Supporting Sustainable General Practice

Innovation in Primary Care – Examples and Case Studies For General Practice

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Document Author: **Robert Connor**
Project Manager
Primary Care Transformation Programme
NHS England South (South West)

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Resource Development Stakeholders

- Bristol CCG
- Somerset CCG
- South Gloucestershire CCG
- NEW Devon CCG
- South Devon and Torbay CCG
- NHS Kernow CCG
- Avon LMC
- Somerset LMC
- Devon LMC
- Cornwall LMC
- South West Academic Heath Science Network
- West of England Academic Health Science Network
- Severn Deanery
- St Austell Health Care
- Beacon Medical Group
- Exeter Primary Care
- St Levan Surgery
- Wells Health Centre
- Frome Medical Centre
- The Old School Surgery
- Health Connections Mendips
- Nailsea Family Practice
- DCIOS Local Pharmacy Committee
- Taunton Dean GP Federation
- NHS England South (South West) Primary Care
- Foxhayes Surgery

Introduction

This document aims to provide examples and case studies of innovation in Primary Care that have been initiated by groups of General Practices, either working together or in partnership with other care providing organisations. It aims to present:

- Original 'vision' and key drivers
- The stakeholders or collaborative partners
- The process from agreement to realisation
- The current status of the venture
- Challenges and Lessons Learnt

Offering these examples could inform other collaborative ventures in how to realise their own 'visions' and objectives, consider how best to mobilise and resource, and learn from previous experience. It could also illustrate the assertion that there is no 'one-size-fits-all' model, and that the reasons why General Practices are coming together to explore and create new models of care are many and varied.

This document focuses on NHS England's South West region and is one of a suite of documents produced by NHS England South (South West) and focused on supporting general practice in achieving and maintaining sustainability, and exploring new, innovative ways of working.

Why Collaborate?

- Demand for Primary Care is increasing – how can General Practice respond?
- The traditional model of General Practice is no longer sustainable – funding shortfall vs. increased pressures on Primary Care service provision
- Growth in General Practice workforce is half the growth of other clinical/medical specialties and this cannot be rectified overnight
- National agenda for change – The Five Year Forward Plan highlights the need to explore innovative use of a range of community partnerships and multi-disciplinary initiatives to better manage those with acute and long term conditions
- Increased commissioning focus on doing business with larger Primary Care organisations, which would impact on larger populations
- General Practice is best-placed to explore how and why it can respond to the range of pressures which it faces
- Exploring ways of reducing cost and maximising limited resources by applying economies of scale to General Practice business models
- Exploring ways of identifying additional income streams e.g. collectively bidding for enhanced service contracts
- Tailoring new ways of working to meet the needs of the local population and the profiles of local General Practices – no 'one size fits all'

Examples and Case Studies

Across the South West region, there are already a number of collaborative ventures that have produced, or are in the process of producing, results. The original reasons for embarking on these ventures are varied, and the scope of each initiative varies in breadth, both in terms of geography and purpose. However, a common element is that for each venture, a group of individuals or practices came to the realisation that, in order to solve a problem, or offer a wider range of services, or enhance income streams, or achieve sustainability and maintain or improve care services to their local populations, working together has yielded, or could yield, results. The following examples describe how these results have been achieved.

St. Austell Health Care

Background

During 2014, a large General Practice in St. Austell with 9,500 patients failed due to the partners' personal financial debts who relinquished their contract back to NHS England. The remaining three practices quickly concluded this was going to put huge pressure on their surgeries and that the most effective method of addressing this was to jointly bid to deliver a 12 month APMS contract to provide services to these patients in the first instance. The collaboration worked so effectively that the practices decided to merge to form St Austell Healthcare and worked with NHS England to incorporate the majority of the

patients. The practices merged on 1st May and anticipate having 32,000 patients once the APMS patients are amalgamated at the end of June.

The St. Austell Health Care cites the key reasons to merge as:

- The pre-existence of a shared ethos
- The opportunity to future-proof General Medical Practice
- The improvement of work-life quality
- The adoption of a flexible model to allowed for improved recruitment potential
- Potential efficiencies derived from economies of scale
- The potential to attract other services
- The perceived benefits of integration
- The pre-existence of solid relationships between local Practices

Talking to the Patients

The group of Practices concluded that a key means of ensuring that their initial objective met with the needs of the local patient populace was to engage and consult with their patient groups. This they did, using a survey method to invite the local patient populace to comment on proposals and needs. As a result, the idea to merge was reinforced by those using and relying upon their local General Practice Primary Care services.

Key Objectives

The group of Practices' vision for a merged and sustainable new entity included:

- A common or uniform IT system (SystmOne)
- The maintaining of all four sites, employing the struggling Practice's site as an 'acute hub' to deal with all urgent on the day need using a number of clinicians including nurses, ECPs, nurse practitioners, GPs, phlebotomists, etc. Also providing contraception services, midwifery, health-visiting, etc. The Acute hub will be open daily 8am-8pm
- The offering of hub services seven days a week. Initially 5 days a week extending to weekends within a matter of months
- The maintaining of the three remaining sites to focus on provision of planned care including palliative and end of life care, long term conditions providing continuity of care for patients with complex needs

The Challenges

The group of Practices identified a number of challenges as they commenced their merger project, including:

- Being faced with a failing Practice

- Maintaining 'business as usual' while merging, which meant an increase in workload
- Recruitment
- The facilitation of TUPE transfers for pre-existing members of staff
- The need for legal and financial planning
- The need to address public anxieties and ensure effective communications to both patients and staff

The Solutions

The group of Practices attempted to address these challenges by applying and adopting the following solutions:

- Focusing on collaborative problem-solving
- Focusing on developing a more accommodating working environment e.g. supporting workforce mothers to work flexibly, the promotion and enabling of Continuing Professional Development for all personnel, professional mentoring, and even undertaking 'burn-out' and wellbeing audits for its workforce
- Focusing on developing a more varied workforce, including pharmacists, nursing staff, ECPs and health care assistants
- The development and implementation of a redesigned appointment system
- Undertake operational and patient pathway process flow mapping and redesign
- Obtaining external management expertise
- Obtaining external communications and PR expertise

Lessons Learnt

The formalised, merged entity St Austell Healthcare Group came into being on May 1st, 2015. During the mobilisation process of this new venture, the group of stakeholder Practices identified the following as issues from which they were able to learn:

- The original need to 'act now' if a local Practice is struggling
- The importance of collaboration as a means of enabling quick results
- The importance of establishing and maintaining local relationships
- The importance of achieving and maintain financial understanding and seeking the relevant expertise
- The importance of developing and adhering to an effective communications strategy

St Austell Healthcare is still in its infancy, and continued evaluation will further help and support it achieve and maintain its initial objectives. However, even though adopting a merger model will not be suitable or appropriate for all General Practices in their consideration of how to achieve and enhance sustainability, the Group's process and early outcomes demonstrate what can be achieved in exploring new ways to provide care and enhance stability in General Practice.

For further information, contact Bridget Sampson, Executive Manager for St Austell Healthcare Group at bridget.sampson@nhs.net or on 01726 626840.

Exeter Primary Care

Background

What began as a Practice Manager-led, collaborative exploration of common objectives and potential options between all Exeter General Practices, is now a GP Confederation, a fully-fledged, legal entity comprising 16 Practices across Exeter. None of the stakeholder Practices were failing. The key driver in the consideration and adoption of a federative model was to form a legal entity to bid for enhanced services and to adapt to the changes on the horizon to ensure sustainability.

Exeter Primary Care (EPC)'s current focus includes:

- The desire to adapt to new care models
- The perceived benefits in collaboration among practices and between other agencies
- The perceived benefits of working together in primary care at scale.
- Increasing accessibility of GP appointments and telehealth
- Enhancing proactive care for the elderly frail population
- Adapting the skill mix of our practices to deal with the workforce and demographic issues
- Having a key role in the prevention agenda
- Being at the heart of the shift of work to the community with funding following activity and whole system outcome measurements aligning different organisations.

EPC formed as a company limited by shares but operates as a social enterprise company, owned by its members with any surplus to be invested directly back into local primary care services.

Key Objectives

Having set up to bid for enhanced services, EPC became aware of the wider landscape and inherent opportunities. In considering options, the initiating group of General Practice stakeholders focused on the following:

- Getting involved with the design and implementation of Integrated Care for Exeter, utilising a multi-agency approach
- Developing an approach to the proactive management of the elderly population's health needs
- Developing a multi-disciplinary team model, to enable relationship-building with local nursing homes and undertaking 'ward rounds' within those homes
- The adoption of IT interoperability between all 16 Practices

- The design and adoption of a weekend, 8.00am – 6.00pm service delivery model with one Practice open for all Exeter patients on a rota, with the patient's medical record available

Lessons Learnt

In mobilising and realising their venture, stakeholder General Practices concluded that the following factors were important:

- Relationship-building
- Establishing trust
- Engagement and communications with each other, the other local agencies and their local patient populaces
- Time to create, plan, implement and communicate innovations is needed outside of the traditional working day.
- Pump priming and headspace are required
- Support from the Area Team and the CCG will be crucial to success
- Partnership working with other agencies will be essential
- Funding will need to follow activity and the right outcomes and incentives will need to be chosen to align all organisations to the same joint goals

Future Plans

Having mobilised and launched EPC, future plans include:

- Exploration and involvement with planning and development of a complex care team approach
- Exploration of social prescribing models
- Exploration of integrated diabetes care/service provision, in partnership with acute trust, community and voluntary sector
- Exploration of virtual hubs, each with 30-50,000 patients, and linking with other community services

EPC is still in its infancy, and continued evaluation will further help and support it to achieve and maintain its both initial objectives and plans for the future. However, even though adopting a formalised federative model will not be suitable or appropriate for all General Practices in their consideration of how to achieve and enhance sustainability, the EPC's vision and early outcomes demonstrate what can be achieved in exploring new ways to provide care and enhance stability in General Practice.

For further information, contact Dr Sally Ewings at sally.ewings@exeterprimarycare.co.uk

Beacon Medical Group

Background

Established as a result of the merger of three General Practices, Beacon comprises 24 GPs and serves 33,000 patients. Key drivers in the consideration and adoption of a merger model were:

- Responding to planned and actual retirements of existing Partners
- A collective desire to collaborate with all relevant organisations
- A collective desire to integrate
- A collective desire to share services
- A shared ethos among its constituent stakeholders

Key benefits of merging were perceived as:

- Achieving a strengthened management team, both operationally and strategically
- The facilitation of partnership investment
- Future planning
- Learning from past experiences
- Promotion of support and resilience
- Achievement of greater scale as protection
- Addressing the expense of long-term sickness
- Preparing for planned new town, and perceived need for a stronger single entity

From Ideas to Action

- Decision to act taken in November 2013, but this was after 12 months of lead-in
- Used 'fighting fund' (£5,000 investment from Partners) to seek and obtain advice on:
    - Banking
    - HR
    - Accounting
    - Legal
    - Partnership Agreements
- Set up Partner-led working parties to look at a range of service-design work-streams:
    - Workload and Workforce HR
    - Management Structure
    - Income Streams
    - New Services
- Commenced patient and personnel engagement in early 2014, all done during evenings and weekends with no additional resources.

- Eventually realised the need for dedicated resource and, on advice from HR specialist, engaged interim project manager who served as catalyst
- Final transition cost calculated at £120k, which was assigned over three years
- Fledgling entity completed and submitted merger application form to NHSE, and also invited pre-emptive involvement from NHSE personnel
- Entity decided to employ a Chief Operating Officer in July 2014 to address soft-change management – facilitating the development of a larger organisation entity against the backdrop of a long-established workforce culture comprising many longstanding staff members
- The entity identified the need to revise processes and protocols for:

    - HR
    - QOF
    - Registration
    - Administrative and Management functions

Prime Minister's Challenge Fund Initiatives

In merging the three Practices, Beacon worked towards establishing new models of service delivery in three key areas:

- Urgent Visiting Service
- Health Care Assistant-led Services
- Practice-based Pharmacy Services

Urgent Visiting Service

The aim of Beacon's Urgent Visiting Service is to provide a GP-led, rapid assessment service for patients unwell at home who might otherwise call an ambulance. Adopting a pilot approach, Beacon deployed locums to back-fill sessions in order to free-up GPs to lead the service, and utilised the mobile SystemOne application to enable access to records. Outcomes achieved by the pilot were:

- Improved awareness of, and utilisation of, community services
- Of the 100 visits undertaken, 36 resulted in the avoidance of unplanned admission to hospital
- 36 unplanned admissions avoided
- The effective reinforcing of treatment escalation plans
- The early use of ambulance services where necessary

HCA-led Services

The aims of Beacon's HCA-led services are to:

- Provide a COPD outreach service

- Offer both telephone and face-to-face consultations and interventions
- Facilitate a named clinician for each patient
- Provide the service to approximately 500 COPD patients
- Focus on patient empowerment and self-care
- Develop a bench-mark model for how to manage long term conditions

Practice Pharmacy Service

The aims of Beacon's Practice Pharmacy service are to:

- Provide telephone and face-to-face access to pharmacy across all sites
- Offer advice on medications, minor illnesses and long term conditions
- Provide benefits across Beacon's workforce and operation – education for the whole team; ePrescribing; supporting QOF; liaison with community pharmacy, etc.

As a further development, Beacon is supporting its Practice Pharmacist by them to train as prescriber, balancing the investment necessary with the perceived benefits in the long-term.

Other Service Developments

- Enhanced use of paramedics as part of the Primary Care Team
- Use of a Nurse Practitioner
- Development of Nurse Prescriber service
- Looking at how to address large population of MSK and dermatology patients – BMG has a number of specialist interest GPs who have been able to focus on dermatology and MSK services, to which patients can be referred internally. For dermatology, images are taken by GP, and there is one week wait from referral to triage, two week wait to allow for ability to attend. 75% of dermatology and MSK patients are seen in-house
- Collaborative working with community pharmacists and other community providers

Lessons Learnt

- As with other ventures described above, Beacon has concluded that engagement and communication with the local patient populace was key to ensuring that their vision and objectives were shaped by local need and feedback.
- Acknowledgement that securing Partner investment and the process of changing to a new legal entity carried degrees of risk and dependency
- CQC struggled with concept of merger, which resulted in a delay in registration. Although all GP Partners had DBS clearance, there was/is no DBS portability, so this carried the requirement for re-clearance and additional registration visits per GP. In addition, as the merged entity proposed the continuation of four sites, each site required a registration visit. Each site has now been registered separately even though they relate to a single entity.
- Requirement to merge Practice NACS (codes) was a lengthy process
- The Carr-Hill allocation formula (used to adjust the global sum total for a number of local demographic and other factors which may affect Practice workload. For

example, a Practice with a large number of elderly patients may have a higher workload than one which primarily cares for commuters) required lengthy process for reallocation
- Not enough guidance from NHSE on the financial and physical process of merging
- Acknowledgement of the importance of, and required skills required for bringing personnel groups together
- Acknowledgement of importance of having a clear understanding of initial objectives – what do all stakeholders want out of the initiative?
- The importance of building relationships with local hospitals to create new service pathways

Beacon Medical Group is still in its infancy, and continued evaluation will further help and support it to achieve and maintain both initial objectives and plans for the future. However, even though adopting a merger model will not be suitable or appropriate for all General Practices in their consideration of how to achieve and enhance sustainability, Beacon's vision and early outcomes demonstrate what can be achieved in exploring new ways to provide care and enhance stability in General Practice.

For further information, contact Claire Oatway, Chief Operations Officer at claire.oatway@nhs.net

Frome Medical Centre

Frome Medical Centre serves a local patient population of 30,000, and while it has a large GP workforce in place, it has been able to maintain and enhance its clinical workforce by testing and adopting a range of innovative new models of care, with as emphasis on carefully designed patient pathways, and the desire to reduce pressure on practice-based GP personnel. By adopting larger economies of scale, Frome Medical Centre's Partners and management team have strived to future proof the service and add greater levels of resilience. It does however acknowledge that both clinical recruitment and workforce retention remain key challenges.

Innovations

- The application of technologies for record keeping and shared access means letters can be produced directly – no need for dictation. Reduces administrative workload for GPs
- Generating electronic prescriptions has removed the need for GPs to sign each one, and has removed the need for GPs to dedicate time to repeat prescription work
- Partnership with *Health Connections* – social prescribing network of volunteers (see below)
- GP session design – daily blocks of four sessions, two in the morning, two in the afternoon. Patient consultation sessions are restricted to ten patients each. Other

sessions include telephone consultations, producing prescriptions, covering the walk-in centre or home visits
- Use of a bank of secretarial/administrative personnel to support GPs
- Use of specialist Mental Health Nurse service model – initial GP consultation refers onwards to practice-based MH nurse. Used evidence-base of average six consultations for MH patients per GP. Now, five following consultations undertaken by MH nurse
- Use of practice call-centre personnel – enhanced training to enable greater fact-finding and therefore signposting to appropriate services
- Management of patients with long-term conditions – evidence showed that a patient with a set of multiple long term conditions received 87 letters relating to each condition. As a result, Frome Medical Centre introduced a 'One-Stop' process of annual reviews per patient. At review, HCAs undertake assessment, to reduce pressure on Practice Nurses. Assessment outcomes then passed to Practice Nurses for review, including titration, and agreement of outcomes/next steps. This has reduced pressure on GP, Practice Nurse and administrative workforce
- Adoption of 'ticket-system' for WIC phlebotomy, which has removed the need for a receptionist
- Adoption of automated arrival/check-in at Practice Reception includes targeted onscreen messages about eligibility for dementia screening
- Development of 'Unplanned Admission Avoidance' hub, utilising multi-disciplinary input incl. clinical, ambulance service, Health Connections. This has facilitated regular case discussion to enable consideration of presenting problems and better care planning.
- Proactive Patient Participation structure, including input into 'ethics committee'.
- Promotion of how patients can better support their GPs during consultations e.g. encouraging patients to prioritise symptoms and maximise the effectiveness of their ten minute consultations
- Adoption of Operational and 'day' management model – Operations Manager is freed up as other personnel are paid a nominal annual sum to cover day-to-day management by rota. This has enhanced the skill-sets of existing personnel e.g. Practice Nurse, Lead Secretary, Scheduler, Lead Admin/Receptionist, has allowed for sickness cover and strengthened business continuity
- Home-based GPs x four, to help with paperwork, results and telephone signposting duties:

Home-Based GPs

Processing of incoming letters, involving scrutinising incoming electronic mail to:

- Pick up any necessary tasks or actions (often frustratingly buried deep in verbose text) and perform them.
- Change/add/harmonise repeat medications.
- Read code as appropriate

- Put information onto EMIS about key points of the letter if appropriate (a new function not currently done to improve communication)
- To write to patients if necessary to reinforce any clinical activities.
- To notify GPs about incoming mail if relevant if:

    - Letter contains information specifically requested by that GP
    - If contains a major diagnosis (e.g. new cancer) of which the GP should be aware.
    - If complex contents requiring GP further opinion.

Processing of Incoming Results

- To file away any normal results with correct annotation so that our systems for patient communication of results can perform correctly.
- For abnormal results to review the records of the patient and action appropriately, options being:

    - To repeat tests
    - To do further tests
    - To arrange a telephone consultation with own GP
    - To arrange a consultation with own GP
    - To telephone patient themselves for clarity or information.
    - To refer back to the requesting GP for further assessment/review.
    - In case of grossly abnormal results requiring immediate action

        - During daytime hours to urgently refer by phone to our duty doctor
        - If out of hours to refer to 111/emergency services as appropriate.

Telephone Calls and Signposting

- Patients who make contact with the surgery for advice or help are put down for telephone calls. These may be:

    - Signposting (i.e. directing the patient to the secretaries for a sick note, or heath visitor for advice)
    - Telephone triage (e.g. directing patients to our walk in same day service or making routine appointment)
    - Completing a discrete and limited range of clinical issues (e.g. treatment of symptomatic UTI)

This service would allow much more efficient use of same day service doctors, who currently spend a lot of time dealing with administrative and signposting items on the phone.

Future Plans

- Telephone consultations/Skype/email consultations/medication reviews
- The development of a 'bank' of Home-based-GPs to offer out to other Practices and therefore create an additional income-stream

Benefits

Ability to recruit GP personnel who, for a range of reasons, are unable to commit to site-based sessional work – flexibility

Challenges

- Secondary care providers e.g. RYH, require paper-based correspondence
- Ensuring onsite induction and training for HB-GPs
- Secondary care Consultant letters serve as both consultation record and request for action – requires additional process layer to identify and separate request from record
- Administration of volume of letters generated by referral, e.g. chiropody, generates acknowledgement, copy of appointment, confirmation of appointment attendance, outcome, etc.
- Data Sharing agreements – culture of resistance and caution blocking anonymized data sharing
- Maintaining and improving internal and external communications
- Managing mandatory training and compliance

Lessons Learnt

- Experimentation is key – not everything will succeed
- Adoption of cost:benefit analysis – not all new models of care have been cost-effective, e.g. dermatology service was not cost-effective
- Importance of the involvement of Practice Partners in management of Practice

For further information, contact Kaylyn Hudson, Operations Manager for Frome Medical Centre at Kaylyn.Hudson@fromemedicalpractice.nhs.uk

Health Connections Mendip

Background

2013

In 2013, a one year project was funded by CCG Clinical Innovations Fund to employ a worker four days per week and to utilise a website designer. The three Mendips Federations worked co-operatively through innovation funding to promote access to peer support for patients with long term conditions. The project promoted patient self-management and

patient empowerment and looked to a future health system which sees its main resources as patients themselves.

The initial project enabled collation of patient groups and community resources for both clinicians and patients, led to gap analysis and the setting up of new groups to meet these unmet needs and develop stronger links between current community groups, to allow them to align their work to greater effect. It provided a website and regular email newsletter to share information on community resources. It provided clinicians with the tools to encourage patient self-management and increased patient access to support and increased patients' involvement in setting up support groups.

2014

Year two saw the work led by the East Mendip Federation which continued to identify the need for developing third sector peer support groups for patients with long term conditions, offering patients and clinicians easy up-to-date information on services. The project evidenced the requirement and success of a service that:

- Developed and increased the number of support groups available to long term conditions.
- Worked with patients with long term conditions to increase people's self-management skills by ensuring they have access to the correct support groups and services.
- Created a searchable website resource for patients and clinicians, with associated publicity materials to raise awareness of the website. Ensuring this website was suitable for clinical staff to undertake social prescribing quickly and with confidence.
- Supported group leaders or potential group leaders with skills training and governance advice and support.
- Co-ordinated the formation of new support groups as needed.

Year two was undertaken by a single individual with significant experience of working with the community sector, employed by a practice, performing all these functions. It was found that a four day a week post could support a patient population of 40,000-50,000 working in this way. Thus in year two the directory of services was available to all three Mendip Federations while the other activities focused solely on East Mendip (patient pop of between 43,000).

2015

In year three the Mendip Federations wanted to sustain and build on the work of the first two years of the project and fund further development to create a responsive local health

system that actively supports patients to self-manage across Mendip. In April 2015, the project was expanded to include three Area Leads who work with the community to increase social capital, map, promote and set up new support groups. The Area Leads line-manage the seven volunteer *Health Connectors* who work 1:1 with patients in GP practices across Mendip. *Health Connectors* listen to patients' stories and help them identify goals that are important to them, as well as signposting patients to groups and/or services in their communities. Patients are key to the project – they help identify gaps in service provision, help set up support groups and are trained to become *Community Champions* – spreading the word about the support that is out there in the community.

Health Connections employs a network of volunteers, undertaking the following roles:

- **Health Connectors** work with patients 1:1 and help run the Self-Management Groups and On Track Groups.
- **Area Leads** work with patients to help them set up peer support groups. They help link and promote services by organizing 'Awareness Raising Sessions' for the voluntary sector in GP practices. They run 'Talking Cafes' and line manage the Health Connectors.
- **Volunteer Coordinator** trains patients to become Community Health Champions, Practice Based Health Champions and Digital Health Champions.
- **Health Champions** are empowered patients who receive training in signposting to community groups and services.

Scope of Services Offered

Trained volunteer Health Connectors work one-to-one with patients in General Practices across Mendip to offer connections to further support in the community and help build knowledge, skills and confidence. Key areas of service include:

- Helping patients to set up issue-focused support groups
- Patient referral to relevant issue-focused support groups
- Sign-posting patients to other community-based support services, either in person or via the Health Connections website
- Raising awareness to promote the work of other organisations in Practices and in the wider community
- Encouraging and mentoring 'Health Champions' – patients who are willing to promote the work of Health Connections. Examples of the work Health Champions undertake include:
    - Sign-posting patients within General Practice settings
    - Supporting people to get online and access reliable health information.
    - Sign-posting people to services within the wider community
- Provision of support programmes and workshops, including:

  - Long Term Health Conditions Peer Support Group
  - Multiple Sclerosis Exercise and Peer Support Group
  - Leg Ulcer Club
  - Chronic Obstructive Pulmonary Disease Peer Support Group
  - Breast Cancer Peer Support Group
  - Stroke Support Group
  - Macular Degeneration Peer Support Group
  - Café Connect – Peer Support Group for people with dementia and their carers
  - Mature Movers – exercise group for older people

- Health Connections also works to respond to patients' requests, and as a result of listening to what patients want, they have been able to set up:

  - 4 Talking Cafés – regular weekly group for people who are isolated and/or want to be signposted to support. One in East Mendip Federation, one in Central Mendip Federation and two in West Mendip Federation.
  - Pain Management Programme – 6 week self-management programme. These run each term in each federation.
  - Relaxation and Wellbeing Workshops
  - The Health Connections website, which includes access to a directory of local services

- Health Connections also works to respond to voluntary and the statutory sector requests, and as a consequence have been able to:

  - Raise awareness in General Practices and in the wider community to promote the work of community organisations e.g. Cares UK, Alzheimer's Society, Deaf Plus and the Warmer Homes Team
  - Spotlight scheduled health events, e.g. World Mental Health Day event, bringing together individuals and organisations to raise awareness of their work.

Lessons Learnt

- One worker couldn't cover the whole of the Mendips and consequently, in 2014 the project was redefined for year two to focus on East Mendip Federation only.
- The impact of the initiative in 2013 and 2014 led to all three Mendips Federations agreeing to fund further development to create a responsive local health system that actively supports patients to self-manage across Mendip.
- The Area Leads need a background in community development and one to one work.
- One full time Area Lead per patient population of 50,000
- Always work from where the patient is. Listen to the patients and the community. Never set up a group because you think there is a need.

- Create as many avenues as possible for patients to find out about support. A website is not enough. You need real people behind the information, e.g. Health Connectors, Community Health Champions, Digital Health Champions, Practice-Based Health Champions and groups such as the Talking Cafes where people can pop along and speak to someone about to where they might like to be signposted.

For further information, contact Jenny Hartnoll, Health Connections Service Lead at j.hartnoll@nhs.net or visit www.healthconnectionsmendip.org

St Levan Surgery

St Levan Surgery serves a local patient population of 6,800, and has adopted an innovative and award-winning approach to patient enquiries and appointment booking.

Patient Access Service

The service offers every patient who contacts the Practice the opportunity to speak to a General Practitioner over the phone. When a patient contacts the Practice, trained reception staff undertake a process of information gathering and then either sign-posts the patient to the relevant service, e.g. nurse, HCA or pharmacy, or logs the caller onto a software application (Microtest), which in turns collates all callers onto a list for call back by a GP. The GP is then able to work through the list, calling each patient and deciding next steps, e.g. advice-giving, prescription, results, tests, face-to-face consultation etc. Face-to-face consultations are offered for that day, or for another day, depending on patient circumstance, availability, continuity of care (other GP involved in the patient's case), etc. The GP is then able to record outcomes and, if relevant, book appointments, either on the current day list, or subsequent days for attention of other GPs.

Outcomes

St Levan GP Partner Dr Hilary Neve believes that "It makes so much sense to use the phone to deal with many patient problems, as well as to follow them up at a later date. I feel I can do my job so much better, by being accessible and by using my time as it's needed instead of allocating all patients identical ten minute slots."

Adoption of the system has also helped reduce pressure on out-of-hours health services, as patients have contact with a doctor on the day they contact the Practice. In addition, in 2012, the number of people registered at the Practice who attend Emergency Departments has reduced by approximately 20 per cent.

St Levan is willing to engage with other General Practices interested in assessing and utilising the Patient Access Service. For more information, contact Liz Brimacombe, Partner Practice Manager, at liz.brimacombe@nhs.net

Pharmacy in General Practice

Background

Devon, Cornwall and Isles of Scilly Local Professional Network for Pharmacy is currently working to address and action the following issues:

- Changing the relationship between Pharmacy and General Practice
- Exploring how to work differently
- How to offer encouragement
- Setting the agenda for innovative partnership working with General Practice and the wider Primary Care environment
- Development and promotion of Pharmacy First – minor ailments; emergency repeat prescriptions; direction of patient groups
- Mapping demand status
- Role of Pharmacy in Practices
- Co-location of GP Surgeries/Community Pharmacies
- Polypharmacy reviews
- Post discharge reconciliation
- Community pharmacy liaison

Key Drivers

Royal Pharmaceutical Society Guidance – Pharmacists in GP Surgeries (Sep 2014)

- Local Commissioners to include pharmacist / community pharmacist expertise in all care path ways that use medicines.
- NHS England to support the spread of good practice and evidence that shows the benefits of pharmacist input in GP surgeries

Royal College of General Practitioners/Royal Pharmaceutical Society Joint Statement (Feb 2015)

The role of practice based pharmacist will be to:

- Deal with medicine related issues
- Liaise with hospitals, community pharmacies and care homes to ensure seamless care and reduce potential medication errors
- Help patients with complex conditions and high risk medicines
- Support frail elderly patients and those receiving polypharmacy.
- With clinicians ensure the most effective treatments are used
- Reconcile medicines when patients move in or out of hospital
- Improve the safety of medicines

- Improve communication and collaboration between pharmacists

Proposed Models and Hybrids

- **CCG Pharmacy in Practice** – medicines optimisation; seconded into Practice
- **Community Pharmacy** – similar to above; one session per 7,000 patients per week at Practice level using top-slice of CCG medicines budget - has shown improved outcomes and relationships within Practice
- **Direct Full-Time/Part-Time Employment of Pharmacy in Practice** – potential for building individual relationship within Practice; opportunity to use role to change the system e.g. looking at Pharmacy outreach, not competitor
- **New Medicines Service** – potential to offer consistency; potential to reduce follow-up by GPs; provision of medicines review; potential for GPs not needing to undertake asthma/COPD reviews
- **Prescribing Pharmacists in Practice AND Community** – Example: Productive GP initiative at Beacon Medical Group
- **Repeat System** – if in Pharmacy with prescriber, can have reauthorized repeat prescribing and clinical check – reduction in workload for GPs and interface with Pharmacy; 20 minutes per patient has potential to save 20,000 GP face-to-face hours
- **Hybrid** - Prescribing community-based Pharmacist one day per week alongside expert lead Pharmacist – networking to deal with complex cases and therefore improve skills sets of generic Pharmacy

Dependencies and Lessons Learnt

- New models of Pharmacy/General Practice joint-working represent significant system and process change, so more research is required to assess and evaluate which models yield the most effective results
- Research may need to be longitudinal on-going learning as models are introduced, to evaluate as new services are implemented and offered
- Identified need to look at process and opportunities, which in turn could lead to the potential to introduce change across General Practice
- Acknowledged that in the South West, there are not enough Pharmacists to realise the potential benefits of enhanced joint-working between Pharmacy and General Practice

Pharmacy in General Practice – The Old School Surgery, Bristol

Background

Having a pharmacist working as part of the team in General Practice isn't a brand new idea – Rachel Hall, practice-based prescribing pharmacist and practice partner at The Old School Surgery in Bristol has been doing this for ten years. After working as a sessional PCT pharmacist for four years, she qualified as a prescriber in 2006, and was offered a fulltime role with the Practice where she is able to help manage patients with long term conditions,

such as diabetes, as well as lending her expertise to the ever increasing repeat prescription workload. In 2013, Rachel became a partner at the Practice.

Practice-Based Pharmacy Service

As practice-based pharmacist and practice partner, Rachel runs either a morning or an afternoon clinic every day and deals with around 50 to 60 patients per week. Her scope of practice covers elderly care, respiratory diseases and cardiovascular diseases. She can perform respiratory diagnostic assessments on patients with asthma and chronic obstructive pulmonary disease, write referrals to consultants and initiate treatment. Rachel sees any patient who requires some form of medicines management or medicines optimisation, such as agreeing concordance plans with patients who are struggling to take their medicines. She also sees patients who are on complex medication regimens or who have had an adverse effect from a medicine and can manage them at clinic.

Rachel also deals with correspondence from secondary care. She is able to consider each medicine on a discharge summary or outpatient letter, review it against the patient's acute and repeat medicines list, make any necessary amendments and organise any dose titrations or blood monitoring that has been advised. She also liaises with consultants who request a non-formulary or unlicensed treatment to be prescribed.

She conducts audits, runs patient engagement forums, shares medicines management updates with the clinical team and provide training for practice staff. She is also able to address any medicines-related queries from patients, community pharmacists, receptionists or GPs. Other duties include authorising some repeat medicines and supporting the Quality and Outcomes Framework (QOF) and medicines management initiatives recommended by the local CCG.

Rachel's role in the practice has enabled her to provide patients with services that are flexible and accessible. Her appointments are 20 minutes long and pre-bookable, providing more time than patients would normally have at a GP appointment. The reduction in GP workload means that they can target their time towards the patients with more complex medical needs. Rachel is also able to refer directly into secondary care services, as required.

The Old School Surgery has one of the lowest A&E attendances in the area, further demonstrating that patients with long term conditions are keeping well thanks to the work of the pharmacist/GP partnership, their own efforts and the care they receive from the whole team.

Practice-Based/Community Pharmacy Hybrid Model

In 2011, Jonathan Campbell took over the management of the Old School Pharmacy. Jonathan believes that community pharmacy is ideally placed to play an important role in helping the NHS manage the needs of these patients and the biggest challenge for the pharmacy profession is to grasp this opportunity.

The first step for Old School Pharmacy was to identify a shared goal within primary care, which would deliver an outcome that would be beneficial to local patients and GP surgeries.

Secondly, the pharmacy had to focus on a proactive service that would:

- Realise the full potential of the professional skills of pharmacists
- Demonstrate the advantages of pharmacists being accessible to patients
- Focus on improving the individual patient experience
- Monitor patients more carefully
- Review patients medicines more frequently
- Improve patient outcomes

Ideas in Action

In discussion with The Old School Practice, the pharmacy established a pharmacy based "Medicines Optimisation Service", which resulted in the pharmacy and the GP surgery working together to identify and support a cohort of approximately 400 vulnerable patients with long term conditions. No additional funding was required for this service as each of the 400 patients were transferred onto a Repeat Dispensing Scheme and were issued prescriptions for 28 days rather than the usual 56 days dispensing period. Old School Pharmacy drives a pro-active culture of "every contact counts" for all their patients, especially the vulnerable cohort. They not only see vulnerable patients such as their elderly population with long term conditions but also those patients suffering from dementia, poor memory, poor medicines compliance, chaotic lifestyles and those with complex needs, such as younger patients struggling to manage their long term conditions.

A number of factors can lead to patients being added to the joint pharmacy/practice vulnerable register:

- Referral directly from the GP Practice
- Referral from a patient's carer or social worker
- Referral from pharmacy staff, based on:
    - Frequent urgent request for their regular medication because they have forgotten to re-order
    - Non-collection of their regular medications
    - Concerns highlighted during a MUR
    - Poor compliance
    - Chaotic lifestyle
    - Learning difficulties

These patients are invited to a yearly Medicines Use Review with the pharmacist to optimise and align their medication.

Each month, the pharmacist rings all the vulnerable patients/carers to identify any concordance/compliance issues that have arisen over the last 28 days. The pharmacist

reviews each and every medicine with the patients to ensure continuing medicines optimisation. If reassured that the patient is complying with their medication, the pharmacy team then dispenses the next 28 days-worth of medication, utilising the Repeat Dispensing Prescriptions. If medication concordance is poor and the patient has missed or forgotten to take their medication, the pharmacy team records the number of medications that require re-aligning and counsels the patient/carer to try and improve concordance. In these cases, the pharmacy only dispenses the exact quantity of each medication to ensure the patient only has enough medication to cover them for another 28 days. This process enables the pharmacy team to continually monitor/advise the patient on a monthly basis and more importantly to continually optimise the patient's medication.

If a patient's medication has to be reset on three consecutive occasions, the pharmacy team highlight their concerns to the surgery so that they can review the patient. In addition, the pharmacy team can refer any vulnerable patient back to the surgery for assessment.

To ensure patient safety, each of these patients is flagged on the GP's and Pharmacy PMR system. If their medication is changed, the surgery sends the pharmacy a "Change Form". This form identifies any changes that have been made to a patient's medication, so that the pharmacy can destroy or replace the Repeat Dispensing Prescriptions that it currently holds in the pharmacy file.

Medication safety is improved through the regular pro-active contact and referral, if necessary. Medicines wastage is reduce through the continual adjustment or re-alignment of their medication back up to 28 days, rather than just issuing another 28 days of all their medicines.

These patients are now monitored by the practice under a direct enhanced service, focusing on Emergency Admissions. The next step is to try and establish any coloration between reduced admissions linked to patients under this service

Future Plans

The pharmacy based vulnerable patient register is a model for the transfer of care from GP practices to community pharmacies for all patients with Long Term Conditions. It could enable large cohorts of patients to be pro-actively managed by pharmacy teams on a regular basis.

Urgent Care Service

A community pharmacy based "Urgent Care Service" which utilises the true potential of the pharmacy workforce. It could reduce the impact on GP Primary Care and A&E services and could go beyond the treatment of Minor Ailments. The service would utilise a range of PGDs to allow patients to access appropriate treatment and medication from their local pharmacy and through advances in near patient testing for C-Reactive protein, it could reduce inappropriate requests/prescribing of antibiotics.

Conclusions and Lessons Learnt

- The impact on use of secondary/urgent care services – enhanced use of pharmacy services has reduced reliance on secondary/urgent care
- The impact on capacity – reduction in reliance on F2F GP consultations
- Impact on medications compliance
- Impact on ability to undertake early interventions, as identified by community pharmacy
- Importance of community pharmacist having full access to patient records and the resultant ability to record and report/escalate to practice-based pharmacist and/or GPs
- Embedded clinical pharmacist within the practice is key – Old School practice-pharmacist is now partner and is able to make secondary care referrals her own right

For more information, contact Rachel Hall at rachelhall1@nhs.net and Jonathan Campbell at oldschoolpharmacy@nhs.net

The Your Health and Wellbeing – Mendip Collaborative

The Your Health and Wellbeing– Mendip Collaborative (YHAW) is a group of twelve General Practices covering a population of 100,000 in Somerset, encompassing Beckington, Coleford, Frome, Glastonbury, Oakhill, Shepton Mallet, Street, Wells. They have a passion to collaborate with all health and social care providers to deliver the best and most appropriate health and wellbeing services to our population. They have a strong desire to maintain continuity of care within local General Practices and have a focus on achieving a sustainable and collaborative workforce by using the principles of health and wellbeing.

Background

YHAW believes that, as there is a strong current of change in the NHS in Somerset, collaboration and integration are the current drivers to try and restore some of the cohesion in the system. They believe that, historically, each organization has had a focus on its own individual role in providing care, and a brief to maximize its own efficiency, but there has not necessarily been a duty to take in to account the impact it has on the rest of the care system. The believe the same also applies to GP Partnerships as providers, and that decisions made about which enhanced services to provide are often based on business principles, and result in variation of what service can be accessed by patients from General Practices. From this perspective, individual Practice's issues as providers mirror those of larger organizations but in a smaller way, and are in part mitigated by the fact there are multiple providers. Lack of effective universal coverage of some services by existing primary care, (particularly the health promotion services) has led to them being tendered out, because non-participation by a Practice effectively precludes their registered patients from being able to access it.

YHAW believes that generally the current model has served the patients of Somerset well, but given that non-GP healthcare care is provided by very large organizations, the impact of decisions made 'at scale' with the CCG can and does sometimes have unintended and negative consequences at the locality level. They believe that reversing or modifying these decisions can be difficult if not impossible because of the 'bigger picture' issues which caused the change in the first place. Patients from the Mendip locality form only a small part of any one provider's overall care activity, and having those providers' voices heard has proved difficult.

Getting from Mendip to elsewhere for care or treatment has always been a significant issue for patients, and is both a financial and physical barrier for both patients and their carers, and is a significant factor in many patient's care choices. This has been consistently voiced by patients and patient groups in the Federation Fora and elsewhere. There is, therefore, a powerful driver to provide as much care within the geographical locality as possible.

Within primary care, there have been detailed discussions about collaboration and doing things 'at scale', within the Mendip locality, via the Test and Learn pilots. YHAW believes that this is a good opportunity to think now about what 'good' would look like for the population of the Mendip localities in terms of both service provision, and the longer term viability of service provision in the locality. They believe that it is for local providers to shape and influence this but, to date, this has been challenging. They cite the new fracture clinic, the withdrawal of ENT outpatients from West Mendip Hospital, and the lack of consistent access to expert consultant advice to one of the largest community hospitals in Somerset are a few examples.

As GP members of the Somerset Clinical Commissioning Group, YAHW members believe they continue to have an important responsibility and role in the commissioning and monitoring of services for patients. They believe that this can be achieved through ensuring the new organization has a "local commissioning intelligence" function, at both practice and locality level, and build on the existing new relationships with other health and social care organizations which have developed through the Test and Learn Pilots to look at commissioning needs at a population level. Both work streams would have a brief to have and maintain an active dialogue with Somerset CCG to enable it to fulfill its "bigger picture" role in coordinating commissioning of healthcare across Somerset as a whole.

Key Visions and Objectives

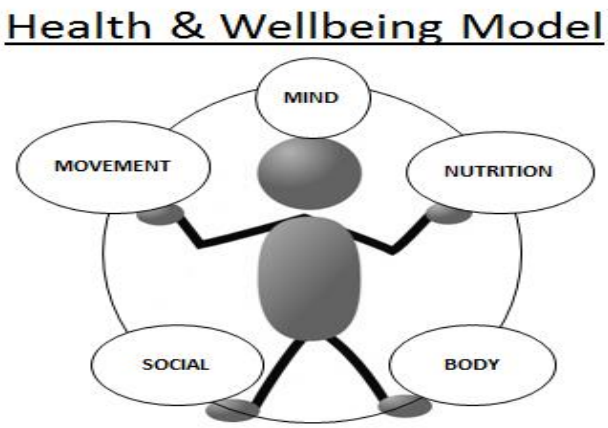
One of the key functions of YHAW is to secure the long term viability and increased diversity of provision of primary care services for the population of Mendip. Its primary focus is therefore as a provider organization, and collaboration with other provider organizations will be on this basis, rather than a GP Commissioner-Provider relationship.

YHAW believes their vision for healthcare in Mendip aligns well with the Somerset CCG priorities. The collaborative working on the commissioning of the Health Connectors pilot (health workers who can signpost and work with patients to define their own health plans)

across Mendip using reinvestment funds, the Mendip-wide Test and Learn multidisciplinary care planning and the House of Care training for delivery of long term condition management were catalysts for their collaboration. This work will continue to evolve and develop over time. YHAW believes they will allow individual practices to consider how best to deliver this agenda, without necessarily being restricted by the resources that a single practice has at its disposal.

YHAW is keen to ensure that, in keeping with the House of Care model and the NHS Year of Care concept, the development and evolution of care in Somerset enables person centeredness and meets the total health and wellbeing needs of the individual. They propose that care could be provided in a manner that encompasses the bio-psychosocial model of health. They believe that, in the current provision of health care, there can be over-medicalization and neglect of important aspects of wellbeing. YHAW believes that the following health and wellbeing model could be used when modeling care provision to ensure that appropriate and thus efficient care is the usual experience of the population.

The Your Health and Wellbeing Model



The Mind – including psychological/psychiatric health, and also the concept of maximising the mind. How we may get the best out of the psychological brain.

Social – a huge and broad range of topics covering everything to do with a person and their world.

Movement – our body is designed to move to interact with our world, but we also seem to gain from the simple action of physical activity.

Nutrition – important in its own right. Poor nutrition is having a hugely detrimental effect on the population.

The Body – another broad range of topics are covered here. This is where much of the traditional medical model of diagnosing and treating pathology sits.

Progress To Date

A Mendip GP collaborative has been created, with representatives from member practices, and described as a joint venture of practices. The collaborative plans to refine the model created to ensure it meets all of their needs and to form a legal entity with a memorandum of understanding. They have started to explore collaboration with non-GP providers (including community and acute trusts).

Short Term Goals

- To develop and agree an organizational model/ structure
- To identify administrative processes that would lend themselves to a collaborative approach. For example, the adoption of some common management procedures, processes and structures
- To agree a core management structure for shared services such as procurement planning
- To commence work to develop shared IT (in conjunction with CCG)
- Identify and implement projects to achieve immediate efficiency and develop collaborative abilities

Long Term Goals

- To achieve an advanced collaborative organization that has the ability to hold contracts for extended primary and intermediate care services on behalf of the constituent practices i.e. be in a position to be part of a MCP. This would be a large step towards creating a Multi-Specialty Community Provider as described in The NHS Five Year Forward View (NHS England October 2014) as a future model for integrated care provision. This would bring together the commissioning knowledge held by local providers, and build existing working relationships within the locality. As members of Somerset CCG, collaborative members' patients would continue to have the benefit of their management of secondary care commissioning, but as a group of practices working together under a formal collaborative structure, they would have the opportunity to develop additional services by making the most of the existing clinical skills within the locality, as well as provide a vehicle to move as much care provision as possible in to the locality
- To remain fully flexible to develop/change/evolve to meet the populations and collaborative members' needs, and use local intelligence to inform commissioning of services on behalf of the population they serve. This would operate as a multi-specialty community provider (MCP) model of horizontally integrated services
- To set up a clinical reference group to reduce variability across the network and share good practice and learning
- To undertake a clinical staffing review looking at skill mix opportunities
- To provide innovative employment opportunities for newly qualified GPs to attract them to the area, by allowing them to experience a number of roles across the different organisations and services they provide

Caveats

The collaborative recognizes that funding and expertise are needed to achieve the best collaborative organization. This is being actively explored (NHSE, CCG, LMC).

The YHAW collaboration welcomes interest or comments on their vision and objectives. For more information, contact the following:

- Dr Campbell Murdoch at Wells Health Centre - campbell.murdoch@wellshc.nhs.uk
- Dr Mike Pearce at Wells City Practice - michael.pearce@wellscitypractice.nhs.uk
- Dr Nick Matthews at Glastonbury Health Centre - nick.matthews@glastonburyhc.nhs.uk
- Sharon Morgan at Vine Surgery (Street) - sharon.morgan@vinesurgery.nhs.uk

Nailsea District Leg Club

Background

Leg Clubs are an initiative, which provide community-based treatment, health promotion, education and on-going care for people of all age groups who are experiencing leg-related problems. They represent a partnership between primary care and community nursing and local communities, with a key focus of empowering patients through a sense of ownership, to become stakeholders in their own treatment. Leg Clubs aim to provide ulcer and other leg condition management in a social environment, where patients are treated collectively and the emphasis is on social interaction, participation, empathy and peer support.

Nailsea Family Practice and Backwell and Nailsea Medical Group

In 2014, the Practice Manager at Nailsea Family Practice in North Somerset was introduced to the Leg Club model of care provision and saw the opportunity to develop a Leg Club for their local patient populace. Together with the Backwell and Nailsea Medical Group, she invited a range of stakeholder partners to consider and support a local club, forging links with:

- North Somerset's Community Partnership, which provides multi-disciplinary community health teams, children's services, learning disabilities services and community hospital services,
- The Nailsea Tithe Barn Trust.
- Curo, the not-for-profit housing a support organisation
- The Ellie Lindsey Leg Club Foundation

Drawing from the support provided by the national Leg Club Foundation and mobilised by a local committee comprising initially of the two Practice Managers, Patient Group members, Tithe Barn Trust representative, representative from the local Rotary Club and the North Somerset Community Partnership, the Nailsea District Leg Club was launched in June 2015.

The Leg Club

The Nailsea District Leg Club offers a weekly service to local people who are living with ulcerous and other leg conditions. Attendees are able to access initial leg assessments, undertaken by nursing personnel, and then receive regular reviews – assessment and review is administered via four nurse-led stations, and a key aspect of these is that they are 'open plan' and visible to other users, allowing attendees to familiarise themselves with the assessment and review process, and encourage peer support. The Leg Club also provides Doppler ultrasound scans. Provided by participating Practices and the Community Partnership District Nursing Team, nursing staff are also able to offer condition management advice to patients, as well as health promotion and suggesting and recommending access to GP consultations, if necessary.

In addition to on-going leg care, the Leg Club also offers support to socially-isolated patients by creating an informal environment, led by volunteers, who are able to provide befriending support, reception and refreshment services. The Curo organisation is able to administer Disclosure and Barring Service checks for all volunteers, and volunteers are trained and co-ordinated by the Tithe Barn Trust, which also provides the venue for the Leg Club service. Each weekly service also offers either informational or entertainment events to attendees. A guiding principle of Leg Clubs is the encouragement of social reconnection for patients who may have become isolated as a result of their leg condition.

The Ellie Lindsay Leg Club Foundation is also providing quality monitoring and evaluation templates, which the local Leg Club can complete and return – annual audits and reports will then be made available by the national organisation.

Future Plans

Although only recently launched, Nailsea District Leg Club organisers plan to enhance both the service and its administration during the coming months, to include:

- Enabling volunteers to take over the administrative committee
- Widen the geographic remit of the Leg Club in partnership with neighbouring Practices, which would allow for services to be offered across a greater number of days, and facilitate cross-cover of clinical and volunteer personnel
- Utilisation of information technology to support clinical record keeping and quality monitoring and evaluation

Caveats and Lessons Learnt

The Leg Club is community funded via donations, fund-raising events and community grant application. Nursing is provided by participant Practices and the Community Partnership, while non-clinical support is provided by volunteers. Equipment was obtained using a loan from the North Somerset Community Partnership and other local donations. Fund-raising expertise for the Nailsea District Leg Club has been provided by the local Rotary Club, and

continued fund-raising is a key element of the on-going service to ensure that all infrastructure costs – premises rent, refreshments, information materials, and clinical waste removal – can continue to be met.

In order to maximise publicity of the new Leg Club service, the organising committee used local newspapers, local surgery displays and leaflets and one-to-one discussion between district nursing and suitable patients. Further local newspaper coverage is also planned.

A key lesson learnt has been the importance of building relationships within the local community, inviting the involvement of relevant organisations and drawing on their support and expertise.

For further information, contact Carole Brooks, Nailsea Family Practice Manager, at carole.brooke@towerhouse.nhs.uk

The Foxhayes Surgery

Background

The Foxhayes Surgery is one of only nine nurse-led Practices across England and was established as a PMS-contract Practice in 2004, comprising one GP Partner and one Nurse Practitioner Partner. Currently, Foxhayes serves a list of 3,700 patients.

The Nurse-Led Model

Foxhayes offers more nurse-led appointments than GP-led – in addition to the Nurse Practitioner Partner, who is also the Practice's business manager, the Practice employs three nurses and one HCA with NVQ3 and a community nursing background. All nursing staff are prescribers. All clinical personnel adopt the same clinical assessment and safety-netting approach. All nursing personnel are accredited (RCN/Sexual Health) and are able to fit implants. They are also experienced in LTC patient management

A key element of the overall model is the role of reception personnel, who are trained to engage with patients at access and offer nurse appointments, emphasising that nurses are able to prescribe. Reception personnel are seen as 'front of house' and emphasis is placed upon customer service, both within training and practice. All appointments at Foxhayes have 15 minute durations.

Another key element is that, in line with patient choice, patients can see the GP if they insist but are always advised that getting to see a prescribing nurse will be quicker. In addition, where patients do wait to see the GP, where relevant the GP encourages the patient to consider seeing nursing personnel at subsequent appointments. An example cited is where the GP has been able to provide back up for when a mother and child had a nurse appointment – the child was assessed, diagnosed and offered treatment but the mother insisted on seeing the GP for confirmation. The GP was able to confirm the diagnosis and treatment, and therefore was able to contribute towards patient education.

Adoption of this nurse-led model allows the GP to undertake significantly more telephone follow ups than face-to-face consultations, and the model also includes initial telephone consultations as well as face-to-face.

Foxhayes has also strived to develop an effective Patient Participation Group, representatives of which sit on recruitment panels. They are also actively involved in fund-raising and Foxhayes has also established a broader 'virtual' PPG, which is consulted on any potential funding applications e.g. the recent NHS England Pharmacy Pilot initiative.

Lessons Learnt and Conclusions

Patient satisfaction surveys have shown that the great majority of Foxhayes' patients are happy with the nurse-led model, and this is further reflected by low patient complaint levels.

A key lesson learnt is the importance of establishing a cohesive working team where every member is respected and these principles are included in the Practice's recruitment process. A cohesive and respected team has enabled flexibility in HR processes and time management for all staff.

Although Foxhayes reports increasing interest and acknowledgement from other Practices/providers within the local geography, it also believes that the model is not widely recognised as being attainable in practice. More leadership and publicity needs to be shown to allow the model of Nurse-led practices to be seen as successful and a beneficial addition to conventionally run organisations.

How Can NHS England Help?

In addition to this guide, NHS England South West is developing a range of support mechanisms and approaches to assist General practices in considering mergers:

Facilitation

Provision of guided facilitation to enable individual, or groups of, General Practices to:

- Consider potential partnerships for mergers, and how to engage
- Consider the business case for merging
- Agree and focus on key discussion items, to identify areas of contention and achieve consensus
- Consider next steps – how to initiate a merger and consider all the required tasks and actions highlighted within this guide.

Information Packs

Provision of the following information resources for General Practice:

- General Practice Sustainability 'Health Check' Tool
- A Guide to Collaboration
- A Guide to Mergers
- A Guide to Networks and Federations
- A Guide to Provider Organisations
- A Guide to Setting Up and Managing a Project
- Examples of Innovation in General Practice

Advice and Guidance

Provision of advice and guidance for:

- Developing a Business Case
- Setting up and managing merger projects
- Project documents and templates
- Problem solving
- Enabling access to existing and on-going merger initiatives
- Sense-checking on progress and development

Who to Contact?

NHS England's GP Sustainability and Transformation initiative is part of the NHS England South (South West) Primary Care Team's work programme. Heads of Primary Care are **Marina Muirhead** (BNSSSG) and **Julia Cory** (DCIOS).

Marina Muirhead can be contacted on **0113 8253 605** or **07525 495691** or by email at marinamuirhead@nhs.net

Julia Cory can be contacted on **0113 8248 967** or **07900 715328** or by email at julia.cory@nhs.net