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NPCN
National Primary Care Network

Finding solutions for general practice: How can we relieve the pressures on GPs?

Report

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Introduction

The National Primary Care Network (NPCN), hosted and supported by the National Association of Primary Care (NAPC), is a group of over 500 healthcare professionals from across primary care including GPs, nurses, dentists, optometrists, allied health professionals and pharmacists.

The NPCN holds a quarterly meeting to discuss topical issues impacting on primary care, from which a report is produced. This is the latest in the series, following a meeting held on 11 May 2016 at Lettsom House. The theme was finding solutions to the current pressures challenging general practice.

Dr Robert Varnam, Head of General Practice Development at NHS England, led the discussions by setting out how the proposals for transforming primary care described in the GP Forward View will impact on general practice. Six thought leaders then gave presentations on a range of ideas for new ways of working in primary care, introducing innovation and providing multidisciplinary services that put patients at the centre of care. Delegates, representing the breadth of primary care, also debated whether primary care needs more GPs.

Microsoft and CloserStill Media, the business media company which puts on NAPC Annual Conference Best Practice, the largest worldwide event for primary care professionals, provide financial support to NPCN, but have no input in end discussions.

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Foreward

I am delighted to introduce the next report, in the series of meetings of National Primary Care Network (NPCN), managed by the National Association of Primary Care.

The NPCN is a unique group in many ways, as its participants and reach demonstrate the strategic direction for Primary Care and possibly represents the most integrated voice for Primary Care currently available.

It provides a safe place for healthy debate, the sharing of ideas and keeps thought leaders in reflective mode. The issues addressed in this report are far reaching and provide many solutions to some of the challenges we seem to have been admiring for far too long.

The participants who helped create this report are self selected from an invitation that goes to all of those professionals involved in health and healthcare who have made themselves available to this network.

I hope that this report helps to stimulate further debate and thinking in delivering real and achievable solutions with take home messages that are ready for implementation.

I hope you enjoy the read.

Dr James Kingsland OBE
President NPCN

Emerging thoughts on the *General Practice Forward View*[1]

New opportunities are opening up for general practice to work in new ways, which will help to relieve the pressures from an increasing volume and complexity of care and a rise in costs and bureaucracy, said Dr Robert Varnam, a GP and Head of General Practice Development at NHS England.

Patient-centred, joined-up care

Work that has been done by NHS England over the last three years has arrived at a consistent view that primary care should be providing comprehensive, joined-up care for a registered population, shaped around patients in the community. This includes:

- A greater focus on wellbeing, prevention and promotion for people on a registered list
- Ensuring patients are given the right access to care, speedy access to care and access at the right time, with the right person providing the right care
- Holistic, proactive, coordinated care, particularly for long-term conditions

"It's quite a big shift, however it does not mean moving away from the British concept of primary care, but rediscovering many of the essential qualities of General Practice because people primarily need what only holistic, multidisciplinary primary care can provide," he said.

Complaints and frustrations

One of the biggest complaints by GPs is that they see many patients who could be helped by other healthcare professionals. Other frustrations include duplication of work by nurses, disintegration of and gaps in services.

Sustainability and transformation

Dr Varnam said NHS England is adopting the language of sustainability and transformation. The work that needs to be done to relieve the pressures on the existing model of General Practice has to be sustainable, but also linked to transformational work like that being carried out by the New Models of Care being established by the Vanguards and the development of integrated care.

Two major problems

The Making time in general practice[2] report, published in October 2015, highlighted that two major problems were:

1. The burden of the bureaucracy that comes from outside the practice
2. The roughly 25% of GP consultations that are avoidable and could be handled better by practices working differently

GP Forward View

The GP Forward View published in April 2016 is both a rescue package to help general practice keep providing all the care it normally does but also a set of incentives for it to work differently. It is intentionally meant to be both. The report sets out 10 High Impact Actions for change.

Ten High Impact Actions:

1. Active signposting to other services
2. Introduce new types of consultations (telephone, e-consultations, text message, group consultations)
3. Reduce DNAs (missed appointments: easy cancellation, reminders, patient recording, read-back, report attendances, reduce 'just in case')
4. Develop the team: Recruit advanced nurse practitioner, physician associates, therapists, medical assistants, paramedics, pharmacists.
5. Productive workflows: Matching capacity and demand, efficient processes, productive environment
6. Personal productivity: Personal resilience, computer confidence, speed reading, touch typing
7. Partnership working: Productive federation, community pharmacy, specialist, community services
8. Social prescribing : Practice based navigators, external service
9. Support self-care: Prevention, long term conditions, acute episodes
10. Develop quality improvement expertise: Leadership of change, rapid cycle change, process improvement, measurement

"What is neat about these High Impact Actions is that implemented to their full extent, they will free up GP time which is one of the biggest current constraints in primary care. So, for example, a receptionist will say to a person wanting an appointment with the GP: 'What is the issue?', 'How can we help you?', 'Who is the best person to

provide you with advice and support today?'", explained Dr Varnam.

The initiatives are being promoted in a series of roadshows. "Nearly 800 people attended the first roadshows in February and March. Almost everyone took away at least one practical idea that they could implement in their practice. Peer-to-peer spreading of innovation seems to be something people find very attractive. Lots of people are starting to talk much more confidently about core productivity in new ways of working. Some of it involves de-medicalising processes or even redesigning whole processes and systems," he said.

General Practice Development Programme

The general practice development programme involves the following five points.

1. Spreading innovation through roadshows, by connecting innovators with peers, refining, measuring and describing successful innovations, promoting case studies, providing implementation guides, recruiting champions and building platforms to spread innovation at scale
2. Time for Care Collaboratives, which will support practices to release time for care: National resources and expertise will be provided to help local groups of practices implement the 10 High Impact Actions of their choosing and every practice will have access to a collaborative over next three years
3. Capability building: This will involve training practice and federation staff as quality improvement facilitators to engage colleagues and lead service redesign
4. Measurement: Resources will be developed to assist practices in identifying priorities and realising the benefits of new ways of working
5. Reception and clerical training: Supporting every practice in England to train reception and clerical staff to undertake enhanced roles in signposting patients and managing clinical correspondence

Funding

Dr Varnam said national money was being set aside to achieve the aspirations of the GP Forward View, including £30 million for a development programme and £45 million for targeted training for receptionist staff and clerical staff. "The aim is that within around 12 months most practices could have implemented one or two changes. The modelling we have done indicates that that would free up about 10% of GPs time."

Sustainability and transformation plans

In addition, for the first time Clinical Commissioning Groups (CCGs) are being required to develop sustainability and transformation plans which set out what they will be doing to support the sustainability of existing providers and in particular what they will be doing to help them in the very near future.

IT developments

Dr Varnam said he was also optimistic that things were beginning to move on IT developments for integrating systems and making interoperability a reality. Fundamental changes in practice software and a new requirement to send hospital discharges and outpatient letters electronically within the year was sharpening people's minds. "It's looking more optimistic than it has for a while that we will start to get records that really follow the patient," he said.

Change is essential

"Traditionally we have been used to only changing things radically at a time of great plenty and ease. The difficult thing for general practice right now is, however attractive it is to say let's not just do more the same, it is really hard to achieve transformational change because it challenges professional identity in a really difficult way and it challenges our time and our emotional energy to risk some of these things.

"However I do believe change is essential. I am hopeful that we can actually do something about delivering the promise of primary care which will be population focused, prevention minded, multidisciplinary and engaged with the community," said Dr Varnam.

References:

1. General Practice Forward View. NHS England, April 2016 https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
2. Making Time in General Practice. Primary Care Foundation and NHS Alliance. October 2015. http://www.nhsalliance.org/wp-content/uploads/2015/10/Making-Time-in-General-Practice-FULL-REPORT-01-10-15.pdf

Who takes responsibility for patient care and what do patients want?

Dr Joe McGilligan, GP and Trainer, former Chair East Surrey Clinical Commissioning Group (CCG), former Co-Chair Health and Wellbeing Board for Surrey, addressed these two important questions.

When the NHS was set up it was designed to support people who retired at 65 and would die aged 66. But now people live until they are 90 and have vastly different needs, said Dr McGilligan.

Change is needed to address the increasing costs of treatment, inexorable demand and the needs of an ageing population. "We need to work better with fewer resources," he said.

There has been a historical inability to manage demand using the current levers in the system and currently the business model is wrong because of a poor alignment of incentives and also because the socialist model of the NHS clashes with capitalist business models.

Micro-commissioning and micro-contracting of an incredibly complex business process/care pathway/ supply chain results in little integration of services. In addition, there is a lack of clinical and financial management and accountability across the system and the population.

The NHS needs to become more patient-focused, said Dr McGilligan. Using the example of his mother, who was badly injured in a car crash, he illustrated how the NHS system is failing to address patient needs.

"The care my mother had being taken out of her car and into an ambulance, then being taken to accident and emergency, was fantastic and could not be faulted. But as soon as she was in hospital I had to intervene at least 30 times in her care because she was being cared for by different people doing different things. Most people work in the way they do because they fear retribution, they don't go to work to do a bad job. But this is why change is needed because the role of who takes responsibility for patient care has changed."

Patients themselves are taking responsibility for their own care – they can now Google their symptoms and know more about them than doctor does and they can get their medicines delivered online.

Dr McGilligan warned that any reforms had to take account of the fact that patients are very protective of their local NHS. The "I Want Great Care" patient feedback website shows that the public rates 90 per cent of their NHS care as five star.

"If I had a one star rating about me I would be really shocked. People are really, really proud of the NHS and we need to make sure we tap into that. Patients love the NHS and don't want it to be denationalised."

Research shows that the public connection to the NHS is overwhelmingly emotional and they switch off when people start talking about NHS in rational business term.

"Although people are aware that things are changing, there is no clarity and they need reassurance that 'care' will still be there. The messages we give to the public must be about quality of care and talk of cost or savings should be secondary unless linked to reductions in waste."

Dr McGilligan said the conversation with the public needs to be wrapped in locally-based, clinically-endorsed narrative, providing clarity on the local situation

"The narrative needs to be written from a patient's point of view (i.e. focused on care) not from an organisational point of view (i.e. focused on efficiencies or structures). The public want to be proud of 'our local NHS' and good media relations can help this."

SelfCare Pharmacy: Supporting patients with long-term conditions

Hemant Patel, Secretary North East London Local Pharmaceutical Committee described how pharmacists are promoting self-care and helping patients with long term conditions in a new model of pharmacy care commissioned by Newham Clinical Commissioning Group (CCG).

What is the SelfCare Pharmacy?

The initiative, called the SelfCare Pharmacy, which went live in 60 community pharmacies in Newham in April 2015, is for patients with conditions such as cardiovascular disease, diabetes, respiratory disease or mental health issues.

Using a psychosocial needs assessment, the pharmacist and the patient jointly create a self-care plan. Patients are referred by a GP, nurse or hospital or can self-refer.

The aim of the consultation is to help people with long-term conditions to control their condition themselves, get the best out of their medicines, make an early diagnosis if necessary and encourage prevention and wellness. The pharmacist can also encourage independent living with help from daily living aids such as wheelchairs and commodes and help patients to prepare for emergencies for example by giving asthmatics a rescue pack and nebuliser to prevent a hospital admission.

The pharmacist, who is trained as a health coach, may also refer the patient onward to external health and social care providers or voluntary organisations, help them through social prescribing or use brief interventions to help patients to maintain their self-care plan.

Four key areas where the pharmacist will intervene:

1. Managing long term conditions
2. Managing complex comorbidities
3. Providing Medicines Use Reviews
4. Helping patients with medicines compliance

12 areas covered by the scheme

The aim is to empower patients to change their behaviour and to improve their health and wellbeing in any of the12 areas listed below during three follow-up sessions held over a 12-week period.

1. Respiratory conditions and smoking cessation
2. Flu vaccination
3. Daily living aids
4. Lifestyle and life skills
5. Weight management
6. Glucose regulation
7. Blood lipids
8. Blood pressure
9. Heart rhythm
10. Mental health
11. Pain management
12. Medicines use reviews and new medicine service

SelfCare Pharmacy will deliver:

- Reduced dependence on GP practices and emergency services by offering minor ailments schemes
- A more systematic and proactive management of chronic disease. This will: improve health outcomes, reduce inappropriate use of hospitals and reduce health inequalities
- Empowerment of patients
- Reduced risk and waste
- A population health approach
- An integrated approach
- Improved patient and clinical outcomes
- Structured and co-ordinated care

Encouraging self-management and taking responsibility for outcomes

Mr Patel said: "My focus is on how we can encourage patients to take charge of their own health and be more reliant on their own resources and how we can reallocate the work differently from what we are doing now.

"We need to start adding value. For example, 85 per cent of people receiving medicines have some information needs that are not met and 50 per cent of patients with long-term conditions aren't taking their medicines regularly. So there is a role for pharmacists to start taking this responsibility for outcomes rather than just dispensing medicines."

Mr Patel said that 70 to 80 per cent of people with long-term conditions can be supported to self-manage by the community pharmacy team. "In the current system there is a big dependency on medical interventions, patients want quick fixes rather than taking responsibility for their own health and they have very little understanding of what options there are in primary care.

"SelfCare Pharmacy is designed to demonstrate a sense of purpose for the practitioners as well as the patient. It gives us a sense of ownership of our decisions and how we can explore the possibilities available to the patient and how we can help them to personalise their choices. This is important because patients often don't feel that they are in control of their long-term condition and to me that is the biggest driver."

The patient will see you now

Letting go, accepting alternate views and deleting current thinking is the way to achieve change, said Dr Marion Lynch, Deputy Medical Director, South Central sub region NHS England.

"When we shift our thinking to 'The patient will see you now' instead of 'The doctor will see you now', we can shake everything up", she said.

"We are living longer and getting sicker. We are not living healthier lives and we want to see more of our healthcare professionals, but the numbers of healthcare professionals are going down. You have to recognise nothing is going to stay stable."

Dr Lynch is an advocate of 'disruptive innovation' a method of achieving change that creates new networks and players that can displace existing structures and actors, and be a catalyst for a real paradigm shift. "It can be an important mechanism for improvement of health while reducing costs and complexity and improving access and empowerment of the patient," said Dr Lynch.

Disruptive innovation has the capacity to:

- Provide improved health outcomes
- Create new services and overcomes challenges regarding accessibility to existing or new services
- Lead to cost-effective methodologies that improve access
- Promote person-centred health delivery
- Empower the patient/person
- Disorder old systems
- Create new professional roles and capacities
- Create new sets of values for the health workforce, patients, citizens and community
- Introduce transformative cultural change

The main focus for disruptive innovations in health care are new models of person-centred, community-based health delivery with a decentralisation from hospitals to integrated care. New technologies are introduced that allow early diagnostics, personalised medicine, health promotion, community-based therapy and care and the empowerment of patients/citizens, as well as potential curative technologies. It involves person-centred approaches for the treatment of patients with multiple chronic diseases and education of the health workforce, transfer of skills and tasks from highly trained, high cost specialists to generalists.

Other examples of disruptive innovations include introducing artificial intelligence to make clinical decisions in a way that is more informed than a single clinical doctor can achieve; health coaching, patients holding their own records or even health services delivered by the Post Office as happens in Japan.

However Dr Lynch said a Health Foundation report has suggested that the barriers to changes such as this include: a shortage of capability to make things happen, a lack of recognition that change is needed, insufficient headspace to make changes and limited motivation for changes.

"To achieve disruptive Innovation in healthcare we need to match the problem to the level of skill, develop technology to address the simple stuff and let go of professional assumptions. We need to disrupt what we are doing and not pretend that that what we've got now is going to continue for ever. In a nutshell we need to match the problems to the level of skill of the healthcare professional, develop technologies to address the simple stuff and let go of professional obstructions. In other words, don't discover new oceans unless you have the courage to lose sight of the shore," said Dr Lynch.

Discussion: Do we need more GPs?

The Government wants to increase the GP workforce by 5,000, but is this the right solution for relieving the pressures on general practice? Dr James Kingsland OBE, President of National Association of Primary Care (NAPC), asked delegates.

Dr Kingsland led the debate by arguing that more GPs would not be needed in the Primary Care Home, the NAPC's multispecialty community provider model of care for a defined population of between 30-50,000 people.

Dr Robert Varnam's figures showed that 25 per cent of current contacts in general practice were avoidable. In addition, the Primary Care Home would offer a multi-professional way of working that would enable an estimated 40 per cent of contacts to be cared for by a healthcare professional other than a GP – a physiotherapist, for example, or they could be referred to social care or receive some social prescribing. "It is a myth that we need 5,000 more GPs," said Dr Kingsland.

Dr Nav Chana, Chair of NAPC, said organising care at population level in the Primary Care Home was exactly what could be expected from the theory of disruptive innovation described by Marion Lynch (see page 9).

Signposting patients

One way of reducing the demand for GP appointments is to train reception staff in every practice to undertake enhanced roles in signposting patients to the most appropriate person, as described by Dr Varnam in his presentation.

Katherine Andrews, Project Manager at NAPC, explained how this has been tested by the NAPC through their Primary Care Navigator programme.

Definition of Primary Care Navigators

Primary Care Navigators are trained to ask people contacting the surgery: 'How can I help you?' If there is a medical problem the patient will be given an appointment with the GP or nurse, but if they have a social issue or are feeling isolated the primary care navigator may instead direct them to a befriending group or, depending on their interests, to a gardening or boat building club or other social activity available in the community.

Ms Andrews said the NAPC has trained 90 Primary Care Navigators to date in how to discover the services available in their communities they can refer people to and how to listen to people to understand their needs.

The NAPC is now working to create a network of primary care navigators so that general practice navigators can link up with other navigators working in hospitals and social housing and for charities like Age UK.

Healthcare workforce and artificial intelligence

Dr Marion Lynch, Deputy Medical Director of South Central sub region NHS England, said the work on disruptive innovation being undertaken in America showed that with system redesign GPs could let go of some of their work to other healthcare staff or artificial intelligence. The problem was that GPs didn't trust other people to do this work at the moment.

She said they were currently doing some work in the South Central region imagining how they would cope in the year 2030 if there were no longer any GPs. They were trying to work out how they would build a new workforce and the new healthcare system that they would need.

A need to change systems

Rhian Last, Education Lead at Education for Health, commented that a common theme running through all the presentations was the need to change systems. To do this she said people needed to understand systems, have a knowledge of the bigger picture of the policies and the key drivers that impacted on systems and the importance of capturing data while also understanding variation. The key issue was the need to understand the psychology of change and how to find ways of winning hearts and minds in order to get people involved and motivated to accept new systems.

Re-designing care with patients

Liz Butterfield, Chair of the Primary Care Pharmacists Association, commented: "In the system we have at the moment there is very little investment in change management and you see that many times as new systems are introduced and superimposed on what's already there. It's very refreshing to hear about the disruptive innovation that might be coming our way because in my experience we don't engage patients very much in all of this how we redesign care. What we need is some resources so that people can have the time to sit back with patients to think about how to co-design things differently."

Giving budgets to those doing the work

However, Dr Joe McGilligan, GP and Trainer, former Chair East Surrey Clinical Commissioning Group (CCG), former Co-Chair Health and Wellbeing Board for Surrey, questioned where the money was going to come from to introduce all the changes that had been talked about when there was no spare money in the system.

Dr Kingsland said the solution was to have whole population rather than capitation budgets. "The rapid test sites of the Primary Care Home have been trialling the whole population budget system and we are seeing the first signs of a heresy that there might actually be enough money in the health service, the problem at the moment is we just don't spend the money we have very well. The resources are in the system, they just need to be given to the people who spend the budgets on the front line for the people who are accessing care. It's about giving the budget to the teams who do the work," he said.

Development of a national network to develop care and support planning

Dr David Paynton, GP and National Clinical Lead, Royal College of General Practitioners (RCGP) Centre for Commissioning, described how the RCGP is developing a network to help practices embed care and support planning into their everyday practice.

Care and support planning, adapted from the House of Care approach, is a much more holistic way of working with people with long-term conditions than the biomedical model which seeks medical solutions to problems.

Patient-centred care

The care and support planning programme is encouraging a shift in general practice to bring the person with a long-term condition, or several long-term conditions, into the centre of the decisions which are made about their care, working in partnership with the practitioner.

Self-management

This biopsychosocial model helps the patient to develop the knowledge, skills and confidence to increase self-management of their condition, building on their personal strengths and harnessing the assets available to them in their social network, such as their carers, as well as the wider community.

What is the process?

The process involves preparation by both the patient and the practitioner, a conversation about what matters to the person, then a record is made for both parties of the care and support plan, which is owned by the person and shared with the practitioner. Then there is a process of making the plan happen with coordination and support from a range of personal, statutory and non-statutory sources, followed by review and adjustment of the plan if necessary.

The principles of this person-centred care and support approach could also be applied to someone with end of life or mental health needs, five different long-term conditions, dementia or a learning disability.

Introducing care and support planning

Introducing this model will require protected time and it does require processes. "It's a long journey, so start small with one condition. For example, apply the model in the context of diabetes, then put diabetes in the context of multi-morbidity so you are not just looking at measuring the HbA1c you are looking at what's important to that person with diabetes. The main thing is to get started, get the process going in order to understand the model, then you can build on that. There are some centres of excellence around the country where people are trying to do this and are encouraging people to work in a fundamentally different way," said Dr Paynton.

Several areas of the country have introduced care and support planning on a small scale and others have introduced it system-wide with some notable successes. After introducing the process Tower Hamlets improved to become one of the top Clinical Commissioning Groups (CCGs) for diabetes, in Leeds practices achieved improved HbA1c levels and practitioners in Gateshead reported improved job satisfaction.

"From the College's point of view this will become a core part of what it is to be a GP. It means that in future up to 40 per cent of your time could be spent on this approach," said Dr Paynton.

Care and support planning is going to be adopted into the curriculum and the College is developing learning materials, contract exemplars and IT templates. The national network covers the UK with champions promoting care and support planning.

Are seven day services necessary – what does the patient want?

Georgina Craig, Director of Experience Led Care Programme, explored what people want from primary care and whether they are looking for those things seven days a week.

Research by The Experience Led Care Programme has found that most people want the same things from primary care. These include:

- Support from health professionals around managing health issues
- A close relationship with their GP
- Time to talk about what is important to the person
- Proactive follow up and review initiated by their practice
- Swift access to clinical reassurance when unexpected symptoms happen

Furthermore, most people want to same things to keep well. These include:

- Being self-reliant and good at managing their own health issues
- Having a strong sense of purpose and contribution – including caring for others
- Staying mobile; being able to get out and about
- Doing things they enjoy
- Spending time with people they like and love

The happier and healthier people are, the less they need their GP in their lives. "Primary Care can improve lives and keep people well by understanding that people crave a life not a service. The care we provide should be a means to this end", said Ms Craig.

Research suggests that most people are not clamouring for seven-day General Practice services, an evaluation of the Prime Minister's Challenge Fund (PMCF) Improving Access to General Practice sites, has shown.

Evaluation of the first wave PMCF pilots found that whilst new slots created on weekdays were in-filled, 25 per cent of appointments with all clinicians created during the extended hours period were wasted in comparison to core working hours when only 6 per cent of appointments were wasted. This 25 per cent equated to 70,750 individual appointments in total, with 46,000 of those GP appointments. The average cost of an extended hour of care in General Practice is £200-280.

Whilst there was some demand on Saturday mornings - mainly for urgent, unplanned care - the weekend offer had been cut back in many areas because of empty clinics. Evaluation also found variable staff satisfaction with extended hours working, with 27 per cent of staff rating the experience of delivering care during this period as poor or very poor.

Perhaps surprisingly, E-consultations uptake was also poor in the initial wave of PMCF pilots, given they are now a big part of the GP Forward View and will be made available in every practice.

"When we ask ourselves the question, is seven-day primary care what people want? It seems quite clear from this evaluation that the answer is no. However, Health Secretary Jeremy Hunt is going to push ahead with routine GP appointments on Sundays. So we don't really have much choice - whether or not patients want it. This challenges us to think creatively about how we use extended access to work with people and communities so they keep well." commented Ms Craig.

She suggested that based on these insights, GP practices who want to improve outcomes and reduce demand could be asking some very different questions, including:

- How can we systematise follow up and review during normal working hours?
- How do we deliver continuity of care?
- How do we design rapid reassurance services?
- How do we help people anticipate the unexpected?
- How can we create time for important conversations with patients?
- How can we better support carers to cope and co-ordinate care?
- How can we connect patients and harness the power of peer support?
- Does increasing peer support reduce demand for clinical input?
- What's the right skill mix and way to practice primary care at the weekend?
- How can we reduce Did Not Attends (DNAs)?
- What about frequent attenders?

Working with an employed integrated team

Caroline Rollings, Managing partner at Newport Pagnell Medical Centre and Manager of MK Diabetes Care, described how a range of different healthcare professionals take the pressure off GPs by working as an integrated primary care team, which employs 110 people and provides services for 19,000 patients at the Newport Pagnell Medical Centre.

The original team comprising practice, district and advanced specialist nurses, health visitors and physiotherapists was formed in 1999. The staff were then TUPE-ed across to the practice in 2006 on a Personal Medical Services (PMS) plus contract. Since then, an advanced paramedic and a community matron have been added to the team. Their aim is to provide a holistic service.

"Being an integrated team gives us a sense of responsibility to find solutions rather than to consider external referrals. This results in a faster response as it avoids providers trying to get out of referrals by saying, 'We would be happy to help but we think it sounds more like the such and such team so think you should probably speak to them first…'", said Ms Rollings.

Other benefits of the team are that there may be less potential for errors as there are fewer external systems, there is increased clinician/team satisfaction as everybody feels more in control and more confident that the needs and expectations of patients are being met. Staff feel well supported and part of a dedicated and meaningful team. The team achieves good patient, family and GP feedback and reduced admissions to hospital.

The GPs have a good working relationship with the team. "It's really all about being a team with good communication and working closely together. We have a named nurse for each care home, for example and the homes call them rather than the GP. We are 22 sessions of GP time a week short so we use the GPs only when we only really have to."

The team carries out long-term condition care and Quality and Outcomes Framework (QOF) and one off interventions such as phlebotomy, vaccines and International Normalised Ratio (INR) monitoring. The health visitors give minor illness advice and deal with postnatal depression which can take up a lot of GP time. The community matron looks after patients with long-term conditions and has some accredited counselling skills and is able to deal with mental wellbeing.

The advanced paramedic, who has been working in the team for about 18 months, works with the GP personal assistant to make sure he can make the most of each day. He does home visits, works with the district nursing team, refers patients to hospital if necessary, carries out review visits and liaises with families and a range of external teams. He has been such a success that the practice is considering employing a second advanced paramedic.

"We can't go working individually in our own silos. The achievements of our organisation are very much about each individual coming together and that's what I'm hearing at this meeting today – that the future is about us all working together. An increased sense of the ownership of patients' health and job satisfaction in caring are some of the many rewards for working in an integrated primary care team providing a seamless, holistic service," said Ms Rollings.

Conclusion and Next Steps

This report is about finding solutions for the issues challenging primary care raised by the GP Forward View[1] and other recent reports by the Health Select Committee[2] and the King's Fund[3].

When I read the GP Forward View, I found it a little apologetic – that is not a criticism, it is recognising that maybe at last the primary care sector hasn't had the investment it needs and that there is still a lot of work to do if we are going to deliver the report's aspirations and achieve financial balance by 2020.

Reflecting on what people want from their health service we don't often hear patients complaining about a substandard quality of their care or that their clinicians are uncaring. Their concerns are: 'I can't get to see a GP or my primary care service isn't available at times that suit my lifestyle' or 'there are too long waits for care'.

As we revisit what we mean by waiting and access it is now far more important to think about the right care at first contact as well as not making patients wait a long time for it. People need to see the right person from a multidisciplinary team, first time, that has a holistic approach and provides finished episodes of care.

I've been a GP for 27 years and sadly, I'm now much more of a broker of care as a provider of care. Integrated, holistic care still needs to have the continuum of a familiar local service, scaled up, but not too large to compromise so the personalised care that list-based practices has always provided. We have to become smarter about managing population health issues and focus on the areas where we can achieve the biggest impact – the early detection, screening and prevention of disease.

Presentations delivered at this meeting have really important messages. They have all reinforced the benefits of multidisciplinary working, the need to work differently, the importance of extended care outside of hospital sector and providing the right care the first time that ultimately improves the deployment of healthcare resources.

We have heard about a whole system solution for primary care that is not based in hospital and is also not GP-centric. We have also heard some powerful evidence that if you get the service right – providing the right care that is accessible – people may not need a routine seven-day service in general practice.

We also heard about the importance of improving patient flows and how vital care navigation and active signposting is on that first contact with the patient.

All this strengthens the concept that the Primary Care Home is a solution for moving more care delivery out of hospital using its principles of workforce development around a registered population that is the right size to allow a 'one team' approach manage the whole population budget.

References:

1. General Practice Forward View. NHS England, April 2016 https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
2. Primary Care. House of commons Health Committee, April 2016 http://www.publications.parliament.uk/pa/cm201516/cmselect/cmhealth/408/408.pdf
3. Understanding pressures in general practice. King's Fund, May 2016 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Understanding-GP-pressures-Kings-Fund-May-2016.pdf

Attendance list

With thanks to all those who attended

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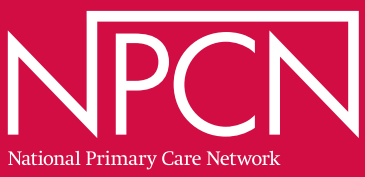
CloserStill events include:



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