NHS England

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

Innovation Showcase Series
Collaboration in delivery

April 2015: Showcase Five

About PMCF

In October 2013, the Prime Minister announced a **£50 million Challenge Fund** to help improve access to general practice and stimulate innovative ways of providing primary care services. The first wave of 20 pilots was announced in April 2014; covering 1,100 general practices and 7.5 million patients.

In September 2014, a further £100m of funding was announced by the Prime Minister for a second wave. Following a selection process, 37 pilot schemes covering 1,417 practices and 10.6m patients were chosen to participate. The fund will also support GPs to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better health outcomes, more personalised care and excellent patient experience.

In total, the two cohorts cover over **18m patients** in over **2,500 practices**.

Innovation showcases

This paper is the fifth in a series of 'innovation showcases' designed to highlight the successes of the **wave one pilots**.

This paper focuses on pilots which are in **collaboration with other providers to deliver primary care services**. The pilots featured are; Brighton and Hove, Devon, Cornwall and the Isles of Scilly and the South Kent Coast.

Key messages

How have pilots managed to collaborate in delivery?

Existing working relationships

Utilising existing working relationships with different providers enables projects to build on previous successes and implement their partnerships quicker.

Ensuring staff are appropriately trained

Collaboration with other providers requires clinical and non-clinical general practice staff to work differently. It is important that all staff feel confident in their new roles.

Shared vision

GP practices and other providers need to be clear on what their vision is for collaboration and how this can be achieved.

Key issues to consider:

Work through issues of accessing patients records

Collaboration can require different providers to access patient records. Issues around IT interoperability, patient confidentiality and consent need to be considered practically and thoroughly at the outset.

Sustainability

It is important to consider whether and how any new service will be sustainable, delivering an advanced service for patients cost effectively beyond the lifetime of PMCF funding.

Evidence of success

Over the first five months of operation, 134 pharmacies have made 6,205 interventions. The pilot estimates the service has saved 2,903 GP appointments, 1,087 OOH and 151 A&E appointments, delivering a potential overall saving of £164,101(£92,689 from GP appointments, OOH and WICs £59,785 and £11,627A&E appointments).

Devon, Cornwall and the Isles of Scilly

Between the 3rd November 2014 - 28th February 2015 the paramedic practitioner team made 314 urgent home visits on behalf of GP practices.

South Kent Coast

"Why haven't we done this before; its simple and I can see it really helping some of our patients."

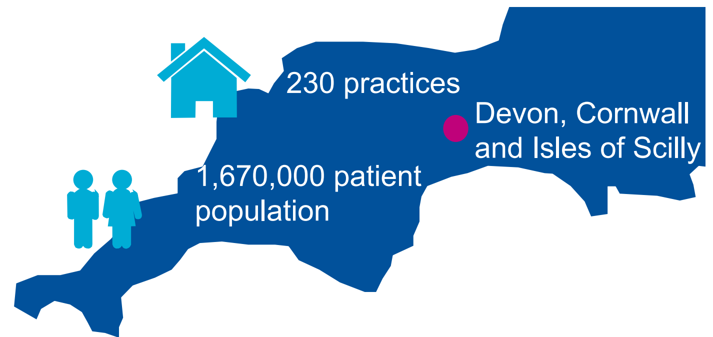
GP at Brighton and Hove

Integrated care across Devon, Cornwall and the Isles of Scilly

Key elements of collaboration

Devon, Cornwall and the Isles of Scilly has implemented:

- A **Pharmacy First** service through the following schemes; Winter Ailments, Minor Ailments and the Emergency Repeat Medication Supply Service in NEW Devon and South Devon and Torbay CCGs.



Service detail

- The **Winter Ailment scheme** promotes self-care through a consultation with a member of the pharmacy team at a community pharmacy. The service has been advertised locally including at GP surgeries. Treatment and symptomatic relief is provided using a set list of medications for self-limiting conditions. The service provides an alternative location for patients to seek advice and treatment rather than a GP appointment, out of hours (OOH) services, walk in centre or A&E.
- The **Minor Ailment scheme** also gives access to self-care advice for the treatment of specific ailments: bacterial conjunctivitis, impetigo, nappy rash, uncomplicated urinary tract infections and oral candidiasis. Using Patient Group Directions (PGDs) developed by GPs and pharmacists, pharmacists are able to provide patients with a prescription-only medicine without the patient needing to visit a GP practice.
- The **Emergency Repeat Medication Supply Service** ensures local patients and visitors to the area can access an urgent supply of their regular prescription medicines. Local residents access the service through OOH only; visitors may access the service at any time. Patients access the service at the pharmacy through their pharmacist rather than requiring a prescription from a GP.
- Prior to PMCF, **NEW Devon CCG (Western) had already been using pharmacies as a way to relieve pressures on GP primary care services**. This initial work was successful and PMCF was identified as a good opportunity to take the initiative forward on a bigger scale.
- In Devon, there are 240 community pharmacies across the county. Residents, regardless of where they live, are able to access a pharmacy. **The pilot views pharmacies as a really important rural access point.**
- The pilot also believes that **utilising pharmacists is a good use of professional skills,** especially in light of the nationwide GP and nurse recruitment challenges.

Recommendations

- **Ensure pharmacists, GPs and OOH providers are engaged** and talking to each other as soon as possible to generate buy in and support.
- **Establish which services are already running and operating successfully** and utilise models for which there is evidence of success, expanding and adapting them, where necessary, to suit local circumstances.
- **Engagement with GPs and OOH services is vitally important.** Ideally pharmacists and project managers need to visit practices in person. Engaging appropriately with GPs builds momentum for the service project.

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"…Absolutely invaluable service to our patients and us! Very useful also for temporary residents. Using the expertise of the pharmacists appropriately."

Local GP

"…Collaborating in this way has helped us to build strong relationships with GP practices; we work together to mutually help each other. PMCF has been really helpful in changing the nature of the relationships between pharmacy and GPs in practices."

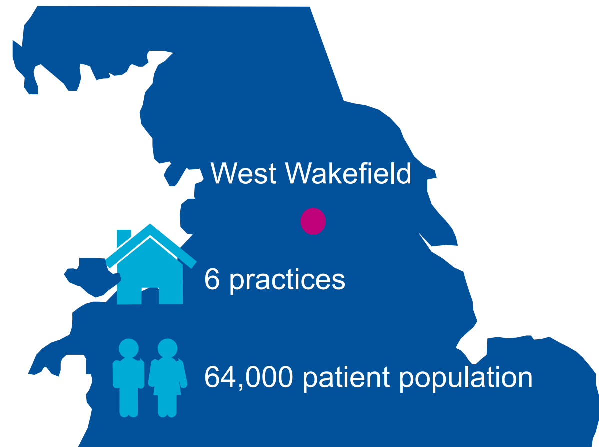
Pilot pharmacist

Moving together towards a wellbeing approach, West Wakefield

Key elements of collaboration

West Wakefield has implemented:

- A **Physio First** service, where patients are referred directly into a physiotherapist by receptionists rather than through a GP. There was an existing community physiotherapy service in four out of the six practices involved in the pilot, which has been running for four years. The existing service was working well and had helped to reduce waiting times. Involvement in the PMCF programme provided an opportunity to develop this service.



Service detail

- The new service differs from the existing offer because it provides **direct access to a physio rather than referrals from the GP**.
- The **Physio First** service was initially implemented in one practice in October 2014 in order to trial the service. Once this had been successfully implemented, it was then rolled out to the remaining practices in early 2015.
- The **timeslots available for Physio First were arranged in consultation with the practices** and are currently at the beginning of the week, when there is the greatest demand for appointments.
- Patients are provided with a **15 minute consultation**, at which point a brief assessment is undertaken, and support and advice provided.
- The physiotherapists have **access to patient records via SystmOne**, and so can either refer patients for a follow up appointment or to the GP.

The pilot estimates that approximately 75% of patients seen through Physio First are then able to successfully manage their own care.

Recommendations

- **Provide sufficient training** for reception staff to support patients in navigating new pathways.
- **Create common templates** to capture information, so that physiotherapists are able to successfully update patient records and ensure consistency of information.
- Develop a **clear model for sustainability** so that any extension of the service can be justified and appropriately planned.
- Ensure that the **impact of the service is measured** in order to record its successes and demonstrate patient and staff satisfaction.

Integrated South Kent coast

Key elements of collaboration

South Kent Coast has:

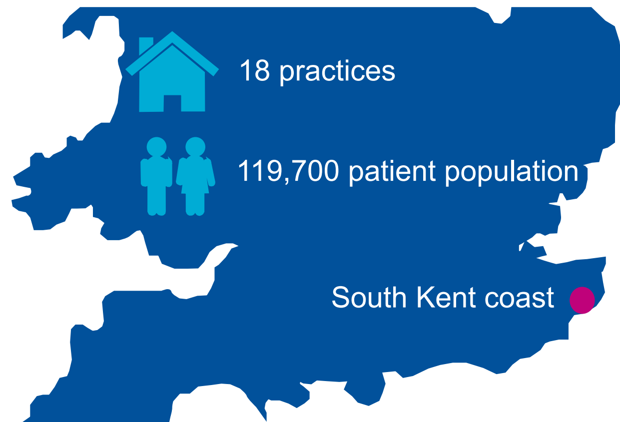
- Contracted the South East Coast Ambulance Trust (SECAmb) to provide a **paramedic practitioner visiting service** to patients in their own home.

Service details

- The paramedic practitioner service provides a **seven day per week visiting service in collaboration with local GP practices** and the 8am-8pm hubs in Folkestone and Dover. The cost of providing this service is approximately £3,000 per week.
- The service provides **unscheduled primary care to patients** who are unable to travel to see their GP. The paramedic practitioner is trained to independently provide care that does not require the intervention of a GP or doctor. The aim of the service is to **minimise the disruption of home visits to GP surgery schedules and reduce the number of A&E attendances.**
- **Referrals to the service are via a GP or NHS 111**. Patients cannot directly request a paramedic practitioner visit.
- In the long term, Invicta Health is planning to work with SECAmb to **integrate paramedic practitioner visits into the overall ambulance service** to increase sustainability, stability and primary care integration.

Recommendations

- **Involve a range of staff** from both partners to ensure that plans are practical but remain open to change.
- **Avoid delaying implementation whilst trying to design 'the perfect system'**; as long as both partners are working safely, improvements can be made as the service develops.
- **Regular communication** with everybody involved is vital. This includes communicating the success of the pilot to staff.
- **Staff are key to success**; chose people who are flexible and can adapt to changing situations and circumstances.



Over the first three months of operation, 11% of patients who used this service would have otherwise resulted in an unplanned admission to A&E.

The service has now seen 260 patients over three months with an average of 87 patients a month; 224 (86%) of these were seen and treated by SECAmb staff.

Since the start of the service in August 2014, there have been no clinical incidents, significant events or complaints.

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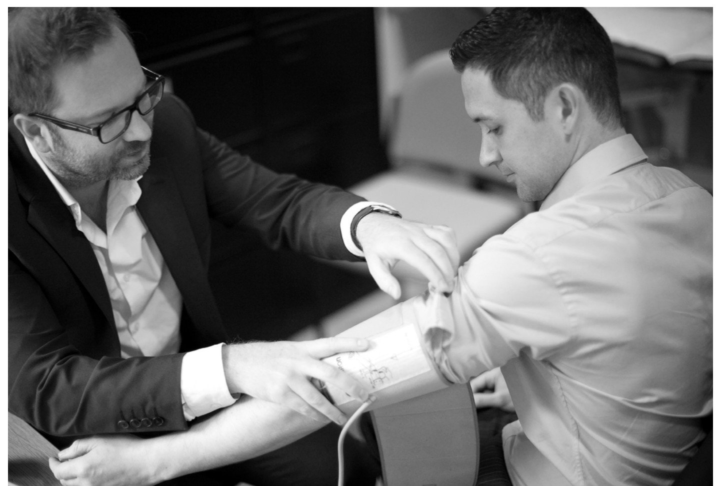


Extended Primary Integrated Care (EPiC) Brighton and Hove

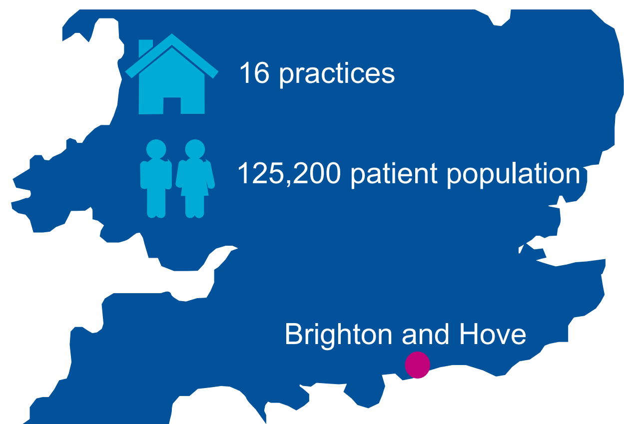
Key elements of collaboration

Brighton has introduced:

- **Community navigators** (CNs), who work with patients with complex needs and signpost these individuals to third sector, voluntary and local resources.

Service detail

- The **CN project is a partnership** between Brighton and Hove Age UK, Impetus (a local voluntary sector organisation) and Brighton Integrated Care Service.
- CNs deal mainly with **patients with low-level mental health issues and elderly patients who suffer from isolation.**
- CNs **undergo extensive training** including one-to-one training. The navigator role is demanding and the pilot recognises that it is important to implement a strong support package over a minimum of three months.
- The pilot originally planned for CNs to have between one and three sessions with patients/ clients, but for more complex cases **up to a maximum of six sessions are now available**. CNs are required to make a request to go beyond three sessions to ensure co-dependency does not occur.
- **Representatives from the voluntary care sector visited GP practices** to explain the CN role in detail, listening to concerns and answering questions. This helped to secure buy-in from practice staff.
- **CNs are assigned to one practice,** which enables them to foster a positive relationship and build trust with practice staff and patients.



Recommendations

- Look for **opportunities to bridge between practices and wider community activity.**
- Try to avoid an implementation deadline and instead **adopt a rolling programme with steady growth.**
- Develop a **flexible approach** based on individual surgery needs.
- Organise an **induction meeting between CNs and practice staff** to develop an appropriate package of support.
- Ensure that **language is accessible** for both the voluntary and clinical sectors.
- **Build on existing positive relationships** within the sector.

> ***"Why haven't we done this before; its simple and I can see it really helping some of our patients."***
>
> **GP at participating practice**

> ***"I have never spoken to anyone about this. I love talking it through with you. This has been really useful."***
>
> **Service user**

> ***"I am feeling really valued and appreciated and the support given is fantastic."***
>
> **Community Navigator**

How have they done it? Common success factors

Utilise existing relationships

All of the pilots which are collaborating with other providers are **utilising their existing relationships**. This enables the pilots to **implement at a faster pace**. In the case of Devon and Cornwall, they had already developed a business case for the further integration of pharmacies and GP practices.

Staff engagement and training

Vital to working collaboratively is the **engagement of staff.** Practice staff need to feel engaged and recognise the benefits of collaborative working. Staff from other providers need to feel included and central to the aims and objectives of the overall pilot. Staff engagement has been fostered by early involvement in service delivery plans and continued communication. **Articulating the benefits of collaboration regularly with staff is important,** as it sustains momentum and demonstrates what has been achieved to date.

Shared vision

Pilots have recognised the value of working across traditional boundaries. GP practices and other providers need to be **clear on what their vision is for collaboration and how this can be achieved.** Developing a shared vision prior to implementation ensures that all staff members are working towards a common goal.

Delivering whilst refining

First and foremost, pilots must ensure that services are safe for patients. However, it will usually be necessary to **continuously evaluate and refine** the service offered during implementation. This allows learning to be incorporated into delivery and ensures that patient and staff experience can be used to further shape the service.

Common themes to consider

Sustainability

Any collaborative working has to look towards the future and demonstrate sustainability. **Developing measurements of cost effectiveness as well as thorough local evaluation** will help to outline the benefits of the service.

Patient records

Collaboration may require **integration of IT.** Issues of IT interoperability and patient consent need to be considered and worked through as soon as possible. This will prevent delays as the project progresses and ensure issues on information governance and data protection are fully thought through with adequate resources assigned.

The National Evaluation

In summer 2014, NHS England commissioned Mott MacDonald, an independent organisation, to undertake an evaluation of the wave one programme. The evaluation team is working alongside the pilots as they deliver their projects, working with them to learn and share delivery lessons. The evaluation involves a multi-methods approach including:

- Interviews with pilot leaders and those involved in implementation during the programme.
- Interviews with pilot partners and stakeholders involved in delivery.
- Engagement with a selection of practices and patients.
- Assessment of the impacts and outcomes measured against nine national metrics.
- Identifying, examining and sharing good practice.

About PMCF

There are three primary objectives of the Challenge Fund programme and also some supplementary objectives that the programme is looking to achieve.

Primary objectives:

- To provide additional hours of GP appointment time.
- To reduce demand elsewhere in the system (e.g. A&E, NHS 111 and existing OOH services.
- To improve patient satisfaction with extended access.

Supplementary objectives:

- To improve staff satisfaction with access.
- To tackle health inequalities in the local health economy.
- To facilitate learning to better enable pilots to implement change.
- To stimulate a culture change amongst staff involved in general practice with regard to future delivery of primary care.
- To deliver value for money and a return on investment.
- To establish sustainable models which go beyond the PMCF pilot lifetime.
- To identify models that can be replicated in similar health economies elsewhere.

Coming up next.....

The next innovation showcases will look at:

- Scale: multiple CCGs, many practices, large patient populations.
- Effective leadership