	%	%	%	
Other primary care services (e.g. practice nurse, pharmacist etc)	19	3	74	5	168
Hospital Services	11	4	76	10	143
A&E Services	14	1	76	9	78

Overall 24% of service uses (i.e. other primary care, hospital services or A&E services) said that they had used these services less often since availing of the treatments, with younger patients using these services less often compared with other age groups (30-49, 31%; 50-69, 23%; and, 70+, 3%).

Patients using health services prior to their treatment, and who indicated using such services less often, were more likely to be economically active (32% vs. 18%), have dependents (36% vs. 18%) and have a higher level of educational attainment (30% vs. 16%).

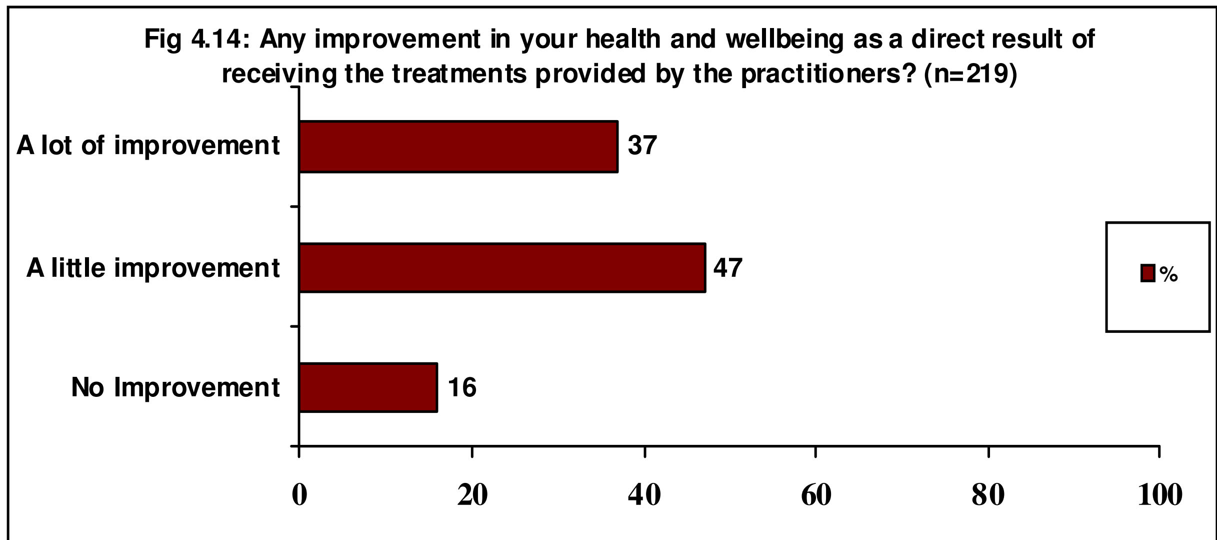
6.30 PATIENT PERCEPTION OF MOST IMPORTANT BENEFIT OF CAM

Sixty percent of patients listed what they felt was the single most important benefit from receiving CAM, with pain relief cited by 43% of patients and reduced stress cited by 10% of these patients.

Table 6.11 Patient Perceived Single Most Important Benefit of CAM (n=137)		
	%	n
Pain Relief	43	59
Less Stress/More Relaxed/Mental Well Being	10	14
More Mobility/Flexibility	9	13
Overall Well Being	9	13
Someone To Talk With And Listen	8	11
No Lasting Benefit/No Benefit	5	7
Great Advice	3	4
Sleeping Better	2	3
Find It Easier To Sleep	1	2
May Have Slowed Down The Deteriorations Of My Spine	1	1
Posture	1	1
Physical Health	1	1
To Get Me Out Of The House	1	1
Able To Eat Properly	1	1
More Energy	1	1
Positive Outlook	1	1
I'd Found A Treatment That Works	1	1
Try A Range Of Therapies	1	1
Hopefully Greater Success With IVF	1	1
No Medication	1	1
	100	137

6.31 PATIENT PERCEIVED IMPROVEMENT IN HEALTH AND WELLBEING

More than eight out of ten (84%) patients said that there had been an improvement in their health and wellbeing as a direct result of receiving the treatments provided by practitioners (‘a lot of improvement’, 37%; ‘a little improvement’, 47%).



6.32 IMPROVEMENTS IN PATIENT EXPERIENCE OF PROJECT

Approximately one in five (19%) patients surveyed said that their experience of the project could have been improved, with 43% of these patients calling for further treatments. Other suggested improvements included: having treatments which would be of most benefit (9%); longer sessions (5%); and, providing sessions according to need (5%).

Table 6.12 Patient Suggestions on How Project Could Have Been Improved

	%	N
Further Treatment	43	19
Choose The Treatment I Believe Would Benefit Me Most	9	4
Longer Sessions	5	2
Sessions Should Be Given According To Need	5	2
Should Be Available All The Time	5	2
Treat More Than One Condition	5	2
Less Waiting Time Between Referral And First Treatment	5	2
Better Appointment Times	5	2
No Judgement On Patients	2	1
Referred Sooner	2	1
A Warmer Room	2	1
Practitioners Arriving On Time	2	1
Less Noisy Environment	2	1
Follow Up With Practitioner	2	1
An Initial X-ray	2	1
Showing More Concern For Your Condition	2	1
Initial Interview With Someone Who Would Discuss Best Mix Of Treatments	2	1
	100	44

7 SURVEY OF GPS

This section of the report presents the finding from a survey of GPs who participated in the project. Of the 31 GPs who participated in the project, 12 completed and returned a questionnaire within the survey fieldwork period. This represents a response rate of 34%.

7.1 GP UNDERSTANDING OF CAM

GPs were asked to rate their understanding of different Complementary and Alternative Medicines (CAM) prior to their involvement in the project. GPs scored their understanding of the various CAM on a scale from 1 (excellent) to 5 (very poor), and Table 7.1 shows that relative to the other therapies, GPs reported having a better understanding of acupuncture (3.00) and a poorer understanding of reflexology (3.67).

Table 7.1 GP Understanding of Different CAM

Therapy	Excellent	Good	Fair	Poor	Very Poor	Mean
	n	n	n	n	n	
Acupuncture		4	4	4		3.00
Massage		2	5	5		3.25
Osteopathy			8	4		3.33
Aromatherapy		1	6	4	1	3.42
Chiropractic			7	5		3.42
Homeopathy		1	5	5	1	3.50
Reflexology			4	8		3.67

Three quarters of GPs (n=9) said that their experience of the project had helped improve their understanding of CAM, with two GPs saying that their understanding had improved ‘a lot’ and seven saying that their understanding had improved ‘a little’.

7.2 GPS GETTING INVOLVED IN THE PROJECT

GPs listed a number of reasons why they got involved in the pilot project with two seeing the potential for improving patient wellbeing, and another two saying that the decision to get involved had been taken at the practice level with no input from themselves. Other reasons as to why GPs got involved in the project included: the explanation from Get Well UK; the potential of the service in benefiting patients; to assess evidence for the use of such treatments; a quick and easy service accessible to patients; a recognition of complementary medicine as an alternative treatment; and, because of a long waiting list to access psychiatric support services.

7.3 GP CONCERNS OR ANXIETIES ABOUT GETTING INVOLVED

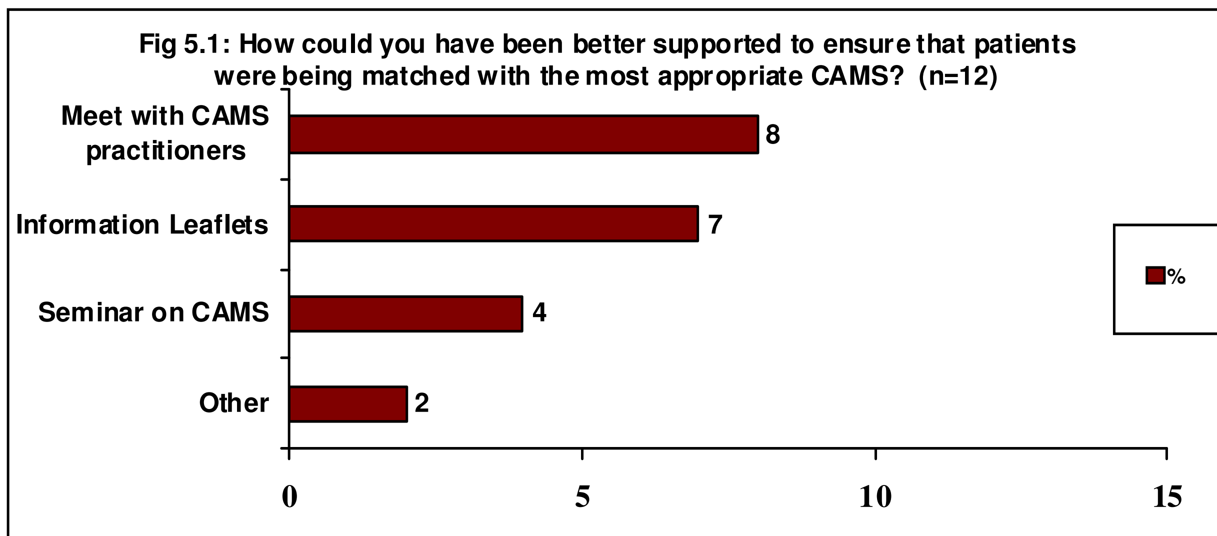
Just two out of the 10 GPs surveyed had initial concerns or anxieties about referring their patients for CAM treatments, with one concerned about the benefits of reflexology and another expressing general concerns about the likely benefits to patients.

7.4 GPS MATCHING PATIENT CONDITIONS WITH THERAPIES

When referring patients for CAM, five of the GPs (42%) said that they had difficulty in matching patient illnesses / conditions to the appropriate therapies available, with one GP struggling with referrals to chiropractic / osteopathy treatments. One of the GPs felt that lack of education on the scope of the various treatments had caused some initial difficulties, with another saying that the referral form did not allow for a 'broad spectrum of complaints' to be listed. Other comments by GPs included: being unsure of what treatments should be assigned to patients, and the need for more choice of treatments for patients.

7.5 SUPPORT FOR GPS

GPs were given an opportunity to say how they could have been better supported to ensure that their patients were being matched with the most appropriate CAM. Of the 12 GPs, most (n=8) said that a meeting with the CAM practitioners would have been helpful, with seven suggesting that information leaflets would be a helpful support. Other suggestions included having a seminar on CAM, and a mix of meetings with CAM practitioners, leaflets and seminars.



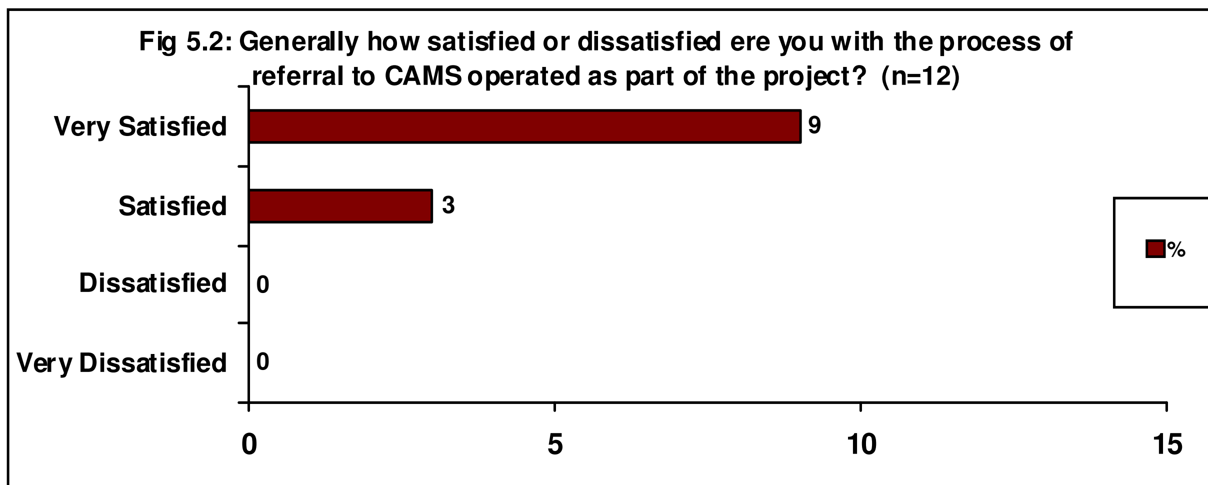
According to the GPs surveyed, most (n=8) said that they were more likely to refer patients with chronic medical conditions, with just one GP saying that they were more likely to refer patients with acute medical conditions. The remaining three GPs referred patients with both chronic and acute conditions.

7.6 PATIENT RECEPTIVENESS TO CAM

All of the GPs said that their patients were receptive to their suggestion to try alternative therapies, with 10 saying patients were 'very receptive' and two saying their patients were 'somewhat receptive'. Three out of the 12 GPs said that they had some patients who declined their invitation to avail of CAM treatments, with these GPs estimating that 10% or less of their patients had declined. According to these GPs, the main reason why these patients declined the opportunity to avail of CAM was 'general scepticism' (n=2), and 'fear of the unknown' (n=1).

7.7 GP SATISFACTION WITH THE REFERRAL PROCESS

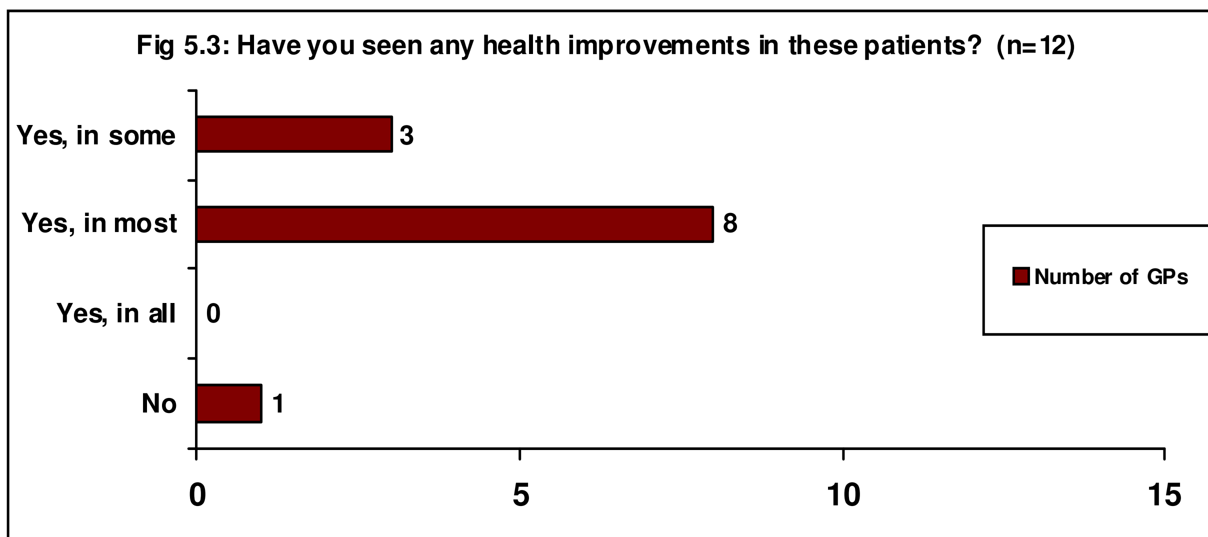
All of the GPs survey said they were satisfied with the process for referral to CAM which operated throughout the life of the project.



One GP believed that the referral process could be improved by including more options for treatment on the referral form.

7.8 GP PERCEIVED IMPACT OF CAM ON PATIENTS

On average, GPs said that they had referred 33 of their patients for CAM, with almost all (92% or 11 GPs) reporting an improvement in the health status of their patients. Among the GPs who had recorded a health improvement in their patients, on average these GPs said that they had seen a health improvement in 63% of their patients.



Of the various complementary therapies available, five of the GPs felt that patients with chronic conditions achieved better health outcomes, with two GPs saying that health outcomes had been better for acute conditions. Two GPs felt that health outcomes had been good for patients presenting with both chronic and acute conditions, with the final two GPs unsure which health conditions benefited most from the treatments.

GPs were also asked to comment on their perception of health outcomes by therapy, with 11 of the view that acupuncture had produced good health outcomes for their patients. Six GPs said that health outcomes had been good for patients availing of homeopathy, chiropractic and osteopathy treatments.

Table 7.2 GPs Views on Which Complementary Therapies Have Produced the Best Outcomes

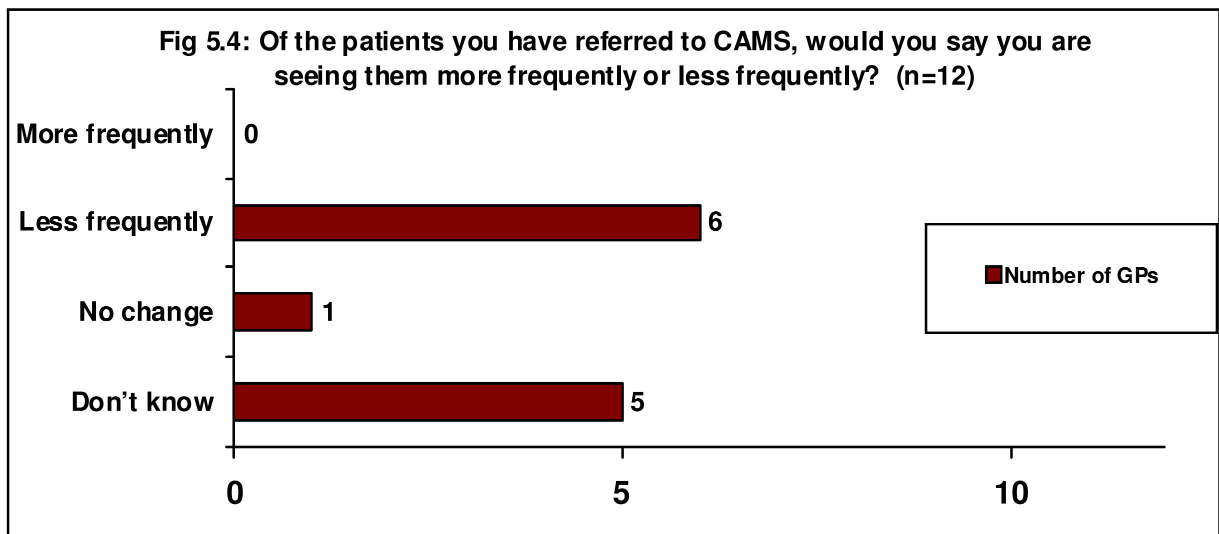
	n
Acupuncture	11
Homeopathy	6
Chiropractic	6
Osteopathy	6
Aromatherapy	3
Massage	3
Reflexology	-

7.9 GP PERCEPTION OF PATIENT COMPLIANCE WITH TREATMENTS

In terms of compliance, GPs felt there was little difference between patients with chronic or acute medical conditions, with 11 of the GPs saying that compliance had been *'excellent'* or *'good'* among their chronic patients, with 10 of the 12 GPs saying the same about their patients with acute conditions.

7.10 SEEING PATIENTS FOLLOWING THEIR CAM TREATMENTS

Half of the GPs surveyed said that they were seeing less of their patients who had been referred for CAM, with one GP saying there had been no change and 5 recording 'don't know'.



7.11 PATIENT BENEFITS FROM THE TREATMENT

All but one of the 12 GPs said that their patients had benefited from the therapies, with nine GPs listing what they felt have been the key benefits to their patients: improved mood / general wellbeing (n=3); satisfaction with treatment (n=2); patients being empowered to deal with their symptoms (n=2); and, having access to treatments which most would have been unable to afford.

Table 7.3 GP Perceived Benefits to Patients

	n
Many Had Improved Mood/General Wellbeing	3
Satisfied With Treatment	2
Most Felt Empowered To Deal With Symptoms	2
Most Would Not Have Been Unable To Afford It Privately	2
Almost All Enjoyed The Experience	1
Able To Have A Non-Pharmacological Treatment	1
Reduction In Medication	1
Better Understanding That It Will Take Time To Improve	1
Easy Access To Treatment	1
Time Spent With Therapist	1
Better Coping Skills	1
Offers Alternative Treatments	1
Seen Quickly	1

7.12 PATIENT USE OF MEDICATION

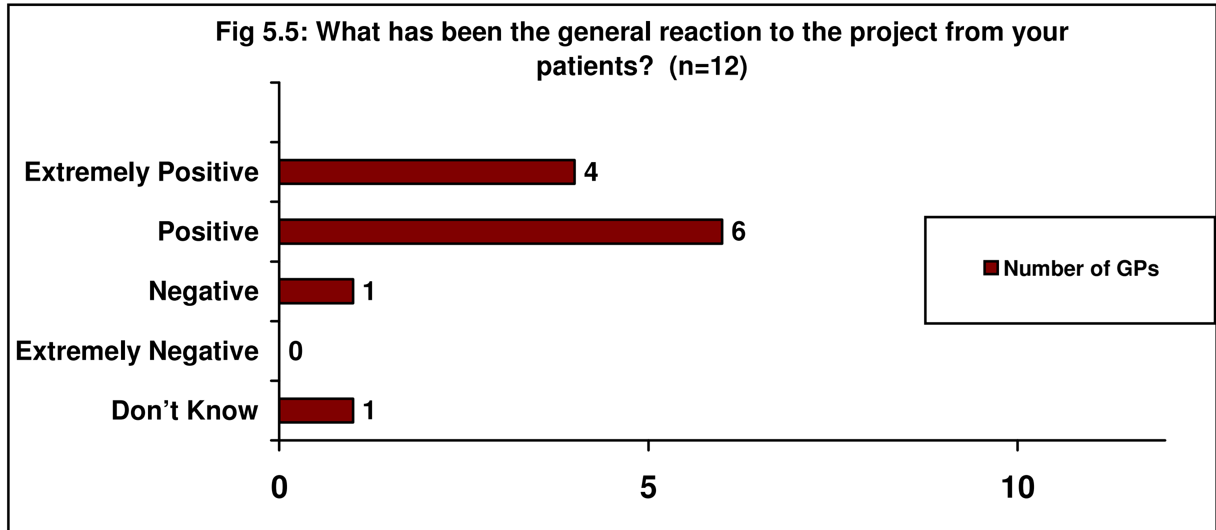
The survey also sought to gain some insight into whether or not the CAM treatments had led to any reductions in patient use of medication. With regard to patients with chronic conditions, four of the GPs said that they were prescribing less medication to these patients, with a similar number (n=4) of GPs prescribing less medication to patients with acute conditions.

Overall, half of the GPs indicated prescribing less medication to patients with either chronic or acute medical conditions, with four of these GPs saying that they have prescribed less medication to more than half of their patients who availed of the therapies and two saying that they are prescribing less medication to between 25% and 50% of their patients.

Six GPs said that patients themselves have said that they need less medication following the therapies, with most (n=4) of these GPs estimating that between 25% and 50% of their patients having indicated to them a need for less medication.

7.13 PATIENT REACTION TO THE PROJECT

According to GPs (n=10), patient reaction to the project has been positive with just one GP saying that patient reaction has been negative another GP 'unsure'.



GPs identified a number of reasons why their patients had found the project a positive experience such as: an appreciation of the therapists' time and skills; it was an opportunity to have the treatments; the patients were more involved in their treatments; and, general positive feedback from patients. The only negative comment from one of the GPs referred to the 'excessive cost' of running the project.

7.14 PATIENTS CONTINUING WITH TREATMENTS

Most of the GPs (n=9) said that they had patients enquiring about continuing with the treatments beyond the pilot project, with all of these GPs saying that they were supportive of their patients in this regard.

7.15 IMPACT ON PROJECT ON GENERAL PRACTICE

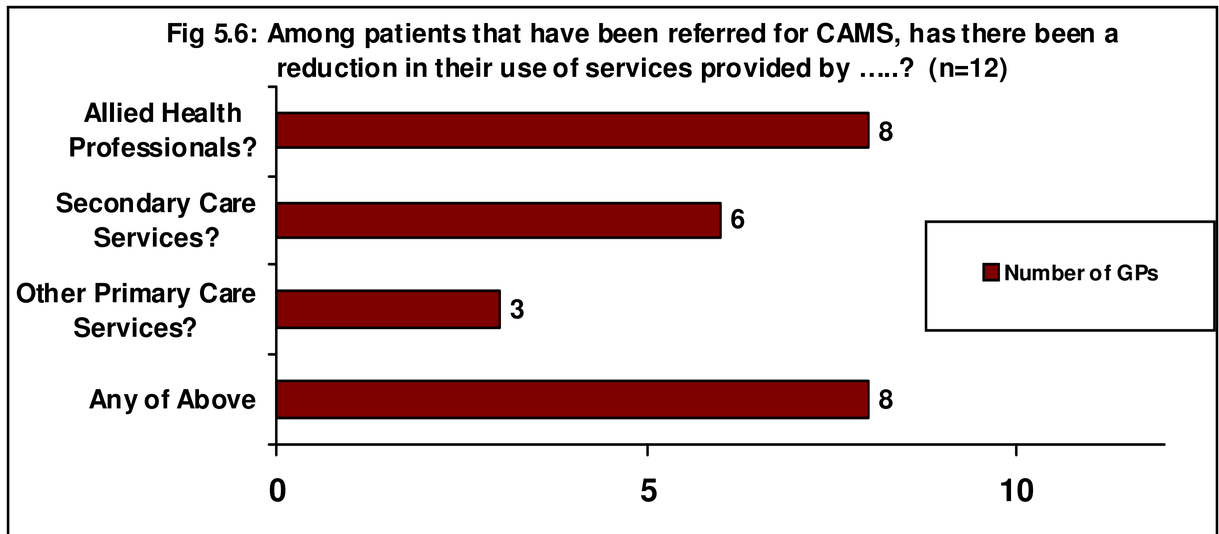
Half of the GPs surveyed (n=6) said that having the option of referring their patients to CAM as part of the pilot project had reduced their workload ('a lot', n=1; 'a little', n=5), with 3 patients saying that their workload had not been reduced. A further three GPs recorded 'don't know' to this question.

Just two out of the twelve GPs said that there had been a financial saving to their practice as a result of offering their patients CAM treatments. GPs were asked to explain their answer to this question, with one GP saying that they did not record the amount of medication used. Other comments included: 'patient's wellbeing is not easily quantified in economic terms'; 'would have referred on to other agencies or tried different medications'; 'finance not an issue at present'; 'I don't deal with practice finance'; and, 'same problem, same patient'.

Eleven out of the 12 GPs agreed that the pilot project had provided them with more options for treating their patients, with the same number of GPs (n=11) identifying the pilot project as a positive development for their practice.

7.16 GP's VIEWS ON USE OF SERVICES BY PATIENTS

Most of the GPs surveyed (n=8) reported that following treatment, their patients were less likely to use services provided by Allied Health Professionals (e.g. physiotherapy, occupational health, dieticians etc) with six GPs reporting that their patients were less likely to use secondary care services. Three of the GPs reported a decline in patient use of other primary care services (e.g. practice nurse, pharmacists etc) following CAM treatments.



7.17 CHANGE IN GP PERCEPTION OF CAM

After taking part in the project, 10 out of the 12 GPs said that they now have a more positive view of the potential for CAM within Primary Care, with all wishing to continue with the option of being able to refer their patients to CAM. Ten out of the 12 GPs said that they would be likely to recommend CAM to other colleagues, with nine GPs saying that they now have a more positive view of CAM. Just one GP said that their view of CAM has become more negative, with another saying that their view of CAM has remained unchanged.

7.18 GPS VIEWS ON INTEGRATING CAM INTO PRIMARY CARE

There was a high degree of support among GPs for the integration of CAM with Primary Care (n=9), with the following comments made in support of this: 'acupuncture, osteopathy and chiropractics definitely have a role [in Primary Care]'; 'very helpful for chronic conditions; allows other treatment opportunities; definite impact on patients who were referred in a very positive way'; 'beneficial to patients'; and, 'another option for treatment'. The single GP who advised against integrating CAM into Primary Care felt that CAM is '…unproven, expensive therapy'.

7.19 GP VIEWS ON PROJECT STRENGTHS

GPs were asked to identify what they believed to be the key strengths of the pilot project. Five of the GPs cited plentiful appointments / reducing waiting lists as a key strength, with three GPs commenting on the good organisation of the project and good communication. Other points made by GPs are listed on a verbatim basis in Table 7.4.

Table 7.4 GP Views on Key Strengths of Pilot Project	
	n
Plentiful Appointment To Keep Waiting List Down	5
Well Organised/Good Communication	3
On-Site Therefore Direct Contact With Practitioners	2
Efficiency	1
Pleasant People	1
Enjoyed The Experience	1
Most Would Have Been Unable To Afford It Privately	1
Some Had Measurable Health Benefits	1
Diversity Of Treatments	1
Regular Reviews	1
Time Spent With Therapist	1
Alternative/Optional Treatments	1
Excellent Therapists	1
Beneficial To Patients	1
Greater Patient Choice	1
More Therapeutic Options	1
Support For Patients With Psychological/Physical Problems	1
Ease Of Use	1

7.20 GP VIEWS ON PROJECT WEAKNESSES

As with benefits, GPs were also given an opportunity to identity what they felt were the main weaknesses of the project. A number of points were made, including a lack of opportunity to assess outcomes, lack of feedback on the project and a lack of knowledge among GPs themselves (Table 7.5).

Table 7.5 GP Views on Main Weaknesses of Pilot Project	
	n
Lack Of Opportunity To Assess Outcomes	2
Would Have Liked Feedback	2
Lack Of Knowledge On My Part	2
That It Ended	1
Not Great Communication With Therapists	1
Still Not Convinced By Homeopathy/Reflexology	1
Limitation Of Treatment Times	1
Requests For X-Rays & Scans	1
Need To Re Refer To C/W Treatments	1
Assessment Form - Poor Format	1
Only Pilot - Needs To Be Carried On	1
Patients May Benefit From Different Therapies	1
Most Need 2 Courses Of Treatment	1
Cost	1
Unproven Outcome	1

7.21 GP SUPPORT FOR CAM IN THE FUTURE

Finally, 11 of the 12 GPs said that if funding were available, they would continue to refer their patients to CAM. Half of the GPs felt that they could be better supported to further explore the potential of CAM for their patients, with suggestions including regular meetings with practitioners, regular updates and more learning days. Other comments by GPs included: ‘this is an excellent service which should be continued’; ‘a useful project’; and, ‘the need for a better feedback form for GPs’.

8. SURVEY OF PRACTITIONERS

This section of the report details the outcomes from a survey of CAM practitioners who provided a range of treatments to patients. All 16 practitioners were surveyed, with 12 completing and returning their questionnaire within the survey fieldwork period. This equates to a response rate of 75%.

8.1 GETTING INVOLVED IN THE PROJECT

Of the 12 practitioners, five (42%) were recruited directly to the project by Get Well UK, with four (33%) recruited via another CAM practitioner and one practitioner reading about the project in the media. Two practitioners had been involved in developing the pilot project.

8.2 CONCERNS OR ANXIETIES ABOUT GETTING INVOLVED

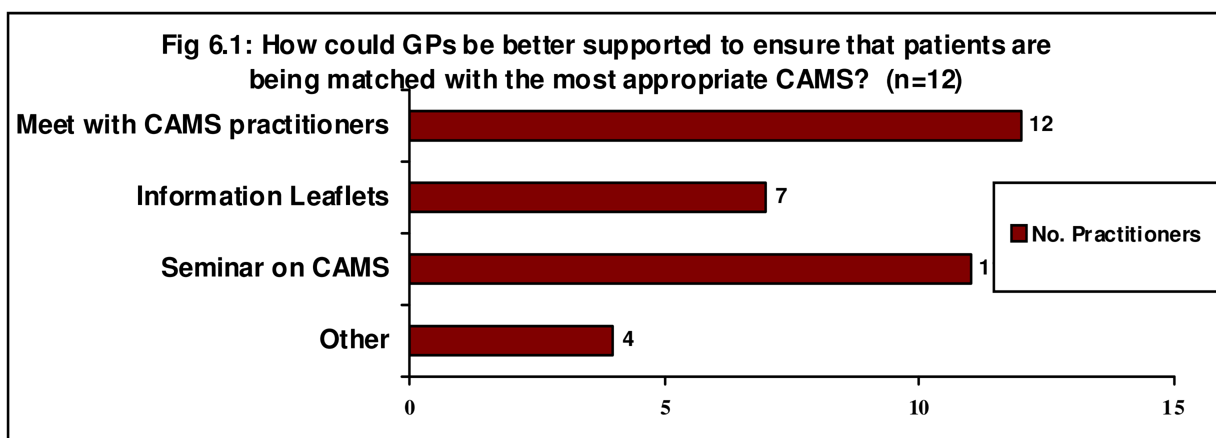
Five of the practitioners (42%) had initial concerns or anxieties about getting involved in the project, with two practitioners concerned about the general attitude of GPs towards CAM and the project itself. Other concerns related to: 'poor patient take-up of the treatments given that they were free'; 'the project should have been run from within Northern Ireland'; and, that some GPs 'would dump their awkward or chronic patients into the service'.

8.3 REFERRAL OF PATIENTS

Over the course of the pilot project, almost all of the practitioners felt that GPs were appropriately matching medical conditions with the treatments available, with three practitioners saying that this was the case *'some of the time'* and eight saying that this was the case 'most of the time'.

8.3.1 PRACTITIONER VIEWS ON MATCHING PATIENTS WITH THERAPIES

Most of the practitioners agreed that GPs matching of patients improved as the pilot project progressed (n=10), with practitioners saying that GPs could be better supported by meeting the practitioners and through the use of seminars on CAM. Leaflets on CAM were also deemed to be a useful support for GPs, with one practitioner saying that GPs should be provided with the opportunity to sit in on consultations. Other practitioners suggested that GPs be encouraged to attend meetings, and to avail of CAM therapies themselves.



8.3.2 PRACTITIONERS BEING PROVIDED WITH PATIENT INFORMATION

Less that half (n=5) of the 12 practitioners (42%) felt that they were being provided with enough information on patient history when patients were being referred, with most (n=7) holding the opposite view. In relation to patient type, almost all (n=11) practitioners felt that GPs were more likely to refer patients with chronic conditions to their service, with four practitioners saying that these patients were not responding or improving using conventional medications. All of the practitioners found that patients were willing to share their medical history with them.

Table 8.1 Practitioner Views on Why GPs Were Referring Mainly Patients with Chronic Conditions

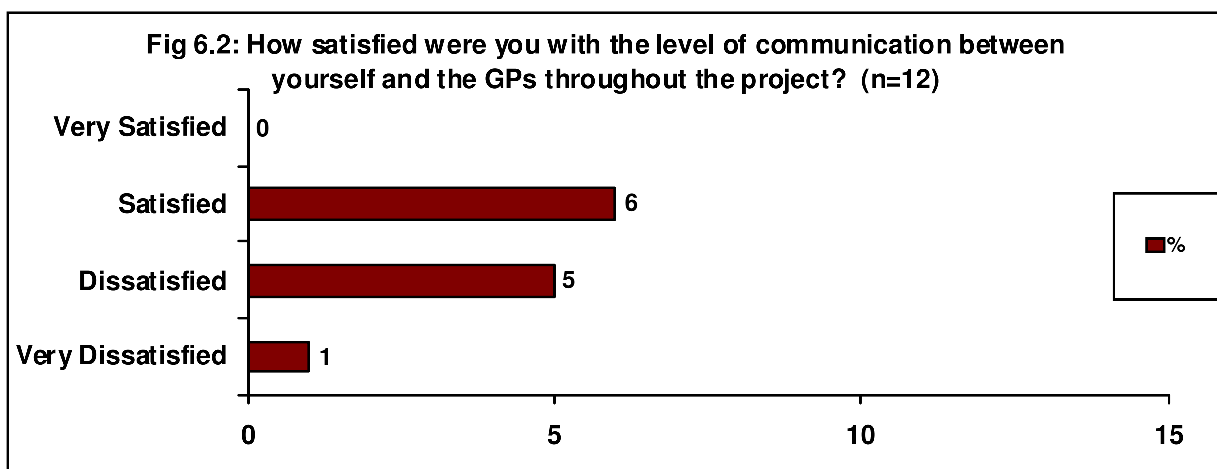
	n
These Patients Were Not Improving On Conventional Medications	4
To Try To Help Patient When Other Treatments Had Failed	1
GPs Discussed The Option Of Cam With Patient Whether Acute Or Chronic	1
There Are Know Effectiveness Gaps In The Conventional Medical Treatments	1
The Number Of Chronically Ill Patients Is A Huge Burden On The GP	1
Patients /GPs Fed Up Not Making Any Break Through In Their Health	1
In Most Instances Homeopathy Had Not Fully Addressed Nor Relieved Symptoms	1

8.3.3 PATIENTS BEING GIVEN SUFFICIENT INFORMATION BY GPS

Less than half of the practitioners (n=5) felt that patients being referred to them had been given sufficient information by their GP, with most practitioners (8 or 66%) saying that patients had concerns or anxieties about their treatments, most of which related to a lack of understanding of what the treatment involved. Other patient anxieties cited by practitioners included: fear of needles; having to undress; ineffectiveness of the treatment; and, lack of time given to them by their GP.

8.4 PRACTITIONER VIEWS ON COMMUNICATION WITH GPS

On commenting on the level of communication with GPs throughout the project, six practitioners said they were satisfied, five were dissatisfied and one was very dissatisfied. Among those practitioners who were dissatisfied, four said there was little or not communication with GPs, with one saying that the number of referrals to homeopathy was initially low. One other practitioner reported having had to go to a GP practice to provide information on the various therapies. Finally, one of the practitioners felt that there was insufficient patient information on the referral forms.



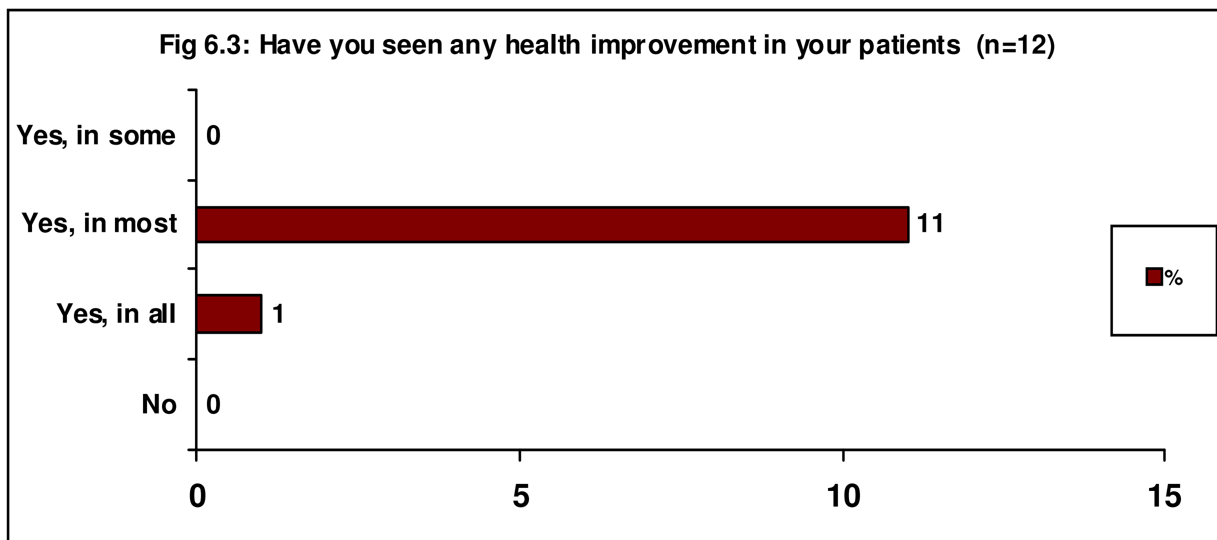
8.5 PRACTITIONER SATISFACTION WITH THE REFERRAL PROCESS

With regard to the referral process which operated during the project, most of the practitioners (n=11) were either 'very satisfied' (n=4) or 'satisfied' (n=7), with just one practitioner 'dissatisfied'.

Seven on the practitioners made suggestions on how the referral process could be improved, with three calling for more information / education for GPs, and regular meetings between GPs and practitioners (n=2). Other suggestions included: providing more detailed information to patients at the point of referral; and, more appropriate (GP) matching of patient conditions with CAM.

8.6 PRACTITIONER PERCEPTION OF PROJECT IMPACT ON PATIENTS

Over the life of the project, practitioners said that they seen an average of 44 patients, with all of the practitioners reporting a health improvement in most (11), or all (1), of their patients.



Practitioners said that on average, 77% of their patients had seen a health improvement. When asked to comment on health outcomes by health condition, five practitioners felt that the outcomes had been similar for patients with acute and chronic conditions, with four saying outcomes were better for patients with acute conditions and two saying that outcomes were better for patients with chronic conditions. As was the case with GPs, all of the practitioners rated patient compliance as either 'excellent' or 'good' regardless of whether the patient had presented for an acute or chronic health condition.

8.7 PRACTITIONER PERCEIVED BENEFITS TO PATIENTS

Nearly all of the practitioners (n=11) said that more than 50% of their patients had benefited from the therapies with the other practitioner saying that between 25% and 50% of patients had benefited from the therapies. Most of the practitioners (n=7) identified pain relief as a benefit to patients, with five practitioners saying that patients had benefited from improved quality of life.

Table 8.2 Practitioner Perceived Benefits to Patients (n=12)

	N
Pain Relief	7
Better Quality Of Life/Overall Well Being	5
Improved Mobility / Relief of Joint Problems	4
Stress Relief	3
Emotional/Mental Issued Improved	3
Improvement In Digestion System	1
Ability To Return To Work	1
Reduction Of Prescribed Drugs	1
Help With Conditions Poorly Served Conventionally	1
Improvement In Health	1
Health Issues Explained	1
Physical Symptoms Alleviated	1
Time With Practitioners	1

Improvement in patient's physical and mental health was reported by 11 out of 12 practitioners, with 10 practitioners reporting that more than 50% of their patients had seen improvements in their physical health, with the same proportion of patients seeing benefits in their mental health.

8.8 MEDICATION

The majority of practitioners (n=7) reported that patients with chronic and acute medical conditions had been using less medication since their treatments. Indeed overall, 11 out of the 12 practitioners reported a general decrease in medication amongst their patients.

Three of the practitioners said that more than 50% of their patients were using less medication since availing of the treatments, with half of practitioners saying that between 25% and 30% of their patients had reduced their medication.

All of the practitioners reported that they had patients who themselves had indicated to them that they need less medication, with four practitioners saying that this had been the case among more than 50% of their patients, with half of practitioners saying that this had been the case in between 25% and 50% of patients. Two practitioners said that between 10% and 25% of their patients had told them that they had reduced their medication.

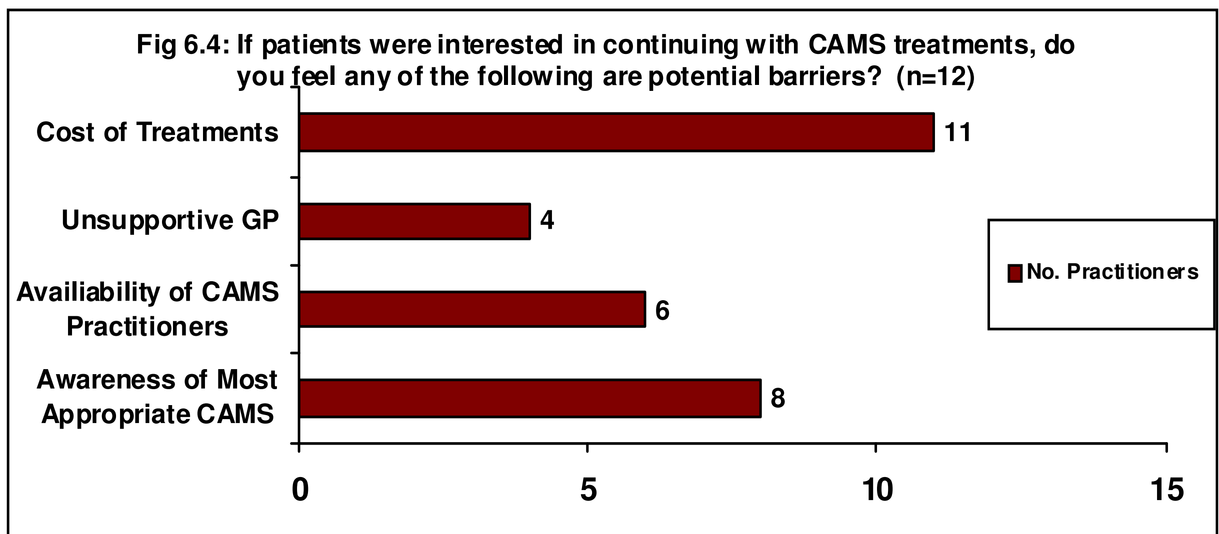
8.9 PATIENT REACTION

All but one of the practitioners (n=11) said that the reaction of patients to CAM had been 'extremely positive', with the other practitioner saying that the reaction had been 'positive'. In support of this view, practitioners said that patients were generally appreciative and thankful for receiving the therapies, and seen CAM as a

welcome alternative to what they had been offered previously. Some of the practitioners felt also that patients had become more aware of their own health and wellbeing as a direct result of receiving the various therapies.

8.10 PATIENTS USING CAM BEYOND THE PILOT PROJECT

All of the practitioners said that they had patients who had enquired about using CAM beyond the life of the project, with cost (n=11) and awareness of the most appropriate CAM (n=8) being the most significant barriers. When asked to identity which of the barriers was likely to be the most problematic, nine out of the 12 practitioners cited cost, with 11 practitioners directly identifying affordability as a problem for patients.

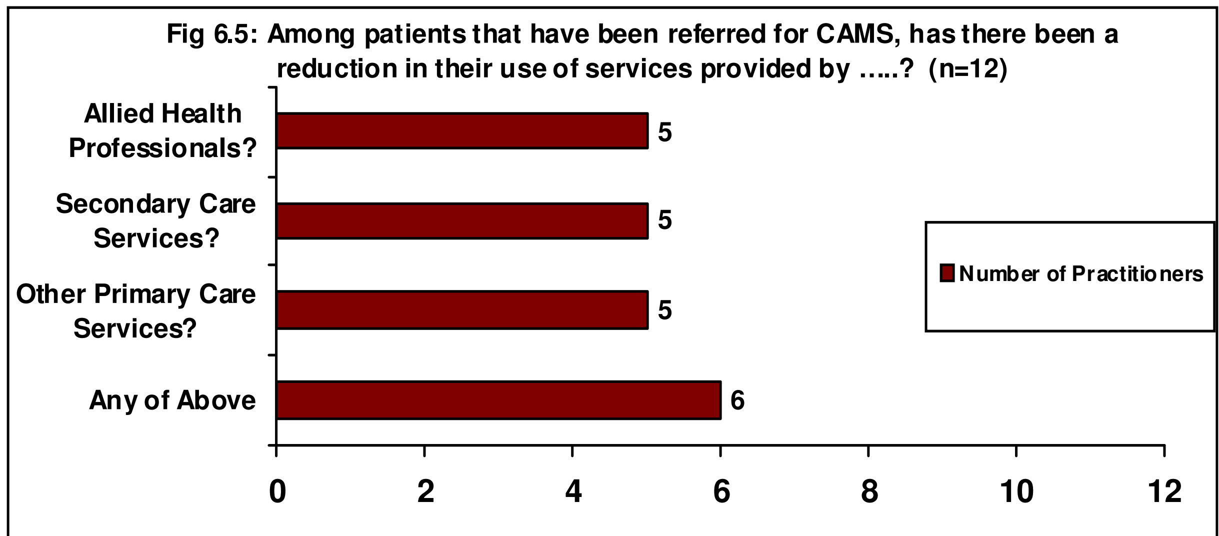


8.11 PRACTITIONER VIEWS ON IMPACT OF PROJECT ON GPS

Eleven out of the 12 practitioners felt that GPs having the option to refer patients to CAM as part of this pilot project had in some way reduced their workload, with 7 perceiving a financial saving to the GP practices. When asked to clarify their response to the question of financial savings, six of the practitioners made the point that if patient symptoms have been resolved, then there is no longer a need for consultations with GPs. One other practitioner stated that they 'would be very surprised if there were no savings'.

8.12 PRACTITIONER VIEWS ON USE OF SERVICES BY PATIENTS

Five of the practitioners reported that following treatment, their patients were less likely to use services provided by Allied Health Professionals (e.g. physiotherapy, occupational health, dieticians etc), with the same number of practitioners (n=5) reporting that their patients were less likely to use secondary care services. Five practitioners also reported a decline in other primary care services (e.g. practice nurse, pharmacists etc) following CAM treatments.



8.13 INTEGRATION OF CAM WITHIN PRIMARY CARE

All of the practitioners supported the view that CAM should be better integrated within Primary Care, with six practitioners specifically highlighting the benefits of CAM in improving patient health.

Table 8.3 Practitioner Views on Why CAM Should be Better Integrated into Primary Care

	n
Effective Tool In Treatment Of Patients/Everyone Benefits / Helping People	6
CAM Is An Excellent Additional Resource For The NHS	1
Provide Appropriate Treatments For Conditions Poorly Served By Conventional Medicine	1
A Number Of Patients Cams Are Their Choice	1
We Need To Be Seen As Being Part Of The Service	1
Cut Down On Anti-Depressants / Painkillers Therefore Less Cost For NHS	1
Would Like To Treat These Patients At The Early Stages Of Their Illness	1

8.14 PRACTITIONER PERCEPTION OF CHANGE IN GP ATTITUDES

Ten out of the 12 practitioners felt that the attitude of GPs towards CAM had become more positive over the course of this project, with the other 2 practitioners recording 'don't know' in response to this question.

8.15 PROJECT STRENGTHS

When asked to identify the key strengths of the project, seven practitioners pointed to the organisation and management of the project as a key project strength, with five practitioners citing the quality of the practitioners appointed to the project.

Table 8.4 Practitioner Views of Key Strengths of Project

	n
Organisation/Management	7
Well Qualified/Best Practitioners	5
Doctor More Positive/Aware Of CAM	4
Patient Focus	2
Commitment By DHSSPSNI	2
Patients Get Benefit From It	2
Effective Treatment	2
Access To Other Staff	1
Communication	1
Work As Part As A Primary Care Team	1
Rapport With Practice Nurses And Nurse Prescribes & H Visitors	1
Cost Effective	1
Patients Want CAM	1
Variety Of Practitioners	1

8.16 PROJECT WEAKNESSES

According to practitioners the main project weaknesses were concerns that some GPs lacked knowledge / education on CAM (n=5), and a lack of discussion / communication between practitioners and GPS (n=5).

Table 8.5 Practitioner Views of Key Weaknesses of Project

	n
Some GPs Lack Of Knowledge/Education	5
More Discussion With GP's / Lack Of Communication	5
No Follow Up With GPs	3
No Referrals From Some GPs	2
1 Yr Too Short A Time	2
Limitation Of Various Therapies	2
No Provision For Maintenance Treatment	1
Lack Of Adequate Working Facilities	1
Insufficient Time Given To Get Well UK	1
Inadequate Time To Design Project	1
Being Run From London Nobody On The Spot	1
We Had To Organise Talks - Get Well UK Should Have Done This	1
Should Have Been A Few More Places	1
Due To Lack Of Knowledge Referrals Were Slow	1

8.17 MOVING FORWARD

All but one of the practitioners (n=11) said that if funding were available beyond the pilot project, they would continue to provide services to the participating practices. All of the practitioners felt that there were ways in which GPs could be better supported to further explore the potential of CAM, with nine practitioners calling for more discussion and meetings with GPs.

Finally, practitioners make a number of additional comments on the project including: 'patients have benefited from the project'; 'some patients were anxious of telling us how much their health had improved because of a fear of having their Disability Living Allowance cut'; 'it would be helpful if GPs knew what we treated'; and, 'would really like to continue with this project'.

9. DISCUSSION

A key objective of this pilot project was to examine the potential for the integration of Complementary and Alternative Medicine (CAM) within primary care in Northern Ireland and to provide an evidence base to show the contribution that CAM can make to improving health gain for patients presenting with both chronic and acute medical conditions. Allied to this aim was a commitment within the project to redress inequalities in access to CAM by providing therapies through the health service, and to assess the impact of these therapies on different socio-demographic groups.

9.1 GET WELL UK DATA

Based on Get Well UK data which was supplied by patients, GPs and CAM practitioners over the course of the project, the evidence suggests that the CAM interventions have produced significant health gains for the vast majority of patients. From the perspective of patients, 81% said that their general health had improved, with 82% less worried about their symptoms.

Using MYMOP, which is a validated instrument for measuring health outcomes within general practice, shows statistically significant improvements on each of the health outcome indicators measured i.e. the severity of patient symptoms; the level of an activity associated with their symptoms; and, overall patient wellbeing.

Also of note is that health improvements identified have been consistent across the different CAM therapies, as well as being consistent for musculoskeletal and mental health conditions. Indeed, analysis of the MYMOP indicators pre and post treatment, shows that 80% of patients recorded an improvement in the severity of their symptoms, with 73% recording an improvement in their level of activity associated with their symptom and 67% recording an improvement their wellbeing. Specifically in relation to patient's main symptom, the proportion of patients saying that it was 'as bad as it could be', fell from 31% prior to treatment to 5% following treatment.

In addition to an improvement in the severity of patient symptoms, the MYMOP data also found a reduction of 14 percentage points in the proportion of patients using medication following treatment (down from 75% to 61%). This is likely to have led to a saving in the prescribing budget of both the participating practices.

The MYMOP data also shows quite clearly that the evidence of health gain documented by patients is consistent with the views expressed by the CAM practitioners, with practitioners saying that in the majority of patient cases there had been an improvement in: the patient's quality of life; relief of presenting symptoms; relief of chronic conditions; increased mobility; increased emotional stability; and, a reduction in patient worry.

Get Well UK's organisation of the project also provided the participating GPs with an opportunity to comment on health gain, if any, among their patients. On a very positive note, and echoing the views of patients and practitioners, GPs documented a health improvement in 65% of patient cases. The evaluation also found a significant correlation between GPs' and patients' views on health improvement, with GPs confirming a health improvement in 73% of cases where the patient

themselves had recorded a health improvement. In cases where GPs had recorded a health improvement, this judgment was supported by 83% of patients. With the level of health improvement recorded among patients using the CAM services offered through the pilot project, it is of little surprise to find that GPs had seen less of patients in 65% of cases. Indeed, in half of all patient cases the GP said that the CAM intervention had reduced their workload.

GPs have seen a positive outcome for their patients, which has led to a high degree of support for CAM. For example, in 99% of patient cases the GP said they would be willing to refer the same patient, or another patient, to the Get Well UK service in the future. Similarly, in 98% of patient cases, the GP said they would be willing to recommend the service to another GP.

Taken collectively, the project monitoring data supplied by Get Well UK shows significant health gain for most patients (e.g. 80% of patients reported an improvement in the severity of their main symptom with GPs recording a health improvement in 65% of patient cases) who availed of CAM as part of the pilot project. This assessment is based on a rigorous analysis of these data, and corroborated by the patients, the CAM practitioners and the participating GPs.

9.2 INDEPENDENT SURVEYS

9.2.1 PATIENT SURVEY

The independent surveys offered an opportunity to assess project impact at a point in time beyond the post-treatment stage. The surveys also provided an opportunity to corroborate and validate the data on patient outcomes provided by Get Well UK, and to examine other project impacts such as the financial impact of the project in terms of financial and other cost savings to health and social services in Northern Ireland.

From the patient's perspective the health outcomes, documented following an analysis of the Get Well UK data, were confirmed through the patient survey. On a very positive note approximately eight out of ten patients reported an improvement in their physical (81%) and mental (79%) wellbeing as a result of the CAM therapies. Indeed for the majority (58%) of patients the treatments had led to a general improvement in their overall quality of life, with almost three out of four (74%) saying that they worry less about their health compared with the period before they received the treatments. Similarly, more than eight out of ten patients (84%) directly linked the CAM treatments provided by Get Well UK to an improvement in their overall health and wellbeing.

Other positive indicators of health gain reported by significant numbers of patients include: an improvement in symptoms (69%), suffering less pain (62%) and having more control over pain (60%). There is strong evidence to suggest that many of the positive changes reported by patients have been sustained, with 23% of patients saying that prior to being treated their general well being was 'as bad as it could be'. At the point of being surveyed, which for most patients would have been six months after their treatment had ended, the proportion of patients saying that their general wellbeing was 'as bad as it could be' fell from 23% to 6%. Again this level of improvement is consistent with what was reported by patients through the project monitoring process operated by Get Well UK.

Not only did the patient survey provide indictors of patient perceived health improvement, but also produced evidence of a change in health behaviours, with 44% of those who were taking conventional medications prior to the treatments saying that they had reduced their use of such medication. Furthermore, given that relief of pain was identified by patients as a key expectation at the initial stages of the project, it is encouraging to find that more than half (55%) of those who were using pain killers prior to treatment, had indicated that they now use less of this type of medication.

For those patients in employment, it is also encouraging to find that for two out of three (64%), the CAM treatments have meant that they now take less time off work because of improvements in their health status. Also among patients not currently in employment, 16% indicated that the improvement in their health condition has encouraged them to think about going back into employment.

The survey also provided some positive indications that patients using CAM were using other health services less often as a result. This is evidenced by 24% of patients who had previously used other health services (i.e. other primary care services, secondary care and Accident and Emergency services) saying that they use these services less often following their treatment. Specifically in relation to GP services, 36% of patients, at the point of survey, said they now see their GP less often.

The patient survey also found that 94% of patients would recommend CAM to other people experiencing the same health condition as themselves. Having experienced the benefits of CAM, almost nine out of ten (89%) patients expressed an interest in continuing with their treatments, however less than on third of patients (30%) said that they could afford to continue with the treatments.

9.2.2 PRACTITIONER SURVEY

At the initial stages of the project some of the practitioners had concerns about the level of take-up of the service, particularly because it was ‘free’ to patients, with some practitioners also concerned that the project may be an opportunity for some of GPs to ‘dump their awkward or chronic patients into the service’. A further concern expressed by practitioners was the level of knowledge and understanding that GPs had of the various treatments and their ability to appropriately match patient heath conditions with the various treatments. However, the consensus among practitioners was that as the project progressed GPs became more effective in matching illnesses with treatments, although it was felt that GPs could be better supported with the referral process through the use of seminars and other educational interventions.

Not being provided with enough information on the patient being referred was identified as a problem by more than half of the practitioners in the survey, which led to practitioners having to invest more time in patient assessment when they first presented for treatment. In contrast, patients providing information to practitioners was not found to be a problem, with all of the practitioners saying that their patients were happy to share their medical history with them. Allied to this point was the finding that less than half of practitioners surveyed felt that GPs had provided patients with a sufficient level of information on what the treatments would involve.

According to practitioners, there was tendency for GPs to refer patients with chronic health conditions, with the concern that the CAM interventions may not prove as effective in this patient group compared with patients with acute medical conditions. However, the evidence from the practitioners themselves, patients and GPs has shown that this concern has proved unfounded, given the health gains reported, regardless of whether the patient had presented with a chronic health condition or an acute health condition. On the referral process itself, all but one practitioner was satisfied with the system operated by Get Well UK.

Setting aside issues around the operation of the project, practitioners presented an extremely positive assessment of the health gains achieved by patients, with all reporting a health improvement in their patients. Practitioners reported that on average, they had seen a health improvement in 77% of their patients. According to practitioners, the key benefits to patients have been pain relief, improved quality of life, improved mobility, stress relief and improved emotional wellbeing. These findings are consistent with the outcomes from other aspects of the evaluation. On the issue of medication, almost all (11 out of 12) practitioners reported a decrease in the use of medication among the patients they treated.

As identified by patients themselves, CAM practitioners also cited affordability as the main barrier for patients wishing to continue with treatments beyond the pilot project. This is set against a belief among most of the practitioners that the project has produced a financial saving to the two participating projects, with practitioners also reporting a decline in the use of other health services among patients who they had treated (e.g. Allied Health Professionals, secondary care services, other primary health care services etc).

All of the practitioners supported the integration of CAM into primary care, with improved health gains for patients seen as the key benefit of such a development. All of the practitioners reported that the attitude of the GPs towards CAM had become more positive as the project progressed, which would be an essential prerequisite for change in health policy in this area.

Finally, practitioners identified the key strengths of the project as being its organisation and management, the quality of practitioners servicing the project and that GPs had become more positive in their perception and attitudes towards CAM. Conversely, a number of weaknesses were also cited, not least a need to address the knowledge and understanding of CAM among GPs, more discussion and communication between CAM practitioners and GPs and limited or no referrals from some GPs whose practice had agreed to participate in the project.

9.2.3 GP SURVEY

The GP survey revealed that improving patient health was the main motivation for GPs to get involved in the pilot project, with some seeing the project as an opportunity to provide evidence of the impact of the different treatments.

Concern expressed by practitioners about the knowledge and awareness of CAM among GPs prior to their involvement in the project is borne out in the survey of GPs, with most rating their understanding of the various treatments as either ‘fair’ or ‘poor’. However, from a very low knowledge base it is encouraging to find that three quarters of GPs surveyed said that their knowledge of CAM had improved through their exposure to CAM via the project.

In terms of improving knowledge of CAM, most of the GPs supported the use of meetings with CAM practitioners and for information leaflets to be made available. It was felt that more information would help them to better match patient health conditions with appropriate treatments, which at the initial stages of the project proved to be a problem for almost half of the GPs surveyed. All of the GPs said that their patients had been receptive to their suggestion that they be referred for CAM, with all satisfied with the referral process itself.

In terms of the impact of CAM on patient health, the results from the GP survey are extremely positive, with all but one GP saying that they had seen a health improvement in their patients. Patient compliance with treatments was also high according to GPs.

In following a consistent pattern, half of the GPs surveyed said that they now see patients who they referred for CAM less often, with none saying that they see them more frequently. Commenting on the perceived benefits to patients, GPs cited improved mood and wellbeing, satisfaction with treatment, feelings of empowerment to deal with symptoms and making the services available to patients who in normal circumstances would not have been able to afford the treatments. Reduced reliance on medication was also another positive outcome for patients, with half of the GPs saying that they now prescribe less medication for chronic or acute patients. Indeed half the GPs reported instances where the patient themselves had told them that they require less medication following the treatments.

Overall, GPs described patient reaction to the CAM services as positive, with most having had patients enquiring about continuing with the treatments, with all supportive of their patients in this regard.

GPs also documented a number of impacts on their own personal workload as well as the wider impact of the project on their practice and other health services. Half of GPs, for example, reported that the option to refer their patients to CAM had reduced their workload, with two pointing to a financial saving for their practice. All but one of the GPs see the project as a positive development for their practice, with all agreeing that it provided them with more referral options. In relation to the use of other health services by patients who availed of the treatments, most reported that their patients were using Allied Health Professionals less often, with half saying that their patients were using secondary care services less often.

In line with the Get Well UK data, 10 out of the 12 GPs surveyed reported having a more positive view of the potential for CAM within primary care, with all wishing to continue with the option of referring their patients to CAM. Ten out of the 12 GPs also said that, following their experience of the project, they would be likely to recommend CAM to their colleagues.

Among the main project strengths cited by GPs were plentiful appointments to reduce waiting lists, good project organisation and communication and having the practitioners onsite which facilitated direct contact. Finally, in terms of project weaknesses, GPs felt that there was a lack of opportunity to assess outcomes, a lack of feedback, their own lack of knowledge and that the project is ending.

9.3 FOCUS GROUPS

9.3.1 PATIENT FOCUS GROUPS

The focus groups with patients presented an opportunity to explore in greater detail the issues being highlighted by patients in the project monitoring data collected by Get Well UK.

On the issue of awareness of CAM, patients in the Derry group were found to have a limited awareness of the various therapies whereas patients in Belfast reported a relatively better understanding, with more patients in this group having had a greater level of exposure to the various treatments. The difference in socio-economic profile between the two areas may explain why this was the case, with patients in Derry less likely to be able to afford treatments in a private capacity due to being older, having had their symptoms for longer and be in receipt of social benefits.

Regardless of social circumstance between the two pilot areas, there was little difference in patient expectation or motivation for taking the CAM treatments, with pain relief, reduced reliance on medication and a willingness to explore alternatives, the main motivations for accepting the invitation to avail of the therapies.

When patients were asked specifically about the level of commitment and support of their GPs for CAM, the response was mixed, with patients in the Derry practice more likely to report a positive reaction from their GPs compared with their Belfast counterparts who in most cases described their GPs attitude to the project as indifferent. This resulted in many of the patients, particularly in Belfast, being provided with limited information on the CAM treatments as well as the potential side-effects with the various treatments. Indeed across both practices, patients called for more detailed information to be made available prior to their first consultation.

The vast majority of patients in the groups were satisfied with the referral process and the waiting times to get treatment, with all appreciative of the flexibility of times and dates for making appointments with practitioners. It was suggested in two of the groups that the project may benefit from some form of ‘triage’ system involving the patient, the GP and the CAM practitioner to ensure that patient medical conditions are matched with appropriate treatments.

All of the patients reported a high degree of satisfaction with their interaction with the various practitioners, with many in the groups highlighting the importance of the practitioner listening to what they had to say about their medical conditions within a holistic framework. None of the patients had any difficulties about sharing their medical history with practitioners, with most reporting that their practitioner had provided them with helpful advice on how best to manage their condition following their treatments.

In relation to health gain, almost all of the patients who attended the groups said that they had experienced an improvement in either their physical or mental wellbeing following the therapies. Again this is consistent with the outcomes from the other elements of the evaluation. Specifically, patients cited a range of health benefits including: pain relief; being better able to manage and control pain; relief

of symptoms; increased mobility; improved mood; less worry; less anxiety; improved mental wellbeing; and, general improved quality of life. For many of the patients their change in health status had been dramatic, even among patients with chronic health conditions which had persisted for many years. With many conventional treatments the side-effects can be debilitating, however the experience from this project has been that the side-effects have been positive, beneficial and welcomed by patients, with many of the patients pointing to an improvement in their general mood and overall wellbeing. With improved wellbeing among patients, many patients said that they were taking less medication, particularly pain killers. Indeed some of the patients said they were reluctant to say that they had experienced a health improvement for fear of losing benefits, particularly Disability Living Allowance (DLA).

Collection of patient data is a key aspect of Get Well UK's approach to monitoring the impact of therapies on patient health. It is of some concern that some of the patients, particularly in Belfast, experienced some difficulty in completing their patient assessment forms, with some patients requiring the support of a practice nurse or practitioner. Although patient assessment forms are an essential aspect of the monitoring process, it was felt that the forms could be simplified, which in turn would make it easier for patients to complete.

When patients were asked to reflect on their experience of the project, their assessment was overwhelmingly positive in terms of the health benefits achieved. Patients however did express concerns that access to such treatments should not be based solely on the attitude of GPs towards CAM, with the consensus view that CAM should be integrated into the health service and be made available to all patients within a primary care setting. Many patients also felt that the process of integrating CAM into primary care should be supported by campaigns to promote awareness of the benefits of the therapies to the wider public in Northern Ireland, and for therapies to be free of charge given that the cost of the therapies were beyond the financial reach of most patients who participated in the pilot project.

Finally, in terms of project improvements patients called for better promotion of CAM services and for more treatments to be made available, particularly for patients with chronic medical conditions whom some patients felt may require ongoing maintenance sessions to maintain their improved level of wellbeing over time. It was also suggested that the potential for CAM therapies be promoted among GPs, which it was felt would go some way to addressing a negative perception held by some GPs, with GP education seen as essential if CAM is to be integrated within a primary health care setting.

9.3.2 GP AND CAM PRACTITIONER FOCUS GROUPS

The focus group discussions with GPs and CAM practitioners found that despite a lack of awareness of CAM among GPs, there was a willingness among most of the GPs to use the project as an opportunity to explore their potential within an evaluation context, particularly as the project was designed to produce a range of health outcome indicators on the impact of CAM on patient wellbeing. GPs have also seen the project as a learning tool to improve their understanding of the various therapies. Among the practitioners in the groups, a key expectation was that at the end of the project GPs would see the value of the different therapies as an alternative but effective option for treating their patients. For many of the

practitioners, the project was also seen as an opportunity to explore the potential for CAM to be integrated within primary health care in Northern Ireland.

As was referenced in other elements of the evaluation, successful patient outcomes are dependent on the matching of medical conditions with appropriate alternative therapies. The experience of the GPs and practitioners in this project, suggests that this is a real difficulty, which requires an adequate investment in GP education coupled with improved communication between GPs and CAM practitioners. Based on the discussions in the groups, both GPs and practitioners not only acknowledge these difficulties, but are also supportive of looking at ways of addressing these problems such as greater use of seminars for GPs, talks by CAM practitioners, provision of written information on CAM, GPs observing treatment sessions and increased communication between GPs and practitioners.

There was also discussion in the groups about the type of patient being referred to the project, with both GPs and practitioners agreeing that it had been mostly patients with chronic medical conditions. Although the health outcomes for both chronic and acute patients were consistent, some of the practitioners in the groups felt that patients with acute conditions may have achieved better outcomes had there been more of a bias towards this type of patient. The GPs accepted this analysis, with some conceding that their limited knowledge of CAM may account for this disparity in patient profile.

Both GPs and practitioners felt that patient reaction to the project had been extremely positive, with the overwhelming majority of patients being receptive to the suggestion that they try CAM. Some GPs and practitioners had initial concerns about both a poor take-up of the service and patient compliance with the treatment programmes. According to GPs and practitioners both these concerns proved unfounded as the project was rolled out.

All of the GPs and practitioners in the groups said that patients had benefited greatly from the treatments, with practitioners saying that they had anticipated such outcomes, whereas GPs tended to be somewhat surprised at the positive outcomes for their patients. GPs in the groups cited examples of patients who had achieved pain relief, improvements in symptoms, less anxiety, less worry and reduced fatigue. Mention was also made of patients using less medication including a reduction in the use of pain killers. Indeed one of the GPs felt that the therapies had particularly benefited patients who were ‘borderline’ depression cases, and gave patients, and GPs, a real option rather than prescribing anti-depressants. Specifically in respect of musculoskeletal conditions, one of the GPs said that their level of referral to physiotherapists had ‘gone way down’ as a direct result of being able to refer patients for CAM.

The way in which the project was structured led to some concern among GPs and practitioners that patient exposure to CAM had raised expectations that CAM therapies should be available to them after the project had ended. The concern was that patients who had gained significant pain relief (e.g. musculoskeletal conditions) may be unable to continue with treatments in a private capacity due to affordability issues. It was suggested that some mechanism be found to ensure that these patients have access to booster or maintenance sessions to allow them to sustain their level of wellbeing achieved via CAM.

GPs identified health gain among patients as a key project strength, with the quality of the CAM practitioners specifically mentioned by GPs. Providing the treatments at no cost to patients was also cited a key strength of the project given that most of the patients in the pilot would not have been able to afford them otherwise. The project also provided GPs with more referral options for their patients, with patients themselves becoming advocates for the therapies within their local communities.

Areas where the project could have been improved included more education on CAM for GPs, strategies to address scepticism among some GPs, simplification and review of the MYMOP forms and improved communication between GPs and CAM practitioners. Finally, it was also suggested that a formal case-control study be commissioned to provide a more scientific basis to examine the relationship between CAM and health outcomes for patients.

9.4 MEETING THE PROJECT OBJECTIVES

In conclusion the evaluation has shown that the project objectives have been achieved. Not only have the health outcomes been measured, but health gain has been the experience for the vast majority of patients who received CAM as part of the project.

The project has also provided an opportunity for patients to access CAM through their local primary care service, with many patients provided with access to therapies which normally would be beyond their reach. On a very positive note, the evaluation has found that the health outcomes have been consistent across the various socio-demographic and equality groupings, which is in keeping with the core health service philosophy of seeking to ensure access for all, regardless of socio-economic circumstance.

The outcomes from this project have provided DHSSPSNI and the project partners with a rich source of learning as to how CAM can be integrated and delivered within a primary care setting in Northern Ireland. The project has served to provide a range of valuable learning points, and provided direction on best practice should a decision be taken for CAM be rolled out on a more extensive basis.

The feedback from patients was overwhelmingly positive, with patients welcoming quick access to expert care provided by a team of high quality and dedicated CAM practitioners. The interaction between the patients and CAM practitioners also led to patients being provided with opportunities to learn and acquire self management strategies to manage, and further improve their health status.

The evaluation has also provided some evidence of a reduction in GP workload, with many of the participating GPs indicating that they were seeing their patients less often. Furthermore, the evaluation has also produced evidence that patients, following their treatments, were using less medication, as well as using other health services less often. This points to the potential of CAM for reducing costs within health and social services in Northern Ireland. Finally, the overall project was delivered to more than 700 patients within the allocated project budget. This was a key objective at the outset.

APPENDICES

APPENDIX 1: PATIENT QUESTIONNAIRE

Complementary and Alternative Medicines Pilot Project

PATIENT SURVEY

&

Social & Market Research (SMR)

February 2008

Please be assured that this questionnaire is confidential and anonymous. Please complete the questionnaire by circling your answers or writing in your answer where required.

PLEASE RETURN YOUR COMPLETED QUESTIONNAIRE BY 28 FEBRUARY 2008 OR AT YOUR EARLIEST CONVENIENCE.

THANK YOU.

SECTION A: FINDING OUT ABOUT THE TREATMENTS

A1. We are interested in how you came to find out that Complementary and Alternative Medicines (CAMS) were being provided through your GP practice. Did you find out about CAMS through your GP, practice nurse or in some other way?
(PLEASE CIRCLE YOUR ANSWER)

My GP	1
The Practice Nurse	2
Other (please specify)	3

A2. Before you had any of the treatments, how much did you know about Complementary and Alternative Medicines? **(PLEASE CIRCLE YOUR ANSWER)**

A lot	1
A little	2
Nothing at all	3

A3. Looking back, were any of the following reasons why you took the treatments? **(CIRCLE ALL THAT APPLY)**

My GP thought it would be a good idea	1
The treatments were free – I'd nothing to lose	1
I had tried everything else and this was a last resort	1
I genuinely thought the treatments would help me get better	1

A4. Were there any other reasons why you took the treatments?
(PLEASE WRITE IN YOUR ANSWER)

A5. Did the fact that your GP Practice was supporting the use of Complementary Medicines influence you decision to take the treatments?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1
No	2

A6. Why do you say this? **(PLEASE WRITE IN YOUR ANSWER)**

SECTION B: BEING REFERRED FOR TREATMENTS

B1. Were you referred for the treatments by your GP or practice nurse?
(PLEASE CIRCLE YOUR ANSWER)

GP	1
Practice Nurse	2

B2. Can you please describe the illness or health condition that you were referred for treatment?
(CIRCLE ALL THAT APPLY)

Back, neck or shoulder pain	1
Joint problems, including arthritis	1
Stress or tension	1
Depression	1
Other (please specify)	1

B3. Please list the one or two symptoms (physical or mental) which bother you most.
(PLEASE WRITE IN YOUR ANSWERS)

Symptom 1

Symptom 2

B4. Thinking about the time you were referred for treatment, would you agree or disagree with each of the following?**(PLEASE CIRCLE FOR EACH)**

	Agree	Neither	Disagree	Don't Know
The reasons for the referral were well explained to me	1	2	3	4
My GP had a good understanding of the treatments	1	2	3	4
My GP fully supported me getting the treatments	1	2	3	4

B5. Do you feel that you should have been given more information about the treatments you were being referred for? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

B6. Do you remember receiving by post an information leaflet on the project. You should have received this leaflet after you booked your first appointment with a CAMS practitioner. **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> go to B7
No	2	-> go to B8

B7. Did you find the patient information leaflet helpful? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

B8. Did your GP tell you that the treatments were designed to complement your existing treatments and were not meant to be alternatives to your existing treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2
Don't Know	3

B9. Did you feel that your GP knew enough about the different treatments to be able to match the treatments appropriately to your illness or condition? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2
Don't Know	3

B10. Please explain your answer? **(PLEASE WRITE IN YOUR ANSWER)**

B11. Do you feel the treatments you received were appropriate for your medical condition? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2
Don't Know	3

B12. Did you have any concerns or anxieties about being referred for complementary therapies? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> B13
No	2	-> B14

B13. What was your main concern? **(PLEASE WRITE IN YOUR ANSWER)**

B14. Overall how satisfied or dissatisfied were you with the way you were referred for treatment? **(PLEASE CIRCLE YOUR ANSWER)**

Very Satisfied	1	-> go to C1
Satisfied	2	-> go to C1
Dissatisfied	3	-> go to B15
Very Dissatisfied	4	-> go to B15

B15. If you were dissatisfied, why was this? **(PLEASE WRITE IN YOUR ANSWER)**

SECTION C: RECEIVING THE TREATMENTS

C1. Which treatments did you receive? **(PLEASE CIRCLE FOR EACH)**

	Yes	No
Acupuncture	1	2
Aromatherapy	1	2
Homeopathy	1	2
Massage	1	2
Osteopathy	1	2
Chiropractor	1	2
Reflexology	1	2
Other (please specify)	1	2

C2. How many treatment sessions did you have in total?
(PLEASE WRITE IN THE NUMBER OF SESSIONS)

C3. Do you feel you were offered enough treatment sessions?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1
No	2

C4. After you were referred for treatment, how long did you have to wait before you got the treatment (s)? **(PLEASE CIRCLE YOUR ANSWER)**

Got treatment immediately	1
Within 1 month	2
More than one month	3
Don't Know	4

C5. Thinking about the treatment(s) you received, please indicate if you agree or disagree with each of the following? **(PLEASE CIRCLE FOR EACH)**

	Agree	Neither	Disagree	Don't Kno w
The treatment Practitioner explained in detail what the treatment(s) involved	1	2	3	4
The treatment Practitioner took sufficient time to find out about my illness or condition	1	2	3	4
The treatment practitioners were courteous and professional	1	2	3	4
I was happy to share information on my medical history with the Practitioner	1	2	3	4
I had trust and confidence in the Practitioner	1	2	3	4
Each time I had a treatment I	1	2	2	4

was given sufficient time by the Practitioner

C6. Did the Practitioner give you advice on how to manage your condition?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1	-> go to C7
No	2	-> go to C9
Don't Know / Can't remember	3	-> go to C9

C7. Was this advice helpful?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1
No	2

C8. How easy or difficult was it for you to follow this advice?
(PLEASE CIRCLE YOUR ANSWER)

Very Easy	1
Easy	2
Difficult	3
Very Difficult	4

C9. Did you complete all of the sessions / treatments that you were referred to?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1	-> go to C11
No	2	-> go to C10

C10. What was the main reason why you did not complete all of the sessions / treatments?
(PLEASE WRITE IN YOUR ANSWER)

C11. Overall how satisfied or dissatisfied were you with the treatments you received?
(PLEASE CIRCLE YOUR ANSWER)

Very Satisfied	1	-> go to C13
Satisfied	2	-> go to C13
Dissatisfied	3	-> go to C12
Very Dissatisfied	4	-> go to C12

C12. Why were you dissatisfied with the treatments?

C13. Were there any ways in which your experience of getting the treatments could have been improved? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> go to C14
No	2	-> go to D1

C14. How could your experience of the treatments have been improved? **(PLEASE WRITE IN YOUR ANSWER)**

SECTION D: IMPACT OF THE TREATMENTS

In this section of the questionnaire we want to find out what effect, if any, the treatments have had on your health.

D1. Would you say that your general **Physical Health** has improved as a result of the treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, a lot	1
Yes, a little	2
No, not at all	3

D2. And has your general **Mental Wellbeing** improved as a result of the treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, a lot	1
Yes, a little	2
No, not at all	3

D3. Has your **General Quality Of Life** changed since you were given the treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, it’s got better	1
Yes, it’s got worse	2
My general quality of life hasn’t changed	3

D4. As a result of the treatments are you less worried about your health now ?
(PLEASE CIRCLE YOUR ANSWER)

A lot less worried	1
A little less worried	2
No	3

D5. And since the treatments would you say that you………?
(PLEASE CIRCLE FOR EACH)

	Yes	No	Don’t Know
Feel more confident	1	2	3
Have seen an improvement in your symptoms	1	2	3
Have a more positive outlook on life	1	2	3
Are better able to get about	1	2	3
Are more likely to get out and about	1	2	3
Feel more in control of your life	1	2	3
Feel more that life is worth living	1	2	3
Have improved relationships with other family members	1	2	3
Are less likely to worry or feel anxious	1	2	3
Suffer less pain	1	2	3
Feel as if you have more control over pain	1	2	3
Have reduced mood swings	1	2	3

D6. Before you were given the treatment(s), were you taking any medication?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1	-> go to D7
No	2	-> go to D8

D7. Since getting the treatment(s) has the amount of medication you take changed?
(PLEASE CIRCLE YOUR ANSWER)

Yes, I’m taking **more** medication	1
Yes, I’m taking **less** medication	2
No change in amount of medication	3

D8. Before you got the treatments were you using pain killers on a regular basis?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1	-> go to D9
No	2	-> go to D10

D9. And since you got the treatments would you say that your use of pain killers has increased, decreased or remained the same? **(PLEASE CIRCLE YOUR ANSWER)**

Increased	1
Decreased	2
Stayed the Same	3

D10. Do you feel that the treatments you were given were appropriate for your condition? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

D11. How well did your condition respond to the treatments you were offered? **(PLEASE CIRCLE YOUR ANSWER)**

Very well	1
Well	2
Not very well	3
Not at all well	4

D12. How would you rate your general feeling of wellbeing **BEFORE** you took the treatments? **(PLEASE CIRCLE YOUR ANSWER)**

As good as it could be					**As bad as it could be**	
0	1	2	3	4	5	6

D13. How would you rate your general feeling of wellbeing immediately **AFTER** you took the treatments? **(PLEASE CIRCLE YOUR ANSWER)**

As good as it could be					**As bad as it could be**	
0	1	2	3	4	5	6

D14. And how would you rate your general feeling of wellbeing **NOW**? **(PLEASE CIRCLE YOUR ANSWER)**

As good as it could be					**As bad as it could be**	
0	1	2	3	4	5	6

D15. Do you have a paid job? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> go to D16
No	2	-> go to D18

D16. Has your illness or condition ever meant that you have had to take days off from your job? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> go to D17
No	2	-> go to E1

D17. And since having your treatments, have you had to take more or less time off due to illness? **(PLEASE CIRCLE YOUR ANSWER)**

More time off	1	
Less time off	2	-> go to
No change	3	E1

D18. Has having the treatments encouraged you to think about going back into employment? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

D19. And how likely is it that you will get back into employment within the next 12 months? **(PLEASE CIRCLE YOUR ANSWER)**

Very Likely	1
Likely	2
Unlikely	3
Very Unlikely	4
Don't Know	5

SECTION E: GENERAL POINTS

E1. Would you recommend Complementary and Alternative Medicines to other people with the same health problem as you? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

E2. Would you like to continue with the treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

E3. Could you afford to continue with the treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

E4. What has been your GP's reaction to the treatments or general project? **(PLEASE CIRCLE YOUR ANSWER)**

Positive	1	-> go to E5
Negative	2	-> go to E5
Don't Know	3	-> go to E6

E5. Why do you say that? **(PLEASE WRITE IN YOUR ANSWER)**

E6. Has your relationship with your GP changed as a result of you getting the treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, our relationship has got better	1
No, our relationship has got worse	2
No change in our relationship	3
Don’t Know	4

E7. Have you discussed the impact, if any, of the treatments with your GP? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> go to E9
No	2	-> go to E8

E8. Would you have liked to have discussed the impact of the treatment with your GP?

Yes	1
No	2

E9. After you got the treatments, would you say that your visits to see your GP have increased, decreased or stayed the same? **(PLEASE CIRCLE YOUR ANSWER)**

Increased	1
Decreased	2
Stayed the Same	3

E10. Would you say that since getting the treatments your use of other services such as the Practice Nurse and your local pharmacist has changed? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, I use these services **less often** now	1
Yes, I use these services **more often** now	2
No change in my use of these services	3
Don’t Know	4
I never used these services in the first place	5

E11. And what about your use of hospital services (i.e. outpatients or to see a Consultant, get an X-RAY etc). Would you say you use **hospital services** less often since getting the treatments, more often or has there been no change? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, I use hospital services **less often** now	1
Yes, I use hospital services **more often** now	2
No change in my use of hospital services	3
Don’t Know	4
I never used these services in the first place	5

E12. And what about your use of **Accident and Emergency services**. Would you say you use A&E services less often since getting the treatments, more often, or has there been no change? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, I use A& E services **less often** now	1
Yes, I use A& E services **more often** now	2
No change in my use of A& E services	3
Don't Know	4
I never used A& E services in the first place	5

E13. Are you interested in continuing with Complementary and Alternative Medicines? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

E14. What has been the single most important benefit to you personally from receiving the treatments? **(PLEASE WRITE IN YOUR ANSWER)**

E15. Taking everything into consideration, please indicate if there has been any improvement to your health and wellbeing as a direct result of receiving the treatments provided by the Practitioners?

A lot of Improvement	1
A little improvement	2
No improvement	3

E16. Thinking back on the project and the treatments you received, is there any way in which your experience could have been improved? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> go to E17
No	2	-> go to E18

E17. What do you feel is the most important improvement which should be made? **(PLEASE WRITE IN YOUR ANSWER)**

E18. Do you have any other comments on your experience with the project which you think might be helpful to the evaluation? **(PLEASE WRITE IN YOUR ANSWER)**

SECTION F: ABOUT YOU

F1. Are you….(**PLEASE CIRCLE YOUR ANSWER**)

Male	1
Female	2

F2. What age are you? **(PLEASE CIRCLE YOUR ANSWER)**

Under 30	1
30-49	2
50-69	3
70+	4

F3. What is your marital status? **(PLEASE CIRCLE YOUR ANSWER)**

Single	1
Married	2
Divorced / Separated	3
Widowed	4
Civil Partnership	5

F4. What was your employment status **BEFORE** you received the Complementary and Alternative Medicines? **(PLEASE CIRCLE YOUR ANSWER)**

Self-employed	1
Working Full-time	2
Working Part-time	3
Seeking work for the first time	4
Unemployed, i.e. not working but actively seeking work	5
Looking after home and family	6
Unable to work due to permanent illness or disability	7
Not actively seeking work but would like to work	8
Not working and not seeking work	9
On a government scheme	10
Retired	11
Student	12
Other (Please specify)	13

F4. What is your employment status **NOW**? **(PLEASE CIRCLE YOUR ANSWER)**

Self-employed	1
Working Full-time	2
Working Part-time	3
Seeking work for the first time	4
Unemployed, i.e. not working but actively seeking work	5
Looking after home and family	6
Unable to work due to permanent illness or disability	7
Not actively seeking work but would like to work	8
Not working and not seeking work	9
On a government scheme	10
Retired	11
Student	12
Other (Please specify)	13

F5. Where is your GP Practice located? **(PLEASE CIRCLE YOUR ANSWER)**

Derry	1
Belfast	2

F6. Do you have someone who is dependant on you, i.e. a child, someone with an incapacitating disability, an elderly person? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

F7. Do you receive state financial benefits? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> go to F8
No	2	-> go to F9

F8. Since getting the treatments, would you say that the monetary amount you are receiving in benefits has increased, decreased or stayed the same?
(PLEASE CIRCLE YOUR ANSWER)

Increased	1
Decreased	2
Stayed the same	3

F9. Is your household income mainly based on income from employment or income from benefits? **(PLEASE CIRCLE YOUR ANSWER)**

Mainly Employment	1
Mainly Benefits	2

F10. What is your highest level of educational attainment?
(PLEASE CIRCLE YOUR ANSWER)

No academic qualifications	1
GCSE's, O'Levels or equivalent	2
A-Levels, HNDs or vocational diplomas	3
University Degree	4
Post-graduate degree	5

F11. Do you live…..? **(PLEASE CIRCLE YOUR ANSWER)**

Own home (paid for or with a mortgage)	1
Housing Executive Accommodation	2
Private Rented	3
Other (please specify)	4

F12. Finally, for the purposes of equality monitoring please indicate your community background. **(PLEASE CIRCLE YOUR ANSWER)**

Roman Catholic	1
Protestant	2
Other	3
Other (please specify)	4
Don't wish to say	5

<u>Thank you</u> for taking the time to complete this questionnaire. Please return it in the FREEPOST envelope provided.
<u>It does not need a stamp.</u>

SOCIAL & MARKET RESEARCH
FREEPOST 8569
3 WELLINGTON PARK
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<u>If You Have Any Queries About Any Aspect Of This Research Please Feel Free To Contact **Zoë Horton at GetWellUk** (0870 438 9355) or **Donal McDade at SMR** (02890 923362)</u>

APPENDIX 2: GP QUESTIONNAIRE

Complementary and Alternative Medicines Pilot Project

SURVEY OF GPs

&

Social & Market Research (SMR)

February 2008

Please be assured that this questionnaire is confidential and anonymous.

PLEASE RETURN YOUR COMPLETED QUESTIONNAIRE BY 29 FEBRUARY 2008 OR AT YOUR EARLIEST CONVENIENCE.

THANK YOU.

SECTION A: GETTING INVOLVED IN THE PROJECT

A1. Before your practice got involved in the CAMS pilot project, how would you have rated your understanding of different Complementary and Alternative Medicines (CAMS)? **(PLEASE ANSWER FOR EACH)**

	Excellent	Good	Fair	Poor	Very Poor
Acupuncture	1	2	3	4	5
Aromatherapy	1	2	3	4	5
Homeopathy	1	2	3	4	5
Massage	1	2	3	4	5
Osteopathy	1	2	3	4	5
Chiropractic	1	2	3	4	5
Reflexology	1	2	3	4	5

A2. And has your experience with this project helped improved your understanding of CAMS? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, a lot	1
Yes, a little	2
Not improved my understanding	3

A3. What was your main reason for getting involved in the project? **(PLEASE WRITE IN YOUR ANSWER)**

A4. Did you have any initial concerns or anxieties about referring your patients for CAMS treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> go to A5
No	2	-> go to B1

A5. Briefly what were your main concerns? **(PLEASE WRITE IN YOUR ANSWER)**

SECTION B: REFERRING PATIENTS

B1. When referring patients for CAMS treatments, did you have any difficulty in matching patient illnesses / conditions to the appropriate therapies available? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> go to B2
No	2	-> go to B3

B2. Briefly say what your main difficulty was?

B3. How could you have been better supported to ensure that patients were being matched with the most appropriate CAMS? **(CIRCLE ALL THAT APPLY)**

Meet with CAMS Practitioners	1
Information Leaflets	1
Seminar on CAMS	1
Other (please specify)	

B4. Were you **MORE** likely to refer patients with chronic or acute medical conditions? **(PLEASE CIRCLE YOUR ANSWER)**

Chronic	1
Acute	2
Referred same number of each	3

B5. Why was this? **(PLEASE WRITE IN YOUR ANSWER)**

B6. Generally, how receptive were your patients when you suggested that they try alternative therapies? **(PLEASE CIRCLE YOUR ANSWER)**

Very Receptive	1
Somewhat receptive	2
Not very receptive	3
Not at all receptive	4

B7. Did any of your patients decline the invitation to avail of the CAMS treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> go to B8
No	2	-> go to B10

B8. Approximately what proportion of your patients declined the invitation to be referred for CAMS? **(PLEASE WRITE IN YOUR ANSWER AS A PERCENTAGE)**

B9. What was their **MAIN** reason for declining the offer of CAMS?
(PLEASE CIRCLE YOUR ANSWER)

General scepticism	1
Happy with current situation	2
Other Reason (please specify)	3

B10. Generally how satisfied or dissatisfied ere you with the process of referral to CAMS operated as part of the project? **(PLEASE CIRCLE YOUR ANSWER)**

Very Satisfied	1	-> go to B12
Satisfied	2	-> go to B12
Dissatisfied	3	-> go to B11
Very Dissatisfied	4	-> go to B11

B11. If you were dissatisfied, why was this? **(PLEASE WRITE IN YOUR ANSWER)**

B12. Is there any way in which the referral process could be improved?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1	-> go to B13
No	2	-> go to C1

B13. Briefly how could the referral process be improved?
(PLEASE WRITE IN YOUR ANSWER)

SECTION C: IMPACT OF CAMS ON PATIENT HEALTH

C1. Approximately how many patients have you referred for CAMS?
(PLEASE WRITE IN YOUR ANSWER)

C2. Have you seen any health improvements in these patients?
(PLEASE CIRCLE YOUR ANSWER)

Yes, in some	1	
Yes, in most	2	-> go to
Yes, in all	3	C3
No	4	-> go to C4

C3. In approximately what percentage of these patients have you seen a health improvement? **(PLEASE WRITE IN YOUR ANSWER AS A PERCENTAGE)**

C4. Generally, would you say that the CAMS treatments have produced better outcomes in patients with chronic or acute health conditions?
(PLEASE CIRCLE YOUR ANSWER)

Outcomes better for patients with **chronic** conditions	1
Outcomes better for patients with **acute** conditions	2
Outcomes similar for patients with **both** acute and chronic conditions	3
Don't Know	4

C5. Of the various complementary therapies available, which do you feel have produced the best outcomes for your patients? **(CIRCLE ALL THAT APPLY)**

Acupuncture
Aromatherapy
Homeopathy
Massage
Chiropractic
Osteopathy
Reflexology
Other (please specify)

C6. Among patients that you have referred, what has been the level of compliance with the treatments among both chronic and acute patients?
(PLEASE CIRCLE FOR EACH)

	Excellent	Good	Fair	Poor	Don't Know
Chronic Patients	1	2	3	4	5
Acute Patients	1	2	3	4	5

C7. Of the patients you have referred to CAMS, would you say you are seeing them more frequently or less frequently? **(PLEASE CIRCLE YOUR ANSWER)**

More frequently	1
Less frequently	2
No Change	3
Don't Know	4

C8. Would you say that your patients have benefited from the therapies?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1	-> go to C9
No	2	-> go to C10

C9. What have been the key benefits to your patients?
(PLEASE WRITE IN YOUR ANSWER)

1.

2.

3.

C10. Do you feel that this pilot project has provided you with more options for treating your patients? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

C11. And has the pilot project been a positive development for your practice?

Yes	1
No	2
Don't Know	3

C12. Among the patients that you have referred to the project, would you say you are prescribing them with more medication or less medication?
(PLEASE CIRCLE FOR EACH)

	More Medication	Less Medication	No Change	Don't Know
Chronic Patients	1	2	3	4
Acute Patients	1	2	3	4

C13. What proportion of your patients have had their medication reduced since availing of the therapies? **(PLEASE CIRCLE YOUR ANSWER)**

More than 50%	1
Between 25% and 50%	2
Between 10% and 25%	3
Less than 10%	4
None	5
Don't Know	6

C14. Are patients who have availed of the therapies themselves saying that they need less medication? **(PLEASE CIRCLE YOUR ANSWER)**

Answer	Code
Yes, more than 50%	1
Yes, between 25% and 50%	2
Yes, between 10% and 25%	3
Yes, less than 10%	4
No	5
Don't Know	6

C15. What has been the general reaction to the project from your patients? **(PLEASE CIRCLE YOUR ANSWER)**

Answer	Code
Extremely Positive	1
Positive	2
Negative	3
Extremely Negative	4
Don't Know	5

C16. Why do you say that? **(PLEASE WRITE IN YOUR ANSWER)**

C17. Have any of your patients enquired about continuing with CAMS treatments beyond the pilot project? **(PLEASE CIRCLE YOUR ANSWER)**

Answer	Code	Routing
Yes	1	-> go to C18
No	2	-> go to D1

C18. Are you supportive or unsupportive of them continuing with CAMS therapies? **(PLEASE CIRCLE YOUR ANSWER)**

Answer	Code
Supportive	1
Unsupportive	2
Don't Know	3

SECTION D: IMPACT OF THE PROJECT ON YOUR PRACTICE

D1. Did the option to refer patients to CAMS as part of this pilot project in any way reduce your workload? **(PLEASE CIRCLE YOUR ANSWER)**

Answer	Code
Yes, a lot	1
Yes, a little	2
No	3
Don't Know	4

D2. In your view has there been any financial saving to your practice as a result of offering your patients CAMS treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, a lot	1
Yes, a little	2
No	3
Don't Know	4

D3. Please briefly explain your answer? **(PLEASE WRITE IN YOUR ANSWER)**

D4. Among patients that have been referred for CAMS, has there been a reduction in their use of services provided by Allied Health Professionals (e.g. physiotherapy, occupational therapy, dieticians etc)? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, a lot	1
Yes, a little	2
No	3
Don't Know	4

D5. Has there been a decline in the use of secondary care services among those patients who received CAMS treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, a lot	1
Yes, a little	2
No	3
Don't Know	4

D6. Has there been a decline in the use of other primary care services (e.g. practice nurse, pharmacists etc.) among patients who have received CAMS treatments?
(PLEASE CIRCLE YOUR ANSWER)

Yes, a lot	1
Yes, a little	2
No	3
Don't Know	4

D7. Would you say that having taken part in this project you now have a more positive view of the potential for CAMS within Primary Care? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2
Don't Know	3

D8. Would you like to continue with the option of being able to refer your patients to CAMS? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2
Don't Know	3

D9. Would you recommend CAMS to other colleagues?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1
No	2
Don't Know	3

D10. Has your experience of the project in any way changed how you view CAMS?
(PLEASE CIRCLE YOUR ANSWER)

Yes, more positive	1
Yes, more negative	2
Not changed my view	3

D11. Based on your experience of this project should CAMS be better integrated within Primary Care? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2
Don't Know	3

D12. Why do say that? **(PLEASE WRITE IN YOUR ANSWER)**

D13. What do you feel have been the 3 key strengths of this pilot project?
(PLEASE WRITE IN YOUR ANSWER)

1.

2.

3.

D14. What do you feel have been the 3 main weaknesses of this pilot project?
(PLEASE WRITE IN YOUR ANSWER)

1.

2.

3.

SECTION E: ABOUT YOU AND YOUR PRACTICE

E1. Is your practice located in Belfast or Derry? **(PLEASE CIRCLE YOUR ANSWER)**

Belfast	1
Derry	2

E2. If funding were available beyond the pilot project would you continue to refer your patients for CAMS? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2
Don't Know	3

E3. Are there any ways that you as a GP can be better supported to further explore the potential of CAMS for your patients? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> go to E4
No	2	-> go to E5

E4. Please suggest how you can be better supported to further explore the potential of CAMS for your patients? **(PLEASE WRITE IN YOUR ANSWER)**

E5. Please provide any additional comments which you feel may be helpful to the overall evaluation. **(PLEASE WRITE IN YOUR ANSWER)**

<u>Thank you</u> for taking the time to complete this questionnaire. Please return it in the FREEPOST envelope provided.
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<u>If You Have Any Queries About Any Aspect Of This Research Please Feel Free To Contact **Zoë Horton at GetWellUK** (0870 438 9355) or **Donal McDade at SMR** (02890 923362)</u>

APPENDIX 3: CAM PRACTITIONER QUESTIONNAIRE

Complementary and Alternative Medicines Pilot Project

Survey Of CAMs Practitioners

&

Social & Market Research (SMR)

February 2008

Please be assured that this questionnaire is confidential and anonymous.

PLEASE RETURN YOUR COMPLETED QUESTIONNAIRE BY 29 FEBRUARY 2008 OR AT YOUR EARLIEST CONVENIENCE.

THANK YOU.

SECTION A: GETTING INVOLVED IN THE PROJECT

A1. How were you approached to take part in the pilot project?
(PLEASE CIRCLE YOUR ANSWER)

Directly through Get Well UK	1
Through another practitioner	2
Through a GP	3
Read about it in the press	4
Other (please specify)	5

A2. And what was your main reason for agreeing to participate in the pilot project?
(PLEASE WRITE IN YOUR ANSWER)

A3. Did you have any initial concerns or anxieties about getting involved in the project?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1	-> go to A4
No	2	-> go to B1

A4. Briefly what were your main concerns? **(PLEASE WRITE IN YOUR ANSWER)**

SECTION B: REFERRAL OF PATIENTS

B1. Over the course of the pilot project, did you feel that GPs were appropriately matching medical conditions with the treatments you were providing?
(PLEASE CIRCLE YOUR ANSWER)

Some of the time	1
Most of the time	2
All of the time	3
No	4

B2. Did their matching of patients with treatments improve as the pilot project progressed?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1
No	2

B3. How could GPs be better supported to ensure that patients are being matched with the most appropriate CAMS? **(CIRCLE ALL THAT APPLY)**

Meet with CAMS Practitioners	1
Information Leaflets	1
Seminar on CAMS	1
Other (please specify)	1

B4. Did you feel that you were being provided with enough information on patient history when patients were being referred? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

B5. Were GPs **more** likely to refer patients with chronic or acute medical conditions? **(PLEASE CIRCLE YOUR ANSWER)**

Chronic	1
Acute	2
Same number of each	3

B6. In your view, why was this? **(PLEASE WRITE IN YOUR ANSWER)**

B7. Did you find that patients being referred to you had been given sufficient information by their GP? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

B8. When patients presented for treatment, did they generally have any concerns or anxieties about the treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1	-> go to B9
No	2	-> go to B10

B9. What were their main concerns? **(PLEASE WRITE IN YOUR ANSWER)**

B10. How satisfied or dissatisfied were you with the level of communication between yourself and the GPs throughout the project? **(PLEASE CIRCLE YOUR ANSWER)**

Very Satisfied	1	-> go to B12
Satisfied	2	-> go to B12
Dissatisfied	3	-> go to B11
Very Dissatisfied	4	-> go to B11

B11. If you were dissatisfied, why was this? **(PLEASE WRITE IN YOUR ANSWER)**

B12. Generally how satisfied or dissatisfied were you with the process of referral to CAMS which operated throughout the project? **(PLEASE CIRCLE YOUR ANSWER)**

Very Satisfied	1	-> go to B14
Satisfied	2	-> go to B14
Dissatisfied	3	-> go to B13
Very Dissatisfied	4	-> go to B13

B13. If you were dissatisfied, why was this? **(PLEASE WRITE IN YOUR ANSWER)**

B14. Is there any way that the referral process could be improved?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1	-> go to B15
No	2	-> go to C1

B15. Briefly how could the referral process be improved?
(PLEASE WRITE IN YOUR ANSWER)

SECTION C: IMPACT OF CAMS ON PATIENT HEALTH

C1. Approximately how many patients were referred to you during the pilot project?
(PLEASE WRITE IN YOUR ANSWER)

C2. Have you seen any health improvements in these patients?
(PLEASE CIRCLE YOUR ANSWER)

Yes, in some	1	-> go to C3
Yes, in most	2	-> go to C3
Yes, in all	3	-> go to C3
No	4	-> go to C4

C3. In what proportion of these patients have you seen a health improvement?
(PLEASE WRITE IN YOUR ANSWER AS A PERCENTAGE)

C4. Generally, would you say that the CAMS treatments have produced better outcomes in patients with chronic or acute health conditions?
(PLEASE CIRCLE YOUR ANSWER)

Outcomes have been better for patients with **chronic** conditions	1
Outcomes have been better for patients with **acute** conditions	2
Outcomes **similar** for patients with acute and chronic conditions	3
Don’t Know	4

C5. Among patients that you treated, what has been the level of compliance with the treatments among both chronic and acute patients?
(PLEASE CIRCLE FOR EACH)

	Excellent	Good	Fair	Poor
Chronic Patients	1	2	3	4
Acute Patients	1	2	3	4

C6. Among those patients that you have treated, what proportion do you feel have benefited from the therapies? **(PLEASE CIRCLE YOUR ANSWER)**

More than 50%	1
Between 25% and 50%	2
Between 10% and 25%	3
Less than 10%	4
None	5
Don’t Know	6

C7. What have been the key benefits to your patients, if any?
(PLEASE WRITE IN YOUR ANSWER)

1.
2.
3.

C8. Approximately what proportion of the patients that you treated reported an improvement in their physical and mental wellbeing as a result of the treatments they received? **(PLEASE CIRCLE FOR EACH)**

	Physical Health	Mental Wellbeing
More than 50%	1	1
Between 25% and 50%	2	2
Between 10% and 25%	3	3
Less than 10%	4	4
None	5	5
Don't Know	6	6

C9. Among the patients that you have treated as part of this pilot project, have there been any general indications that they are being prescribed more medication or less medication? **(PLEASE CIRCLE FOR EACH)**

	More Medication	Less Medication	No Change	Don't Know	Patients hasn't discussed medication
Chronic Patients	1	2	3	4	5
Acute Patients	1	2	3	4	5

C10. What proportion of your patients, if any, have had their medication reduced since availing of the therapies? **(PLEASE CIRCLE YOUR ANSWER)**

More than 50%	1
Between 25% and 50%	2
Between 10% and 25%	3
Less than 10%	4
None	5
Don't Know	6

C11. What proportion of patients, if any, reported using fewer painkillers as a result of the treatments? **(PLEASE CIRCLE YOUR ANSWER)**

More than 50%	1
Between 25% and 50%	2
Between 10% and 25%	3
Less than 10%	4
None	5
Don't Know	6

C12. Are patients who have availed of the therapies saying themselves that they need less medication? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, more than 50%	1
Yes, between 25% and 50%	2
Yes, between 10% and 25%	3
Yes, less than 10%	4
No	5
Don't Know	6

C13. What has been the general reaction to CAMS from the patients you have treated? **(PLEASE CIRCLE YOUR ANSWER)**

Extremely Positive	1
Positive	2
Negative	3
Extremely Negative	4
Don't Know	5

C14. Why do you say that? **(PLEASE WRITE IN YOUR ANSWER)**

C15. Have any of your patients enquired about continuing with CAMS treatments beyond the pilot project? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

C16. If patients were interested in continuing with CAMS treatments, do you feel any of the following are potential barriers? **(CIRCLE ALL THAT APPLY IN COLUMN C16 BELOW)**

	C16	C17
Cost of treatments	1	1
Unsupportive GP	1	2
Availability of CAMS Practitioners	1	3
Awareness of CAMS which are appropriate to their medical condition	1	4
Other (please specify)	1	5

C17. Of the barriers you identified above, which do you feel is the greatest barrier? **(PLEASE CIRCLE ONE ANSWER IN COLUMN C17 ABOVE)**

C18. Have you found that patients are willing to share their medical history with you? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2

C19. Do you feel that affordability of the treatments is a problem for the patients you have seen as part of this pilot project? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, a major problem	1
Yes, a minor problem	2
No, not a problem	3
Don't Know	4

SECTION D: IMPACT OF THE PROJECT ON YOUR PRACTICE

D1. Do you feel that GPs in having the option to refer patients to CAMS as part of this pilot project, has in any way reduced their workload? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, a lot	1
Yes, a little	2
No	3
Don't Know	4

D2. In your view has there been any financial saving to the GP practices as a result of offering their patients CAMS treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, a lot	1
Yes, a little	2
No	3
Don't Know	4

D3. Why do you this? **(PLEASE WRITE IN YOUR ANSWER)**

D4. Among patients that have been referred for CAMS, has there been a reduction in their use of services provided by Allied Health Professionals (e.g. physiotherapy, occupational therapy, dieticians etc)? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, a lot	1
Yes, a little	2
No	3
Don't Know	4

D5. Has there been a decline in the use of secondary care services (e.g. hospital services etc.) by patients availing of CAMS treatments? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, a lot	1
Yes, a little	2
No	3
Don't Know	4

D6. Has there been a decline in the use of other primary care services (e.g. practice nurse, pharmacists etc.) by patients availing of CAMS treatments?
(PLEASE CIRCLE YOUR ANSWER)

Yes, a lot	1
Yes, a little	2
No	3
Don't Know	4

D7. Based on your experience of this project should CAMS be better integrated within Primary Healthcare? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2
Don't Know	3

D8. Why do say that? **(PLEASE WRITE IN YOUR ANSWER)**

D9. Do you feel that the attitude of the GPs towards CAMS has changed over the course of this project? **(PLEASE CIRCLE YOUR ANSWER)**

Yes, they have become much **more positive**	1
Yes, they have become much **more negative**	2
No change	3
Don't Know	4

D10. What do you feel have been the 3 key strengths of this pilot project?
(PLEASE WRITE IN YOUR ANSWER)

1.

2.

3.

D11. What do you feel have been the 3 main weaknesses of this pilot project?
(PLEASE WRITE IN YOUR ANSWER)

1.

2.

3.

SECTION E: ABOUT YOU AND YOUR PRACTICE

E1. Did you treat patients in Belfast or Derry? **(PLEASE CIRCLE YOUR ANSWER)**

Belfast	1
Derry	2
Both Belfast and Derry	3

E2. If funding were available beyond the pilot project would you continue to provide services to the participating practices? **(PLEASE CIRCLE YOUR ANSWER)**

Yes	1
No	2
Don't Know	3

E3. Are there any ways in which you feel GPs can be better supported to further explore the potential of CAMS for their patients?
(PLEASE CIRCLE YOUR ANSWER)

Yes	1	-> go to E4
No	2	-> go to E5

E4. Please suggest how you think GPs can be better supported to further explore the potential of CAMS for their patients? **(PLEASE WRITE IN YOUR ANSWER)**

E5. Please provide any additional comments which you feel may be helpful to the overall evaluation. **(PLEASE WRITE IN YOUR ANSWER)**

<u>Thank you</u> for taking the time to complete this questionnaire. Please return it in the FREEPOST envelope provided.
<u>It does not need a stamp.</u>

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<u>If You Have Any Queries About Any Aspect Of This Research Please Feel Free To Contact **Zoë Horton at GetWellUK** (0870 438 9355) or **Donal McDade at SMR** (02890 923362)</u>

APPENDIX 4: DISCUSSION SCHEDULE – FOCUS GROUPS

The Complementary And Alternative Medicine Pilot Project

Questions, Issues and Themes
to be Addressed in the Focus Groups

October 2007

SMR
SOCIAL & MARKET RESEARCH

Patient Groups

1. **Introduction and Background to the Project**

2. **General warm-up discussion**
   - **CAMS services used;**
   - **Conditions being treated;**

3. **Understanding of CAMS prior to the project;**
   - **level of awareness of CAMS;**
   - **source of awareness;**
   - **perception of CAMS;**
   - **expectations about using the service;**
   - **ability to pay for treatments;**

4. **Referral to the Project**
   - **process of referral;**
   - **Interaction with GP / GP explain reasons for referral;**
   - **any apprehension or anxiety;**
   - **level and detail of the explanation given by GP;**
   - **Did GP indicate that treatments complementary and not alternative?**
   - **should you have been provided with anything additional?**
   - **how long did they have to wait;**
   - **issues around waiting time;**

5. **Treatments**
   - **Types of treatments;**
   - **Location accessible / timing of treatments;**
   - **How many treatments / sessions;**
   - **Given advice and information on how to manage condition?**
   - **Was this advice / information helpful;**
   - **Did patients make any lifestyle changes as a result of this info/advice?**
   - **Should you have been provided with anything additional;**
   - **Completion of Treatments;**
   - **If not completed treatments – why not?**
   - **Views on practitioners / explanation / communication;**
   - **Understanding the treatments;**
   - **Sharing medical history with someone other than GP;**
   - **Practitioner respect, interest, attention and friendliness etc;**
   - **Satisfaction with amount of time given by practitioner;**

6. **Impact of Treatments**
   - **Views on completing the MYMOP questionnaires;**
   - **General views on impact of the treatments;**
   - **Please list the effects if any (i.e. relief of symptoms; increased mobility; reduction in worry; reduction in pain; improvement in social and emotional wellbeing; reduction in social isolation etc);**
   - **Has quality of life improved;**
   - **Has general health improved?**
   - **Did symptoms improve?**

- **Did you feel as if you were getting a sense of control over the pain associated (if appropriate) with your condition?**
- **Which symptoms were more / less responsive to treatments;**
- **If treatments were ineffective, were alternative treatments offered and did you avail of these treatments if offered?**
- **Any reduction / increase in use of medications?**
- **Did they see the treatments as being complementary to their existing treatments rather than alternatives?**
- **Are patients less worried about their health / health condition as a result of the treatments;**

7. Other Impacts

- **any changes to circumstances as a result of the project e.g. change in employment status; benefits; uptake of voluntary / community work etc;**

8. Service Improvement / Development

- **Anything about the treatments / services they would like to see changed or improved;**
- **identify key strengths of the project;**
- **identify key weaknesses of the project;**
- **recommend treatments to others;**
- **likelihood of continuing with treatments in a private capacity;**
- **affordability issues;**
- **Concluding comments.**

GPs and Practitioners

1. **Introduction and Background to the Project**

2. **Understanding of CAMS prior to the project;**
   - **why get involved with the project;**
   - **level of awareness of CAMS (directed at GPs);**
   - **source of awareness (directed at GPs);**
   - **perception of CAMS (directed at GPs);**
   - **enquiries about CAMS (directed at GPs);**
   - **expectations about getting involved in the project;**

3. **Selection and Recruitment of Patients**
   - **identifying patients to participate;**
   - **patient reaction;**
   - **overview of patient profile – particular conditions etc / single conditions or multiple conditions;**
   - **capacity to deliver treatments;**

4. **Referral to the Project**
   - **process of referral – efficient, straightforward etc;**
   - **any apprehension or anxiety;**
   - **level and detail of the explanation given;**
   - **any other materials / support which should have been made available to patients;**
   - **level of uptake;**
   - **reasons why some patients declined – any pattern?**
   - **waiting times;**
   - **issues around waiting time;**

5. **Treatments**
   - **Types of treatments;**
   - **Location accessible / timing of treatments;**
   - **How many treatments / sessions;**
   - **Did the project offer enough treatment sessions;**
   - **Give advice and information on how to manage condition?**
   - **Was this advice / information accepted / compliance;**
   - **Did patients make any lifestyle changes as a result of this info/advice?**
   - **Should you have been provided with anything additional;**
   - **Completion of Treatments;**
   - **If not completed treatments – why not?**
   - **Sharing medical history with someone other than GP;**

6. **Impact of Treatments**
   - **Views on completing the patient questionnaires;**
   - **General views on impact of the treatments;**
   - **Please list the effects if any (i.e. relief of symptoms; increased mobility; reduction in worry; reduction in pain; improvement in social and emotional wellbeing; reduction in social isolation etc);**
   - **Evidence of any change in quality of life of patients?**
   - **Has general health improved?**
   - **Did symptoms improve?**

- **Which symptoms were more / less responsive to treatments;**
- **If treatments were ineffective, were alternative treatments offered and did you avail of these treatments if offered?**
- **Any reduction / increase in use of medications?**
- **Did they see the treatments as being complementary to their existing treatments rather than alternatives?**
- **Are patients less worried about their health / health condition as a result of the treatments;**
- **Relationship between GP/ Practitioner and patient;**

7. **Other Impacts**
    - **any reduction in workload of GPs;**
    - **impact of project positive or negative – explain;**
    - **has the level of prescribing changed;**
    - **has referral level of secondary care services changed?**
    - **any other economic benefits for the practice?**
    - **Savings versus outcomes?**
    - **Other impacts on patients;**
    - **Raising patient expectations?**
    - **Would they have liked to have referred more patients?**
    - **Any tensions between supply and demand?**
    - **Measuring outcomes – any concerns?**

8. **Service Improvement / Development**
    - **Anything about the treatments / services they would like to see changed or improved;**
    - **identify key strengths of the project;**
    - **identify key weaknesses of the project;**
    - **recommend / refer treatments to others;**
    - **likelihood of patients continuing with treatments in a private capacity;**
    - **practice support for CAMS;**
    - **should CAMS be available on the NHS?**
    - **Issue of using chaperones;**
    - **Role and skills of practitioners;**
    - **Capacity in N Ireland;**
    - **Cost of CAMS;**
    - **Evidence of patients availing of CAMS privately following project;**
    - **the fit between complementary therapies and general practice;**
    - **Concluding comments.**

Cabby:

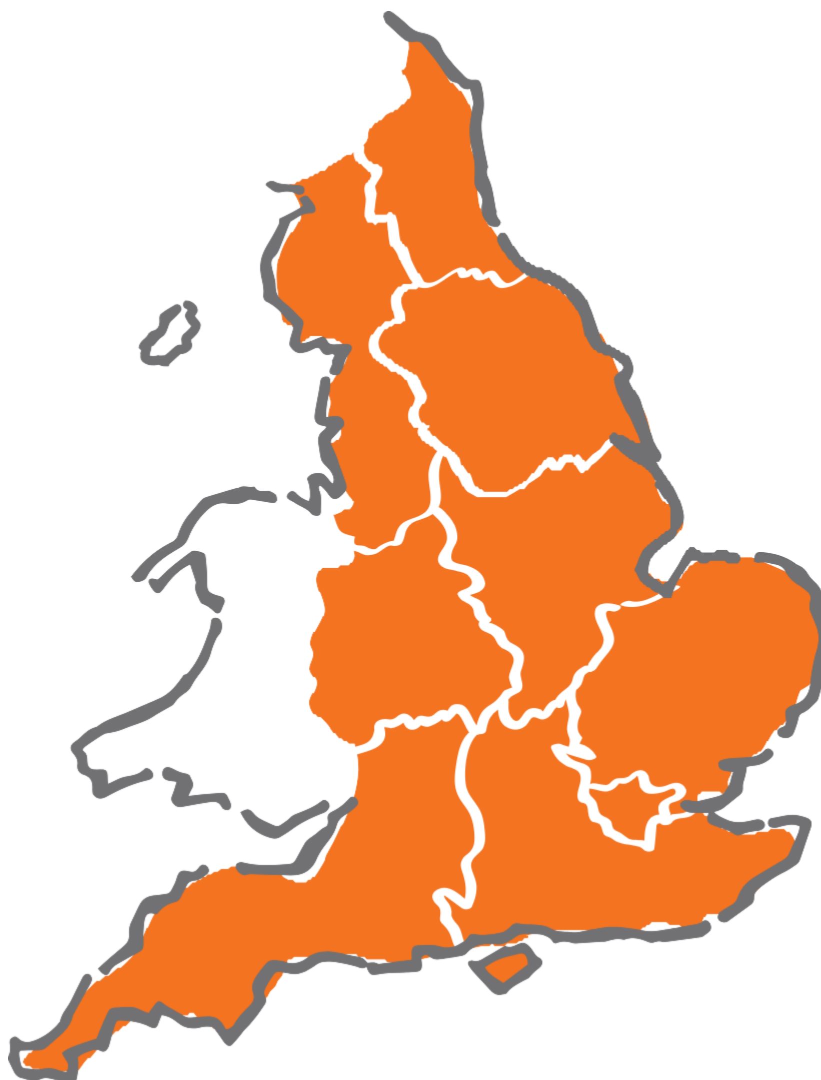
Low point;
Building up;
Lucky practitioners;
Links practitioners with Get Well UK;

Next page

Arthritis Research UK

A FAIR ASSESSMENT?

Musculoskeletal conditions: The need for local prioritisation



ARTHRITIS RESEARCH UK

Arthritis Research UK is the charity dedicated to stopping the devastating impact that arthritis has on people's lives. Everything that we do is focused on taking the pain away and keeping people active. Our remit covers all conditions which affect the joints, bones and muscles including osteoarthritis, rheumatoid arthritis, back
pain and osteoporosis. We fund research into the cause, treatment and cure of arthritis, provide information on how to maintain healthy joints and bones and to live well with arthritis. We also champion the cause, influence policy change and work in partnership with others to achieve our aims. We depend on public support and the generosity of our donors to keep doing this vital work.

CONTENTS

1. Introduction 3
2. Executive Summary 5
3. A background to common characteristics 5
4. What we did 7
5. Why are musculoskeletal conditions of interest to local authorities? 8
6. Why should this report be of interest to local authorities? 9
7. The system 11
8. Results 12
9. Conclusion and recommendations 15
10. Appendix including methodology and data tables 19

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1. INTRODUCTION

Arthritis and musculoskeletal conditions encompass a wide range of health conditions affecting bones, joints and muscles, pain syndromes and rarer conditions of the immune system. They are predominantly long term conditions and are characterised by pain, stiff and limitation of movements. Musculoskeletal conditions such as osteoarthritis, back pain and fragility fractures owing to osteoporosis have a considerable impact on quality of life.

The pain caused by musculoskeletal conditions can have a devastating impact on people's lives. It is a widespread problem which affects every community: for knee osteoarthritis (the most common form of osteoarthritis) prevalence ranges from 15% to 21% of people across England.[1] Each year there are 89,000 hip fractures, at an annual cost of £2 billion.[2,3] Back pain is a substantial cause of working days lost and its indirect economic costs to the UK are £10 billion.[4]

The wider national impact of musculoskeletal conditions has been known for some time. They represent the 4th largest NHS programme budget, and each year one in five of the general population consults a GP about a musculoskeletal problem.[5,6] 30.6 million working days are lost each year owing to these conditions, with rheumatoid and osteoarthritis costing the economy £14.8 billion each year.[7,8]

This is a problem which will only become more acute as we live longer as a population. An ageing population combined with growing levels of obesity and physical inactivity, will result in an increase in the number of people living with musculoskeletal conditions. Such an increase could lead to health and social care services becoming overwhelmed, unless early action is taken.

There is often a misunderstanding that '*nothing can be done*' if you have arthritis. There is, however, much that can be done to take a *public health* approach: increasing physical activity and keeping a healthy body weight can markedly reduce the risk of developing a musculoskeletal problem. A public health approach* can also reduce pain and increase mobility for those already living with the conditions, helping to mitigate the impact on their lives.

Prior to the Government's reform of the health and social care system in 2012, the system was geared towards a centrally directed approach to tackling these problems. Following the reforms, responsibility for public health now resides with Public Health England and *delivery* of a public health approach has been devolved to local authorities.

At the heart of devising and delivering this new responsibility are the two documents that local authorities have a statutory duty to produce: the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS). It is from these two documents that the direction of local healthcare activities should flow, particularly in relation to public health.

The UK analysis of the Global Burden of Disease 2010 identifies musculoskeletal conditions as the largest contributor to the burden of disability in the UK – in 2010, such conditions accounted for 30.5% of all years lived with disability.[9] When this data is considered alongside local authority prevalence figures for hip and knee osteoarthritis[†] the picture is clear: the prevalence of musculoskeletal conditions is such that all local authorities should include these conditions in their assessments.

We were concerned that this widespread prevalence is not reflected in these documents. We therefore examined every JSNA and JHWS for the number of mentions of musculoskeletal conditions alongside the context in which they are mentioned.

The results of this work are required reading for all councillors and public health officials. They demonstrate that whilst some local authorities are delivering quality assessments, many are failing to capture the health needs of people living in their community with musculoskeletal conditions. We hope that this report is the first step to changing that.

*A life course approach to musculoskeletal conditions is outlined in Arthritis Research UK's 'Musculoskeletal health: a public health approach'. [†All fi es are available at www.arthritisresearchuk.org/mskcalculator]

2. EXECUTIVE SUMMARY

2.1 Key findings

- One in four local authorities (26%) have not included any mentions of arthritis, musculoskeletal conditions or osteoarthritis in their Joint Strategic Needs Assessment.
- Only 36% (55) of local authorities mentioned osteoarthritis in their Joint Strategic Needs Assessment; only 38% (58) of local authorities included back pain.
- 93% (142) of JSNAs and 57% (86) of JHWSs mention falls, fragility fractures, bone health and osteoporosis. Overall, musculoskeletal conditions were included in 95% (144) of JSNAs.
- Only one local authority included osteoarthritis in their Joint Health and Wellbeing Strategy.
- There was variation across the JSNAs and JHWSs examined, both from the perspective of number of mentions and their context.

2.2 Recommendations

- Overview and Scrutiny Committees to conduct an investigation in local authorities that this report identifi as failing to accurately assess the needs of those in their area living with musculoskeletal conditions.
- Local authorities should include data on major musculoskeletal conditions in their JSNA and JHWS, using data sources including the musculoskeletal bulletins produced jointly by Arthritis Research UK and Public Health England.
- The Department of Communities and Local Government and the Department of Health should jointly host a national portal with up to date links to every JSNA and JHWS, to share learning between local people, national charities and local government.
- For the National Audit Offi , using its new responsibilities under the Local Audit and Accountability Act 2014, to assess the effectiveness of the JSNA/JHWS process in relation to long term conditions including musculoskeletal conditions, and in particular to determine whether this can be improved through the availability of increased guidance for local authorities in relation to these conditions.
- Public Health England should act as a hub for the dissemination of best practice and data amongst local authorities, driving improvement in services for people with musculoskeletal conditions.

3. A BACKGROUND TO COMMON CHARACTERISTICS

Musculoskeletal conditions encompass a wide range of health conditions affecting bones, joints and muscles, pain syndromes and rarer conditions of the immune system. They are predominantly long term conditions and are characterised by pain, stiff and limitation of movements. Symptoms and severity can vary greatly amongst different people, different joints and over time. Broadly, there are three main groups of musculoskeletal conditions
– infl ory conditions, conditions of musculoskeletal pain, and osteoporosis and fragility fractures‡.

Figure 1 explores each of these groups in greater detail.

Figure 1: The common characteristics of musculoskeletal conditions

Group	1. Inflammatory conditions	2. Conditions of musculoskeletal pain	3. Osteoporosis and fragility fractures
Example	Rheumatoid arthritis.	Osteoarthritis, back pain.	Fracture after a fall from a standing height
Age	Any.	More common with rising age.	Mainly affects older people.
Progression	Often rapid onset.	Gradual onset.	Osteoporosis is a gradual weakening of bone. Fragility fractures are sudden discrete events
Prevalence	Common (e.g. around 400,000 adults in the UK have rheumatoid arthritis.)	Very common (e.g. 8.75 million people in the UK have sought treatment for osteoarthritis.)	Common (e.g. around 89,000 hip fragility fractures occur each year in the UK.)
Symptoms	Common musculoskeletal symptoms include pain, joint stiffness and limitation of movement. Symptoms often fluctuate in severity over time.		Osteoporosis itself is painless. Fragility fractures are painful and disabling.
Extent of disease	Can affect any part of the body including skin, eyes and internal organs.	Affects the joints, spine and pain system.	Hip, wrist and spinal bones are the most common sites of fractures.
Main treatment location	Urgent specialist treatment is needed, and usually provided in hospital outpatients.	Primary care for most people. Joint replacement requires hospital admission.	Primary care for prevention. Hospital for treatment of fractures.
Interventions	A range of drugs and support.	Physical activity, pain management. For severe cases joint replacement may be necessary.	Bone strengthening drugs and fracture liaison services reduce future fracture risk. Fractures may require surgery
Modifiable risk factors	Smoking.	Injury, obesity, physical activity.	Smoking, alcohol intake, poor nutrition including insufficient vitamin D, physical activity

‡In this report we have focused on fractures that are due to an underlying musculoskeletal

4. WHAT WE DID

The research collated and analysed Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs) for the 152 local authorities with a statutory duty to produce these documents.§
We specifically focused on these documents because local authorities, alongside their Clinical Commissioning Groups and through their Health and Wellbeing Board, have a statutory duty to produce them. There is also a clear expectation that such documents will be publicly available to ensure local transparency and accountability.

The research included supporting documents to JSNAs and JHWSs which were publicly available online.

The purpose of the research was two-fold: firstly, to understand if local authorities were routinely identifying and planning for the needs of people with musculoskeletal conditions in these documents. Secondly, for those
musculoskeletal conditions which received the *most* mentions in each JSNA and JHWS, we looked at the context to identify the level of understanding of burden, risk factors and commitments to action.

The first part of the analysis was a quantitative assessment of the JSNAs and JHWSs. The number of references to musculoskeletal conditions within each JSNA and JHWS across England were recorded. These mentions were categorised and logged for each document across four categories:

1. Generic mentions of arthritis and musculoskeletal conditions/diseases;
2. Osteoarthritis;
3. Back/back pain;
4. Fragility fractures, bone health, osteoporosis, and falls owing to an underlying musculoskeletal condition

The second part of the research was an assessment of the context of the musculoskeletal mentions. Using the number of mentions of each category as a proxy for the prioritisation in any given JSNA, we examined the leading category/categories to understand the context across three aspects:

- The burden of musculoskeletal conditions;
- The awareness of the risk factors;
- The local and national commitments to action.

This enabled us to identify whether a local authority was ‘at the start’ of their journey in planning for musculoskeletal conditions or whether the understanding in these documents was developed or advanced.

Please see the Appendix for the methods section, and detailed results.

5. WHY ARE MUSCULOSKELETAL CONDITIONS OF INTEREST TO LOCAL AUTHORITIES?

5.1 Musculoskeletal conditions: the impact

Musculoskeletal conditions have a substantial impact on society, the health service and individuals.

Society: Affecting nearly 10 million people, the impact of musculoskeletal conditions on society is significant.
30.6 million working days lost are due to sickness absence caused by a musculoskeletal condition.[10] The combined indirect cost of osteoarthritis and rheumatoid arthritis to the economy is estimated to be £14.8 billion and the indirect economic costs of back pain in the UK is £10 billion.[11,12]

The impact of an ageing society is likely to have a profound impact on the numbers of people living with a musculoskeletal condition. The number of people aged over 65 with a musculoskeletal condition in England and Wales is predicted to increase by over 50% by 2030.[13]

The health service: In 2012 alone musculoskeletal conditions led to 86,000 hip replacements and 90,000 knee replacements.[14] Each year 20% of the general population consults a GP about a musculoskeletal condition.[15] There are 89,000 hip fractures each year in the UK,[16] accounting for annual health and social care costs of around
£2 billion.[17]

Individuals: Musculoskeletal conditions stop people from doing things that are so often taken for granted like going to work, playing with our children or grandchildren, or going out with friends.

6. WHY SHOULD THIS REPORT BE OF INTEREST TO LOCAL AUTHORITIES?

Musculoskeletal conditions have often not received the same level of policy attention or interest as other long term conditions. Barriers to prioritisation have included a lack of prevalence data, the complexity of these diseases and a mis-perception that 'nothing can be done'. Often, musculoskeletal conditions have been placed in the 'too difficult' box.[18]

This is unacceptable, because as the 2010 Global Burden of Disease demonstrates, musculoskeletal conditions are now the largest contributor to the burden of disability in the UK.[19] The high prevalence of these conditions
– which includes back pain, osteoarthritis and fragility fractures – is such, that irrespective of locality, musculoskeletal conditions will have a great impact on the health needs of local people. Nationally 1 in 5 people has osteoarthritis; 1 in 10 severe back pain; and each year 89,000 people will have a hip fracture.[20,21]

As the main risk factors for developing a musculoskeletal condition are ageing, obesity and physical inactivity the number of people experiencing these conditions will only grow in number. This will result in an even greater burden being placed on health and social care.

One of the main symptoms of arthritis is pain. There has been a historic misconception that nothing can be done, and pain should be tolerated, because this is just part of 'getting older'. But the growing weight of evidence is clear: the pain of arthritis is not inevitable. There is much that can, and should, be done to ensure that people have good bones, muscles and joints throughout their lifetime.

A public health approach across the life-course has much merit for musculoskeletal conditions. From a primary prevention perspective, risk factors such as obesity are common to the development of many conditions,
such as osteoarthritis and diabetes. From a secondary prevention perspective, ensuring a person with painful osteoarthritis exercises and maintains a health body weight, can reduce the impact of the disease. In the case of fragility fractures, there is also good evidence of what works well: a fracture liaison service linked to every hospital can help prevent further fractures.[22]

Reform of the health system in 2012 devolved significant powers to local authorities in relation to public health. The significant economic impact of musculoskeletal conditions, coupled with financial constraints facing local authorities, means that there is a strong impetus to *include musculoskeletal conditions in health plans now, to save funds later.* Musculoskeletal conditions should be placed on an equal footing with other long term conditions. The pain of arthritis may not be visible, but the people who live with its pain should be recognised.

6.1 Working in partnership with Arthritis Research UK

This report contains details of the extent to which local authorities included musculoskeletal conditions in their Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies available in February – March 2014. Publishing the data enables people with an interest in public health – and the performance of their local authority – to understand the extent to which the burden of musculoskeletal conditions is included. You can see the full data tables in the accompanying document "A Fair Assessment: Data on the extent that local authorities prioritise musculoskeletal conditions. " This can be seen at **www.arthritisresearchuk/jsna**.

Our decision to collect and publish the data on inclusion of musculoskeletal conditions in JSNAs and JHWSs was taken to enable local authorities to understand the extent to which the burden of musculoskeletal conditions on individuals, the health and social care services and society are being recognised and understood. It also enables comprehension by focusing on the evidence base. Arthritis Research UK is keen for this to be the beginning
of a conversation about how we can work in partnership to develop the health and wellbeing of people with musculoskeletal conditions.

To facilitate such a discussion, Arthritis Research UK has worked with Public Health England to produce a range of briefings and tools which can be of use in this field. In part these are based on work that Arthritis Research UK has undertaken in partnership with Imperial College London to provide local prevalence estimates for four musculoskeletal conditions: hip and knee osteoarthritis, rheumatoid arthritis, back pain and fragility fractures. As the data becomes available we are sharing it with local authorities and others at **www.arthritisresearchuk.org/mskcalculator**

To help public health practitioners and local authorities respond to the needs of people with, or at risk of, musculoskeletal conditions, Arthritis Research UK has also published a report focusing on *Musculoskeletal health: a public health approach.* This report details a life-course approach to musculoskeletal health and brings together the evidence on the relevant risk factors. This report will be of interest to those who wish to understand the key facets of a primary and secondary prevention approach to musculoskeletal conditions. Copies alongside other policy reports are available online at: **www.arthritisresearchuk.org/policyreports**

7. THE SYSTEM

7.1 Role of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy

Joint Strategic Needs Assessments (JSNAs)

Since April 2013, it has been the statutory duty of local authorities and Clinical Commissioning Groups to produce a JSNA. The core purpose of this document is to undertake 'a comprehensive analysis of the current and future needs and assets of their area'.*[23] This allows Health and Wellbeing Boards (HWBs) to investigate the range of resources available and consider wider factors that may be relevant in improving health and wellbeing outcomes.

The JSNA is specific to their local area in both content and design. As such, there is no structure, format or data set that is compulsory; however, both quantitative and qualitative evidence should be included and they should draw on existing tools. Local authorities do have 'equal and joint duties' to prepare their JSNAs via their Health and Wellbeing Boards.[24]

People living with musculoskeletal conditions will have different needs, depending on the severity of the condition they have. JSNAs should accurately refl t the diverse nature of musculoskeletal conditions, and provide a comprehensive assessment of the burden placed on their local community by all musculoskeletal conditions.

Joint Health and Wellbeing Strategies (JHWSs)

JHWSs are designed to provide 'a continuous process of strategic assessment and planning' with a core aim of developing 'local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities'.[25]

JSNAs will outline the health needs of the local population. Using this as a starting point, JHWSs will move local authorities from 'assessing needs and available assets to planning the delivery of integrated local services based upon those needs and assets, and collectively addressing the underlying determinants of health and wellbeing'.[26] The JHWS should look to address the needs identified in the JSNA. JHWSs are also expected to take into account the Government's priorities for NHS England as outlined in the Mandate.[27]

How the assessment of local health needs translates into the planning and commissioning cycle

Health and Wellbeing Boards aim to employ an outcomes-based approach. The health needs of the local population will infl priorities and these will be translated into outcomes. This outcomes based approach will infl services and inform local commissioning.[28]

HWB membership is varied and therefore by design encourages consideration of priorities across health, social care and public health services to develop a shared set of priorities and outcomes for the area. The JSNA and the JHWS should flow seamlessly within the commissioning cycle to provide integrated, outcome-driven services. If a health need is identified at the beginning of the process it can have a ripple effect as a local priority across the commissioning cycle.

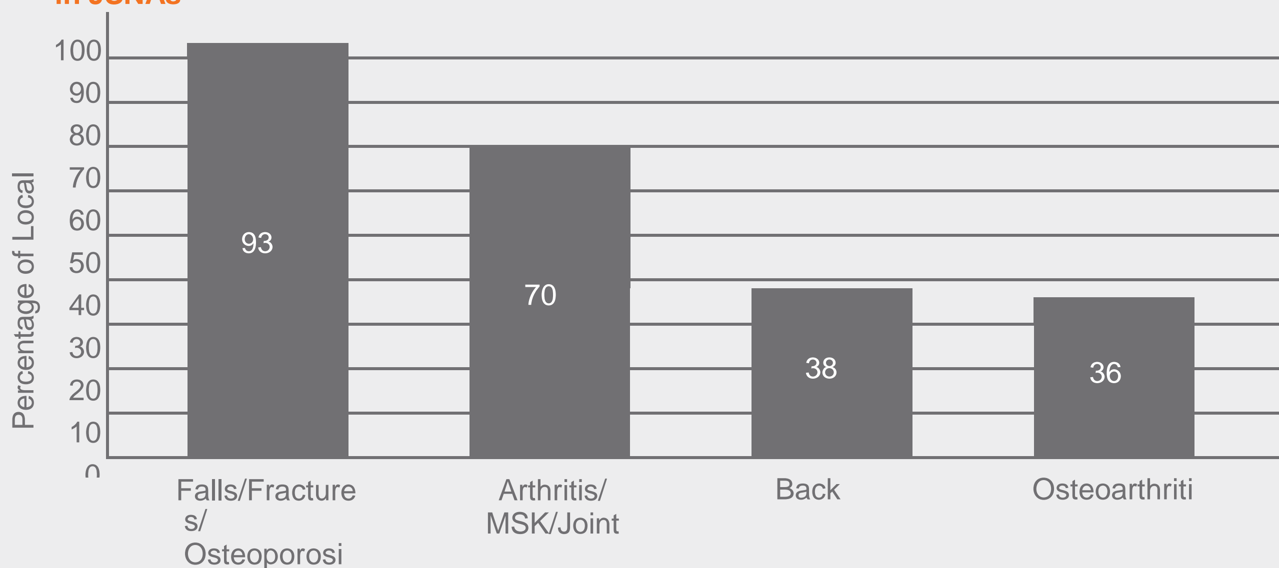
*An 'asset' includes anything which could be utilised to improve outcomes and have an impact on the wider determinants of health.

8. RESULTS

8.1 Frequency of mention

Nearly all local authorities included musculoskeletal conditions in the JSNA to some extent. This was dominated by *falls, fragility fractures, bone health and osteoporosis* which featured in 142 (93%) of JSNAs. When general mentions of *musculoskeletal conditions* are combined with *osteoarthritis* in the analysis, it emerged that 26% (40) of local authorities did not include any mentions of arthritis.

Figure 2: Inclusion of musculoskeletal conditions by local authorities in JSNAs



Falls, fragility fractures, bone health and osteoporosis

Of the 142 local authorities that included these conditions, 27% (38) made frequent reference to these in their JSNA (over 50 mentions), suggesting a highly detailed consideration. In the JHWS, this category was
mentioned by 57% (86) of local authorities. Almost three quarters (73%, 63) of those strategies which included this category did so fewer than five times ("basic"), with only one mentioning this over fifty times ("substantial").

General mentions of arthritis and musculoskeletal conditions

The second most common category was *arthritis and musculoskeletal conditions*, which appeared in 70% (106)
of JSNAs. Of these, only four mentioned these conditions frequently (over 50 mentions) in their JSNA. In the JHWS, this category was mentioned by 15% (23) of local authorities, all fewer than five times ("basic").

Back pain

Only 38% (58) of local authorities included back pain in their JSNA. Of those JSNAs which did include back pain the majority (83%, 48) mentioned back pain fewer than 5 times ("basic"). In the JHWS, ten local authorities (7%) mentioned back pain, all fewer than five times ("basic").

Osteoarthritis

Osteoarthritis was mentioned in 36% (55) of JSNAs. Of these, the vast majority (93%, 51) of these mentioned it fewer than 5 times ("basic"). Only one local authority in England mentioned osteoarthritis in its JHWS.

Content analysis

A content analysis was carried out to understand more about how local authorities had handled musculoskeletal conditions. Selecting the musculoskeletal condition that was mentioned most frequently, reviewers rated JSNAs and JHWS by the degree to which they included an assessment of the burden, the associated risk factors for this condition and the commitment to action to address the health need.

Falls, fragility fractures, bone health and osteoporosis were the most common category in 127 JSNAs. Overall ratings were strong with 40% (51) of these being rated by reviewers as “developed” with 25% (32) awarded the highest rating of “advanced”. The second most commonly mentioned category was arthritis and musculoskeletal conditions which was the leading category in 16 JSNAs.[††] The majority, 87.5% (14) were rated “at the start”.

In the JHWS content analysis, *falls, fragility fractures, bone health and osteoporosis* was again the most common category, leading in 60% (86) of JHWS reviewed. These were treated less comprehensively than in the JSNAs with 73% (63) of these assessed as being “at the start”, and only three thought to be “developed”. The leading categories in the remaining JHWS were *arthritis and musculoskeletal conditions* in 16 cases, and back pain in four.

Analysis

The high level of recognition of falls, fragility fractures and osteoporosis is welcomed. Fragility fractures have a substantial impact on people’s lives, in particular those of older people. There are 89,000 hip fractures each year and 14,000 people each year die following a hip fracture.[29] Local authorities have a large role supporting and enabling people to return to their home after a fall via community interventions such as home adaptations, reablement and care services, alongside providing supported living and care home environments for those unable to return to independent living. The high costs associated with this role may in part explain why these conditions were strongly represented in the assessments and strategies.

It is disappointing that other musculoskeletal conditions are getting missed in comparison. 26% of local authorities did not recognise the needs of people living with *arthritis* in their JSNAs. This is worrying considering the large size of the burden.[30] Given the widespread prevalence of osteoarthritis, it is unfair for local authorities to fail to identify the needs of people living with painful osteoarthritis.

Key risk factors for osteoarthritis are ageing, obesity and physical inactivity. Osteoarthritis is amenable to a public health approach and has been described as ‘an unrecognised public health priority’ by the Chief Medical Officer, Professor Sally Davies.[31] Obese people are more than twice as likely to develop osteoarthritis of the knee as those of normal body weight.[32] The increase in risk of developing knee osteoarthritis due to obesity appears to be similar to that of developing high blood pressure or type 2 diabetes due to obesity.[33] Local authorities with their recently realised responsibility for delivery of public health, are ideally placed to incorporate lifelong musculoskeletal health within their physical activity and weight management programmes.

62% of local authorities also failed to recognise the health needs of people living with back pain in their JSNAs. Back pain is a major cause of both pain and working days lost. Though often self-limiting, one in six adults aged over 25 years reports *back pain lasting over three months in the last year*.[34] There is a wider societal impact: £10 billion of indirect costs are attributable to back pain in the UK.[35]

The prevalence of back pain is high: 17% of the population in England has back pain.[36] When even the local authorities with the lowest prevalence[‡‡] have more than one in ten of their population with back pain, there is no justification for not including it in their JSNA.

Across all musculoskeletal conditions, mentions in JSNA did not necessarily translate clearly into JHWSs. There could be a number of reasons for this: local authorities may have focused across all long term conditions or risk factors which impact on a number of conditions. Or arthritis may not be a local priority; or there may be a local perception that ‘nothing can be done’ to tackle the pain of arthritis. For more detailed information please see the tables in the Appendix and the detailed companion document online at www.arthritisresearchuk.org.

[††] Please note that 6 local authorities mentioned two categories of conditions the most frequently and therefore more than one condition was included in the second analysis for 6 local authorities.

[‡‡] The range for back pain is between 11.78% and 21.44% of the population in England. The average is 17% of the population has back pain.

What does good look like: Hampshire County Council's focus on musculoskeletal conditions

Hampshire County Council published two dedicated chapters about musculoskeletal health: one assessing the needs of people living with musculoskeletal conditions specifically and a second looking at chronic pain generally. While recognising the difficulties posed by the lack of population level data about prevalence of musculoskeletal conditions, they were clear that an ageing population will most likely increase demand for services.

Using national data about GP visits, they estimated the local population affected by musculoskeletal conditions. They illustrated current impact and predicted future demand by incorporating clinical activity and trend data for fall and fractures, and hip and knee replacements. Unexpected variation in rates of a number of clinical procedures was described and questioned. Their focus on the impact of chronic pain was particularly strong. They included national data from sources including the Health Survey for England 2011 chapter on chronic pain, and the Labour Force Survey statistics for musculoskeletal work-related illnesses to understand relationships with quality of life and workplace participation.

Hampshire's assessment of the needs of the population with musculoskeletal conditions is generally good. It takes a life-course approach to bone health, demonstrating that at every age there are modifiable factors that will reduce fragility fractures in later life. The breadth of musculoskeletal conditions and their impact is addressed, recognising the burden on individual health, the impact on workplace participation and the implications for services. There is a thorough presentation of the evidence for what works to improve

9. CONCLUSION AND RECOMMENDATIONS

The transfer of responsibility for public health to local authorities is a welcome opportunity to adopt new approaches to old problems, not least in relation to musculoskeletal conditions.

Local authorities should know the needs of their local residents better than anyone, and it is right that they, in conjunction with other agencies, are the ones to produce JSNAs to assess the health needs of their local community and then devise a strategy to meet those needs.

This is why it is so disappointing that so many local authorities seem to have a blind spot when it comes to the most common musculoskeletal conditions, osteoarthritis and back pain. The evidence is clear: there is widespread prevalence of osteoarthritis in local authority areas, ranging between 15% and 21%.[37]

It is therefore regrettable that only 36% of local authorities have included osteoarthritis in their JSNA; and 26% of local authorities have not mentioned either osteoarthritis or arthritis. It is even more regrettable that, despite the impact that it can have on quality of life, only one local authority included osteoarthritis in their JHWS.

Unfortunately the picture is similar in relation to back pain. Although our musculoskeletal calculator shows that 17% of the general population suffer from some form of back pain across the country,[38] only 38% of local authorities have assessed the needs of those with back pain in their JSNAs.

There is an opportunity for change and improvement here. It is for this reason that we are calling on Overview and Scrutiny Committees to investigate why the needs of people – in particular those with arthritis and back pain
– are being missed from Joint Strategic Needs Assessments.

Although musculoskeletal conditions remain an area in which we need to collect much more data, estimates on prevalence are now becoming available,[§§] and they must be used if local authorities are to develop a more accurate picture upon which to base their decisions about services.

Whilst we welcome localism in relation to public health and all of the opportunities that it brings, there is an opportunity for greater partnership working between local and national agencies. Public Health England
should act as a hub of best practice; and the National Audit Office should use its new responsibilities to bring greater understanding of the effectiveness of the JSNA/JHWS in relation to long term conditions, including musculoskeletal conditions.

Finally, we would like to see the Department of Communities and Local Government working in partnership with the Department of Health on a national portal for JSNAs and JHWSs. This will enable local authorities to learn from each other: it will also enable easy access and comparison by those residents who wish to hold their local elected representatives to account.

This project has recognised that, in relation to falls and fragility fractures, local authorities are demonstrating the potential of the assessment process, with 93% mentioning osteoporosis, falls and fractures. This is to be welcomed. But if the JSNA process is to provide a *fair* assessment of musculoskeletal conditions in England, it needs to ensure that the documents truly reflect the health needs of the local population.

[§§] Sources include the 2011 Global Burden of Disease and Arthritis Research UK's MSK Calculator.

9.1 Recommendations

The following recommendations are intended to build upon the work that is already done, or is in progress, to improve the health and wellbeing, both physically and mentally, for people affected by musculoskeletal
conditions. They reinforce how organisations at different levels each have a role in ensuring that the needs of the population are accurately assessed and services are subsequently available, easily accessible and fit for purpose to ultimately deliver real improvements in musculoskeletal health.

» Overview and Scrutiny Committees should conduct an investigation in local authorities that this report identifi as failing to accurately assess the needs of those in their area living with musculoskeletal conditions.

» Local authorities should include data on major musculoskeletal conditions in their JSNA and JHWS, using data sources including the musculoskeletal bulletins produced jointly by Arthritis Research UK and Public Health England.

» The Department of Communities and Local Government and the Department of Health should jointly host a national portal with up to date links to every JSNA and JHWS, to share learning between local people, national charities and local government.

» For the National Audit Offi , using its new responsibilities under the Local Audit and Accountability Act 2014, to assess the effectiveness of the JSNA/JHWS process in relation to long term conditions including musculoskeletal conditions, and in particular to determine whether this can be improved through the availability of increased guidance for local authorities in relation to these conditions.

» Public Health England should act as a hub for the dissemination of best practice and data amongst local authorities, driving improvement in services for people with musculoskeletal conditions.

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This report was produced by by the Arthritis Research UK policy and public aff team. Further information on our work is available at **www.arthritisresearchuk.org/policyreports**

10. APPENDIX

Methodology

The purpose of the research was two-fold: fi , to understand if local authorities were routinely identifying and planning for people with musculoskeletal conditions in their JSNAs and JHWSs. Secondly, for those
musculoskeletal conditions which received the most mentions in each JSNA and JHWS, we wished to identify the level of understanding of burden, risk factors and commitments to action.

1. Collection of JSNA and JHWS documents

A list of all 152 local authorities with responsibility for public health in England was assembled. This list identifi that there was a mix of local authorities ranging from London boroughs to unitary authorities with upper
tier responsibilities. In the context of this report when we refer to 'local authorities' we are referring to those local authorities with a statutory duty to produce a Joint Strategic Need Assessment and Joint Health and Wellbeing Strategy.

This list was utilised to source all JSNA and JHWSs over a period of three weeks from 17th February 2014 and 7th March 2014. The documents were sourced primarily from internet sources with a small number being sourced by contacting the relevant local authorities directly.

2. Quantitative analysis

The fi part of the analysis was a quantitative assessment of the JSNAs and JHWSs. The number of references to musculoskeletal conditions within JSNAs and JHWSs across England were recorded for 152 JSNAs and 151 JHWSs.* These mentions were categorised and logged across four categories:

- Generic mentions of arthritis, musculoskeletal (MSK) conditions/diseases and joint pain;
- Osteoarthritis: the most common form of arthritis;
- Back pain;
- Fragility fractures, osteoporosis, and falls owing to an underlying musculoskeletal condition

There are a substantial number of musculoskeletal diseases, but this project sought to focus on those musculoskeletal conditions with a high prevalence. In the interest of fairness, we focused on musculoskeletal conditions in which the burden is such that we would envisage an assessment of population level health conditions would result in the identifi of these conditions.

The specifi terms we searched for under each category were as follows:

- **Generic mentions of arthritis and musculoskeletal conditions:** we looked at the inclusion of the key words: 'arthritis'; 'musculoskeletal' and its abbreviations (MSK/MSD/MSC) and 'joint pain'.
- **Osteoarthritis:** we looked at the inclusion of the specifi term 'osteoarthritis'.
- **Back pain:** we looked at the inclusion of the specifi term 'back' and 'back pain'.
- **Fragility fractures and osteoporosis:** we looked at the inclusion of the specifi terms 'fragility fractures' (this is a term which refers to a fall from standing height which results in a broken bone), 'osteoporosis', 'bone health' and 'falls' when used in relation to osteoporosis.

We began by seeking to understand, which local authorities utilised the broad terminology of 'musculoskeletal conditions/disease/problems', alongside 'arthritis' and 'joint pain'. Owing to the prevalence of osteoarthritis, the most common form of arthritis, and back pain, a major cause of working days lost, we wished to focus on these as separate entities. We also wished to focus on fragility fractures owing to the prevalence and impact on both the health and local authority services. By collecting these data separately, we would be able to identify and understand if local authorities were stronger at identifying one musculoskeletal condition above others.

* Please note that we were unable to obtain Herefordshire County Council's JHWS.

Any mention of the above terms was logged as a single mention with the total number of mentions collected by local authority and by document type (JSNA/JHWS). To understand the frequency of mentions, we grouped these together under four headings:

- 0 mentions: no mentions
- 1-4 mentions: basic
- 5-49 mentions: moderate
- 50+ mentions: substantial

This then enabled us to understand how a local authority was performing across the different categories of musculoskeletal conditions, but also for us to identify any variation or commonalities across England.

3. Depth of understanding analysis

The second part of the project was an assessment on the depth of understanding demonstrated and context. We examined the four categories of musculoskeletal conditions and identifi which 'category' of condition had the most mentions in each JSNA and JHWS.

We then examined the quality of understanding given to three areas:

1. the burden of musculoskeletal conditions (an assessment of the numbers affected – prevalence and incidence – morbidity including disability; mortality rates; cost and impact to individuals, the health service and social care);
2. awareness of the risk factors (characterisation of the risk factors in relation to musculoskeletal conditions. These risk factors include age, physical activity, nutrition and obesity);
3. commitments to action (reference to national guidance, local initiatives and commitments).

For each JSNA and JHWS we gave an impressionistic rating out of 3 for each category. For example, if a local authority gave a cursory assessment of burden of musculoskeletal conditions then they were rated one out of three; whilst a full assessment and articulation of burden would be ranked as three. Each JSNA and JHWS could therefore achieve a maximum rating of 9 each; or 18 in total.

Following assessment, we then grouped the ratings together under four headings:

- 0 = no contextual mentions
- 1-3 per JSNA or JHWS: at the start
- 4-6 per JSNA or JHWS: developed
- 7-9 per JSNA or JHWS: advanced

This enabled us to identify whether a local authority was 'at the start' of their journey or whether the understanding in these documents was well developed ('advanced').

In order to develop consistent ratings for each category, local authorities were assessed on:

- The level and range of information included
- The balance of information and data included particularly between national information and more detailed local assessments

4. Challenges

Obtaining JSNAs and JHWSs

Local authorities choose to display their assessments in a number of different ways: some included all documents in their primary JSNAs; whilst other decided to 'house' some of their insights in supporting documents. As this project wished to compare 'like with like', if the supporting document was of clear and substantial relevance
to the assessment (eg identifying health needs for people with long term conditions) it was included in the assessment.

Part of the statutory duties relating to JSNAs is that they should be publicly available. If, therefore, a public health team did have supporting documentation which was not made publicly available on their website, this project would not have been able to identify it.

It was challenging to both identify and obtain all JSNAs and JHWSs across England. The ease of fi
them on
websites varied; clarity of what formed part of the assessment and what didn't varied; there were also references to documents which were then not publicly available. A few areas had to be contacted multiple times in order to receive them and in the end, one local authority did not supply a JHWS.

We do recognise that local authorities may have other internal supporting documents which articulate in greater detail their understanding of musculoskeletal conditions. As JSNAs and JHWSs are intended to be publicly available statutory documents, the research wished to focus on the published information that can be utilised
to hold the system to account. As these documents are supposed to both exist and be publicly available, it's important for accountability that local residents are able to access these with ease.

Language

We appreciate that some local authorities may have utilised the generic terms of 'arthritis' when they were referring to osteoarthritis, the most common form of arthritis. This meant that whilst they were assessed as having identifi the generic 'arthritis 'category, they may have been assessed as not having identifi 'osteoarthritis' as a local health need.

Interpretation of documents

Any process for rating local authorities in this manner is naturally subjective, being open to interpretation and therefore cannot be deemed comprehensive.

One challenge of the approach taken was that, JSNAs are primarily focused on burden and therefore evaluating them on their inclusion of commitments to action may result in a lower mark for those local authorities which focused on commitments to action in their JHWSs.

Likewise, JHWSs are focused on how a local area can meet the challenges set out in the JSNA and are therefore more action-orientated. Again, a local authority which focused on a strong and clear articulation of the burden in its JSNA rather than in its JHWS may result in a lower result.

It's important to recognise that those local authorities whose documents were identifi as developed and advanced are still leading the way in their understanding of musculoskeletal conditions at a local level.

10.1 Overview of data tables

You can see the full tables, including the results for each local authority in the accompanying document "A fair Assessment: Data on the extent that local authorities prioritise musculoskeletal conditions". This can be seen at **www.arthritisresearchuk.org/jsna**

Table one: Number of local authorities which mentioned musculoskeletal conditions in their Joint Strategic Needs Assessments.

Number of mentions by local authorities with statutory responsibility for public health in their Joint Strategic Needs Assessment (% of 152 councils with responsibility for public health)				
	Arthritis, musculoskeletal conditions and joint pain	Osteoarthritis	Back pain	Fragility fractures, osteoporosis and bone
Not included (0)	46 (30.26%)	97 (63.82%)	94 (61.84%)	10 (6.58%)
Basic (1-4)	65 (42.77%)	51 (33.55%)	48 (31.58%)	35 (23.03%)
Moderate (5-49)	37 (24.34%)	4 (2.63%)	7 (4.61%)	69 (45.39%)
Substantial (50+)	4 (2.63%)	0	3 (1.97%)	38 (25%)
Overall inclusion	**106 (69.74%)**	**55 (36.18%)**	**58 (38.16%)**	**142 (93.42%)**

Table two: Spread of mentions by local authorities in their Joint Strategic Needs Assessments by condition

Spread of mentions by local authorities with statutory responsibility for public health in their Joint Strategic Needs Assessment by condition (% level of mentions in each JSNA by condition)				
	Arthritis, musculoskeletal conditions and joint pain	Osteoarthritis	Back pain	Fragility fractures, osteoporosis and bone
Basic (1-4)	65 (61.32%)	51 (92.73%)	48 (82.76%)	35 (24.65%)
Moderate (5-49)	37 (34.91%)	4 (7.27%)	7 (12.07%)	69 (48.59%)
Substantial (50+)	4 (3.77%)	0	3 (5.17%)	38 (26.76%)
Overall inclusion	**106 (100%)**	**55 (100%)**	**58 (100 %)**	**142 (100%)**

Table three: Number of local authorities which mentioned musculoskeletal conditions in their Joint Health and Wellbeing Strategies

Number of mentions by local authorities with statutory responsibility for public health in their Joint Health and Wellbeing Strategies (% of 151 councils* with responsibility for public health)				
	Arthritis, musculoskeletal conditions and joint pain	Osteoarthritis	Back pain	Fragility fractures, osteoporosis and bone
Not included (0)	128 (84.77%)	150 (99.34%)	141 (93.38%)	65 (43.05%)
Basic (1-4)	23 (15.23%)	1 (0.66%)	10 (6.62%)	63 (41.72%)
Moderate (5-49)	0	0	0	22 (14.57%)
Substantial (50+)	0	0	0	1 (0.66%)
Overall inclusion	**23 (15.23%)**	**1 (0.66%)**	**10 (6.62%)**	**86 (56.95%)**

(The Health and Wellbeing Strategy for Herefordshire County Council was not publicly available for analysis).

Table four: Spread of mentions by local authorities in their Joint Health and Wellbeing Strategy by condition

Spread of mentions by local authorities with statutory responsibility for public health in their Joint Health and Wellbeing Strategies by condition (% level of mentions in each JHWS by condition)				
	Arthritis, musculoskeletal conditions and joint pain	Osteoarthritis	Back pain	Fragility fractures, osteoporosis and bone
Basic (1-4)	23 (100%)	1 (100%)	10 (100%)	63 (73.26%)
Moderate (5-49)	0	0	0	22 (25.58%)
Substantial (50+)	0	0	0	1 (1.16%)
Overall inclusion	**23 (100%)**	**1 (100%)**	**10 (100%)**	**86 (100%)**

Table fi e: Rating of context of mentions by local authorities in their Joint Strategic Needs Assessments

Rating of the depth in which MSK conditions are considered in Joint Strategic Needs Assessments by most frequent category mention (144 JSNAs – 94.74%) included a MSK condition)				
	Arthritis, musculoskeletal conditions and joint pain	**Osteoarthritis**	**Back pain**	**Fragility fractures, osteoporosis and bone**
Rating of the extent to which MSK conditions are addressed in the JSNA	16 local authorities mentioned this category most frequently amongst MSK conditions	No local authorities mentioned osteoarthritis most frequently amongst MSK conditions	1 local authority mentioned back pain most frequently amongst MSK conditions	127 local authorities mentioned fragility fractures most frequently of all MSK conditions
No context	0	0	0	1 (0.79%)
At the start (1-3)	14 (87.50%)	0	0	43 (33.86%)
Developed (4-6)	1 (6.25%)	0	1 (100%)	51 (40.16%)
Advanced (7-9)	1 (6.25%)	0	0	32 (25.20%)

Table six: Rating of context of mentions by local authorities in their Joint Health and Wellbeing Strategies

Rating of the depth in which MSK conditions are considered in Joint Health and Wellbeing Strategies by most frequent category mentions (100 (66.23%) included a MSK condition)				
	Arthritis, musculoskeletal conditions and joint pain	**Osteoarthritis**	**Back pain**	**Fragility fractures, osteoporosis and bone**
Rating of the extent to which MSK conditions are addressed in the JHWS	16 local authorities mentioned this category most frequently, with their mentions being considered as	No local authorities mentioned osteoarthritis most frequently amongst MSK conditions	4 local authorities mentioned back pain most frequently, with their mentions being considered as	86 local authorities mentioned this category most frequently, with their mentions being considered as
No context	0	0	0	0
At the start (1-3)	16 (100%)	0	4 (100%)	63 (73.26%)
Developed (4-6)	0	0	0	20 (23.26%)
Advanced (7-9)	0	0	0	3 (3.49%)

Please note that 6 local authorities mentioned two categories of conditions the most frequently and therefore more than one condition was included in the second analysis for 6 local authorities.

Notes

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EVALUATION OF THE KENSINGTON & CHELSEA BEATING BACK PAIN SERVICE:

FINAL REPORT

ANNA CHESHIRE, MARIE POLLEY & DAMIEN RIDGE

August 2012

Kensington & Chelsea Beating Back Pain Service: Final report

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Contents

Executive summary 1
Introduction 4
Background Literature 4
The Beating Back Pain Service 6
Evaluation findings – Patient outcomes and experiences 7
Aims 7
Methods 7
Participants 8
Procedure 8
Data analysis 9
Results 10
Participant characteristics 10
Information sessions 11
Patient outcomes 12
Patient experience of BBPS 15
Conclusions 17
Evaluation findings – Stakeholder perspectives 17
Aims 17
Methods 17
Participants 17
Procedure 17
Analysis 18
Results 18
Service development and liaison 18
Patient issues 22
Communication within the BBPS team 22
Communication between the BBPS team and stakeholders 23
The Beating Back Pain Service 23
Conclusions 26
References 27
Appendix 1 – Flow of participants through the evaluation 31

Executive summary

Background The Kensington & Chelsea Beating Back Pain Service (BBPS) was a pilot service for patients with persistent low back pain delivered from October 2010 until December 2011. An evaluation, conducted by a team of researchers independent to the service, collected patient outcomes in order to examine clinical changes in patients using the service, and patient experiences of the service. In addition, interviews were conducted with a wide range of key stakeholders involved in the service. The aims of the interviews were to (a) understand the service from the perspectives of key stakeholders, and (b) improve the service by identifying any problems or issues so that they could be fed back to the service provider.

Methods Patient outcome and experience data: questionnaires were used to collect predominantly quantitative data from patients at three time points: immediately pre-BBPS intervention, on completion of the BBPS intervention, and 3 months after completion. Measures collected included musculoskeletal (MSK) pain, health-related quality of life, self-efficacy for managing pain, level of physical activity, positive well-being (hope, positivity, understanding of pain, ability to face problems and relaxation), painkiller use and work status. Open-ended questions collected written data regarding patient experience of the BBPS. All patients who attended a BBPS information session were invited to take part in the evaluation.

Interview data: Semi-structured interviews with 12 key stakeholders (including members of the BBPS Team and those who were able to refer into the Service) were conducted 6 to 8 months into the Service. Data were analysed using thematic analysis. The qualitative data analysis software tool NVivo was used to code and analyse the data in a systematic way.

Key findings

Patient outcomes and experiences

- BBPS patients often reported pain in multiple areas of their body (not just low back pain), and high levels of chronicity and mental health issues (69% of patients reported moderate to high levels of anxiety and depression).
- The majority (66%) of patients rated their information session as 'good' or 'excellent'. Patients found information sessions informative and felt they increased their understanding of pain and how to manage it.
- Comparisons between patients pre-, post-treatment and 3-month follow-up revealed a statistically significant improvement in MSK pain post-treatment, including total pain score, reduced interference with daily, work and social activities, and less anxiety associated with pain. These changes had been maintained at 3-month follow-up.
- Data analysis also showed statistically significant improvements for patients post- treatment for health-related quality of life, understanding of pain, level of physical activity and ability to relax. These improvements were maintained, with the exception of ability to relax.

- 39% of patients experienced a clinically significant improvement in their pain post-treatment and 38% experienced a clinically significant improvement at 3- month follow-up.
- There was no change in medication use and current work status.
- Patients attending self-management and acupuncture sessions experienced greater improvements in their pain, quality of life, self-efficacy for managing pain, and positive well-being (hope, positivity, ability to face up to health problems and relaxation) than those who only received acupuncture. Interestingly, changes in self-efficacy for managing pain and positive well-being became evident at 3-month follow-up (not post-treatment), suggesting improvements in these areas develop, but take time to do so.
- Patients who continued to use what they had learnt on the BBPS at 3-month follow-up experienced greater improvements in their pain and ability to self- manage compared to those who did not continue to use what they had learnt.
- Patients at high and medium risk of developing persistent symptoms experienced improvements in their MSK pain at similar levels to those at low risk of poor outcome, after using the BBPS. This suggests that the BBPS triaged patients appropriately allowing resources to be distributed appropriately according to patient need.

Stakeholder perspectives

- BBPS contact with patients using the Service was described as professional and generally well-managed
- Working as an external provider during a time of re-organisation within the NHS created challenges delivering the BBPS service and communicating with the PCT
- Referrals to the Service, especially during the first quarter, were lower than anticipated
- Challenges for stakeholders included establishing an adequate reception for acupuncture patients, two large organisations (the University and NHS) learning to work together, engaging with NHS governance, increasing referrals, and promoting patient motivation
- The challenges encountered resulted in extra demand on time and effort needed to work through the issues for the BBPS Team
- In response to patient challenges, the self-management programme needed to be restructured to meet patients' needs more effectively
- It became clear that service referral criteria of 'no upper limit for duration of pain' was most appropriate for patients, due to the relapsing-remitting nature of back pain
- More regular face-to-face meetings for the BBPS Team and the establishment of a steering group were suggested by a number of stakeholders as a key way to improve communication, and ultimately the project outcomes
- Referrals to the Service were largely considered appropriate, however, there were instances of inappropriate referrals such as disc pain, spinal stenosis or chronic pain syndromes
- Combining BBPS information sessions and acupuncture was thought to ultimately have worked well for patients

- Effective self-management programmes for relapsing low back pain are needed in the NHS, however, patient adherence to self-management may be challenging. This evaluation suggests that a flexible programme structure and better integration with existing services may improve patient engagement

Conclusions The evaluation showed that the BBPS provided Kensington and Chelsea PCT patients with a MSK pain management service that many found effective and valuable. The service was delivered in a local alternative care setting and assisted in implementing NICE Guidance for persistent low back pain locally, by working with local GPs and health professionals. Appropriate BBPS triaging of patients allowed resources to be distributed appropriately according to patient need. Patient satisfaction with the BBPS was high. Patients using the BBPS experienced improvements in their pain, quality of life, understanding of their pain, levels of physical activity and levels of relaxation, which continued 3 months after they finished treatment (with the exception of relaxation). In addition, over one third of patients maintained a clinically significant improvement in their pain. These results are despite high levels of pain chronicity and mental health issues, which can result in slow responses to treatment. Patients receiving a combination of acupuncture and self-management sessions and those who continued to use what they had learnt from the BBPS produced the most positive results. Nevertheless, the BBPS faced a number of challenges when working as an external provider for back pain services in the NHS. With the Health and Social Care Bill based on the recent Government White paper[1] designed to encourage more services to be offered by external providers in the NHS, our findings may be instructive in this new climate.

Acknowledgements
We would like to thank Kensington & Chelsea PCT for funding the study, all Kensington & Chelsea staff who assisted with the promotion of the Beating Back Pain Service, and Veronica Tuffery for providing statistical advice. We would also like to thank the Beating Back Pain Service Team, including Anna Kiff the acupuncturist, for facilitating the delivery of the evaluation and their professional delivery of the Service. In addition, we would like to thank all patients who participated in the Service and completed the evaluation assessments and all stakeholders who took time to participate evaluation interviews.

Introduction

The Beating Back Pain Service (BBPS) was delivered within a primary and community care setting across the Royal Borough of Kensington and Chelsea between October 2010 and December 2011. The aims of this pilot service were to support the PCT in implementing their 10 year Primary Care Strategy by fulfilling key objectives related to the provision of care closer to home outlined in the operating plan[2]; contribute to the delivery of their Commissioning Strategy primarily by providing an alternative care setting in the community for MSK pain management[3]; and assist in implementing National Institute of Clinical Excellence (NICE) Guidance for persistent low back pain[4] locally. The specific objectives of the service were:

- To reduce reliance on healthcare professionals and pain medication through better self-management
- Improve self-management and education to empower patients to better manage their lower back pain
- To reduce referral into secondary care through improved self-management
- To prevent the need for patients with yellow flags[a] to use chronic pain management services by providing an early intervention
- To address unmet pain management needs for non-specific lower back pain
- To prevent unnecessary diagnostic procedures such as MRI scans;
- To encourage best practice around non-specific lower back pain with yellow flags[a], with a focus on working with local clinicians such as GPs

The aim of this report is to present the final BBPS evaluation findings. The report begins by setting the findings in context, presenting the background literature from the areas of back pain, acupuncture, self-management and evaluation. This is followed by details of the Beating Back Pain Service. Evaluation findings are then presented in two sections, patient outcomes and stakeholder perspectives.

Background Literature

Low back pain is common among adults in the UK. Each year around one third of the UK population is affected and around 20% of them (that is, 1 in 15 of the population) will consult their GP about it[4]. Four in five people will report back pain at some point in their lives[5] and for 62% of people with low back pain the problem will continue to exist for over 12 months, 33% of these will have a reoccurrence causing absence from work[6].

This places a heavy burden on primary care services and resources[7] and results in considerable financial cost to industry due to work absenteeism[8]. It has been reported

[a] indicates psychosocial barriers to recovery

that up to 60% of people who are on long-term sick leave cite musculoskeletal problems as the reason[5] and in 2004 the estimated cost of back pain to the UK economy was £5billion[9]. In addition, there is a cost to the individual in terms of their quality of life; research has shown chronic pain is associated with poorer quality of life and increased psychological distress[10].

There are a number of treatments currently recommended for musculoskeletal (MSK) problems, including low back pain. These include pharmacological treatment, surgery, physiotherapy, exercise, manual therapy, acupuncture and behavioural modification. Nevertheless, there is little consensus as to which options are best for MSK problems[11] and NICE Guidelines state that treatment and care should take into account individual's needs and preferences. In addition, treatment for MSK problems is perceived by GPs and other health professionals as one of the main 'effectiveness gaps' within the NHS[12 13].

The BBPS offered patient education, self-management and acupuncture for patients with persistent low back pain. Both acupuncture and self-management are currently recommended by NICE Guidelines as treatment options for persistent low back pain[4].

Acupuncture is commonly used by people with MSK pain[14] and randomised controlled trials, systematic reviews, meta-analyses and a Cochrane review have provided evidence that acupuncture can reduce low back and neck pain (including chronic pain)[e.g. 15 16-22], temporomandibular disorders[23], chronic shoulder pain[24] and the symptoms of osteoarthritis[e.g. 25 26 27] compared to control groups. Acupuncture can also provide additional improvement in chronic low back pain when combined with other treatments such as exercise[28] and muscle relaxants[29]. Initial research from acupuncture RCTs indicates that modest patient clinical benefits (for up to 2 years) are available for a relatively small additional cost[30].

Randomised controlled trials, reviews and meta-analysis have shown that self-management courses can be clinically effective in terms of improving pain (including low back pain), compared to control groups (controls include usual care, inpatient or outpatient non-multidisciplinary treatments, wait-list controls or alternative treatments)[31-34]. In addition, these same studies have shown self-management courses can have wider benefits, such as improvement in self-efficacy, cognitive coping, energy, emotional well-being, fatigue, function and reducing behavioural expression of pain[31-34]. Self-management has been shown to be cost effective in terms of reduced NHS resource utilisation and quality of life adjusted years[35]. In addition, randomised controlled trials of mindfulness techniques (which are included in the Beating Back Bain self-management course) can be effective in reducing pain, and improving quality of life, psychological variables and coping in patients with pain[36-38].

MSK back pain problems appear to be good candidates for receiving acupuncture and self-management training, given current effectiveness gaps within the NHS, and evidence of efficacy of these interventions. Acupuncture services integrated into the NHS for MSK pain and other conditions have been shown statistically significant improvements in patients' conditions after treatment, wider patient improvements (such as changes in well-being, coping, healthy lifestyle behaviours and emotional health), high levels of GP and patient satisfaction with the service, reduced medication use, reduced burden on GP time and other primary care services, and that integration allowed patients to access

CAM services who would otherwise be unlikely to use CAM services[e.g. 12 39 40-46]. However, what is not clear from the research evidence is what happens when acupuncture and self-management training - which should theoretically work for pain – are actually introduced into the NHS together. This document presents the results of an evaluation examining patient outcomes and a range of stakeholders' perspectives from the NHS Kensington and Chelsea Beating Back Pain acupuncture and self-management programme.

The Beating Back Pain Service

The BBPS accepted referrals from GPs, physiotherapists, osteopaths of patients with lower back pain lasting over 6 weeks. On referral to the BBPS all patients initially attended an information session. Patients could then attend either acupuncture or self-management sessions, or a combination of the two.

Information sessions
Information sessions were group sessions for up to 12 patients. They were delivered by Prof David Peters, a qualified GP and musculoskeletal specialist, also trained in osteopathy and acupuncture, and Emerald Jane Turner, an occupational therapist and psychotherapist. Sessions lasted up to three hours and covered topics such as understanding back pain and how to manage it. They also encouraged patients to share their experiences of back pain and their ways of coping with it. During sessions patients and facilitators decided which interventions were likely to be most helpful for patients using the STarT Back Questionnaire[47] - a questionnaire which helps to identify patients most at risk of developing persistent symptoms. Intervention options provided to patients included an individualised combination of acupuncture, self-management groups and using the BBPS pack (booklet and CD with information and exercises, for mobility and strength, to manage back pain provided to every patient attending information sessions). Patients identified most at risk for of developing persistent symptoms by the questionnaire were encouraged to attend acupuncture and self-management sessions, as opposed to just acupuncture and/or BBPS pack.

Acupuncture
Patients referred to acupuncture received up to six sessions of individualised Chinese acupuncture treatment.

Self-management course
The self-management course comprised six weekly, 2½ hour group sessions. This was restructured part way through the service to provide on-going drop in sessions in order to meet patient need more effectively. Sessions aimed to provide patients with the knowledge and skills to manage their back pain. Topics covered included breaking the pain-tension cycle, pacing, goal setting, staying active, relaxation, and managing pain and stress. Sessions also included explanation time, activity time and group discussion/support.

Evaluation findings – Patient outcomes and experiences

Aims
The aim of this part of the report is to provide information on patient outcomes (e.g. changes in pain, quality of life, well-being) and patient experiences of the BBPS.

Methods
Questionnaires were used to collect predominantly quantitative data from patients at three time points: immediately pre-BBPS, on completion of the BBPS and 3 months after completion of the BBPS. The following data were collected:

MSK pain was measured using the Bournemouth questionnaire (BQ) core items [48]. The BQ was developed specifically for patients with MSK pain and has been shown to be reliable, valid and responsive to clinical change[48]. The BQ incorporates dimensions of the biopsychosocial model for MSK pain including levels of pain, interference with everyday tasks and social activities, anxiety, depression, the extent to which work affects their condition and coping ability. It comprises seven items scored from 0 to 10 which can then be summed to provide a total score ranging from 0 to 70. Higher scores indicate increased MSK problems.

Quality of Life (QoL) was measured using the EuroQol-5D (EQ-5D)[49], a widely used, generic measure of health-related quality of life. It is quick and easy to complete and has been shown to be valid and reliable[50 51]. The first part comprises five items (measuring mobility, self-care, usual activities, pain and anxiety/depression) which are graded on three levels according to severity. Using the established algorithms for the UK[52], these items were translated directly into index scores, ranging from -0.59 (worst possible health state) to 1 (best possible state). The second part is a visual analogue scale (VAS) measuring overall health, anchored 0 (worst possible health state) to 100 (best possible health state).

Self-efficacy for managing pain was measured using the Pain and Self-efficacy Questionnaire (PSEQ)[53]. The PSEQ measures patient beliefs regarding their ability to perform activities whilst in pain. The scale has been shown to be valid and reliable among patients with low back pain[53], and to predict pain-related behaviour[54]. The scale comprises 10 items scored from 0 to 6 which are summed to provide a total score ranging from 0 to 60, with higher scores indicating stronger self-efficacy beliefs.

Positive well-being was measured using 5 different scales which asked participants to rate their understanding of their pain, positivity, hope, ability to face up to health problems and relaxation on a scale of 0 (not at all active) to 10 (extremely active).

Participants were also asked if they were using *analgesics*, and about *areas where they experienced pain* and *work status*. They were also asked to rate their *physical activity* levels on a scale of 0 (strongly disagree) and 10 (strongly agree).

Demographic data (age, gender, ethnicity) were collected in the pre-treatment questionnaire only.

Satisfaction with the *information session* was collected by questions asking patients to provide an overall rating for the information session on a 5-point Likert scale, on the pre-treatment questionnaire.

Qualitative data were collected via open-ended questions (providing free text boxes for answers) at the end of questionnaires. The pre-treatment questionnaire asked patients what they had learned from the information session. The post-treatment questionnaire asked patients about any benefits they had got from the acupuncture/self-management course, improvements that could be made to the service, if there was anything else in their life that may be affecting their health, or any other comments they would like to make about the Service. The 3-month follow- up questionnaire asked patients if they were still using anything they had learnt from the BBPS.

In addition to questionnaire data, data collected from the STarT Back Questionnaire[47] was also used for the evaluation. The STarT Back Questionnaire[47] was designed to identify patients most at risk of developing persistent low back pain, in order to aid decision making and target treatment more effectively. It comprises nine questions which are then used to split patients into low, medium and high risk of poor outcome. It has established reliability and validity[47 55] and its use has been shown to achieve greater health benefits for patients at a lower cost to the NHS[56]. The STarT Back Questionnaire was completed by BBPS patients in information sessions, to help the BBPS team decide which BBPS interventions were likely to be most helpful for patients.

Participants

All patients who attended an information session were invited to take part in the evaluation. Eighty patients chose to participate in the evaluation, 74% of the total number of patients attending information sessions. Please see appendix 1 for a flow diagram of how participants moved through the evaluation.

Procedure

At the information session patients listened to a short talk from a member of the Evaluation Team regarding the BBPS evaluation. Questionnaire packs were then handed out to those who wished to participate. Questionnaire packs comprised a covering letter, patient information sheet, consent form, all 3 questionnaires and 3 stamped addressed envelopes for returning questionnaires to the evaluation team. Patients were able to complete the pre-treatment questionnaire at the information session, or take it away to complete at home. Email and text reminders were sent to patients when it was time to complete their post-treatment and follow-up questionnaires. Participants who only attended an information session and not any self-management or acupuncture sessions were not asked to complete post-treatment or follow-up questionnaires. Identical copies of the questionnaires were also available to be completed online, according to patient preference.

Ethical approval for both parts of the evaluation (patient outcomes and stakeholder perspectives) was obtained from the University of Westminster Research Ethics Committee. NHS ethical approval was not required due to the service evaluation nature of the study.

Data analysis

Quantitative data were analysed using SPSS version 16. Statistical significance was set at the 5% level. To ensure a conservative analysis, non-parametric tests (Friedman, Mann Whitney-U, Wilcoxon Signed Rank, Kruskal-Wallis, McNemar and Chi-square as appropriate) were used throughout. Initially, data were examined for differences between those who did and did not return questionnaires on baseline variables. To examine patient outcomes Friedman tests were used to compare pre-, post- and follow-up data including the BQ, EQ-5D, PSEQ, positive well-being and physical activity levels. Post-hoc analyses using Wilcoxon Signed Rank tests were conducted in order to establish at which time point (pre-, post- or follow-up) change occurred.
Cochran's Q tests were used to compare pre-, post- and follow-up data for analgesic use and current work status. Percentage of participants experiencing a clinically significant improvement was determined by calculating the effect size for the BQ (raw change score divided by the standard deviation of the baseline scores). An effect size of 0.5 represents a clinically significant change for the BQ[57].

In order to establish if the BBPS was meeting its aim of providing an early intervention to prevent the need for patients at high risk of developing persistent symptoms using chronic pain management services, we compared BQ change scores at 3-month follow-up for patients categorised as low, medium and high risk of poor outcome (as identified by the STarT Back Questionnaire).

Data were also examined for differences between patients who attended acupuncture only and those who attended acupuncture and self-management sessions; change scores were calculated for all study variables and compared using Mann Whitney-U tests for pre- and post-treatment, and pre-treatment and follow- up.

Qualitative data collected from open ended questions on the questionnaires were analysed using thematic analysis[58]. The researcher immersed themselves in the data highlighting key sections of text and words. An initial list of themes/codes was developed and then organised into themes to create a final coding list. Data were inputted, coded and explored in the qualitative data analysis software environment, NVivo[59]. All data were assembled into themes, and full reports on themes were analysed, in order to explain all the data. Typical quotes are used to illustrate findings. Participant identification numbers are used to protect participant anonymity.

In addition, two pieces of qualitative data were analysed using content analysis[60], to convert it into numeric data. On the post-treatment questionnaire patients were asked to write down if there was anything else in their life that may be affecting their health. Textual responses were coded into 'positive' and 'negative' events. These categories were then compared with post-treatment study variable change scores using a Mann Whitney-U test, in order to establish if other events in patients' lives were affecting the outcome of their treatment[61]. On the 3-month follow-up questionnaire patients were asked if they were still using anything that they had learnt from the BBPS. Textual responses were coded into 'yes' and 'no'. These categories were then compared with 3-month follow-up study variable change scores using a Mann Whitney-U test, in order to establish if using BBPS advice influenced patient outcomes.

Results

Participant characteristics

As can be seen in Table 1 below, there were more females than males (approximately two-thirds female), a wide spread of ages and a mix of ethnicities participating in the evaluation. There were high levels of chronicity: Nearly three-quarters of participants had previously experienced a complaint similar to their current episode, with average duration of current painful episode lasting 18 months. Nearly half of patients had pain in more than two areas of the body. Mental health issues were also evident: 69% of patients reported moderate to high levels of anxiety and depression.

15 (18.8%) patients attended an information session only, 47 (58.8%) received acupuncture only, 1 (1.3%) person attend self-management sessions only, and 17 (21.3%) attended self-management and acupuncture sessions. Those receiving acupuncture attended an average of 5.2 (range: 1 to 12) sessions. Those receiving self-management attended an average of 9.3 sessions (range: 1 to 31).

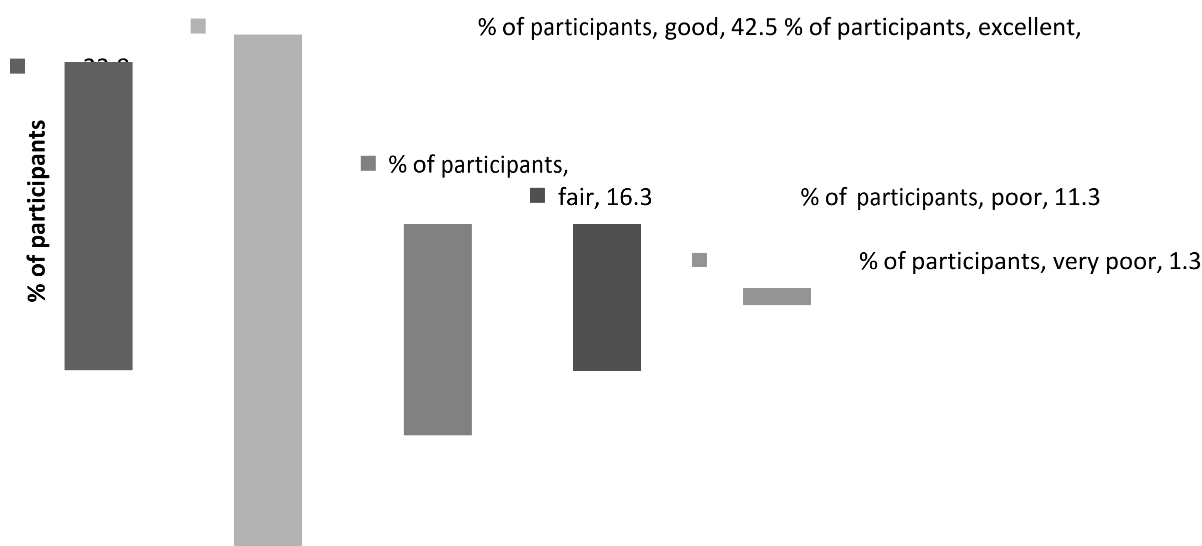
Table 1 – Evaluation patient statistics

Gender	35% Males; 65% females
Age	mean 47 years old, range 18 - 83
Ethnicity	
White	39%
Afro-Caribbean/African	14%
Asian	9%
Arabic	9%
Mixed	6%
White-European	6%
Other	7%
Missing	10%
Mean time current painful episode has lasted	78 wks, range 0.5 – 1092
Percentage of patients who have previously experienced a complaint similar to their current episode	74%
Majority have pain in:	
Lower back	91%
Leg or knee	53%
Shoulders	40%
Neck	39%
Pain in more than one area of the body Pain in more than two areas of the body	80% 46%
Reporting anxiety and depression Moderate Extreme	54% 16%

Information sessions

The majority of patients rated their information session as 'good' or 'excellent' (see Figure 1).

Figure 1 - Ratings for the information session



The analysis of qualitative data from the pre-treatment questionnaire expanded on patients' ratings of the information sessions. Patients described information sessions as "informative" and reported a range of learning as a result of attending. Reported outcomes of attending information sessions included

- Increased knowledge and understanding of chronic pain such as how the spine works, what causes pain and what to do to help alleviate it
- Understanding of the importance of keeping active in managing pain –that is was important to do exercises and stretching and that this would not make the pain worse
- Increased understanding of the body-mind connection in pain and the importance of relaxation, breathing and positivity for pain management
- Increased knowledge of the kinds of treatments that might help pain (e.g. acupuncture and osteopathy)
- Learning other pain management strategies and tips, for example how to get out of bed in the morning or using heat and cold.
- A small number (n=3) of patients felt that they had learnt little from attending the session

"Before I came to this meeting I didn't understand much about my pain, but now I do. I think it is very good that the PCT is doing this 'Beating Back Pain'. Very helpful." P35

Patients also described aspects of the session that they enjoyed and those they felt could be improved. Many patients reported enjoying the group format. They liked meeting others with similar problems to their own - people who understood what it was like to live with pain. They enjoyed sharing their experiences and listening to the experiences of others.

"Nice to hear other people have similar problems and understand. Can be difficult when others can't see your injury to sympathize." P16

However, not all patients enjoyed the group format. A minority said that they did not enjoy the group situation and discussing pain with others, that it was not for them.

"I didn't like that group situation. … Loads of people in trouble, it's not for me." P60

Some patients reported that after the session they felt encouraged and supported. They felt more hopeful about their future, and grateful that people had taken time to listen to their experiences. Some reported they wished they had received this kind of information and support years ago.

"Pain clinic has been very helpful for me I wished I could get this help years ago. I feel I have a support for all my pains. People who understand exactly what I'm going through." P32

In terms of the content of the sessions, many reported they liked the information and advice that was provided. For others it seemed that they had not been fully aware of the content of the information session before they arrived and said that they had been expecting (and wanting) something more diagnosis-based. A few patients said they felt too much time was spent on individuals talking about their pain.

"I'm not really interested in discussing pain with other sufferers. I would rather have talked for shorter time to a health professional about my individual case which hasn't been investigated and advice on physio tailored to me." P55

A small number of patients would have liked more information on what treatments were available to them, feeling that this part of the information session was mostly directed towards acupuncture. A few patients made comments about the venues, particularly in relation to Kensington library. They felt that the room had been difficult to find and access, that it was quite a gloomy room and that the chairs had been uncomfortable.

Patient outcomes

Of the 80 patients attending an information session and participating in the evaluation, 65 attended acupuncture and/or self-management sessions and were asked to complete follow-up questionnaires, 61 (93.8%) completed both their post- treatment and 3-month follow-up questionnaires. No statistically significant differences were found on demographic or study variables between responders and non-responders. All statistical analyses were based upon the 61 completed data sets.

Changes in MSK pain

For the primary outcome measure of MSK pain (BQ), comparisons revealed a statistically significant improvement over time (pre-treatment, post-treatment and 3- month follow-up) in MSK problems for BQ total score ($p < 0.0001$) and four out of seven subscales: pain ($p < 0.0001$), interference with daily activities ($p = 0.023$), interference with social routine ($p < 0.0001$), anxiety ($p = 0.024$). There was a trend towards an improvement for the effect on work subscale ($p = 0.075$). No statistically significant differences were found for 2 of the subscales depression ($p = 0.334$) and

coping (p=0.412). Post-hoc comparisons revealed that statistically significant improvements immediately post-treatment were maintained (p ≤ 0.05) for BQ total score and the subscales pain, interference with daily activities and anxiety; there was a trend towards maintained improvement for the interference with social routine subscale, see Table 2.

Applying the threshold of 0.5 for effect size[57], 24 (39.3%), 95%CI [27.1%, 51.6%] of participants experienced a clinically significant reduction in their MSK pain immediately post-treatment and 23 (37.7%), 95%CI [25.5%, 49.9%] of participants experienced a clinically significant reduction in their MSK pain at 3-month follow-up.

No statistically significant difference was found on BQ changes scores at 3-month follow- up between patients identified as low, medium or high risk of poor outcome (using the STarT Back Questionnaire) (p = 0.382).

Table 2 - BQ total and sub-scale scores pre- and post-treatment

	Pre- treatm Median (interqu	**ent ile**	**Post-treatment Median (interquartile range)**		**3-month FU Median (interquartile range)**		**p-value**
BQ total score (range 0-70 ↑ = worse)	**46.**	**(35.0-**	**36.0**	**(23.5-**	**40.0**	**(25.5-51.0)**	**<0.0001**
BQ subscales (range 0-10 ↑ = worse)							
Pain	8.0	(6.0-8.0)	6.0*	(4.0-8.0)	6.0*	(4.5-7.8)	<0.0001
Interference with	6.0	(4.8-8.0)	5.0*	(3.0-7.0)	5.0*	(4.0-7.0)	0.023
Interference with social	6.0	(4.0-8.0)	4.0*	(3.0-7.0)	6.0[a]	(2.3-8.0)	<0.0001
Anxiety	7.0	(5.0-8.0)	5.0*	(3.0-7.0)	6.0*	(2.0-7.0)	0.024
Depression	6.0	(4.0-8.0)	5.0*	(2.5-7.0)	5.0	(3.0-7.0)	0.334
Effect on work	7.0	(4.0-8.0)	5.0*	(3.0-7.0)	6.0	(4.0-8.0)	0.075
Coping	5.0	(4.0-7.0)	5.0[a]	(3.0-6.0)	5.0	(4.0-7.0)	0.412

*significantly different from pre-treatment (p ≤ 0.05)
[a] approaching significantly different from pre-treatment (p = 0.051 to 0.099)

Changes in other study variables
For the measures of health-related QoL (EQ-5D index and EQ-5D VAS), comparisons revealed a statistically significant improvement over time (pre-treatment, post-treatment and 3-month follow-up) in health-related QoL EQ-5D index (p = 0.006), post-hoc analysis revealed that improvements seen at post-treatment were maintained at 3-month follow- up. There was a trend towards an improvement in EQ-5D VAS (p = 0.074), see Table 3.

Further comparisons revealed a statistically significant improvement over time (pre-treatment, post-treatment and 3-month follow-up) in understanding of pain (p ≤ 0.001), physical activity (p = 0.047) and ability to relax (p = 0.012). There was no change in ability to self-manage PSEQ (p=0.286), positivity (p = 0.265), hope (p = 0.207), and ability to face up to health problems (p = 0.779). Post hoc comparisons revealed that statistically significant improvements immediately post-treatment were maintained (p ≤ 0.05) for understanding of pain and physical activity, but not relaxation, see Table 3.

There was no change in medication use (p = 0.920) and current work status (p = 0.368).

Table 3 – Study variable scores pre- and post-treatment

		Pre-treatment Median (interquartile range)		Post-treatment Median (interquartile range)		3-month FU Median (interquartile range)		p-value
EQ-5D - index worse)	(range -0.-.59-1 ↑ =	0.1 9	(-0.02-0.69)	0.62 *	(0.32-0.73)	0.62 *	(0.08- 0.74)	0.006
EQ-5D – VAS	(range 0-100 ↑ = better)	60.	(38.3-70.0)	61.0	(40.0-75.0)	60.0	(40.0-	0.074
PSEQ	(range 0-60 ↑ = better)	34.	(15.2-44.0)	39.0	(22.6-47.0)	37.0	(19.5-	0.286
Physical activity	(range 0-10 ↑ = better)	5.0	(3.0-7.0)	6.0*	(4.0-7.0)	6.0*	(3.0-7.0)	0.047
Positive well-being scales	(range 0-10 ↑ = better)							
Understanding of pain		5.0	(3.0-7.0)	7.0*	(4.0-8.0)	6.0*	(3.5-8.0)	<0.0001
Positivity		6.0	(3.0-8.0)	6.0*	(4.0-8.25)	6.0	(4.0-8.0)	0.265
Hope		6.0	(4.3-8.0)	6.0	(4.0-8.0)	6.0	(4.0-8.0)	0.207
Ability to face up to health problems		6.0	(5.0-8.0)	7.0*	(5.0-8.0)	6.0	(4.0-8.0)	0.779
Relaxation		5.0	(3.0-6.0)	6.0*	(4.0-8.0)	5.0	(3.0-7.0)	0.012

*significantly different from pre-treatment (p ≤ 0.05)

[a] approaching significantly different from pre-treatment (p = 0.051 to 0.099)

Acupuncture vs. acupuncture and self-management patients

Patients who attended acupuncture only (n=43) were compared with patients who attended acupuncture and self-management sessions (n=17), in order to establish if attending self-management in addition to having acupuncture improved patient outcomes. Results showed that patients who attended acupuncture and self- management sessions improved more than patients who attended acupuncture only; post-treatment there was a statistically significant difference for MSK pain (p = 0.022) and a trend towards improvement in health-related QoL (EQ-5D index) (p = 0.057), these differences were still evident at 3-month follow-up (p = 0.047 and p = 0.057 respectively). In addition, at 3-month follow-up (but not post-treatment), there were statistically significant differences for hope (p = 0.041) and ability to face up to health problems (p = 0.050) and trends towards a difference in positivity (p = 0.063) and ability to self-manage PSEQ (p = 0.061).

Anything else that may be affecting patients' health?

All patients were asked if there was anything else in their life that may be affecting their health over the course of their treatment, 6 (9.8%) patients described positive events, 20 (32.8%) described negative events, 35 (57.4%) said nothing/did not answer and one (1.7%) described a combination of positive and negative events. Those experiencing positive and negative events were compared on post-treatment variables. Results showed that there were statistically significant differences for BQ (p = 0.046), health- related quality of life (EQ-5D VAS) (p=0.030), PSEQ (p=0.025), level of physical activity (p
= 0.039) and relaxation change scores (p=0.033): during the course of their BBPS treatment, those experiencing positive events experienced greater improvements in their MSK pain, quality of life, self-efficacy for managing pain, physical activity and ability to relax, compared with those experiencing negative events. There were no statistically significant differences for other study variables.

Patients who continued to use what they learnt on the BBPS
At 3-month follow-up, patients were asked if they were still using anything that they had learnt from the BBPS, 35 (57.4%) said 'yes', 9 (14.7%) said 'no' and 17 (27.9%) did not answer the question. Those answering 'yes' and 'no' were compared on improvement in 3-month follow-up scores. Results showed that patients still using something that they had learnt on the BBPS experienced more improvement in their MSK pain and their ability to self-manage; there was a statistically significant difference for BQ change score ($p = 0.003$) and PSEQ change score ($p = 0.030$). There were no statistically significant differences for other study variables. A thematic analysis of the data provided information regarding what it was patients had learnt from the BBPS that they were still using. Many patients said that they were still ensuring they were physically active (exercise and stretching), practising relaxation and breathing exercises, and implementing general lifestyle management advice (e.g. time management/pacing, eating a healthy diet, getting out of bed properly): all things that they had learnt about on the BBPS to manage their pain. Other patients said they were still using coping skills they had learnt on the BBPS, Emotional Freedom 'tapping' technique, the BBPS CD and social support to reduce isolation.

"When my back is particularly troublesome I do the stretching exercises I learnt from the beating back pain booklet. However I find if I do the stretches at least a few times a week my back generally feels better." P40

I've have just changed the way I sleep and how to get out of bed and I am more careful how I lift things and I do not drive so many hours now." P68

"The most important things I leant, which I am using day-to-day are the relaxation exercises, tapping, and also use of external resources, such as ball to massage the back." P13

Patient experience of BBPS
Qualitative data from the post-treatment questionnaire provided insights regarding patients' experiences of the BBPS. When asked about changes to their condition since receiving BBPS treatment, many patients described improvements in their pain, these reports ranged from complete to temporary pain relief. Some patients reported that this relief had led to improved mobility and relaxation, and reduced muscle tightness. Some patients reported psychological benefits as a result of treatment such as feeing more in control, confident, positive, hopeful and 'mentally stronger'. Patients especially described feeling better able to manage their pain. Some patients reported that the self-management group had been particularly useful for providing them with support. Others reported increased knowledge regarding their condition. Some participants said that treatment had not helped their pain and one reported a temporary worsening of their condition. Another patient reported sometimes feeling tired and depressed after treatment.

"*Pain relief, sense of well-being, mentally stronger as I felt I was tacking the problem. Fantastic advice from [acupuncturist]." P19*

“Learnt how to manage pain useful CD/leaflet/group to encourage and learn various routines both physical and mental. Changed my approach to coming positive, energised – a can do practice with planning and pacing.” P33

“Have confidence in taking control of my lower back pain as the pain reduced more than expected after the acupuncture treatment.” P7

When asked how acupuncture and self-management sessions could be improved, the overwhelming number of suggestions related to expanding and extending the service. Patients wanted more acupuncture sessions of longer duration, others suggested maintenance sessions would be appropriate. Some patients wanted to see the whole service more widely available on the NHS and one person suggested the service could be extended to people with all types of pain. Three patients reported that they would have liked more flexible times / locations for the self-management course. One patient explained how some of the self-management group were hoping to continue meeting once sessions had finished so that they could continue to share experiences and supporting one another.

“Happy with the quality, could have done with more sessions.” P31

“6 sessions are not enough to treat someone who has severe back pain. I also think there is a need of maintenance as per acupuncture principles.” P13

“More readily available on the NHS.” P14

Other changes to the Service suggested by patients included the provision of written information such as online self-management information or a typed sheet explaining why acupuncture should work. One patient suggested having more information on the self-management course related to posture and what is good and bad for the back, this information was subsequently added to the self-management sessions. One patient suggested an online booking facility, another would have liked to have seen the BBPS more linked with osteopathy and chiropractor courses. One participant would have liked to have received acupuncture with electricity, as they had found this beneficial for their condition on a previous occasion.

“Both courses should be linked with osteopathy and chiropractor courses.” P22

“Maybe a printed out sheet of the treatment given with explanation of why it should work would be helpful.” P80

When asked about other comments they would like to make about the service many participants praised the practitioners that delivered the BBPS; they had found practitioners professional, knowledgeable and efficient. In particular, what was prominent in the analysis was the praise practitioners received for their human qualities, including kindness, understanding, empathy, encouraging and caring. The importance of the human qualities of complementary medicine practitioners to pain patients has been highlighted by other research[45].

“I felt that I was listened to when I was describing what was going on and they even took note and interest in my other medical problems. Seemed more understanding and compassionate than any consultation I have had under the NHS.” P61

“The people who run the course are very professional, caring and very friendly. They give much support and help to us all. [Acupuncturist] is wonderful, very professional and efficient.” P35

Conclusions

Patient satisfaction with the BBPS was high, with a number of patients wanting to see the service extended. Patients also valued the professionalism, knowledge and human qualities of BBPS staff. Patients using the BBPS experienced improvements in their pain, quality of life, understanding of their pain, levels of physical activity and levels of relaxation, which generally lasted 3 months after they finished treatment (with the exception of relaxation). In addition, over one third of patients reported a clinically significant improvement in their pain 3 months after finishing BBPS treatment. These results were obtained despite high levels of pain chronicity and mental health issues, which can result in slow responses to treatment. Receiving a combination of acupuncture and self-management sessions produced the most positive results; patients who attended acupuncture and self-management sessions experienced greater improvement in their pain, quality of life, self-management and positive well-being, compared with those who only attended acupuncture. In addition, patients who continued to use what they learnt on the BBPS experienced a greater improvement in their pain and ability to self-manage their pain, compared with those who did not.

Evaluation findings – Stakeholder perspectives Aims

The aim of this part of the evaluation was to report on the stakeholder data pertaining to their perspectives on the Service. The hope was to improve the Service by identifying any problems or issues so that they could be fed back into the Service. A report of initial findings was written and distributed in July 2011 to help fine tune the service. This section of the report presents a more comprehensive examination of the final findings.

Methods

Participants

Interviews were conducted with a range of 12 professionals involved in the Service including members of the BBPS Team and representatives from healthcare professionals able to refer into the Service.

Procedure

Participants were invited to take part in the evaluation and the interview was arranged at a time that was convenient for the participant and researcher. A semi-structured interview schedule was used to elicit participants’ views and experiences of the Service. Topics included benefits of the service, problems encountered, helpfulness to patients, ease of incorporation, and suggested improvements to the service. Informed consent was obtained from all participants. Interviews lasted between 10 and 60 minutes. All of

the interviews were recorded.

Analysis

Interviews were transcribed verbatim by a professional transcriber, and the data were analysed using thematic analysis[58]. The first author immersed themselves in the data noting key points arising from the interviews on the manuscript. An initial list of themes/codes was developed, which was then debated with the third author to arrive at a final coding list. The first author coded all the data. Data were inputted, coded and explored in the qualitative data analysis software environment NVivo[59]. All data were assembled into themes, and full reports on themes were analysed, in order to explain all the data. Typical quotes are used to illustrate findings. No identification for individual quotes is included in order to protect participant anonymity. All authors were involved in debating and editing the write-up to arrive at the final report.

Results

The interview analysis findings are presented around the themes Service Development and Liaison, Referral Issues, Patient Issues, Communication within the BBPS Team, Communication between BBPS Team, and Stakeholders.

Service development and liaison

The BBPS Team encountered a number of challenges that could be considered part of the expected teething problems associated with setting up a new service (e.g. refining referral forms, developing effective databases). However, in addition, the PCT was undergoing major organisational changes, which added to the burden of change the service provider and NHS needed to deal with. For example, shortly prior to the BBPS commencing, a number of last minute changes were made including a change of premises to where the Service would be delivered and how referrals to the Service would be made (discussed further in the 'referrals' section below). These changes required additional work for the BBPS Team to successfully deliver the service.

"We were discovering things that were not at all the same as we had been told. So some of our documents that we had made up in advance proved to be wrong. So we had to fire fight at the last minute, produce new things rapidly so that patients didn't get lost because we were telling them to go to the wrong place."

Developing a new service within a backdrop of NHS reorganisation created particular issues for the BBPS Team in communicating with the NHS. With many people leaving or changing their role, it became unclear who within the PCT the BBPS Team should communicate with. In addition, the BBPS champion within the NHS left the PCT just as the Service launched. Without this person's support and guidance liaison became unclear, making integrating the Service into the NHS all the more challenging.

"Our main contact, the person with the responsibility for setting this up left … we were given names, contacts and they have evaporated over the course of time. And I think that, generally speaking, as a result of the changes this project has not really been given the priority it might otherwise have been given had there been a more stable environment in the PCT. People have got much bigger issues going on than looking after one tiny project like this."

The NHS and University of Westminster are two large organisations with their own sets of systems and protocols, and getting these two organisations to work well together created initial problems. The University and BBPS Team were relatively new to working with NHS governance procedures. Thus, negotiating a 200 page contract for the BBPS delayed the start of the service by over four months. In addition, data confidentiality was a high priority given that NHS patient data was being made available to an external provider. Developing a system for working with patient data that complied with NHS governance was also time consuming. In addition, the NHS staff were also learning to deal with external providers, and this took time. These issues delayed the Service setting up its procedures.

"I think a large organisation like a primary care trust trying to interface its governance and contracting procedures with another large organisation is extremely difficult. It involves a lot of learning, a lot of negotiation; in addition to be doing this at the time of massive reorganisation inside the NHS has amplified all the problems of inter-organisation collaboration."

The Private Practice Software (PPS) system was used by the BBPS Team for sharing patient information within the Team, recording patient attendance at information and acupuncture sessions, and acupuncture session notes. There were initial issues getting PPS running due to accessing the Hospital IT facilities, the PPS software not being compatible with MAC computers, and the University's firewall blocking the software. However, once PPS was up and running, participants said it worked very well: it complied with NHS governance procedures, the BBPS Team were able to access the patient information that they required, and it could be used to generate letters using pre-populated letter templates. Pretty Good Privacy (PGP) software was used to encrypt confidential emails, once it was established that it would not be practical to use the NHS's N3 Network.

Owing to late changes in referral route into the Service, a method to feedback to referrers information regarding their patient's progress within the BBPS needed to be established. However, this was not finalised until some months into the Service.

"To say something about the clinical impact about what they'd [patient] done, it would be normal. But we haven't agreed a format for that and so that just needed to get resolved."

These sorts of challenges setting up the BBPS resulted in additional workload demands on members of the BBPS Team.

A significant issue occurred at reception for BBPS acupuncture. Acupuncture was delivered in a hospital-based GP practice. The GP surgery reception area comprised two reception desks for two different GP surgeries. The acupuncturist and some BBPS patients who approached the wrong reception desk (which was apparently easy to do) described difficult communication and some patients missed their acupuncture appointments as a result. This issue was eventually rectified by moving the acupuncturist into a different room. However, administrative delays in implementing the move meant it took a number of months to rectify.

"One of the receptionists has stand up rows with the patients if our patients check in to [the other reception desk], which let's face it, is not the end of the world."

Finally, as is often the experience with universities paying externals, some of the BBPS Team found that the University was too slow to pay them, and payments were delayed to Kensington Town Hall for library room hire where some of the information sessions were held.

Referral issues

Initially it was intended that the BBPS would receive patient referrals through the Musculoskeletal Clinical Assessment and Treatment Service (MSKCATS). MSKCATS accepts patients with musculoskeletal problems via GP referral. They assess patients predominately using the paper-based information provided to them and then determine the most appropriate management for the patient. However, MSKCATS became unavailable to refer patients to the BBPS just prior to the commencement of the Service. The BBPS responded quickly to this change by allowing GPs, physiotherapists and osteopaths to refer directly into the Service. However, there was limited time prior to the Service start date to promote the Service to these new communities. Although the BBPS received good support from the GP liaison contact who helped GPs to access the Service, communication with GP networks to publicise the Service was very challenging; GPs are very busy and had scant time to consider an unfamiliar incoming service such as the BBPS. Face-to-face contact was considered to be the best way to promote the Service (to GPs, osteopaths and physiotherapists), but accessing GPs was problematic. There were also some issues in getting the message through to GPs on how to refer into the Service (by printing out a form from their Choose and Book system), consequently referrals came through on a variety of platforms, often with information missing. When a new opportunity like the BBPS arises to handle patients, it can take a while for people to change their clinical referral habits. These kinds of challenges resulted in the BBPS Team working hard to promote the service (see document Beating Back Pain Service interim report on activity and evaluation data[62]), nevertheless, the Service only received a small number of referrals during its first quarter.

"We immediately opened up the service to general practitioners. … Because we were up against our launch deadline when we suddenly decided to open up to GPs there wasn't really time to sell the service, to market the service well enough. Although we've had some pretty intensive campaign of contacts with physios, osteos, GPs since we still are running at probably twenty five percent capacity, which is a great shame."

Referral criteria were relaxed to increase throughput. Initially BBPS accepted referrals for patients with pain over six weeks but less than a year. However, the reality of postural low back pain is that it can relapse/remit over many years. Thus, referral criteria were altered so that there was no upper limit on pain duration. These referral criteria were more satisfactory to referring practitioners and did increase referrals to the Service, but again this message took time to get out, or had not filtered through to some referrers.

"The criteria that they wouldn't take patients who've had pain for longer than a year, because of the nature of the types of patients that we see here, a lot have had pain, for more than a year. So that was a bit of a problem for us. And I think that changed after a couple of months. And it took a little while to get that filtered down."

Once referral issues were resolved, many GPs and osteopaths seemed happy to refer to the Service. However, there was an ongoing low referral rate from some referrers. Some referrers felt that they were already providing similar services to those provided by the BBPS. These referrers preferred to work with patients within their existing treatment system, rather than refer them out to a relatively unknown provider in whom they did not have confidence that patients would be worked with in the ways they felt were appropriate. For example, some referrers constructed acupuncture as a 'passive' treatment on which patients could become dependent. Although, many referrers felt that self-management was a useful complement to existing NHS back pain services, some believed that there should have been more initial consultation about the BBPS instigated by the PCT:

"Just the lack of information about what was going to be provided, the qualifications of those who are providing the… how are the services… particularly the fact that there was information and acupuncture tagged together."

Some participants felt that it would be useful for the BBPS to be able to refer patients on to other services such as physiotherapy and osteopathy, creating a more integrated and joined up service for back pain patients. Two referrers said that they would like the referral form to be shorter and simplified.

The BBPS Team felt that patients referred to the Service had been generally appropriately referred. There were some instances of inappropriate referrals, for example, where patients had disc pain, spinal stenosis or had already attended the chronic pain service. Having a qualified GP and back specialist delivering the information sessions meant that these inappropriate referrals were more likely to be identified. However, there were no facilities for clinical examination which meant patients had to be sent back to their GP for further investigation. Appropriate triage of patients should be a consideration for future services.

"We've had examples of patients coming in with stenosis, disc pain and mental health problems …. I was not in a position to do a full examination but sometimes I would take a patient aside and check, for example, for root entrapment. On several occasions the clinical signs had not been found, or at least not been conveyed on the referral form by GPs. It became my practice, therefore, to write a letter back to referrers."

Although referral numbers improved after the initial slow start, they did not reach the numbers initially anticipated. The low number of referrals sometimes lead to feelings of frustration amongst the BBPS Team, and resulted in the Team taking on additional roles to try and generate referrals to the Service. In addition, the BBPS Team responded by extending the duration of the year long Service by two months in order to increase the number of patients that would receive the Service.

"I feel concerned because we have a fully funded service which can't meet its expected numbers of throughput. I feel frustrated. … A sense of having to work rather hard or the whole Team having to work rather hard in order to sell the service to the people that refer into it."

Patient issues

The BBPS Team found referred patients were a challenging and interesting group to work with. Although patient attendance at acupuncture sessions was reasonable, there was a much lower demand for the self-management element of the BBPS. Despite patients agreeing at the information sessions that attending self-management sessions would be useful for them, agreeing to attend, and being encouraged to attend at acupuncture sessions by the acupuncturist, attendance was still low. This was surprising given that other data suggested that there was a desire amongst patients to interact with others in a similar situation; patients would often spend time talking with one another in the acupuncture waiting room and questionnaire data found that patients enjoyed the group aspect of the information sessions.

"She's expecting 9 people and 3 turn up. And it doesn't work well, 3 doesn't constitute a group, so it's very tricky to know how to get these patients on board and committed on a regular weekly basis."

The importance of the BBPS administrator for patients was greater than anticipated. Patients not only needed more administrator time than was initially expected (in terms of engaging patients, booking them into information and acupuncture sessions, and encouraging them to attend sessions), but patients also identified her as their point of contact for the Service.

"We worked out that about half an hour per patient would be needed. And it's much more than that, on the straight forward ones, then it is about half an hour, from first contact, booking their information day, and then booking their acupuncture, and then generating a few letters. But those patients are very few and far between, the majority of patients are not straight forward for various reasons."

The BBPS intake criteria did not include patients with persistent mental health problems or chronic pain syndromes. Nevertheless, a significant sub-group of patients using the BBPS had these complex issues, including mental health problems, depression, feelings of hopelessness, social isolation, fixation on the physical aspects of pain, external locus of control, being 'psychologically stuck' and lack of motivation. This created challenges when supporting patients to self-manage their pain at information and self-management sessions.

"We're working on this self-management program, it's on a level of people really quite depressed, isolated, they've got big problems. So, I'm going to need to break the program right down, what I think can be achieved in a stress program in the first session, it takes three sessions."

Communication within the BBPS team

For communicating with fellow BBPS Team members, email was the most used and found to be the most useful by individual Team members. However, working across

different sites and the time-consuming nature of developing the Service hindered some types of communication, in particular highly valued face-to-face meetings.

"All of us communicate through email it's really handy and helpful, I think it's fantastic. Because imagine all of us phone calling each other it wouldn't work, so that's actually really good."

"Face-to-face the meetings haven't been prudent enough. … It's purely been time, I think."

Communication between the BBPS team and stakeholders
As has been presented throughout this document, there have been a number of communication issues between the BBPS Team and other stakeholders: communicating with the NHS during a time of transition, negotiation between the NHS and the University of Westminster, familiarising GPs and other referrers with the BBPS, problems in feeding back on patient progress to referrers, and lack of consultation with other NHS employees regarding the setting up of the BBPS.

A number of participants felt that a regular steering group for the Service including the BBPS Team and those who were able to refer into it would be useful to improve communication more generally, feedback issues within the Service, get patient feedback to referrers, and improve engagement of referrers with the Service. However, under the circumstances that BBPS was functioning, setting up a steering group proved challenging.

"I feel that we've kind of, been given the initial information, we've started to refer, and then we've just been left to it, which is ok. But I guess for a pilot it could have, you know, had a bit more oomph, and I would have been happy to have been on the steering group."

The Beating Back Pain Service
Despite the numerous 'behind the scenes' issues encountered by the BBPS, the Service delivered to the patients was felt to be professional and useful. BBPS contact with patients using the Service was described as professional and well-managed, although there were some concerns that the 48 hour deadline from patient referral to patient contact was not always met.

"[Administrator] has been very efficient in organising the contact with the patients and logging that contact very well. So that there's not been any delays in patients being referred, and being contacted and booked on to an information day. So I think that's one side of it, which is a key part of it that has worked well."

Stakeholder perceptions of the information sessions were that they were generally working well and were useful to patients. Stakeholders felt that sessions provided patients with an explanation for their pain, helped them understand their pain and how to manage it, and provide an opportunity to talk, be listened to, and to meet and share with others in a similar situation. Although some referrers had concerns about the provision of acupuncture being too 'passive', other participants felt that acupuncture sessions could be used to 'hook in' patients who were reluctant to attend self-management sessions, with self-management techniques being encouraged by the

acupuncturist in acupuncture sessions. Some participants felt that acupuncture had helped patients become more active by improving their pain, making activities of daily living and work easier, increasing sleep, and thus promoting happiness.

"Improving pain, daily things they are able to do, improving the work situation, improving relationships at home, improving being able to pick up their kid, physically pick him up, walking the dog, nine times out of ten sleeping better, reducing medication, increase happiness, that sounds a bit weird saying that but it's literally… they often feel lighter in themselves and not just… they talk about mood feeling just lighter, and enthusiasm, suddenly wanting to do such and such and looking forward to doing such and such, so that has been really clear."

Although patient engagement with the self-management element of the BBPS had been disappointing, those that had attended were reported to be benefitting from the programme.

"This man came and he made a total… he came off his pain-killers, he's having fun with his wife, he said when he goes to work he's learning all these new jobs, he's not frightened anymore, he stands differently, when he goes shopping he doesn't get so wound up, uses his relaxation, fantastic."

In response to the lack of patient attendance, the self-management programme was restructured in order to meet patient need more effectively. The programme structure was changed from a small cohort of patients attending 6-weekley sessions, to less rigid structure of on-going drop in sessions that any BBPS patients could attend as and when they were able / felt they needed. This increased flexibility for patients meant that it was not important if patients missed a session and patients could attend for longer than six weeks, which was often needed because of the length of time many patients took to engage. The content of the programme was also altered. The therapist running the programme found she had to think more creatively about its content. It was decided that because patients were so fixed on the physical aspects of their pain it was important to incorporate this element in to the programme more, in order to improve patient engagement. A body worker (who was also a psychotherapist) was brought on board to provide information on aspects such as sitting, breathing, standing and exercise. It was also found that exercises that focused patients on being in the moment were a helpful addition to the programme. The restructured self-management programme was found to be more successful for patients. However, attendance was still low given the number of patients it was felt would benefit from self-management.

"We run it as an on-going support and self-management group and people don't have an end time. So they don't come for six weeks. They come as and when they can, for as long as they want to. If they miss one or two sessions, or three sessions it doesn't matter. They can come for one and see how it is. It's the focus is on exercise, relaxation and breathing and then on psychological support like pacing and CBT type stuff. So we've got a sort of rhythm to it now, so it's good, it's good. And I'm hoping that we can integrate more people in to it and actually use it as an expert patient program, so that the people who've come for longest can be integrated into helping the new people."

Whilst some patients used the information pack handed out at information sessions and found it useful, others did not engage with it. The BBPS addressed this by incorporating more elements that were in the pack into the information sessions. In addition, the acupuncturist gave patients she was seeing exercises from the CD as 'homework' in-between sessions, which seemed to encourage them.

"You give them something to do which is relevant to their condition and homework… I'm talking specifically physical exercise and they do tend to do them, because I'm checking up and because it's not very much."

Amongst those referring into the Service there was a great enthusiasm for the self-management element of the BBPS. Many felt that self-management for chronic pain was a useful complement to existing back pain services that was currently lacking in the NHS. However, as mentioned earlier in the report, some were reluctant to refer into the Service owing to issues of inter-professional trust. Some felt that if self-management training was provided by pre-existing services, patients would benefit from a more joined up approach to treatment where self-management could be offered alongside exercise and other treatment as part of a programme for patients.

"Particularly the education sessions would have been very welcome, it's something that we lack. Throughout my… I've worked across various NHS organisations around London and the rest of the country and actually consistently the education and the sort of psychological sort of elements are something it's lacking in every service across the country. And actually it's fantastic if we had somewhere we could send patients with confidence that they were going to get the right messages and appropriate environment, then there would be a fantastic thing. But it has to be, sort of, in conjunction with their care, not as an add on, strapped on the side but which didn't really fit in with the care.

Referrers considered that the Service was particularly useful for patients who were anxious about exercising, and who could benefit from support, education and information about their condition and how to manage it. The fact that the Service was provided in the community was also considered useful to 'de-medicalise' pain and to help patients to manage it themselves.

"*It was quite useful for those patients that needed more understanding, perhaps had lost a bit of confidence. … For people who are very reluctant to do exercise. And I would guess that it's as a result of a pretty awful experience previously, and they are very anxious, understandably. And they might need a lot of education, to start with and the pacing and it's a great model for that."*

"It's a good resource that we've got, because once a patient gets to the pain clinic, they tend to become, because it's in the hospital, it's still part of medical care. So instead trying to demedicalise and hand it back to them and to look at different ways of controlling pain, is very useful actually, out…outside of a hospital setting."

Given that the causes of chronic pain can often be the same wherever the pain is located in the body and many low back pain patients using the Service had pain additional areas, some referrers said they would like to see the service provided for all types of chronic MSK pain, not just low back pain.

As a result of all the issues that have been described in this report, all interviewees felt that the Service had not sufficiently integrated into the NHS at the time of evaluation.

> *"Apart from the referral, at the point of referral I don't think there's any integration into the NHS really it's been a very much a little stand alone project really I think."*

Conclusions

Setting up and running an externally provided service for back pain in the NHS was challenging. Issues included those relating to referrals; developing the NHS/external provider interface; large organisations needing to find ways to work together; the current situation and uncertainty within the NHS and PCTs; and finding ways to motivate and engage patients. These issues resulted in lag in the Service integrating into the NHS, and extra time and effort having to be invested by the BBPS Team to adapt and deliver the Service. Nevertheless, BBPS contact with patients using the Service has been described as professional and generally well-managed. In addition, the idea that acupuncture is a passive treatment was challenged, and self-management training for patients with chronic pain was considered an important addition to pain services. These findings are salient given that Health and Social Care Bill based on the recent Government White paper2 currently going through Parliament is designed to encourage NHS services to be offered by external providers.

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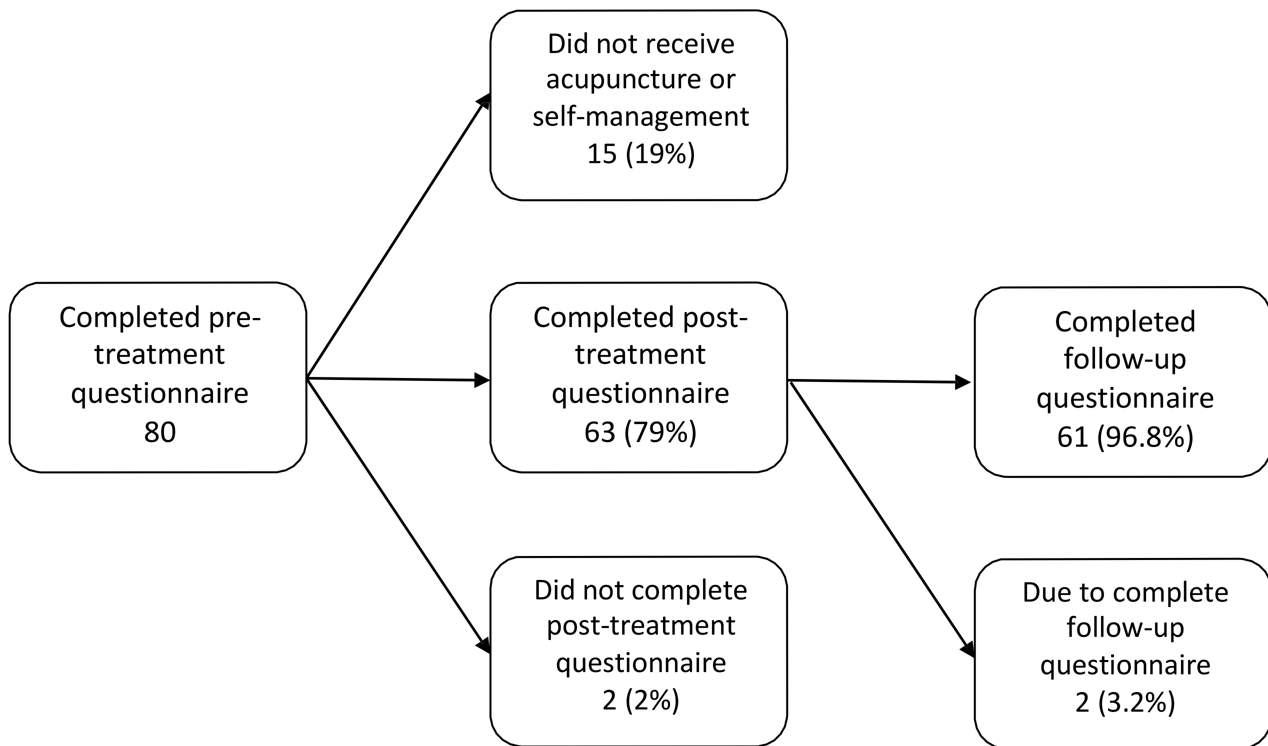
Appendix 1 – Flow of participants through the evaluation



FF95 NHS England

Rapid review protocol: Diagnostic ultrasound services in community settings

Background

This focused review is being undertaken as part of a larger review project looking at provision of diagnostic services in community settings. Initial literature mapping revealed a very limited number of published studies comparing different models of service. One of the few comparative studies found compared a primary care-based mobile diagnostic ultrasound service with a hospital-based open access service.(1) There are other potentially relevant papers not found by the mapping search, which was not focused on specific technologies.(2, 3) Diagnostic ultrasound was chosen as a topic for further review based on existence of some evidence and expert advice about the need for evidence synthesis to identify critical evidence gaps and to guide policy and practice. Nationally, health policy is supporting development of more community-orientated service models with the overall aim of making a range of services more accessible and more effective/efficient though more local provision. This has also been facilitated by changes in service organisation and commissioning arrangements introduced following implementation of the Health and Social Care Act 2012 which allow CCGs to commission a wide range of different models of service from a wider range of service providers. New care models envisaged in the *NHS five year forward view*, particularly the multispecialty community provider model, envisage a major expansion of diagnostic testing in community settings.(4)

Diagnostic ultrasound is used in a wide range of medical specialties, including cardiology (echocardiography), emergency medicine, gastroenterology, urology and musculoskeletal medicine. Its advantages over other forms of imaging include a lack of exposure to potentially harmful ionising radiation. Of particular relevance to primary care/community services, the equipment is relatively inexpensive and small portable scanners (including hand-held devices) are available.(5) The quality of ultrasound images is dependent on the skill and experience of the operator, which suggests that staffing/training issues could be a barrier to expanding diagnostic ultrasound in community settings.

Community diagnostic ultrasound in the form of open access services provided to GPs using hospital-based staff and equipment has been available for many years, for example echocardiography services for diagnosis of cardiac conditions.(6) The focus of this rapid review is on services provided in primary care/community settings using the organisation's own staff and/or equipment.

Review question

What is known about the implications of different ways of providing diagnostic ultrasound services in community or primary care settings? This includes implications for both NHS organisations (e.g. related to provision of staff, premises, training and equipment, costs and cost-effectiveness) and patients (e.g. related to changes in management/pathways, acceptability to patients, accuracy of diagnosis and longer-term clinical outcomes).

Inclusion/exclusion criteria

Population: people requiring diagnostic ultrasound for any condition (excluded: population screening and monitoring, including pregnancy). Studies described as screening may be included if the people being screened are identified by having a specific risk factor for a medical condition (rather than a screening programme offered to all individuals on the basis of age and/or gender) and the identified factors are either common or concentrated (e.g. common within a particular minority ethnic group) within the UK population.

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

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

Outcomes and study designs: the main focus is research studies in developed countries that evaluate community diagnostic ultrasound services and have a comparator; given that we expect comparative studies to be scarce we will also include evaluative studies without a comparator group (e.g. audits and service evaluations (UK only)) and descriptive studies that provide usable information about service delivery in UK settings. Systematic reviews, UK-relevant economic evaluations/cost studies and qualitative research studies will also be eligible for inclusion.

In addition, we will include relevant expert opinion pieces or reports from professional bodies that identify and/or discuss practical issues related to the provision of community diagnostic ultrasound services (e.g. staffing, training, equipment and premises) in UK settings.(7)

Outcomes of interest include patient outcomes (e.g. waiting times; acceptability; changes to diagnosis or management; and any clinical outcomes) and service/process outcomes (e.g. costs/resource use; cost-effectiveness; needs for training, premises and equipment). Resource use outcomes include any implications for test ordering by GPs(8).

Given that the focus of the review is on models of service, studies that focus on the diagnostic accuracy of ultrasound in community settings for particular conditions(9) will not be included unless they are relevant to the primary–secondary care interface, as defined in the accompanying protocol (e.g., they contain information on referrals or changes to diagnosis or management pathways).

Methods

Searching

The following databases will be searched:

- MEDLINE via Ovid SP
- Embase via Ovid SP
- Cochrane Library
- Cumulative Index of Nursing and Allied Health Literature (CINAHL)
- Web of Science

From the initial mapping exercise it has become evident that ultrasound in a primary care setting goes back to the mid-1990s.(10) The proposed search strategy in Appendix 1 therefore includes a date restriction of 1995 to current.

No methodological filters have been applied to the strategy since we are interested in all types of evidence and the evidence base is in any case relatively small.

Given the limited nature of the evidence base, citation searches of key titles will be performed as a supplementary exercise.

In addition to the database/citation searches, searches for grey literature will be undertaken. Along with some general searching via a search engine such as Google, the following websites will be searched:

- Oxford Diagnostic Evidence Co-Operative
- Websites of service providers

The grey literature element of the searches is likely to be informed by our contact with clinical experts, who may be able to suggest particular resources/websites of interest.

Study selection

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

Data extraction and quality assessment

Any included experimental or observational studies will be assessed for quality using relevant tools (e.g. Cochrane risk of bias tool for clinical trials, Newcastle–Ottawa scale for observational studies). Data will be extracted using forms/tables set up in advance and piloted on a small number of studies. Data extraction and quality assessment will be checked by a second reviewer. Any discrepancies will be resolved by discussion and consensus, with reference to a third reviewer if necessary.

Synthesis of evidence

Given the nature of the topic and the likely evidence base, quantitative synthesis by meta-analysis is unlikely to be possible. We expect to perform a narrative synthesis using patient-related and service-related issues (as defined above) as a framework for the synthesis. Evidence will be grouped by type of service model and if appropriate by indications/patient groups covered. The synthesis will provide an analysis of the quality of evidence and the strength of conclusions which can be drawn from current studies. We will also seek to identify evidence gaps to inform future research.

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Timeline

Activity	Start	Finish
Protocol development	20 January	6
Protocol sign-off (HS&DR team & Prof.	8 February	13
Literature searching	16	6 March
Study selection and data extraction	9 March	3 April
Analysis and report writing	6 April	30 July
Delivery of draft report		31 July

*Including internal peer review by team

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Appendix 1: Proposed MEDLINE search strategy

Database: Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R) <1946 to Present>

Please note: The proposed search strategy is for MEDLINE only, and will be adapted according to each of the other databases.

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1 primary care.tw. (73448)

2 general practi$.tw. (63001)

3 primary health care.tw. (15131)

4 Community Mental Health Services/ (16715)

5 Family Practice/ (59984)

6 Home Care Services/ (27904)

7 Physicians, Family/ (14697)

8 Community Health Services/ (27031)

9 Community Health Nursing/ (18468)

10 Community Pharmacy Services/ (2926)

11 Community Health Workers/ (3300)

12 Preventive Health Services/ (10983)

13 or/1-12 (266825) – Primary Care terms

14 *Diagnostic Services/ (1050)

15 *Clinical Laboratory Services/ (94)

16 *Genetic Testing/ (12574)

17 *Mobile Health Units/ (1937)

18 diagnostic service$.ti,ab. (1039)

19 clinical laboratory service$.ti,ab. (121)

20 genetic test$.ti,ab. (12840)

21 mobile health$ unit$.ti,ab. (52)

22 mobile health$ clinic$.ti,ab. (21)

23 (point of care testing or point-of-care testing or POCT or near patient testing or near-patient testing).ti,ab. (1720)

24 diagnos$.ti,ab. (1712643)

25 test$.ti,ab. (2238299)

26 24 or 25 (3648877)

27 26 and primary care.tw. (24260)

28 or/14-23,27 (51312) – diagnostics terms

29 13 and 28 (24994) – PC and diagnostics terms combined

30 Ultrasonography/ (63040)

31 ultrasonic diagnos$.ti,ab. (1831)

32 (ultrasound adj3 imaging$).ti,ab. (10335)

33 (ultrasonic adj3 imaging$).ti,ab. (1257)

34 sonograph$.ti,ab. (44056)

35 ultrasound scan$.ti,ab. (7156)

36 Echocardiography/ (67752)

37 (echocardiography or echocardiogram).ti,ab. (85342)

38 (echo adj2 cardi$).ti,ab. (555)

39 **or/30-38 (227956) – terms around ultrasonography/echocardiography**

40 **29 and 39 (315) – all elements combined in the final line**

41 **limit 40 to yr="1995 -Current" (289) – date limit**

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FF96 NHS England

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

Background

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

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

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

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

Review question

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

Inclusion/exclusion criteria

<u>Population</u>: people requiring diagnostic services for any condition (excluded: universal screening and monitoring, including pregnancy). Studies that describe screening for selective populations (e.g. by age, gender, ethnic group) or for individuals indicated to be at

risk will be included provided factors that are identified are either common or concentrated within the UK population.

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

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

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

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

SKILLS: Skill mix; Extended roles; Inappropriate Test Ordering
TRAINING: Training Needs; Training Costs; Duration
EQUIPMENT: Equipment for modality and for analysis; consumable costs
PREMISES: Cost of Premises
USER PERSPECTIVE: Waiting Times; Acceptability; Repeat Procedures.
PRIMARY-SECONDARY INTERFACE: Referrals, Changes to Diagnosis or Management Pathways; Differential rates of Diagnosis in Primary versus Secondary Care

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

Methods

Searching

We will undertake a two stage search strategy:

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

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

Search methods:

a. Database searches: 2005 to present using review filters.
b. Citation searching
c. Internet searching: Specified websites (including Oxford Diagnostic Evidence Co-Operative) plus limited searching of Google Scholar

d. Contact with experts

(ii) Stage Two - Population of extended STEPUP framework with empirical evidence

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

Search methods:

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

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

c. Citation searching

Study selection

Stage One: Development of Framework

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

Stage Two: Population of Framework

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

Data extraction and quality assessment

Stage One: Development of Framework [Any reference type]

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

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

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

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

Synthesis of evidence

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

SKILLS & EXPERTISE: Skill mix; Extended roles; Inappropriate Test Ordering
TRAINING: Training Needs; Training Costs; Duration
EQUIPMENT: Equipment for modality and for analysis; consumable costs
PREMISES: Cost of Premises
USER PERSPECTIVE: Waiting Times; Acceptability; Repeat Procedures.
PRIMARY-SECONDARY INTERFACE: Referrals, Changes to Diagnosis or Management Pathways

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

Deliverables:

Stage One: Development of Framework

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

Stage Two: Population of Framework

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

Timeline

Activity	***Start***	***Finish***
Protocol development	20 January	6 February*
Protocol sign-off (HS&DR team & Prof. Denton)	8 February	13 February
Literature searching – Phase 1 – Iterative Development of Framework	16 February	13 March
Literature searching – Phase 2 – Population of Framework	13 March	31st March
Presentation of draft framework to HS&DR Team	Late March – Early April	
Study selection and mapping	1st April	31st May
Analysis and report writing	1 June	30 July
Delivery of draft developed and populated framework		31 July

*Including internal peer review by team

References

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

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

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

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

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

Appendix – Search Strategies

Stage One

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

Stage Two

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

	Point of Care Testing (haemoglobin A1c (HbA1c) and urine albumin: creatinine ratio (ACR) on patients with diabetes, total cholesterol, triglyceride and high density lipoprotein (HDL) cholesterol on patients with hyperlipidaemia, and international normalised ratio (INR) on patients on anticoagulant therapy).	Point-of-Care Systems
	Radiology/X-Ray	exp Radiography
	Respiratory Tests	exp Diagnostic Techniques, Respiratory System
	Ultrasound	exp Ultrasonography /ultrasonography
FACTORS/ CONSIDERATIONS	**S**KILLS & EXPERTISE: Skill mix; Extended roles; Inappropriate Test Ordering	Physician's Practice Patterns /manpower
	TRAINING: Training Needs; Training Costs; Duration	/education
	EQUIPMENT: Equipment for modality and for analysis; consumable costs	Diagnostic Equipment Equipment Safety Equipment Design Equipment Failure Equipment Failure Analysis Maintenance /economics /utilization
	PREMISES: Cost of Premises; Health & Safety	/economics
	USER PERSPECTIVE: Waiting Times; Acceptability; Repeat Procedures.	Waiting Lists Patient Acceptance of Health Care
	PRIMARY-SECONDARY INTERFACE: Referrals, Changes to Diagnosis or Management Pathways	/utilization

FF97 BASW

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Integration and disintegration of health and social care services

A Charter for Social Workers in integrated health and social care services in England

Is the creation or removal of formal partnership agreements between health and social care a good thing or a bad thing?

The last year has seen some major changes in partnerships[1] between health and social care. At one end of the spectrum social service departments are pulling out of agreements with mental health trusts and at the other end social service departments are setting up new partnership agreements. The latest of the new partnerships is in Staffordshire and Stoke on Trent which from April 1st 2012 has created the Staffordshire and Stoke-on-Trent Partnership NHS Trust. This will be responsible for adult social and community healthcare within Staffordshire and all community healthcare in Stoke-on-Trent creating one of the UK's biggest integrated health and social care providers.

David Cameron made integration one of his five "personal NHS guarantees" in 2010, when he said the health reforms must not "break up or hinder efficient and integrated care, but to improve it".[2] Cameron has ordered health and social care services to be brought together to benefit patients (sic) in a move which government advisers are calling the NHS's most urgent overhaul.[3] It is anticipated that Health Secretary Andrew Lansley will demand that integration (for people with complex needs) be given the same priority as the waiting time targets. That new target is the key recommendation of a new report on integrating care by the King's Fund and Nuffield Trust. However it is notable that in the King's fund recommendations they say "No single 'best practice' model of integrated care exists. What matters most is clinical and service-level integration".[4]

BASW has met hundreds of social workers in the last year who are being and will be affected by these changes. The overwhelming view of social workers is that they want what is best for the service users and who they are employed by ultimately does not matter. Social workers are proud of their professionalism and their identity and feel strongly that partnerships and integration can be good, but can also be disastrous for them and the service users that they work with. There has been good discussion on "integration" on twitter[5]

This document does not consider the details of the complexities of integration – for example funding models or organisational models. However it should be noted that many social workers have seen wave after wave of policies and strategies to implement integration, all of

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[1] Partnership is now commonly termed integration. The change in wording is perhaps symptomatic of the more structural approaches in vogue, which can ignore the more subtle psychology of the term partnership, which in its etymology implies equality

[2] http://www.channel4.com/news/david-camerons-five-nhs-pledges

[3] http://www.guardian.co.uk/politics/2012/jan/05/david-cameron-health-social-care?newsfeed=true

[4] Kings Fund (5.1.11) Integrated care for patients and populations: Improving outcomes by working together. Authors: Nick Goodwin et.al. http://www.kingsfund.org.uk/publications/future_forum_report.html

[5] http://swscmedia.wordpress.com/tag/swscmedia/

which have been Government or managerially led and nearly all of them have failed because this is an enormously complex issue.[6] Our focus is on the experience of front line social workers and what they feel works on a practice level to aid or hinder disintegration. This front line experience is so often ignored which leads to failures of well (and poorly) intentioned policies.

Partnership, or integration can be of real benefit to service users, however there are some crucial clauses to this view[7]:

- Social workers say that it is essential that there is good governance to support them. This includes having a senior lead manager, who is a social worker who can represent the views of social workers
- Social workers want the right to have support and supervision from a qualified social worker, particularly practice supervision
- Social workers are very worried about the Payment by Results (PbR) system that is getting embedded in health. Payments by Results means that the Trust will get money for certain outcomes and these outcomes can be defined in medical or clinical terms. For example in mental health PbR can mean that the "treatment" identified is defined by the clinical label, not by need. Someone with a "diagnosis", of say clinical depression could be allocated x and y treatments, regardless of their social situation and their own resilience. Increasingly treatment for "psychosocial" need follows the PbR route of CBT. Social workers are experts in holistic care and do and should have a recognised role in psychosocial interventions, not just called in to arrange discharge. (For a good explanation of the complexities of PbR see NDTI report) [8]
- If "health" dominate the partnerships then the roles and identities of social workers could easily be further eroded
- Social workers are far from mercenary; however they understandably are concerned about their terms and conditions of employment – are the partnership arrangements subject to TUPE, or are staff seconded? If the former what guarantees are there to ensure that in the long term they will not be sold down the river? Are there (and there often seems to be) less favourable terms and conditions of employment for social work and social care staff then health colleagues? Will social workers still receive appropriate training and development opportunities?
- Are the partnership arrangements a cover up for cuts? Health services have "pioneered" new ways of working, and aspects of that are great. However there are aspects that are very concerning. There is far more complex care being undertaken by support staff, with worrying consequences for the quality of care. Will there be the same number of social workers, or will chunks of the job be hived off to support workers, with consequent reductions in the number of social worker?

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[6] http://swscmedia.wordpress.com/tag/swscmedia/

[7] A recent article used the word collaboration, which is a useful way of thinking about partnership. The article argues that formal agreements are not necessary, it is relationships that are important http://www.guardian.co.uk/social-care-network/2012/jan/11/nhs-confederation-adass-join-integration?INTCMP=ILCNETTXT3487

[8] National Development Team for Inclusion. Getting it together for mental health care: Payment by Results, personalisation and whole system working. www.ndti.org.uk

- What happens to independence? It is very hard as a member of a multi-disciplinary team to criticise professional decisions. Will the social worker be supported when they refuse to undertake something that is unethical, or indeed in some cases unlawful? The independence of AMHP is arguably more difficult to retain if they are employed by health and indeed some of the dis-integration that has taken place has been because of these ethical concerns

Social workers are practical people and they know from bitter experience that so often partnerships have been set up without the infrastructure to support integration. It is very common to be told that even 10 years into a partnership social workers are having to operate two IT systems – the local authority and the health one and much recording work has to be duplicated. Or they no longer have access to the local authority intranet. Having to complete two lots of meaningless performance targets is another thing that social workers find particularly gruelling.

> "*The best thing that has happened to me in the last year was the local authority breaking off the section 75 agreement with health. I am now back working in the local authority, I have social work colleagues (I was very isolated), got now support for my professional identity and CPD when working for health and all I was called upon to do was section people under the mental health act and arrange packages of support once a decision had been taken by others to discharge someone". Social worker, Nov.11*

> *"Being part of an integrated team is great. I now work alongside district nurses, GPs, community OTs and others. We have a much better understanding and appreciation of each others' roles and also respect for each others' roles. I am sure the service user gets a better service". Social worker, Dec 11*

So is partnership a good thing or a bad thing? So much depends on what this means in practice. BASW has drawn up a charter for social worker entering into such relationships:

- The BASW Code of Ethics must be adopted by Health Trusts and Social Service Partners to underpin the relationships within and between the partners
- Health managers must recognise that social work is a profession with its own principles and codes of conduct and unique knowledge and skill set. This knowledge and skill set includes safeguarding, the mental health act, case management and personalisation, but also relates to wider knowledge emanating from research and practice. This includes a high level of understanding of the social model of disability.

Practices and processes to be adopted in order to achieve the principles

It is recommended that the following practices and processes are adopted in order to ensure that social workers are well supported in integrated health services:

- There must be genuine service user and carer involvement in both the creation of partnerships / integrated services and in the on-going management of them

- The implications of the introduction of PbR must be seriously considered by Health Trusts and Social Service Departments in order to avoid the disintegration of multi-disciplinary teams
- Interagency groups must be established to oversee section 75 agreements
- Regular governance meetings at senior management level must take place to monitor partnership arrangements
- There needs to be social work representation at Trust Board level. This representation should be from someone who clearly “owns” the local authority social care portfolio
- Social care and social work must be included as an integral part of the health trust’s mission statement
- There needs to be strong on-going local authority engagement at senior management level with health services in order to ensure that the social care model, personalisation and the social work role are effectively embedded in Health Trusts
- Social care models must be incorporated into the training of all health professionals
- That clear lines of accountability, leadership and support to middle managers are set up in order to take the social care agenda forward
- There must be active promotion of the value of the social care workforce
- Everyone responsible for personnel issues – recruitment, disciplinary, grievance and absence must be trained in the requirements of the local authority, Care Quality Commission, Social Work Codes of Practice and Social Work Reform Board recommendations
- Social care leaders should ensure that that support services are in place for social workers – IT HR, finance, learning and development. This includes ensuring that social workers, whether seconded to Trusts or directly employed, have the tools to engage with social service departments (such as access to local authority internet and intranet and recording systems) Without the support arrangements the anticipated cost savings will not materialise
- Social workers and social work managers should be engaged from the outset in the development of plans to reconfigure and change services
- Robust arrangements must be put in place to ensure that social workers receive good quality supervision from qualified social workers
    - Professional supervision within the team from an experienced social worker
    - Support for the experienced social worker from an external mentor
- There should be an adequate number of social workers in multi-disciplinary teams
- There should be a social work forum in each locality, that is separate from other professions in order to build and sustain identity.

Conclusion

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Finally, "integration" can work and does work without structural changes, partnership agreements etc. Social workers have successfully worked for years as part of multi-disciplinary teams in hospitals and in the community and a huge part of our role is liaising and working with other professionals.

Joe Godden, (BASW Professional Officer) and the BASW Mental Health Reference Group. 17.1.12

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Twitter debate http://swscmedia.wordpress.com/tag/swscmedia/

FF98 BASW

BASW Evidence

We know that primary care in the UK already provides very high quality care in many areas and primary care in the NHS is often held up as a model in other countries. Nevertheless, there are major challenges in terms of workload and the changing nature of that workload. In relation to the main groups with needs for primary care (e.g. acute illness, long tern conditions, frail elderly, end of life care and preventive care), the Commission would like to consider;

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

Social work is an internationally recognised profession, which is regulated in England by the Health and Care Professions Council (HCPC). Despite the clear restrictions on people calling themselves social workers, literature and the media frequently confuse social work and social care. Social workers are part of the social care workforce just as nurses and doctors are part of the health workforce. In this document we will be specific about when we are talking about the social care workforce in general, and when we are talking about the social work profession specifically. The social care workforce is equivalent in size to the NHS workforce, but for the majority of the workforce their qualifications are at pre-degree level. This makes the profile of the health and social care workforces very different, and has undermined many attempts to integrate the services.

Social work is a graduate profession, with increasing numbers of new social workers qualifying at Masters level.

Many universities now have health and social care programmes located together in their structures. This sometimes leads to good integrated cross professional teaching and learning, but quite often the packed professional demands to meet regulatory standards can militate against this. Social work programmes can often be caught by the competing and contradictory expectations of the Department of Health and the Department for Education. Too often, social work finds itself being politically fought over by others, so that even in initial education social workers feel they are being forced to choose between being part of primary health care or children's services. Until adult and children's safeguarding is at the heart of primary care services, and social workers do not have to make this artificial choice within their initial education, then the location of social work within integrated care services through education and employment will always be harder to achieve.

What drives the services apart are the competing educational requirements of the different professions, the significantly different educational profile of the health and social care workforces, the diversity of the professional cultures

characterised as “medical” and “social “ models, as well as the practical differences of funding regimes, reporting structures, lack of coterminous boundaries for services, etc.

The theme of many good models of integrated work is that it has happened despite their organisations rather than because of them. They occur because of the commitment of people on the ground working in their local universities and organisations, where individuals see the need to work together for the good of service users, students and workers.

Social work is bringing to the primary care workforce:

1. A particular focus on a person centred approach, prevention and safeguarding within the community context.

2. The core offer of social work. A recent version of this is expressed in the Knowledge and Skills statement for social workers in adult settings produced by the chief social worker in the Department of Health.

3. The important role that social worker contributes to the implementation of statute, good practice and guidance e.g. the Community Care Act, Mental Capacity Act, the Care Act

4. Promotion of a multidisciplinary approach to integrated primary care commissioning

5. Practitioner and Consultant - social workers can provide direct services within a primary care setting as well as providing advice, knowledge and expertise to other skilled practitioners from different disciplines including community matrons, district nurses, community physiotherapists, occupational therapists and community outreach mental health nurses.

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

Social work is committed to working with service users in the planning and delivery of our services. It is welcome that this is now at the heart of health planning too, although there can still be professional differences as to what this means in practice. Common understanding of this is fundamental to the successful delivery of any integrated service.

The legal responsibilities of local government for safeguarding vulnerable children and adults and assessment of mental capacity, are delivered primarily by social workers, and are central to social work knowledge and skills and understanding of their job. Increasing public awareness of groups being criminally involved with vulnerable children and adults in all parts of the country requires social workers to have a clear understanding of community dynamics and group inter-relationships. It is no longer sufficient to understand the needs of the single service user and their immediate support networks, and

many social workers would argue that it never was acceptable. But equally it is not enough to understand population trends or health statistics. What is needed is clear personal engagement by professionals, including social workers, with people of all ages in the community. Social work can help bring this understanding into the primary care planning and delivery of services, but only if professionally supported to do so. This is stressful, complex work, which requires appropriate social work management and supervision and continuing professional development.

This can be built into many different models of multi-professional team working, but must be explicit. This is necessary to enable social workers to meet their regulatory requirements as well as their own mental health and professional development needs. Thus the clarity of the professional governance structure is more important than the details of the location, line management and organisational processes.

We have examples from our members of designated social workers meeting regularly with GPs and nurses to share concerns about cases, to discuss issues whereby there may be patterns of challenges, to share knowledge of resources. These meetings are about the establishment of communication, trust and problem solving. They can also feed into CCGs. Some places like Torbay and Staffordshire are/have created health and social care trusts, and our understanding is that the issues of better relationships and communication are down to the time spent on organisational development and personal trust, with the importance of diverse professional identities being accepted and owned.

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

Models will work which are focused on the service user, and value the different and complementary roles of the professionals delivering the service.

Social workers are working very effectively within integrated services for primary care where their contribution is valued, and they are professionally supported in their own professional development with clear professional governance structures as well as line management structures.

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

As with much organisational change, the success of change depends on the inspiration and determination of the leaders, and the personal dynamics between the workers involved. Organisational change literature holds up many examples of key success stories for particular models of organisational change, but which when followed up a few years later, the models have been changed as new leaders come in and reorganise to impose their own preferred model. We have seen this repeatedly within national government, local government and the NHS, as well as private industry.

We strongly believe that good models of integrated working should be widely shared so that others can learn lessons of good practice, but that there should

not be any move to impose one model. We hear regularly from our members in Northern Ireland about the very real challenges of working in a unified structure, where the sense of professional isolation and undervaluing can be as real as in separate structures. Time and energy of good managers should be focussing on the needs of their service users in financially challenging times, not tied up in repeated organisational change.

This is challenging in the current political climate. We recognise that the push for integrated services is in part driven by the needs of service users, but also meets several competing political drivers. The role of local government commissioning helps bring local political legitimacy to general practice commissioning. It also brings the strong traditions of private providers of social care services and community providers into the mix for community health care provision. This was clearly part of the last government's agenda. The fallacy is that commissioning is local – and that procurement is sophisticated enough to predict and respond to the changes in service needs over period of 10 – 15 years, or longer. With the demise planned for local government, more and more procurement is done on a larger cross local authority scale, and more GP commissioners are coming together into larger practices or being taken over by large companies.

Thus the positive language of services delivered by local people alongside or round the service user, is becoming increasingly at odds with the large-scale market led procurement mechanisms in place to deliver them.

Social workers, as other professionals, are currently employed in a myriad of employment structures, which can support the delivery of good social work services, so long as the professional needs for regulation and professional identity, including ethical values, are met.

Our profession has survived by being adaptable to organisational change because it focuses on the needs of the people who use the service. This makes social workers central to the success of any plans for integrated services where the needs of service users are the key to success.

Safeguarding boards, at their best, demonstrate how different employers and professional groups can meet together with a common purpose focussed on the needs of children and adults, and hold each other to account for good practice.

This sort of good practice is replicated up and down the country at local team level and cross-organisational level. But a key requirement is stability.

We have endless examples of good practice that was developed for the delivery of integrated primary care practice that has been broken up through wider organisational change. This is not only wasteful of resources, but also demoralising for the staff involved.

Bridget Robb CEO BASW Appendix 1: BASW Charter

FF99 RCN

Next page

Improving primary care for patients

Joint statement of principles

British Medical Association
Royal College of Nursing

Royal College of Nursing

BMA

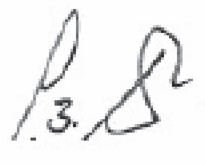
Improving primary care for patients
Joint statement of principles

Foreword

The current challenges for healthcare in the English NHS are radically different from those in the past, with increasing demand from an ageing population many of whom have complex needs and/or long term conditions. For many patients, care has moved from hospitals into the community but often without the necessary funding or co-ordination for this to be successful. This has often led to patients being readmitted to hospital where proper support in the community would have allowed them to stay in their own homes. There is growing consensus that the health service needs to do things differently; to shift the emphasis to better co-ordinated care and prevention at home and in the community; to promote patient independence and to ensure the best care in the most appropriate setting.

Building on the principles of intermediate care for the elderly, and on initiatives in general practice such as the unplanned admissions enhanced service, the British Medical Association (BMA) and the Royal College of Nursing (RCN) have taken the opportunity to work together to draw up this joint statement of the principles that should underpin joint working between doctors and nurses. We believe that this is vital, particularly to respond to the need to provide more co-ordinated care in the community, based around the individual patient's needs.

Our organisations and our members are at the forefront of delivering care to patients and we are sufficiently concerned about the difficulties currently facing this delivery of care to make this rare joint statement. We urge government to ensure that these measures are funded and put in place to support patients.



Dr Chaand Nagpaul
Chair
BMA General Practitioners Committee

Dr Peter Carter
CEO and General Secretary
Royal College of Nursing

1. Professionals working together

> ***"We share a vision of the primary and community care workforce as professionals working together to develop services in their local communities."***

We believe that care should be provided across multi-agency and multi-disciplinary teams, with the right people in the right place working with patients to understand their needs. There should be trust among health professionals and a joint approach to providing care. This should be co-ordinated by the most appropriate person within that team and should be underpinned by a well devised care plan that has been agreed with the patient. Information sharing is critical and a co-ordinated approach will also help avoid wasteful practices, such as patients having to repeat their histories, and instil collective responsibility while at the same time clearly defining roles and responsibilities.

Community healthcare teams can often be built around GP practices, and should keep the patient at the forefront of care at all times. There should be a clear understanding of the vital role played by each member of the team to avoid any tensions. These teams should identify clearly their common vision, and from the outset establish a commitment to work together for the best outcomes for their patients, working effectively across boundaries as many do already.

2. Workforce

> ***"We believe it is vital to plan for increases in the GP and nursing workforce, to recognise the demographic change of an ageing population and as services increasingly move into the community."***

This, along with the move to integrate health and social care services, increases the demand for a skilled and competent primary and community workforce which includes GPs, district and specialist nurses, mental health services, social workers and others. However, the primary care workforce is currently facing a crisis, with a shrinking number of GPs, clinical nurse specialists and community nurses. Without a clear and comprehensive strategy to deal with this, the numbers will simply not be there to deliver the kind of co-ordinated care in a community setting that patients now desperately need. While recruitment of additional staff will take time, it is vital that the current workforce is maximised, including retention initiatives and schemes to encourage and facilitate the return to work of qualified staff not currently working.

There is also a case for the provision of additional healthcare support workers, with appropriate training and mandatory regulation. Furthermore, administrative requirements in the community are not currently aligned with existing administrative support, so that clinical staff spend too much of their time undertaking administrative tasks that could be performed by a non-clinical support team. This applies to GPs and nurses alike, and the provision of additional administrative support would ensure that clinical professionals can get on with their essential role of supporting and caring for patients.

3. Integrated care pathways

"We believe that while localised services best suit local needs it is vital to ensure that these are joined up, consistent and that best practice is funded and delivered across the country."

When services are duplicated or organisational boundaries prevent access to care, we see patients' fundamental needs not being met and resources being wasted. Duplication and time-consuming bureaucracy, due to lack of co-ordination and integrated working, make things stressful and confusing for patients and their families and often causes delays in the provision of care.

GPs, primary and community based nurses working with colleagues in secondary and social care and across voluntary and community settings are best placed to design and provide care pathways which start and end in the person's home. The outcomes would be that every person requiring care would have a properly co-ordinated care plan within an agreed multi-disciplinary and multi-agency framework. As an example, integrated health and social care should start with a single joint assessment involving key members of the multi-disciplinary team, and a single care plan, with an identified member of the care team to lead and co-ordinate the implementation of the plan – this could be a doctor or a nurse – ensuring a whole systems approach.

While the BMA and the RCN support the principle of integrated care and the best practice outlined above, we are mindful of the impact on different roles and in particular on workload, especially in view of the current workforce crisis in both professions.

4. Primary care infrastructure

"We believe that doctors and nurses and their wider teams must be provided with the resources they need to provide high quality, effective services."

As has been widely reported, practices are struggling to expand the range of services they can offer due to difficulties in extending or upgrading their premises. Practice teams need access to appropriate IT, premises and administrative support. Community based clinical staff must be involved with the development and structure of these, particularly in relation to the way in which IT can be used to maximise the working of community based multi-disciplinary teams. Ideally, there should be common or inter-operable systems that allow for information to be shared, with appropriate safeguards, to avoid duplication and improve co-ordination of care within the primary/community healthcare team. In particular, the supply of hardware should be accompanied by strategies to ensure it is used effectively and that staff receive appropriate training.

Other specific initiatives could target improvements in the physical infrastructure or practices, for instance providing a hub for community teams within practices, to enable community nursing team members to meet GPs and their practice teams.

5. Supporting self care

"We share the aim of empowering patients and their carers to develop their knowledge, skills and confidence to become active partners in their own healthcare."

Well planned and co-ordinated community interventions can promote self care and resilience, and prevent conditions getting worse thus helping to avoid unnecessary hospital admissions or a move to residential based care and/or long term nursing care. Care plans, drawn up with the involvement of patients, carers, and the multi-disciplinary team, should ensure that care is centred on the patient based on their individual needs, but supports individuals to set their own agenda with regard to their health and wellbeing.

We support a national self help strategy, allowing patients to manage self-limiting minor illnesses to ensure that doctors and nurses can focus on those who really need them, particularly those with long term chronic conditions or who are elderly and frail.

6. Supporting clinical judgement

"We believe that meeting the demands of increasing co-morbidity and complexity of care by shifting more care into community settings requires clinical assessment, judgement and prioritisation undertaken by trained professionals."

Timely intervention and leadership from the right staff at the right time prevents more costly care being required further down the line. The clinical staff caring for patients in the community with significant health needs have the ability to manage risk and make complex decisions about care and treatment, and it is important that there is support for those who may be making these decisions in relative isolation, for instance nurse prescribers.

There are also particular pressure points in relation to access to out-of-hours care. We uphold the principle that clinical judgement is retained and supported when organising services to meet these pressures. We have already seen the quality of the NHS 111 service adversely impacted by the loss of qualified and regulated health professionals, with patient care suffering and resources being wasted when the person taking the call is unable easily to access staff with the clinical expertise to make the best decisions. In addition, budget pressures on out-of-hours services providers have led to not enough GPs or nurses being employed to meet the rising need of patients, leading to rising complaints which in turn puts off GPs and nurses from working in such stressful environments.

7. End of life care

"We believe that more support is needed for the community workforce to meet the projected demand for end of life care."

Our two professions are choosing to highlight this particular issue because of its importance to patients, their families and carers, and because nurses and doctors have such key roles to play in making sure that individuals are treated with dignity and respect, and given as much choice as possible about the care their receive as they approach the end of their life. Despite the development of national end of life care strategies, there has been insufficient investment to enable the community workforce to meet the projected demand for end of life care.

Emerging evidence on the value of expert palliative care services based in the community suggests that these teams are shifting the emphasis away from hospital based care towards better co-ordinated, person centred home-based care where – with the right support – most people prefer to be in the last weeks of life. Once a care plan has been agreed, it is essential that all the services the individual requires are effectively co-ordinated between primary care community and hospital based providers, general practitioners, the local hospice, transport services and social care. A lack of co-ordination can ultimately mean that a person's needs and preferences are not met.

To meet the palliative care needs of people who chose to remain at home, investment is needed in all primary and community care services, including well developed 24-hour district nursing services. This investment would enable nurses to provide 24-hour anticipatory care to ensure that people with complex health needs die well at home, in the way that they chose, supported by home visits from their nurses and GP if they wish.

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FF100 Health Education North West London

Next page

Practice Nurse Education Needs Analysis survey results:

Buckinghamshire New University

University of West London

REPORT OF COMBINED DATA

February 2015

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Summary of results

Participants

- A total of 272 practice nurses and HCAs in the NW London region completed the survey.
- One hundred and 28 practice nurses within the CWHHE CCG collaborative completed the survey. Nurses from Ealing CCG completed the survey between January and April 2014. Practice nurses from the Hounslow, West London, Central London and Hammersmith and Fulham CCGs completed the survey between July and December 2013. These data were collected by Bucks New University.
- Forty two respondents were from Ealing CCG (33%), 28 from West London CCG (22%), 21 from Hounslow CCG (16%), 16 from Central London CCG (13%) and 12 from Hammersmith and Fulham CCG (9%).
- One hundred and forty four practices nurses, health care assistants and nurse practitioners completed the survey from the Brent, Harrow and Hillingdon CCGs between May and July 2014. These data were collected by the University of West London.
- Seventy one percent of respondents were practice nurses, 12% advanced nurse practitioners, 7% Support Worker/ Health Care Assistant (Bands 1-4) and 6% specialist practitioners.
- Most respondents (87%) indicated that they were registered nurses.
- Of the 240 respondents, most had either a Diploma in Higher education (48%) or a BSc (33%). Six percent of the respondents also had an MSc.
- The average number of years since starting work in community or practice care was 16, ranging from 0 to 52 years. Only 14% of respondents had 5 or less years' experience and nearly half the sample (46%) had more than 15 years' experience in community or practice care.
- Of those respondents who gave a band level, the most common band was 6 (33%) with most respondents at band 6 and above (67%).

Previous training

- The survey asked about levels of training achieved in the areas of asthma, diabetes, COPD, heart disease, family planning, triage and travel health. Over all areas, forty percent of training was classified as uncertified, 36% as certificated and 24% of the training received in these areas was through an academic qualification (diploma / degree / post-graduate).
- The level of academic training was also assessed for nurses who had sole or shared responsibility for a specific service. For this group, 33% was uncertified, 39% classified as certificated and 29% of the training received in these areas was through an academic qualification (diploma / degree / post-graduate).
- The numbers of nurses who did not specify any training in the area in which they had shared or sole responsibility for a service (by stating N/A or giving no response) was low, ranging between 1 and 11 nurses for each service area (3% to 16%). Areas with more than 10% of respondents stating they had no training were heart disease and triage/minor illness.

- Respondents were asked whether they had attended training in the last 12 months in 21 specific areas. Fourteen respondents had not attended training in any of these areas. The average number of areas for which training had been achieved was 6.9, ranging from 0 to 21. The most commonly achieved areas of training with more than half the respondents having completing training in the last 12 months were CPR (83%), immunisation and anaphylaxis (72%), child safeguarding (72%), cervical cytology (63%), fire safety (62%), adult safeguarding (62%) and infection control (57%).
- Training was generally rated favourably or with an average response. Over all courses attended, 56% was rated in the top two categories (4 or 5-excellent) and only 5% in the two poorest categories (2 or 1-poor).
- Training had been led by a range of different providers. The most frequently used providers were In-house training (24%), the CCG (22%) and on-line (20%).

Education needs

- For the 21 specific training areas, respondents were asked whether they would be interested in attending training in that area. The average number of the specified areas where respondents said they would like training was 7.2, ranging from 0 to all 21. Sixty four nurses (27%) did not say they needed training in any of these areas. However, 29 of the 64 listed specific training areas they required in the open training needs question. The percentage of respondents who listed neither specific training needs nor training in the specific areas was 13%.
- The highest percentage of positive responses for training was shown in the areas of specialist COPD (50%), flu update (44%), infection control (44%), specialist diabetes (43%) and ear care (42%).
- Areas of least interest were equipment training (24%), moving and handling (21%) and customer service (19%).
- Over half of the respondents (51%, 140) specified some additional training needs in the open question with 295 training areas specified in total. Of these, 47 (16%) were specifically requested as training updates. Areas for specific training needs given by more than 15 nurses were minor illness, asthma, COPD, family planning, diabetes and prescribing.
- Thirty respondents (12%) were currently studying for an academic award.
- More than half of the respondents (58%) belonged to a professional network. The RCN and the Practice Nurses Forum were the most commonly used networks.
- A third of respondents (33%) had a clinical mentor and 43% had access to clinical supervision.
- Thirty eight percent of respondents mentored or supervised others. Of these, 43 nurses (44%) either did not state any formal training or stated that they had not received any formal training in clinical supervision and mentoring.
- Most respondents had appraisals conducted by the GP (70% of those who responded) Others had appraisals conducted by a practice/service manager (14%), nurse (10%), or a combination of senior staff.
- Of the 191 respondents who gave an appraisal date, 59% had had an appraisal in the last year, 29% had their last appraisal between 1 and 2 years ago and 5% more than 2 years ago.

- Focus group data indicated a workforce which lacked career progression, role autonomy or a coherent educational framework. Practice nursing was found to be undifferentiated in scope and isolated from the wider health and social care network with whom the patients interacted. Practice nurses recognised the strength of their role in building relationship- centred care with patients over an extended period of time. They valued this aspect of their role and would welcome opportunities to develop this to benefit patients.

Introduction

This report describes the outcomes from a questionnaire completed by practice nurses in the CWHHE CCG collaborative and the outer NWL CCGs. Data from the CWHHE CCGs were collected by Bucks New University. Data from the outer NWL CCGs were collected by the University of West London, using a survey based on that used by Bucks. This report combines data only from questions which were asked in both surveys, for a total of 276 respondents. The report is divided into 6 sections:

- Description of the participants
- Previous training
- Training needed
- Mentorship and supervision
- Commissioning Group
- Summary of focus group findings

The Aims of the study were to:

- identify the key education priorities for practice nursing across the 8 NW London CCGs;
- explore future practice and education requirements for practice nurses to:
    - further service transformation to improve health outcome and patient/client experience eg to deliver 'out of hospital care' in line with both CCG and NW London wide strategy;
    - ensure that practice nursing is well placed to deliver on (and where appropriate lead) service and practice development in line with local commissioning and service delivery priorities.
- identify the education, training, development and support needs of the practice nurses in undertaking current and future roles and activities.

Description of the participants

One hundred and 28 practice nurses from GP practices within the CWHHE CCG collaborative completed the survey. Nurses from Ealing CCG completed the survey between January and April 2014. Practice nurses from the Hounslow, West London, Central London and Hammersmith and Fulham CCGs completed the survey between July and December 2013. One hundred and forty four

practices nurses, health care assistants and nurse practitioners completed the survey from the Brent, Harrow and Hillingdon CCGs between May and July 2014. The survey was available on-line though some respondents completed a written copy of the survey.

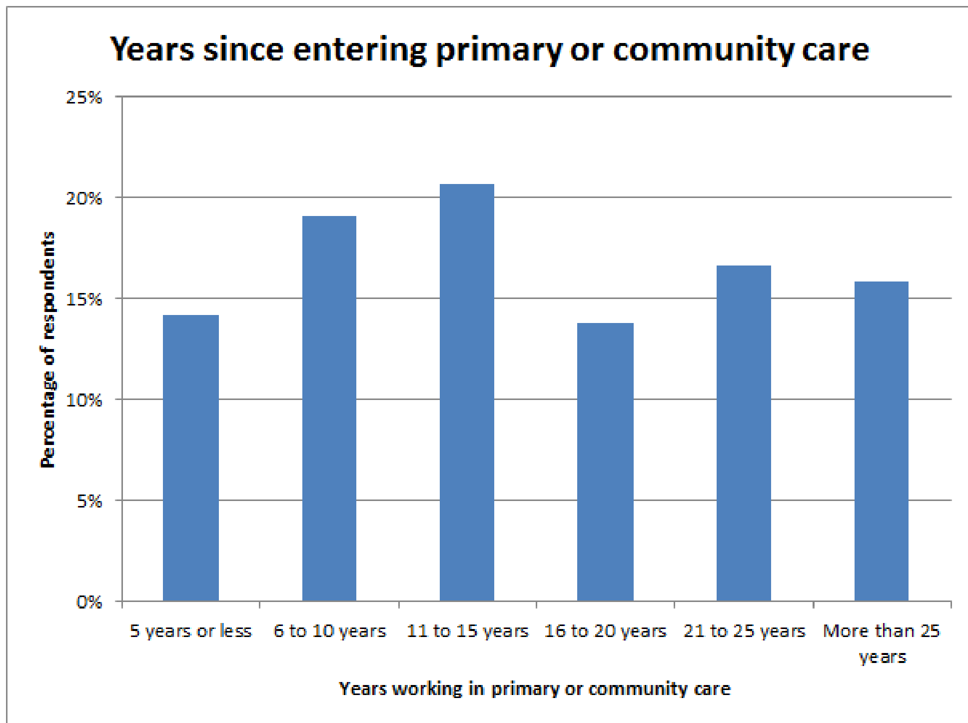
Three Focus Groups were held with Practice Nurses in NW London involving 39 Practice Nurses from GP practices across NW London – The focus groups were digitally recorded and transcribed with the consent of the participants – Each focus group lasted about 45 minutes to 1 hour. Where requested transcripts have been sent to the Practice Nurse lead for further discussion. Additionally 34 Practice Nurses from NW London attended a workshop and worked in small groups to produce written recommendation for Practice Nurse education and training.

Survey Findings

Seventy one percent of respondents were practice nurses, 12% advanced nurse practitioners, 7% Support Worker/ Health Care Assistant (Bands 1-4) and 6% specialist practitioners. Other job titles were Nurse practitioner (6), Phlebotomist (2), Clinical Service Director, Lead Practice Nurse, Nurse Practitioner & Assistant Practice Manager, Outreach Lead, Practice Development Nurse, Practice Nurse & Clinical Administrator and Practice Nurse Team Leader, Outreach Lead, Practice Development Nurse and Trainee advanced Nurse Practitioner.

Just under half the sample worked part-time (43%) and 56% worked full-time. One respondent was currently not employed and two respondents were agency/bank staff. Thirty five percent worked out of hours.

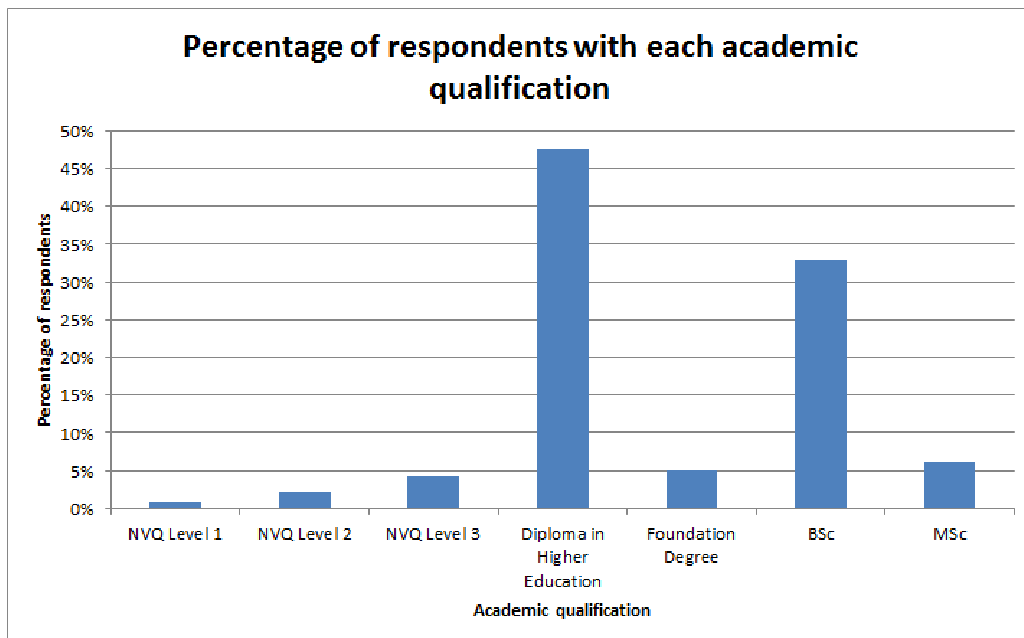
The average number of years since starting work in community or practice care was 16, ranging from 0 to 52 years. Only 14% of respondents had 5 or less years' experience and nearly half the sample (46%) had more than 15 years' experience in community or practice care.



Graph showing the percentage of respondents within each category of years worked in primary or community care.

Academic qualifications

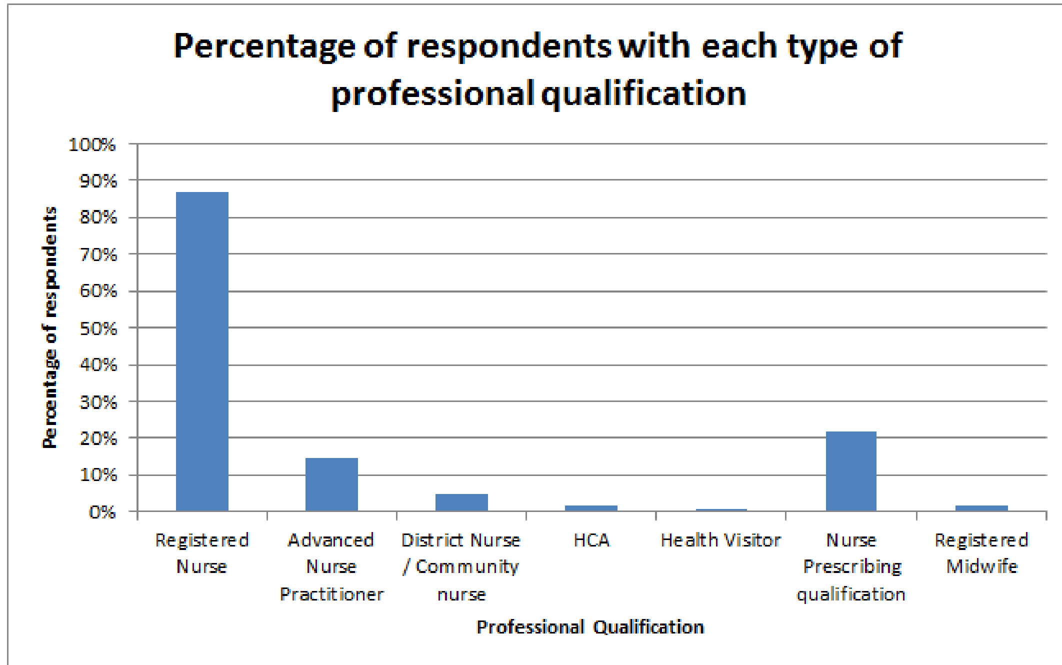
Of the 240 respondents, most had either a Diploma in Higher education (48%) or a BSc (33%). Six percent of the respondents also had an MSc.



Percentage of nurses with each level of academic qualification. (Respondents could select more than one option.)

Professional level

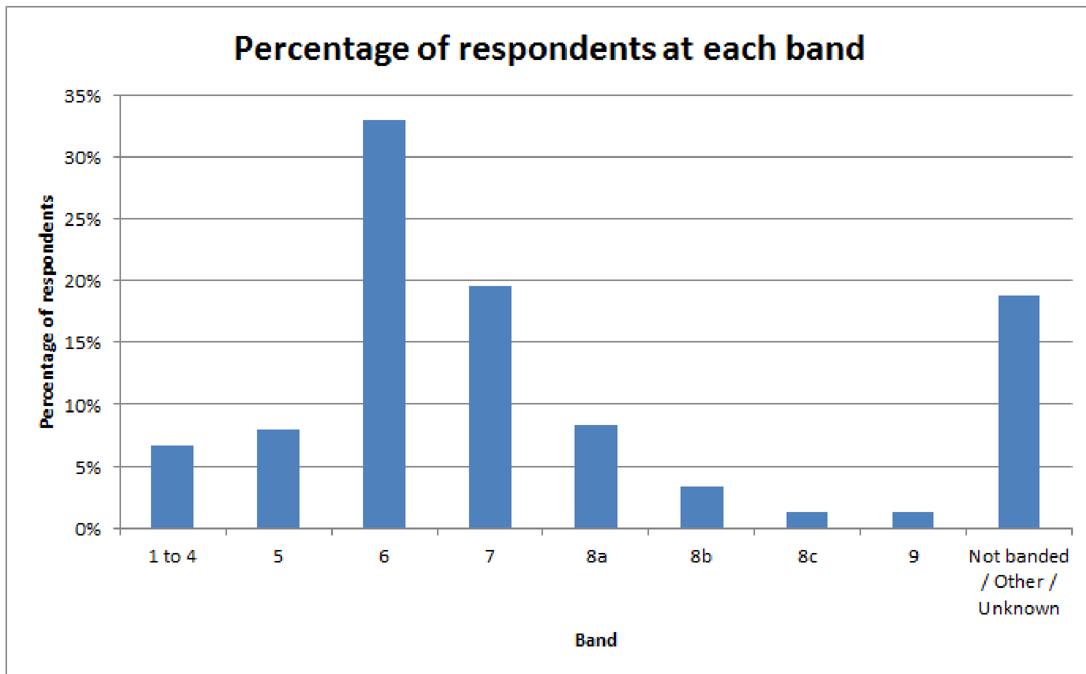
Most respondents indicated that they were registered nurses (87%). Many respondents also indicated additional professional qualifications. The chart below shows the percentage of respondents with each type of professional qualification.



Bar chart showing the percentage of nurses with each professional qualification. (Respondents could select more than one option.)

Current grade

Of those respondents who gave a band level, the most common band was 6 (33%) with most respondents at band 6 and above (67%). Nineteen percent of respondents either did not have a band, used a different grading system or stated 'Other' for band level.

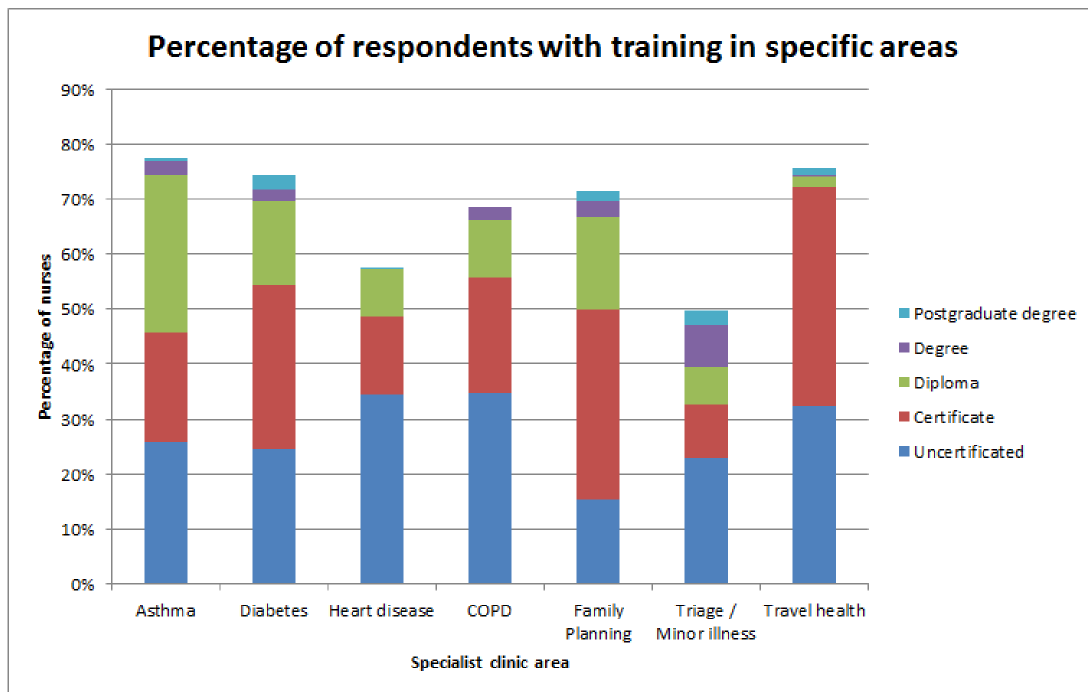


Percentage of nurses at each band.

Previous training

Levels of training achieved

The survey asked about levels of training achieved in the areas of asthma, diabetes, COPD, heart disease, family planning, triage and travel health. Over all areas, forty percent of training was classified as uncertified, 36% as certificated and 24% of the training received in these areas was through an academic qualification (diploma / degree / post-graduate). The graph below shows the percentages of training received at each level in each area for all nurses, not just those who responded to the question. The high levels of blank responses (even for those who answered questions within the same group) suggested that many respondents left the questions blank rather than selecting 'N/A' if they had not received training in that area.



Bar chart showing the level of training for all nurses. Values are given as a percentage of the whole sample, including those who did not respond to the question.

The level of academic training was also assessed for nurses who had sole or shared responsibility for a specific service. For this group, 33% was uncertified, 39% classified as certificated and 29% of the training received in these areas was through an academic qualification (diploma / degree / post-graduate). The numbers of nurses who did not specify any training in the area in which they had shared or sole responsibility for a service (by stating N/A or giving no response) was low, ranging between 1 and 11 nurses for each service area (3% to 16%). Areas with more than 10% of respondents stating they had no training were heart disease and triage/minor illness.

	Number of respondents with no training	**As a percentage of those with a shared /sole responsibility for the service**
Asthma	6	1%
Diabetes	5	3%
Heart disease	8	11%
COPD	8	4%
Family Planning	4	6%
Triage / Minor	12	13%
Travel health	9	5%

Table showing the number and percentage of respondents who had a shared or sole responsibility for a specific clinic area yet did not indicate they had received training in that area.

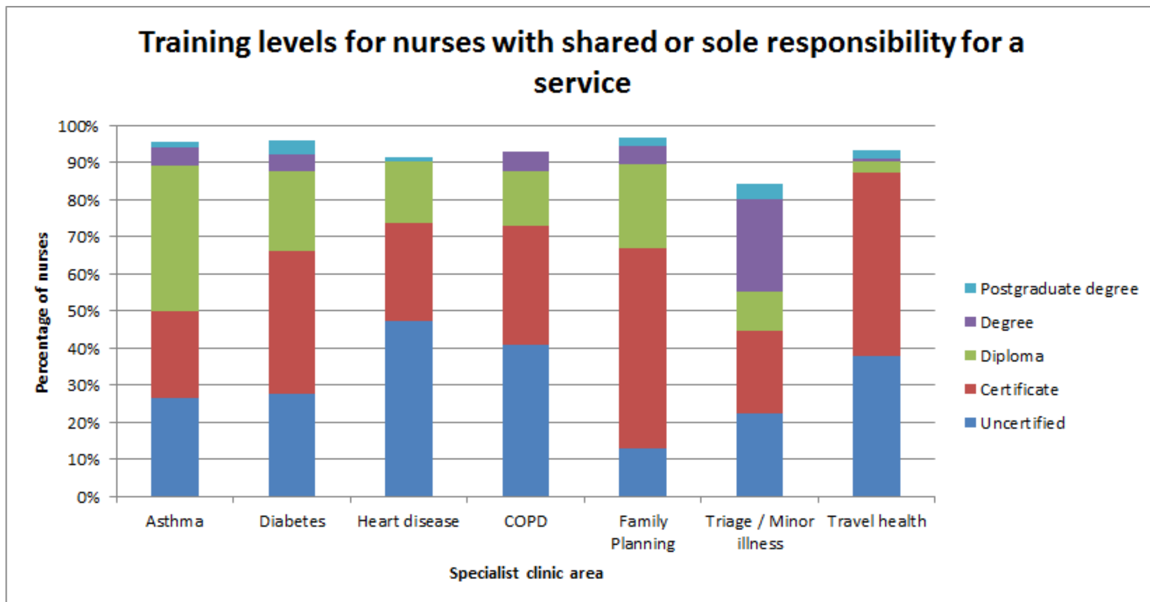
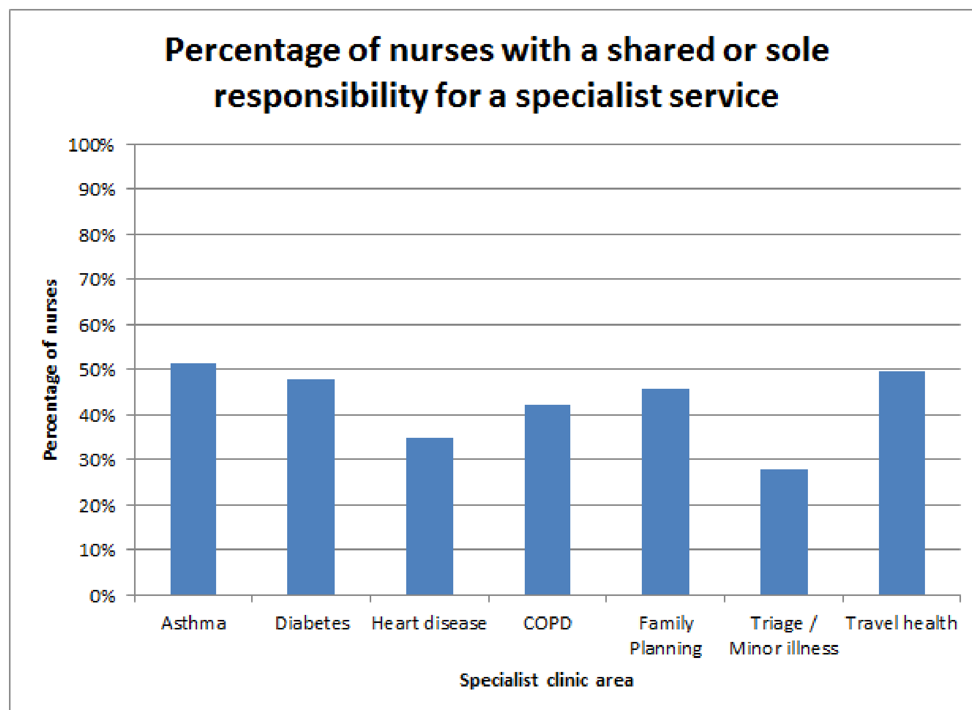


Chart to show the percentage of nurses with sole or shared responsibility for a service who have received training at each level.



Bar chart to show the percentage of nurses who have a sole or shared responsibility for each specialist service.

Specific areas of training attended in the last 12 months

Respondents were asked whether they had attended training in the last 12 months in the areas of: Cardio-pulmonary resuscitation (CPR), adult and child safeguarding, infection control, fire safety, moving and handling, health and safety, equipment training, immunisation and anaphylaxis, cervical cytology, ear care, flu update, independent non-medical prescribing, independent non- medical prescribing annual update, specialist COPD, specialist diabetes, specialist long-term conditions (LTC), cardio-vascular disease (CVD), health check, consultation skills and customer service. Fourteen respondents had not attended training in any of these areas in the last 12 months. The average number of areas for which training had been achieved was 6.9, ranging from 0 to 21.
The chart below shows the percentage of nurses who rated training on a 5-point scale from 1-poor to 5-excellent. The most commonly achieved areas of training with more than half the respondents having completing training in the last 12 months were CPR (84%), immunisation and anaphylaxis (73%), child safeguarding (73%), cervical cytology (64%), fire safety (63%), adult safeguarding (63%) and infection control (58%). Training was generally rated favourably or with an average response. Over all courses attended, 56% was rated in the top two categories (4 or 5-excellent) and only 5% in the two poorest categories (2 or 1-poor).

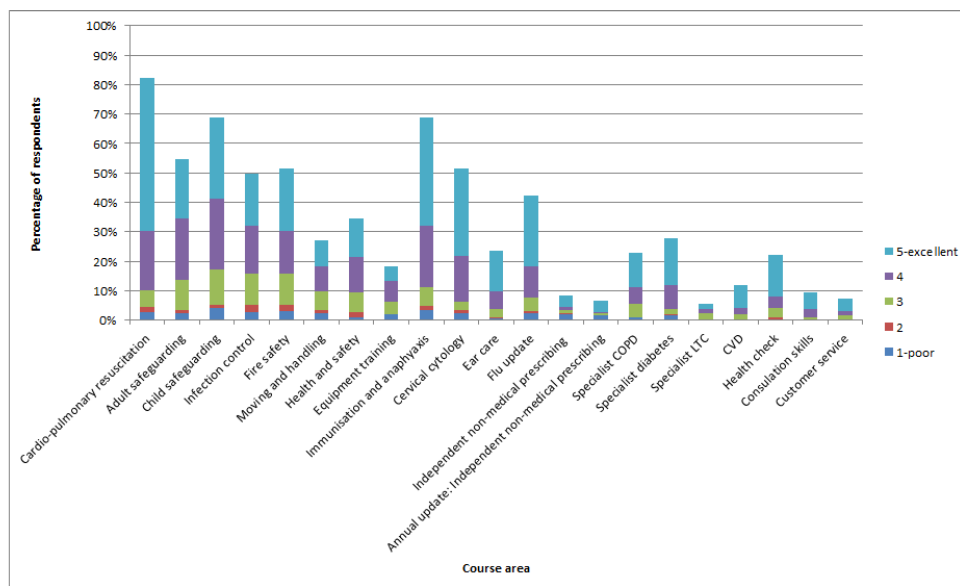
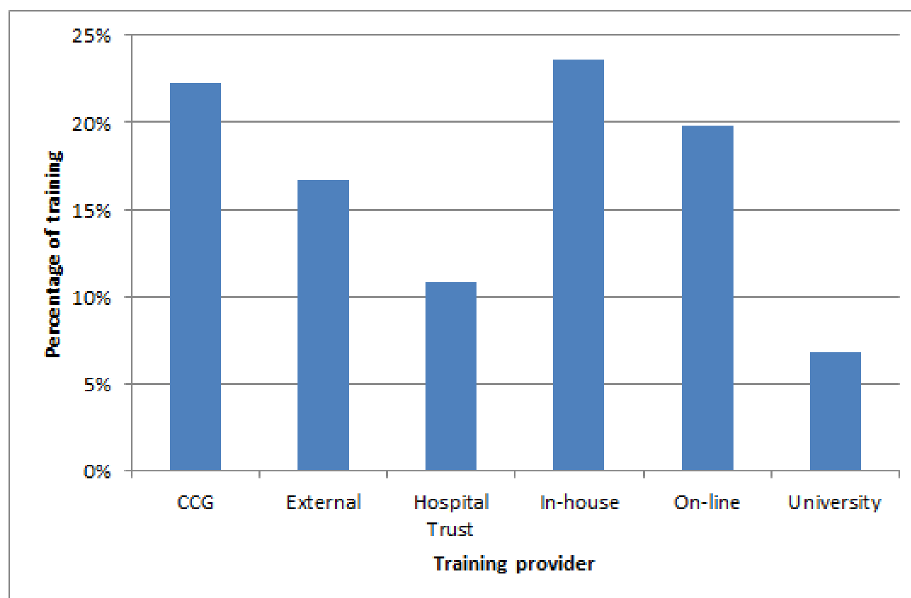


Chart showing the percentage of respondents who attended training in each subject area in the last 12 months. Training was rated on a scale from 1 (poor) to 5 (excellent).

Training providers

Training had been led by a range of different providers. From an open question, responses were categorised into in-house training, by external organisations, the CCG, Trust, on-line or a University. The most frequently used providers were In-house training (24%), the CCG (22%) and on- line (20%).



Bar chart showing the percentage of training courses run by each category of provider.

Training needs

Interest in training

For the 21 specific training areas, respondents were asked whether they would be interested in attending training in that area. The average number of the specified areas where nurses said they would like training 7.2 and ranged from 0 to all 21. Sixty four nurses (24%) did not say they needed training in any of these areas. However, 29 of the 74 listed specific training areas they required in the open training needs question, see below; either their training needs differed to those listed or they did not answer those questions in the survey. The percentage of respondents who listed neither specific training needs nor training in the specific areas was 13%.

The chart below shows the percentage of respondents who would like training in each of the areas listed. The highest percentage of positive responses for training was shown in the areas of specialist COPD (50%), flu update (44%), infection control (44%), specialist diabetes (43%) and ear care (42%). Areas of least interest were equipment training (24%), moving and handling (21%) and customer service (19%).

	Number interested in attending	Respondents	Percentage interested in attending (of who answered	Percentage interested in attending (of whole sample)
Specialist COPD	136	150	91%	50%
Flu update	120	131	92%	44%
Infection control	119	135	88%	44%
Specialist diabetes	118	137	86%	43%
Ear care	115	145	79%	42%
CVD	109	122	89%	40%
Immunisation and anaphyaxis	108	121	89%	40%
Consulation skills	103	126	82%	38%
Adult safeguarding	100	123	81%	37%
Cardio-pulmonary resuscitation	97	121	80%	36%
Health and safety	97	122	80%	36%
Cervical cytology	96	115	83%	35%
Child safeguarding	96	120	80%	35%
Independent non-medical prescribing	85	128	66%	31%
Health check	83	116	72%	31%
Specialist LTC	80	105	76%	29%
Annual update: Independent non-medical prescribing	78	115	68%	29%
Fire safety	71	115	62%	26%
Equipment training	65	105	62%	24%
Moving and handling	57	115	50%	21%
Customer service	53	92	58%	19%

Table showing the number and percentage of nurses interested in attending training in each area, and as percentages of those who responded and of the whole sample.

An open question was asked to specify any areas of training they required. Over half of the respondents (51%, 140) specified some additional training needs with 295 training areas specified in total. Of these, 47 (16%) were specifically requested as training updates. Areas for specific training needs given by more than 5 nurses are given in the table below. Most people listed a number of areas which are counted separately in the table.

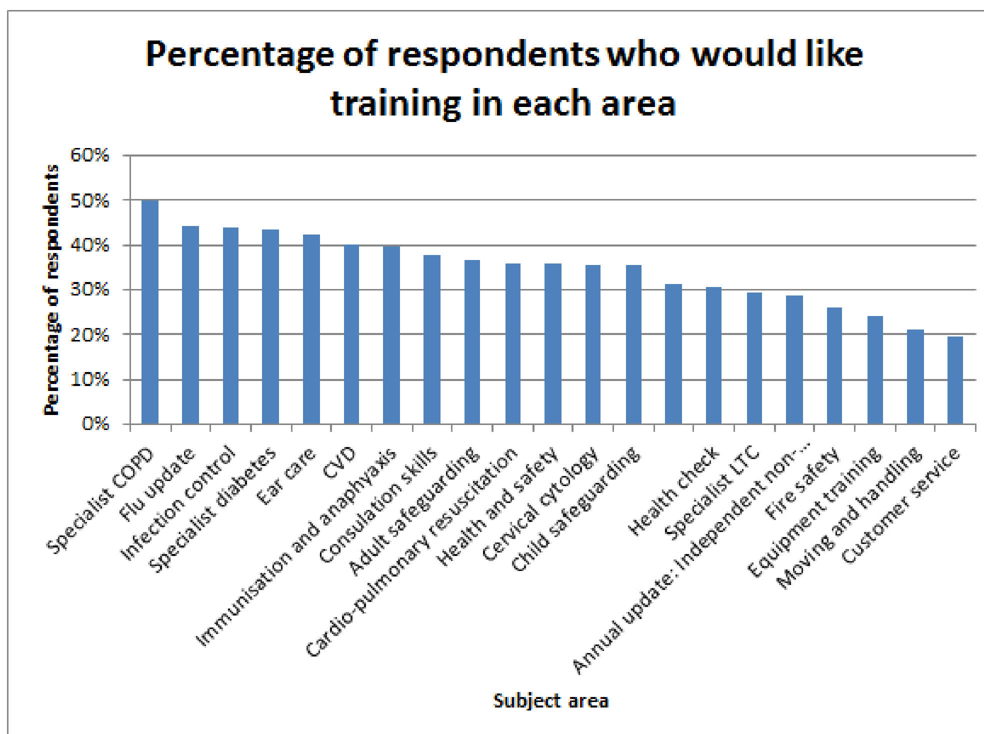


Chart showing the percentage of practice nurses who would be interested in attending a course in each subject area (in descending order).

Training area	Number of nurses who stated they needed training in that	Percentage of sample
Minor illness	25	9%
Asthma	23	8%
COPD	21	8%
Family Planning	19	7%
Diabetes	18	7%
Prescribing	17	6%
Travel health	13	5%
Triage / minor injuries	12	4%
All clinical updates	10	4%
Spirometry	10	4%
Wound care /leg ulcers	10	4%
Mentoring	9	3%
Ear care	6	2%
Sexual health	5	2%
CHD	4	1%
CVD	4	1%
Cervical cytology	3	1%
Immunisations	3	1%

Table showing the number and percentage of nurses who said they were

interested in specific areas of training in the open question, in descending order

Areas of training which were each specified by fewer than 5 nurses were CHD, CVD, cytology, immunisations, consultation skills, anticoagulation, breast examination, current Clinical supervision and revalidation training, HF, IT training, leadership, mentorship, prescribing, ABPI Doppler, adult safeguarding, advanced assessment, chronic disease/ long-term conditions, appraisal training, assistant Practitioner, breast feeding, child health update, communication skills, conflict training skills, decision making, degree in Health Science, dermatology, diploma/degree, fire safety, flu jab training, health & safety, hypertension update, Implant insertion, infection control, INR, Interpretation of blood test results, leadership, level 3 child safeguarding, menopause and HRT, mental health overview, minor ops assistant, NHS health checks, nurse practitioner degree, nutrition, ophthalmology, paediatric care update, physical assessment, PN induction, primary care developments, QOF, running searches, smoking cessation update, substance misuse (alcohol), System 1 training, telephone triage, tissue viability, treatment room skills, weening and weighing / monitoring babies and children.

Mentorship and supervision

A third of respondents (33%) had a clinical mentor and 43% had access to clinical supervision. Thirty eight percent of respondents mentored or supervised others. Of these, 43 nurses (44%) either did not state any formal training or stated that they had not received any formal training in clinical supervision and mentoring. As categorised from responses to an open question, the type of training most commonly received by nurses who mentor and supervise others is given in the table below. Training received by only one respondent *was* 12 month degree level course, ENB 997, mentorship degree course, mentorship diploma, Nebs accredited teaching, NVQ assessor and mentorship, SNVQ level4 learning and development, sometimes, teachers training Diploma, teaching and learning and TVU.

Training	Number of respondents	As a percentage of all nurses who mentor or supervise others (N=97)
None / None specified	43	44%
ENB 998	18	19%
Mentorship course	10	10%
HCA	3	3%
Module on degree course	3	3%
Clinical supervisor training	3	3%
Mentor & preceptor training	2	2%
Mentor training LMC	2	2%
Mentorship in practice	2	2%

Table showing the most common mentoring training courses attended by respondents who mentor and supervise others.

Appraisals

Most practice nurses had appraisals conducted by the GP (70% of those who responded) Others had appraisals conducted by a practice/service manager (14%), nurse (10%), or a combination of senior staff. Of the 191 respondents who gave an appraisal date, 59% had had an appraisal in the last year, 29% had their last appraisal between 1 and 2 years ago and 5% more than 2 years ago. Nine respondents (5%) were new in post and so had not yet had an appraisal.

Professional networks

More than half of the nurses (58%) belonged to a professional network. The table below shows networks belonged to by more than one of the nurses as stated in an open question.

Professional Network	Number of members	Percentage of whole sample
RCN	42	15%
Practice Nurse forum /NIPs	26	9%
Local group	16	6%
NMC	13	5%
MDU	5	2%
LMC Practice nurse leads	3	1%

Table showing the professional networks used by most respondents.

Other networks each mentioned by only one or two respondents were: BMJ Learning, NHS, Nurse practitioner, Safeguarding children's network, PCRS Practice nurse leads. The local groups included Ealing practice nurse forum, WLCCG PN Forum, LMC Londonwide Practice Nurse Leads, Hounslow nurses' forum, London nurses network, NiPs - Harrow and Brent PN Group, Harrow nurses forum. Harness forum, ANP forum, Nurse practitioner UK, Nurse prescribing forum, Nurses forum in Bucks, Travel Health Forum, Nursing in Practice Forum- Harrow, Brent & Ealing and UKCC.

Current academic award

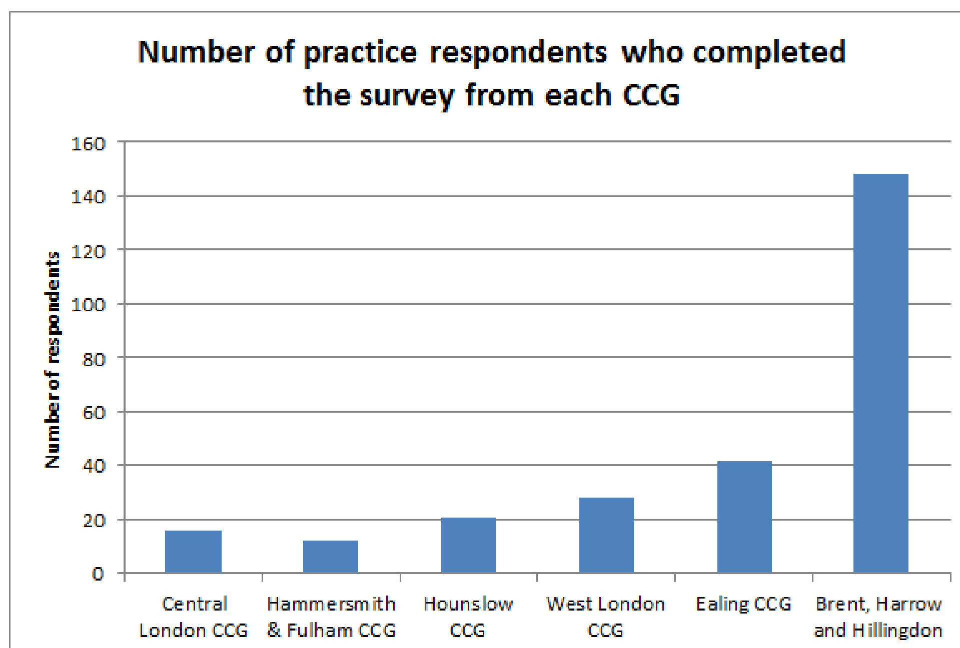
Thirty respondents (12%) were currently studying for an academic award. The courses given were: Advanced Nurse Practitioner, BSc Health Care Practice, BSc Managing Long-Term Conditions, BSc Practice Nursing in Primary Care, BSc Women's health, Nurse prescribing, V300, Asthma diploma, Certificate in diabetes care, COPD and Spirometry degree module, COPD diploma family planning certificate, ITEC anatomy and physiology, Pg/Dip/Msc ANP, sexual health and clinical history taking.

<u>Nurses from each CCG within the collaborative</u>

The CCG was derived from address/postcode details given by each participant. The bar chart below shows the number of practice nurses from each CCG who completed the survey. Most

respondents, 144 (55%) were from the UWL data from Brent, Harrow and Hillingdon CCGs. Of the 119 respondents who gave a surgery postcode in the survey run by Bucks, 42 were from Ealing CCG (16%) , 28 from West London CCG (10%), 21 from Hounslow CCG (8%), 16 from Central London CCG (6%) and 12 from Hammersmith and Fulham CCG (4%).

If you have a list of postcodes which correspond to each CCG, I can split the UWL data into the individual CCGs.



Bar chart showing the percentage of practices nurses from each CCG in the NW London area who completed the survey.

Summary Findings from Focus Groups

Themes that emerged during the focus groups with practice nurses included:

- Significant increase in the Practice Nurse workload that was both unmanaged and undifferentiated in terms of clinical focus and administrative responsibilities;
- Lack of professional autonomy to determine the scope of their role and lack of a competency framework that enabled Practice Nurses to move from novice to expert;
- Lack of understanding by their employers about the need for training before undertaking clinical work with which they are unfamiliar and confusion about statutory and mandatory updates when, what and why they are needed.
- A perception that current commissioning models are not accessible to Practice Nurses and fail to reflect the employment context of Practice Nurses such as the need for backfill to cover study time and the lack of a pool of nurses who can backfill for study time;

- Practice nurses commented about the frustration of courses being cancelled by HEIs at short notice because of insufficient demand;
- Practice Nurses do recognise population needs and want to develop their practice to meet these needs but currently feel constrained by systemic factors of workload and lack of planning autonomy.
- Practice nurses identified the need for coordinated teamwork with community and hospital nurses to reduce duplication and systemic inefficiencies in the management of long term conditions, but felt unable to address these issues in their current role mainly because of workload, but also because this required leadership.

Discussion and Conclusions

The primary observation from this survey is the variation in training, through level, provider and subject area. This indicates a lack of consistent framework across the region for both initial and on-going training of practice nurse staff.

Focus group data indicated a workforce which lacked career progression, role autonomy or a coherent educational framework. Practice nursing was found to be undifferentiated in scope and isolated from the wider health and social care network with whom the patients interacted. Practice nurses recognised the strength of their role in building relationship-centred care with patients over an extended period of time. They valued this aspect of their role and would welcome opportunities to develop this to benefit patients.

Most respondents felt that they needed more training in a number of areas. While significant interest in training was shown across all areas (at least 19% of respondents in every area), the highest percentage of positive responses for training was shown in the areas of specialist COPD (50%), flu update (44%), infection control (44%), specialist diabetes (43%) and ear care (42%). There could be a variety of reasons for requests for training in specific areas; for example, increased workloads/nurse-led clinics in these areas, poor or no training received previously; perceived changes in best practice.

However there were some subject areas for which high levels of training were reported in the last 12 months: CPR (83%), immunisation and anaphylaxis (72%), child safeguarding (72%), cervical cytology (63%), fire safety (62%), adult safeguarding (62%) and infection control (57%). Perhaps there exist models of provision for these subject areas which could be extended to cover a wider range of training areas where needs have been identified.

The quality of all training was also a concern. Only half the training received was rated as good or excellent. Forty percent of training was uncertified and of short duration.

While numbers were low, there were some nurses with a shared or sole responsibility for a service who had received no training in that area, most significantly for heart disease and triage/minor illness. While most nurses with this responsibility had received some training, this survey did not elucidate when this had taken place nor how often updates were received.

An additional training need identified was for those who supervise or mentor others (38%) as 44% of theses respondents had not received any training in this area.

Another concern highlighted in this survey is the ageing workforce in practice nursing. Nearly half the sample had 15 years or more experience in primary or community care.

The focus groups indicated practice nurses are a committed and engaged workforce, aware of the pressures on the NHS and the need for primary care to engage in developing solutions to those pressures. However, as a group they felt overworked and isolated and unable to effect the changes they recognised were required.