HEALTH SERVICE JOURNAL FOR HEALTHCARE LEADERS

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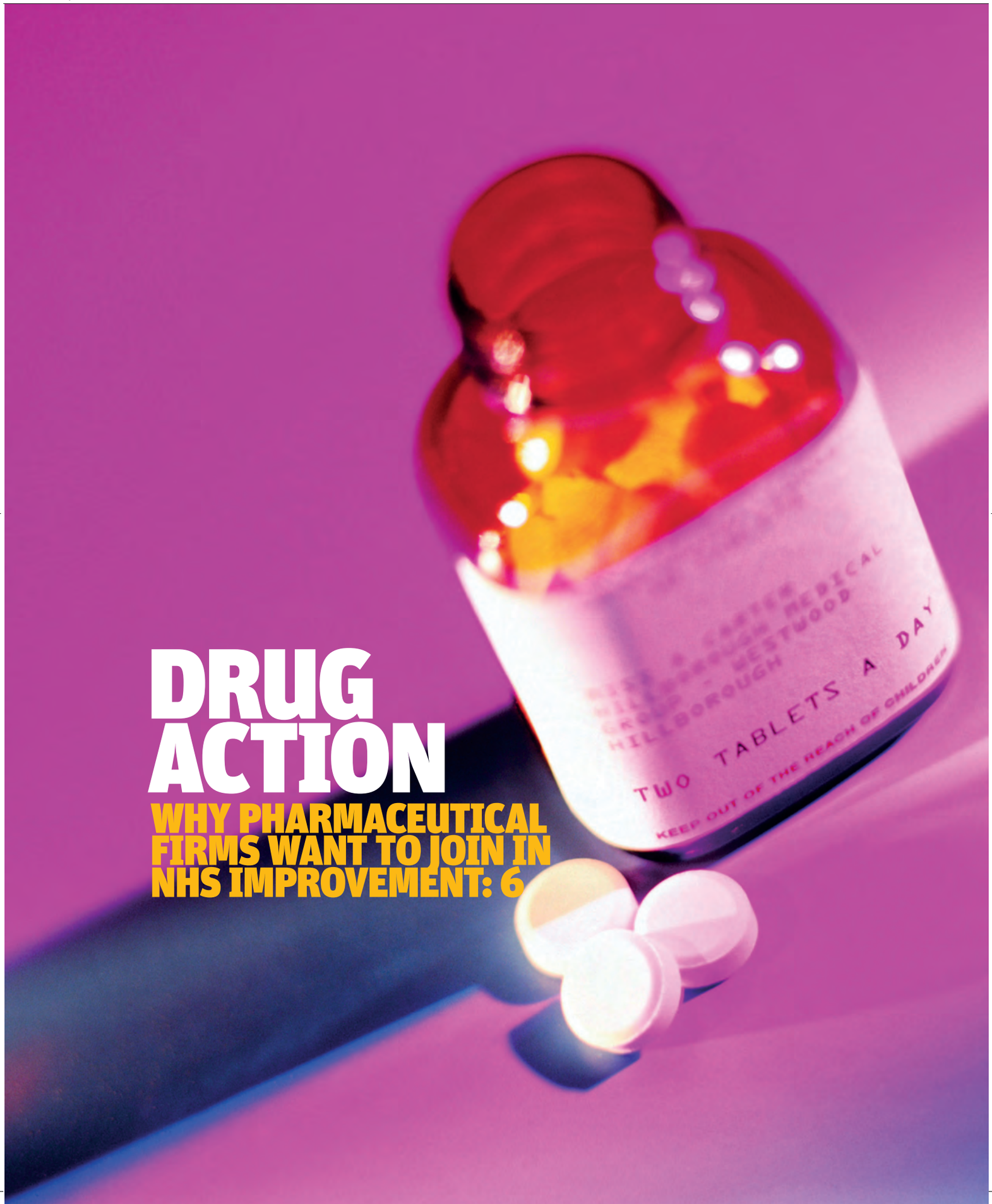

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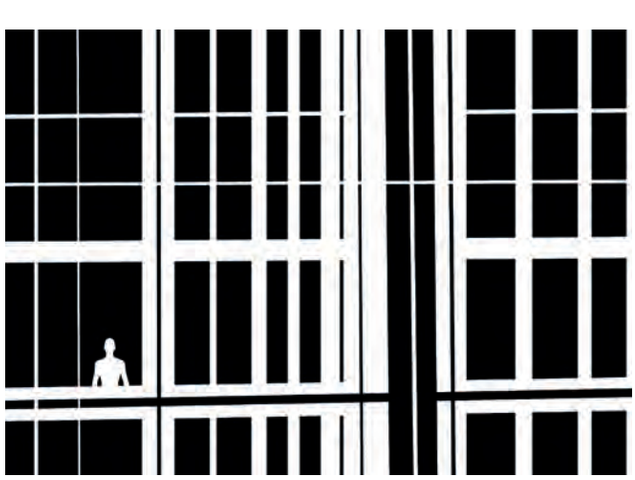

STEPHEN HOCKEY ON RECRUITMENT

IN ASSOCIATION WITH HCL PERMANENT

HCL Permanent

The new NHS landscape prescribes that greater care be delivered in the community. Yet evidence about how this shift in care provision will be resourced is less easily found. Having recently collaborated with many primary care providers, it has become evident that clinically led commissioning will further evolve. It is therefore essential that these providers continue to efficiently source experienced and compliant healthcare professional to meet workforce requirements.

The increased demand in GPs is not being met. The shortage of trainee GPs coupled with restrictions surrounding non-EU candidates has created holes in succession planning. Furthermore, official statistics indicate that more than 10 per cent of current GPs are above the age of 60. In addition, the location or specific skill requirements of some roles can drastically reduce the appeal and suitability of some candidates from the talent pool.

Once care is pushed into the community, overseen by 200-plus clinical commissioning groups, primary care will fragment, opening the system up to risk. Inexperienced staff in charge of recruitment will not be familiar with compliance, or how to attract people with the relevant skill mix required to deliver primary care. This results in large amounts of time and money being spent on potentially unsuccessful recruitment processes and an opportunity for unscrupulous staffing providers to become part of the furniture.

'Inexperienced CCG staff will not be familiar with compliance or how to attract people with the relevant skill mix'

To shore up the primary care talent pool, managers need to focus on patient care, collaborating with expert, innovative providers who can mobilise the workforce and guarantee compliance. By working closely with a GP practice at the start of a recruitment process, a compliance-led workforce solutions provider can advise on long term planning, suggest temporary solutions and provide savings through screening candidates and advertising.

In the acute sector, outsourcing workforce solutions has helped NHS trusts ensure patient safety, support continuity of care, increase efficiency and deliver substantial cost savings. Recently, HCL worked with a large NHS acute trust that was working with over 50 staffing agencies and struggling to staff its busy A&E department. By completing a comprehensive review of the workforce, and moving to a single service outsourcing model, the trust reduced its risks and made an annual saving of £2.8m.

Stephen Hockey is managing director of HCL Permanent

www.hclplc.com/permanent-division

WORKFORCE

CAN'T GET THE STAFF?

Demand for GPs and other primary care workers is surging. How can practices maximise their chances of getting the quality people they need? By Alison Moore

The future opportunities for primary care look rosy. Clinical commissioning groups put GPs and practices in the driving seat and the shift of care out of hospitals gives practices an unprecedented opportunity to start providing more services to patients. But there is growing concern that attracting the doctors and other staff needed to deliver this care will be harder than ever. The BMA said last month that 13 per cent of doctors intended to retire within the next two years – even though only 5 per cent would reach retirement age – and more than 40 per cent were considering leaving medicine.

"If work comes down from secondary care into primary care we are going to need more doctors and nurses," says BMA GPs' leader Laurence Buckman, "Sessional doctors are more and more needed. Finding nurses who can take on extended roles is a real issue. Nurses can be choosy about where to go." "There's a big government initiative to push out more people into the community and put an extra burden on primary care," says Stephen Hockey, managing director of recruitment consultants HCL Permanent. "But I don't think anyone has thought through what this will mean for those organisations.

"At the moment the position is varied depending on where practices are based and which staff they are looking for but, by and large, there is a shortage across the UK of suitably qualified individuals."

The position for those seeking to recruit GPs can be particularly difficult as they are widely spread across the UK and can therefore be harder to reach than, say, practice nurses who might be recruited through an advert in a local paper. In the past the UK has recruited many healthcare professionals from overseas. This has become harder as immigration restrictions have tightened – and there has been a flow in the other direction with UK professionals leaving for jobs in Australasia and the Gulf.

This can pose problems for practices looking to recruit. "You are working with a small population of people who are not moving around very often," says Mr Hockey. Finding GPs with particular skills or experience – such as foreign languages – can be harder still. There may be only a few of them in the country and pinpointing them can be difficult.

Mr Hockey suggests there are not enough GPs coming through the system overall to meet the demand. That's a view supported by the Royal College of General Practitioners has recently run a consultation on the GP workforce and has highlighted the need to attract more doctors into general practice and retain those who work there already.

So how should practices go about meeting the challenge and opportunity that this shift of care could offer? Mr Hockey suggests that first they should think about what services they want to deliver in their community and what staffing implications this could have. Then they need to look at recruiting the staff to deliver this care – and this may require them to think beyond their normal methods of finding new staff.

'There is a shortage across the UK of suitably qualified individuals'

If a practice is in a "hard to recruit" area, it may need to think laterally about how it is going to find someone and what would make it attractive to a potential employee or partner. Looking for something which makes a job or location a little bit different can help, says Mr Hockey. The salary has to be competitive as well – but salary may not be the factor that makes the difference.

The problems around recruitment are not limited to GPs. Competition for good practice staff can be intense, especially in

CASE STUDIES OVERLEAF ▶

high cost areas such as London and the surrounding counties.

Mr Hockey has noticed some practices are now looking to employ new types of staff – assistant accountants, for example – as they start to look at budgets more closely. Practice managers may also require additional skills and are often taking a more central role in the practice.

"It is not just GPs, it is going to be practice nurses, business managers, physiotherapists, podiatrists, reception staff. Some staff may be providing care at home packages. You will need to look at it from a number of different angles – both permanent and locum solutions will be required here."

Perhaps the greatest challenge is that practices will all be going through this process of assessing what additional services they want to offer at the same time and will be seeking to recruit from a limited pool of people.

He suggests practices should work closely with a professional recruitment partner who can offer advice, act as a one stop shop for recruiting and ensure compliance.

Crucially, an agency should be able to draw on a bigger pool of potential candidates than other recruitment methods.

"A national agency can find people who may not be currently living or working in the local area but may have expressed an interest in this area," he suggests.

Agencies will also carry out all the necessary compliance checks on candidates for both permanent and temporary jobs - ensuring that they have the right to work in the UK, for example, and that GPs are on a PCT performers list. Practices, which only recruit occasionally, may not be as familiar with all the requirements – which also change frequently – as a professional agency.

Recruitment can also be time consuming for practices who may want to involve both GPs and practice manager in shortlisting and interviewing applicants. Agencies can pre-select candidates according to the preferences of the practice and present for interview a small number of candidates who best meet their requirements.

Getting a thorough understanding of the practice and what it is looking for is essential, he says: "Our approach would be to go in and meet people and understand the requests and culture in full. That helps us to make sure that we put forward the right candidates. "We do a lot of preparation as we want to make sure that all the qualifications, checks and so on are done. We try to make it as hassle free and cost effective for the practice as we can." ●

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WORKFORCE: CASE STUDIES

DO YOU SPEAK POLISH?

How health organisations have sought expert help with recruitment, including a west London practice that wanted a GP with unusual skills

CHISWICK FAMILY PRACTICE

West London has attracted many people from Poland over the last few years – leading to a vibrant and young community.

But meeting the needs of this population can be a challenge for health services who may find some patients don't speak English well enough for effective communication.

So Polish speaking healthcare staff are invaluable but are often in short supply. The Chiswick Family Practice has been fortunate in that it has had both a GP and practice manager who speak Polish and could help with the 50 per cent of registered patients who were of Polish origin – of whom about a fifth do not speak English.

This has proved to be a big draw with Polish patients coming from a wide area to access this service.

The practice has been able to manage without making much use of the telephone interpreting services used by many NHS organisations. Patients sometimes bring in a friend or relative who speaks English and online translating tools have helped as well – but the main attraction for many of its 4,000 patients has been a GP who speaks their language.

So when Polish-speaking partner Dr Andrew Weber decided to reduce his hours the practice wanted to replace him with a salaried GP who could continue this service for its Polish patients.

"Dr Weber is a popular GP who has been here for many years," explains Monique Luciano, the deputy practice manager. "If we did not get a Polish-speaking GP to replace him then we were concerned we would lose a lot of our patients."

The practice wanted to offer a permanent job but recruiting a Polish speaking GP was to prove difficult. "We tried our own recruitment process just after Christmas," explains Ms Luciano. The practice advertised in various doctors' magazines – including some with a national readership – but got very little response. So it decided to try recruitment agencies and eventually turned to HCL Permanent.

"Finding a Polish-speaking GP has been a real challenge. However, through headhunting, advertising and utilising the existing HCL database of GPs we managed to find three GPs who spoke Polish and two were put forward as potential candidates to the practice. Even the practice was amazed at how we managed to find Polish-speaking GPs as it was aware that it's a specific requirement," says Arminder Shergill, the HCL recruitment consultant who worked with the practice.

"The approach used by HCL was more tailored specifically around the needs of Chiswick Practice. I spoke to deputy practice manager Monique Luciano in depth about the service that HCL Permanent can provide in helping their practice with their permanent vacancy."

HCL's approach included nationwide advertising to try to pinpoint a GP who might fit the needs of the service, as well as using its team of consultants to pick out likely candidates from those GPs who had already registered with it.

"It was a breakthrough moment when I realised that I could find GPs who met all the practice's criteria – that they should have

UK experience, be on a PCT performers' list and speak Polish!" says Ms Shergill.

HCL was able to co-ordinate interview times with the practice and ensure candidates had all the necessary paperwork in order. The practice has now interviewed a GP who meets its requirements and who has accepted the offer of a job.

CONCORDIA HEALTH

Concordia Health provides a range of services from primary care through specialist community outpatients clinics.

Its wide range of services means that it needs staff ranging from practice clinicians to specialist consultants at different locations in London and across the country.

Finding such staff in a very competitive environment can be a challenge and, at points, the company has had to use locum GPs. Although these can be of a high standard, Concordia is committed to continuity of care whenever possible and wanted to ensure that patients could see a GP who would come to know both them and their medical history, and would develop a lasting relationship with them.

Director of human resources Robert Sandry says: "Recruitment processes are

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time consuming, I and my managers ideally would like to spend less time dealing with recruitment processes and agencies and getting on with the important business of providing a creditable and effective health service in support of the NHS – especially as we envisage we would be looking to make a significant number of permanent hires over the next six to twelve months."

Concordia was prepared to put a lot of effort into recruitment, ensuring applicants had the opportunity to visit the sites, got a trial session if they wanted, met other staff and got an opportunity to discuss the job in depth. It reviewed salaries to make them competitive, and ensured staff had good opportunities for professional development. In some cases, it employed people who it felt would grow into a role.

But it still found attracting suitable applicants for permanent jobs difficult with some asking for higher salaries or using Concordia's interest as a lever to discuss higher pay with their existing employer. And some applicants had to be weeded out as they did not meet Concordia's requirements.

The company had tried a variety of ways of recruiting before it was approached by HCL. These had included detailing jobs on its own website, asking current staff for the names of possible candidates, and advertising in NHS Jobs and BMJ Careers.

'It was a breakthrough moment when I realised that I could find GPs who met all the practice's criteria'

All of these had their pros and cons – advertising in specialist magazines is expensive, for example, but does raise the company's profile – but the company was still left with vacancies.

It had also tried other recruitment agencies in an attempt to fill specialist and hard-to-recruit jobs but found sometimes it was still being sent CVs of candidates who did not meet its stated requirements. "Although using agencies can be expensive it reduces the administrative burden on the company and time spent by managers on the recruitment process," says Mr Sandry.

HCL suggested a different approach was needed. It was able to sit down and discuss the exact needs of the company and how these would develop in the future, with a particular focus on its needs in Kent. Concordia was taking over a practice in Thanet in late 2011 and also wanted to provide outpatient dermatology services, for which it needed to employ consultant dermatologists part time.

HCL was able to help the company recruit two GPs and a dermatology nurse. "HCL has adopted a business partnership approach taking the time to fully understand our business and recruitment requirement. HCL's friendly and personal approach enforces their commitment to helping us succeed and make you feel valued as a client rather than merely being one of numerous accounts being serviced," says Mr Sandry. "The rapport that has been built up between members of Concordia Health and HCL has made it easier for both parties to act on short notice requirements to meet our business needs."

But Mr Sandry recognises that recruitment will remain difficult. "Every organisation has an element of staff turnover so there will always be a need for us to recruit. But we should recruit the right person for the job. The challenge is that the pool of suitable qualified clinicians within the UK is shrinking," he says. ●

DR SIMON CLOUGH ON NEW RELATIONSHIPS

Joint working projects – where pharmaceutical companies and the NHS work together to solve particular problems with both sides providing funding and staff time – mark a sea change in the relationship between the two sides and have the potential to benefit all parties, but most especially patients.

There is legacy of suspicion about the motives of the industry in engaging in such schemes but this is being broken down as such projects become more common. There are suspicions that the schemes are a form of disguised promotion, or the industry is buying friendship or trying to enhance its reputation, and that trusts that sign up to such projects will be obliged the use the company's products. These fears are unwarranted.

It is no longer a question of providing a grant and letting the NHS do the work. Often it is a question of pharmaceutical industry staff time and expertise that is being asked for to solve particular local challenges – not just money. Our projects at Daiichi Sankyo range from medicines adherence, the identification of missed patients with long term conditions, training and educational videos and one scheme to help reduce hospital re-admissions.

Increasingly we see ourselves as partners, not just suppliers to the NHS. If we compare it with what has gone before, which in many ways was an unrefined promotional exchange with

'Industry expertise is being asked for to solve local challenges'

prescribing physicians, today we are increasingly saying our product works best with these type of patients rather than that type. And that is often a much narrower set of patients than the indication that was granted during the regulatory process. Ultimately the reputation of our product is enhanced if we can be precise in our recommendations as to where our products work best. Then in the fullness of time the outcomes speak for themselves and our product reputation is what it should be.

Joint working should be, and can be, the coming together of some very powerful allies. First, the pharmaceutical industry knows its products best and knows where its products can bring most benefit. Second, the NHS and our individual customers clearly know the NHS best and also the needs of their particular patients. When you bring together these two in an open and transparent way the benefits are clear.

The best product can be used with a particular patient group and ultimately those patients can benefit maximally not only from pharmaceutical products but the whole pathway of care that has been developed around the diagnosis and management of their condition.

Dr Simon Clough is managing director of Daiichi Sankyo UK

www.daiichi-sankyo.co.uk

JOINT WORKING

A DOSE OF PARTNERSHIP

Pharmaceutical firms are offering financial support and expertise to NHS organisations. What do both sides gain from joint improvement projects? By Alison Moore

The NHS is facing a period of tremendous change at both a national and a local level. For many working in trusts or commissioning organisations this will involve painstaking work looking at how the NHS can be turned into a more efficient and effective organisation, better serving patients while also controlling costs.

But having both the capacity and the expertise to look at every worthwhile change can be a challenge for many organisations, especially as manager numbers have fallen and there is pressure to restrict the use of external consultants.

But they may be missing out on help from an unusual direction: the pharmaceutical industry. Many companies are keen to enter into joint working arrangements which can include offering some financial support or expertise to NHS organisations around particular projects. This can include areas such as changing care pathways or improving compliance among patients with long term conditions.

The government, the NHS Confederation and the Association of British Pharmaceutical Industries have been at pains to stress that this sort of working can be entirely acceptable. The ABPI – supported by the DH and NHS Confederation – have produced guidance (*Joint Working: a quick start reference guide for NHS and pharmaceutical industry partners*) including a flow chart to show how NHS organisations can enter into a joint working project. This covers critical areas of governance which might otherwise cause concern for boards such as having written agreements and internal review committees. Companies will also be bound by the ABPI code of practice around joint working and the Department of Health has its own best practice guidance.

Simon Clough, managing director of Daiichi Sankyo, says what companies can contribute will vary but is not necessarily just about money. Sometimes it can be expertise or help with project management – as has happened with East Kent Hospitals University Trust where the company has supplied an interim project manager to work on reducing re-admissions. And sometimes it will be accessing resources or services which the company can either provide itself or can put the NHS organisation in touch with. Pharmaceutical companies are used to working with a supply chain of other specialist suppliers. These smaller companies may have skills that the NHS does not have internally or know how to easily access.

What do the companies get out of this? Dr Clough is adamant this is no longer about selling more medicines and is very different from the sort of promotional activity the industry used to be involved in. The world has moved on from this sort of "transactional relationship" he says.

Instead what the industry gains is much longer term. "We are genuinely keen to understand what are the challenges that face our customers," he says. The pharmaceutical industry is keen to move from a model of just providing medicines to one where it offers a service as well – and

'The industry is keen to move from a model of just providing medicines to one where it offers a service'

for this, it needs a deeper understanding of the pressures and problems of the NHS.

And there is a growing awareness that medicines need to be used to "best effect" in the NHS. That means selecting the patients who will benefit and ensuring they take them. So companies are likely to be interested in schemes which help to identify

CASE STUDIES OVERLEAF ▶

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patients who will benefit, educate them and support compliance.

"It is in our best interests to have our product used with the right patients to optimise their outcomes," says Dr Clough.

Ultimately, this leads to a different sort of relationship to the traditional one, much more like other sectors' relationships where suppliers and customers will work together on matters which offer mutual benefit.

"Our message to clinical commissioning groups is that we are willing to explore a relationship which could provide some surprising value," he says.

But sometimes it can be hard to overcome old stereotypes. Dr Clough says that relationships with pharmaceutical companies can still be "shrouded in a little bit of mystery and cynicism. What this results in is a challenge to get around the same table and enter into an open dialogue".

While government rhetoric is very supportive of joint working, there can be a disconnect between this and reality. NHS organisations facing massive change can find it hard to think about developing new relationships and old suspicions can resurface. Small scale research carried out for the company has highlighted how many CCGs and trust have yet to realise the full benefits of joint working. Concerns centred around potential links to prescribing, the time and cost of involvement, and a general distrust of the industry.

But one way highlighted to overcome this, and maximise the opportunities offered by successful joint working, was clarity and consistency in the initial stages of any project. This very much echoes the approach of the ABPI guidance with its emphasis on a written framework.

So what is the company looking for in a joint project? Dr Clough says any joint working it gets involved in has to be an opportunity for it to add value and that is likely to include involvement at an early stage of a project. Pragmatically, Daiichi Sankyo is also most likely to be able to add value in an area it understands – so one in which it has some products and is already working.

Some of this can be about adding a different perspective and many successful projects are actually based on extremely simple ideas, he says.

The sort of projects it is looking for are less likely to be ones where it is simply asked to sponsor something but more ones where it can get actively engaged, and offer something the NHS partner could not provide itself. That might be project management expertise or a new approach to education and compliance.

As a smaller company, Daiichi Sankyo does have finite resources. However, it is at the beginning of joint working and would be keen to take on additional appropriate projects, under what it calls its Kaizen healthcare initiative. Even if it cannot help, it may be able to refer NHS organisations to other sources of help.

His hope is that successful projects will benefit not just the partner organisation but also the wider NHS. Work done in Dorset on education about primary angioplasty is being replicated elsewhere, for example. And projects around compliance and care pathways for one chronic condition might have lessons for others.

But improving healthcare will always be a journey for the partners, he says: "When the two partners are not even speaking to one another then we can't make significant progress with that journey." ●

JOINT WORKING: CASE STUDIES

FILM CREDITS

Benefits of partnership have included cash to fund a training film that convinced staff of the need for change and the loan of a project manager

ROYAL BOURNEMOUTH HOSPITAL

Providing a 24/7 primary angioplasty service means lives can be saved – but is a huge task, often involving several trusts, PCTs, and ambulance and hospital staff all agreeing to work in a different way.

In Dorset, a daytime primary angioplasty service has run at the Royal Bournemouth Hospital since 2005. But doctors knew a round-the-clock service would provide the gold standard to improve outcomes for heart attack victims from across the county.

While such a service has run in major cities for some years, there are added challenges to setting them up in smaller urban centres and rural areas. Patients need to travel further and for a longer time, while the smaller population covered means more is demanded of staff in terms of on-call hours. Yet the service still has to meet the goal of treating patients within a maximum of two-and-a-half hours from first call – and ideally less.

Setting up the service – which started on October 1 – has taken much planning. Initially the trust and PCT had to agree on the need for a service and how it could be funded. But staff – whose working patterns were to change – and the two ambulance trusts serving the county had to be brought on board.

How ambulance crews on the ground reacted to heart attacks had to change. In some cases, this meant crews driving past a nearby A&E to deliver the patient to the Royal Bournemouth – then bypassing A&E there to ensure the patient got into the cath lab as soon as possible. Ensuring they were aware of the right pathway and the potential benefit to the patient of getting the right treatment was essential.

One of the ways interventional cardiologist Peter O'Kane was able to do this was to get all stakeholders together for a day. Nearly 100 people attended for the day which outlined the new service and how it would operate, and allowed discussion and debate. "It was incredibly useful," says Dr O'Kane.

A professionally produced video showing how the primary percutaneous coronary intervention service works was shown and is now a standard part of training on the service. Participants were also able to see a live PPCI procedure. Dr O'Kane says showing how PPCI actually works – and the dramatic impact it can have on a seriously ill patient – was very important in influencing staff. "It is an incredibly powerful message," he says.

The idea and funding for elements of the training day and for the video came from Daiichi Sankyo. Dr O'Kane says the day could have been put on without financial support from the company but it provided little extras that NHS budgets often don't stretch to. And, without outside help, a professional video would not have been possible.

Although the company does have a drug which is used in primary angioplasty, the sponsorship was not linked to prescribing and has not affected prescribing in the trust, he says.

He is now hoping to make the training day a yearly event, allowing feedback on how the service is working out in practice and discussion of any refinements. Dr O'Kane says: "It was a hard service to set up but very important."

The hospital hopes to repeat the training event

EAST KENT HOSPITALS

Changes to the funding of patients re-admitted after hospital treatment mean acute hospitals could lose millions of pounds unless they address the reasons patients come back.

So trying to ensure that patients have the right information and support to ensure they don't return to hospital unnecessarily has become a priority. Daiichi Sankyo has been helping East Kent Hospitals University Foundation Trust to address readmissions by providing an interim project manager.

The trust had between £4m and £5m at risk from the new approach to funding and had decided to appoint a project manager to examine and tackle some of the issues. However, it faced a delay before one could be recruited and Daiichi Sankyo offered to help fill the gap with experienced manager Andi Orlowski.

The trust had worked with a consulting group to develop a tool to identify patients most at risk of re-admission, having identified

Bournemouth ambulance staff had to change their response to heart attacks

that it had a slightly higher level than neighbouring trusts. Working with colleagues in the trust Mr Orlowski has put together a pilot project which will offer patients at one of the hospitals in the group:

- a "ticket home" once they come into hospital with a planned discharge date;
- patient education for when they return home, especially about self care;
- a follow-up telephone call once they have returned home to check they are okay and resolve any problems; and
- medicines reconciliation. This can avoid interactions between medicines and ensure patients are not taking them unnecessarily.

The pilot is being rolled out in four areas: urology, healthcare of the elderly, heart failure and respiratory medicine – at the Kent and Canterbury Hospital, one of the trust's three main sites. It is hoped that the approach will then be rolled out to cover all of the trust's sites.

Medical director Dr Neil Martin says that the challenge is that patients return to the trust because they feel they have nowhere else to go. By offering them more information and telephone follow up, the trust hopes to reduce the numbers re-admitted from 8.9 to 8.4 per cent – effectively ensuring an extra 550 people a year are confident enough to remain at home.

He says Mr Orlowski has been able to bring project management skills and wide NHS experience to the role.

NORTHENDEN GROUP PRACTICE, MANCHESTER

Identifying patients with long term conditions and ensuring they get the right care to prevent them ending up in hospital is one of the big challenges for general practice over the next few years.

The Quality and Outcomes Framework encourages practices to test patients to find out if they are suffering from conditions such as hypertension and does include some elements rewarding monitoring of these conditions.

A Manchester GP is developing a solution which will work with existing practice software to enable GPs to provide an additional layer of care, going beyond simply monitoring to look at treatment and compliance, which can contribute to better outcomes. Many existing systems prompt GPs to check blood pressure or ask patients about smoking, but don't go beyond this.

Dr Paul Wright of the Northenden Group Practice is developing a system that will use available practice data to identify patients who are not complying with prescribed medication.

The system can also be used to trawl practice databases to identify patients who are at risk of long term conditions but have not been diagnosed or followed up – for example, those whose blood pressure has been measured and is high but no action has been taken, perhaps they have not returned for further monitoring.

'The challenge for any practice is time and resource and that's where the grant funding comes in'

He points to evidence that many patients are currently being missed in primary care. Nationally around 13 per cent of patients have hypertension but in Manchester only 10 per cent have been diagnosed – despite an age profile that would suggest the area should have above average rates.

He has received financial support from Daiichi Sankyo to support this work. "The challenge for any practice is time and resource and that's where the grant funding comes in," he says. "It gives you the extra manpower."

Although he is currently looking at hypertension, a similar approach could be used across a range of long term conditions. It is being used across the 11,000 patients at the Northenden practice and could ultimately be rolled out across three clinical commissioning groups in Manchester. In theory, it could be adapted to work with any GP software system. The project also has a strong patient education and self care side.

And it could both improve outcomes and save money. Dr Wright has already used a similar approach to identify an additional 20 patients with atrial fibrillation in his own practice and offer them interventions. This has been adopted across three CCGs in Manchester and offers the potential to make significant savings as untreated AF patients are at increased risk of strokes. By identifying them and offering interventions, not only can strokes be avoided but there could be cost savings for the NHS. ●

DR MANDEEP MUDHAR ON COLLABORATION

Pharmacies remain an underused resource in helping to tackle the public health agenda and can do a lot more to help improve the health of the local populations they serve and to help control costs.

Helping people take greater responsibility for managing their own health, especially those with long term conditions is one example of where we can help. The Co-operative Pharmacy is involved in a trial of an existing forecast alert service to help improve patient outcomes and to reduce chronic obstructive pulmonary disease hospital admissions, which are increasing by about 5 per cent a year. The service has proved to be successful and some PCTs have shown a 20 per cent reduction in hospital admissions. Offering the service in pharmacies widens access to health advice, empowers patients and helps to reduce GP workload.

Medicines optimisation is another area perfectly suited to the pharmacist, as we have access to each stage of the patient medicine journey. There are increasing concerns about patients not sticking to medicines regimes, contributing to £150m of avoidable medicines wastage in primary care each year and a growing number of preventable hospital admissions. We can assess adherence, monitor patients and offer advice at regular intervals in collaboration with primary care colleagues.

In a community pharmacy setting, we already offer medicine checks and the New Medicines Service, which focuses on patients with long term conditions, but there is also an opportunity for pharmacists to bridge the gap between primary and secondary care when a patient leaves hospital with a new prescription.

'Medicines optimisation is perfectly suited to the pharmacist'

As part of a research project with the University of Bradford we are trialling a pharmacy-wide hospital discharge medicines use review from our outpatient dispensary at Doncaster Royal Infirmary. Patients who leave hospital with a new prescription can present at their local pharmacy for advice and follow-up to make sure they are supported with their new medicines regime. If successful, this could help to reduce the preventable adverse effects of medicines which account for 5 to 8 per cent of all hospital admissions.

At this time of dramatic change in the NHS, with immense pressure on the public purse, it is more important than ever for us to work with colleagues, including commissioners and those who deliver services on the front line, to shape a health system that offers both value for money and the best treatment for patients.

Dr Mandeep Mudhar is head of business development at The Co-operative Pharmacy

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PHARMACY

CHANGE THE SCRIPT

Most people are in easy reach of a pharmacy – which is why, those who run them argue, they must be given a bigger role in improving health. By Alison Moore

Pharmacies reach nearly everyone in the UK and are probably the most accessible of primary healthcare providers. Yet their potential to do much more than dispense medicines is often overlooked.

Pharmacists and businesses running pharmacies want to change that. With pharmacies scattered across towns and villages and often open extended hours and weekends, when other health services are hard to access, they argue that pharmacies could become the first port of call for those looking for health advice – and relieve the pressure on other parts of the NHS.

There are 13,000 community pharmacies with 99 per cent of the population within 20 minutes drive of one – and 96 per cent can reach one on foot or by public transport within the same time, according to the Royal Pharmaceutical Society. Catherine Cox, primary care services manager at The Co-operative Pharmacy, believes the changes coming into play at the moment could offer the opportunity to start realising this vision.

The new roles pharmacies could take on could help health economies tackle inequalities, reduce the pressure on GP services and provide convenient access to healthcare for those with long term conditions. They could become the natural place for patients to have their anti-coagulation treatment monitored, regular checks on their long term condition or their cardiovascular risks assessed.

Part of this is about standardising and spreading services already available in some pharmacies but are not widespread. Ms Cox points to the national minor ailments scheme, where pharmacists and their staff will offer advice on self care or over-the-counter medicines. At the moment doctors' surgeries are full of patients with minor conditions – limiting the time GPs have to spend with patients with more serious or complex illnesses.

Ms Cox says that there is research that suggests 40 per cent of patients visiting a GP could be dealt with in a pharmacy.

Patient education is likely to be part of any shift of this work, so that instead of taking their minor ailments to the GP, they first consider visiting a local pharmacy.

For Ms Cox this is just an extension of pharmacies' existing role in offering enhanced services. "They don't just dispense scripts, they can give advice and review medications, they can do smoking cessation and so on," she says. "We are trying to develop commissioners to see pharmacies as partners in the community."

As well as dealing with minor ailments, pharmacies can deal with substance abuse and weight management – although the extent to which these skills are utilised differ around the country.

'One new area where Ms Cox thinks pharmacies could really make a difference is in long term conditions'

However, one extra service recently taken on by pharmacies – the New Medicines Service, which offers checks to patients who have been prescribed a medicine for the first time – has been offered by more than 80 per cent of them.

Trying to reduce variation so that patients know what to expect from a pharmacy could encourage patients to make better use of them. Ms Cox, a former commissioner, says: "When you go to a GP you automatically know you will get X, Y and Z services delivered by them. At the moment if you go into a pharmacy they might only do emergency contraception but the one down the road will offer a full range of services."

She adds: "Pharmacies have not historically been perceived as the natural

CASE STUDIES OVERLEAF ▶

choice for helping to tackle health inequalities." But with their ease of access and bigger range of services, they could be a partner in tackling some of these issues.

The approach to this has to be both national and local. Patients will need to be reassured that services are going to be available regardless of which pharmacy they visit – so a model which can be followed by independent pharmacies as well as the multiples is important. This is likely to need some sort of national template.

But, in addition to this, pharmacy businesses are now visiting all clinical commissioning groups to discuss with them what could be provided and encourage them to commission enhanced services locally. This could help primary care cope with the work coming down from secondary care.

One new area where Ms Cox thinks pharmacies could really make a difference is in the treatment of long term conditions. The Co-operative Pharmacy is working with three other pharmacy chains – Boots, LloydsPharmacy and Rowlands – to demonstrate this. A pilot project has been set up in the Wirral where chronic obstructive pulmonary disease patients are monitored by their pharmacist for six months. They will have regular consultations with their pharmacist including medication checks but also encompassing how they are feeling more generally and any issues which have arisen with their condition.

"It's looking at their home circumstances and making sure they are getting all the support they need, as well as their medications," she says. There will be liaison between pharmacy and practice, when needed. And patients will have a "passport" where changes in their healthcare are noted.

At the end of the six months, the project will be evaluated to see if it has made any difference to outcomes – for example, whether patients have been admitted to hospital less frequently. The pharmacies hope evidence from this trial will enable them to convince the Department of Health could lead to this sort of service being included in a national contract.

A separate pilot scheme in Wigan is looking at how pharmacists can enhance care for elderly people who are on multiple medicines. But fulfilling pharmacies' potential will also require them to change. In some cases, staff skills will need to be enhanced to enable them to take on this additional work. "Giving more education and training to our staff is something we are actively looking at," says Ms Cox.

Much of this extended role may seem to intrude on what has been seen as GPs' territory. But a joint statement from the Royal Pharmaceutical Society and Royal College of General Practitioners last year recognised that pharmacists are already moving beyond traditional dispensing to provide a broader range of services and advice. And it highlighted areas such as minor ailments and travel vaccinations where pharmacies' role could be extended.

With so many organisations seeing the benefit of change, pharmacies may finally be coming into their own. ●

The co-operative pharmacy

PHARMACY: CASE STUDIES

TAKE THE WEIGHT OFF

How pharmacies have tackled obesity, long term conditions and medicines management, easing the pressure on conventional NHS services

MANAGING COPD

Patients with chronic obstructive pulmonary disease often experience worsening symptoms with changes in the weather. Too hot or too cold weather, changes in humidity, and viruses circulating in the community, can aggravate their symptoms and in some cases lead to hospital admissions.

For several years patients in some areas have been receiving personalised advice through the Met Office's Healthy Outlook scheme. This gives warnings if the weather for a region is likely to affect COPD sufferers and prompts them to take simple measures to help avoid a worsening of their conditions. Because the warnings are given days in advance of changes in the weather, patients have time to prepare – for example, by checking they have medicines to deal with any worsening of their condition.

The service, which has been used by 45,000 people so far, has been shown to reduce hospital admissions in this vulnerable group by around 20 per cent. That equates to about a £5,000 per year saving for a practice with 10,000 patients.

This service has been provided through GP surgeries, with some – but not all – PCTs commissioning the service and paying for it. However, if a local PCT does not buy the service, or it decides not to recommission it, there has been no way for individual patients to access it.

The Department of Health is now looking at different ways of providing the service and the Met Office approached The Co-operative Pharmacy to see if there was a way to work together to offer a way to meet patients' needs. Working with a pharmacy meant that a patient enrolling on the scheme would have contact with pharmacy staff who might be able to offer advice on staying healthy as well as giving them an information pack about both the scheme and other elements of self management.

Under a pilot project, DH will fund the service for 1,000 COPD patients in Lancashire who will be able to choose whether to receive weather warnings by text, email or on a phone.

But The Co-operative Pharmacy is also offering a service to patients who want to get the benefits of the scheme but are not in this pilot scheme. They will be able to pay £29 (£19 for Co-operative members) to gain access to the weather warnings, together with the self care advice and pack.

They will be able to call a telephone line where an automated system will process their answers to a few simple questions to give them personalised advice. The service is available to patients in the East Midlands and Lancashire through branches of The Co-operative Pharmacy and also to those nationwide through its online service.

"It's something that patients have benefited from significantly in the past. It empowers them to take action to keep well," says Jane Devenish, clinical services pharmacist with The Co-operative Pharmacy.

"It gives them a degree of control over their illness. It's about making sure the patient is managing the whole of their condition."

PCTs and CCGs are still able to commission the service from the Met Office but it is possible the pilot with the DH will pinpoint a more cost-effective way of reaching a larger number of patients.

MANAGING OBESITY

Patients who are overweight or obese are a major challenge for GPs. Once a patient leaves the surgery it is largely up to them what they do and the GP will not know whether or not they have followed their weight loss advice.

With pressure on primary care, GPs and their staff can struggle to offer much beyond initial advice to patients: monitoring weight loss regularly would add additional burdens to their workload.

Yet losing weight will have health benefits and is increasingly a gateway to some NHS services such as hip and knee replacements. Obese patients may also end up undergoing bariatric surgery, which is both costly for the NHS and carries the risk of complications. Pharmacies can play a part in encouraging and monitoring weight, utilising their convenient access and approachable staff.

More than 300 Co-operative pharmacies have been offering overweight people a

Doncaster Hospital outpatients go to pharmacies for support with medication

weight loss programme that meets the National Institute for Health and Clinical Excellence criteria on very low calorie diets.

As well as completing a comprehensive medical questionnaire before they embark on the diet, all participants can only buy a week's supply at a time. This ensures they have to return to the pharmacy for follow-up each week – where they have a weighing plus an opportunity to discuss concerns with the pharmacist or staff. Patients who reach their target weight can be helped to start eating normal food again and are get advice on issues such as portion size.

Fiona Caplan-Dean, clinical services manager for The Co-operative Pharmacy, says the diets can lead to weight loss of a stone a month for women and more for men. Monitoring of 5,000 obese people who stuck to the diet for more than a month showed an average weight loss of around 7kg.

GPs can refer patients who want to lose weight and have a BMI of over 25, although patients normally have to fund the food replacements themselves. They use the Lipotrim programme, which started in 1987 and was initially only available through GPs – but in 2000 was extended to pharmacies. It provides a complete food replacement with all the nutrients the patient needs.

'Patients don't want to bother the GP every week and may find pharmacy opening hours make them more accessible'

Ms Caplan-Dean says: "Patients often feel more comfortable talking to pharmacist and their staff. They build up a really good rapport and will talk about their eating habits. They don't want to bother the GP every week and may find pharmacy opening hours make them more accessible."

NEW MEDICINES

Patients who start on new or additional medicines after an outpatients appointment may have side effects or forget to take medicines. In extreme cases, they can end up being admitted to hospital as a result of problems with medications. For patients with a range of long term conditions – including respiratory conditions, diabetes, hypertension and patients needing anti-platelet or anti-coagulation treatment – a way of helping them maximise the benefit from their medicines and avoid problems has been introduced.

The New Medicines Service enables patients to get tailored advice from a community pharmacist. These reviews take place around 14 and 28 days after the medicines are started – identified as the most effective points to intervene.

But there can be problems for patients in accessing services. If the first prescription for the new medication is issued by their GP, they will be directed to their local pharmacy. But if it is dispensed by a hospital pharmacy and the patient then returns to their GP for the ongoing prescription, they will have missed the opportunity to be reviewed.

Pharmacies in hospitals operate under a different contract and are not able to take part in the New Medicines Service – so can't invite patients to return for advice. In Doncaster, The Co-operative Pharmacy, which serves outpatients at the acute hospital, is working with community pharmacies to overcome this. It has set up a scheme where, as the first prescription is dispensed at the hospital, the patient is given a form requesting them to go to their normal local pharmacy for a medicines review at 14 and 28 days. There are around 70 local pharmacies in the area served by Doncaster Royal Infirmary, including chains of pharmacies and independents, and the local pharmaceutical committee is working to ensure they are all aware of the scheme. Pharmacies get a fee for each eligible patient reviewed so there is an incentive for them to be involved. The project is being evaluated by researcher Alison Blenkinsopp from the University of Bradford to see how many patients take up the opportunity to consult with a community pharmacist.

If the scheme is successful it could be replicated in other hospital pharmacies, and extended to inpatients discharged on new medications. Richard Harris of Doncaster LPC says patients who have just been diagnosed and prescribed new drugs often feel bombarded with information. "There is research to show that interaction with pharmacists at 14 and 28 days improves adherence," he says. New asthma patients, for example, often struggle with using inhalers correctly and may even end up as emergency admissions because of this.

Saghir Ahmed, NHS business partner at The Co-operative Pharmacy, says: "It is a win-win situation. There are financial benefits for the pharmacies but patients should benefit as well." ●

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BEN RICHARDSON, THOMAS KIBASI AND OLEG BESTSENNYY ON INTEGRATION

Patients and users with some of the most complex needs today do not receive care that is as good as it should be. Care is too often poorly coordinated, reactively addressing avoidable acute exacerbations rather than proactively keeping people as independent as possible.

Not only is this distressing for the individual and their family, it is expensive for the NHS too. Indeed, McKinsey analysis shows that the 20 per cent of the population most at risk of emergency admission to hospital account for 80 per cent of health and social care costs.

This challenge has been recognised for some time and is a source of enduring frustration for care givers. There have been many attempts to integrate care, some with significant success. The integration of health and social care in Torbay has kept people out of hospital and reduced the time they stay when admitted. In North West London, the integrated care pilot has delivered 22,000 care plans and 15 multidisciplinary case conferences a month, resulting in higher patient satisfaction and lower emergency admissions. These examples show not only that high quality integrated care is possible – but that it is also not happening at anything like the breadth that it needs to.

From southern Spain to northern Germany, from the east coast to the west coast of the United States and all the way down to New Zealand, integrated care systems exist that deliver high quality care at 10-25 per cent lower cost than peers. They deliver care to individuals earlier, before they deteriorate and they need to go to hospital. And when help is required, they respond rapidly in a coordinated way. It is what we would want for our families. And it makes sound financial sense, too.

'Plan ICT based on need. Then build the solution from the bottom up'

Wherever we look around the world, the systems that have reduced costs whilst raising quality have transferred sufficient risk to providers to motivate the disruptive innovations in delivery, people, and systems. How much is sufficient is a subject of debate, but our colleagues in the US believe that at least 30 per cent of provider income needs to be at risk to cause these changes.

The point is to make it happen. The first step is to create a leadership coalition with ambition that is high enough and scale that is big enough to make this the top priority for the local health economy. That's the only way that the effort and investment in making the change happen can be justified. And only through doing this will integrated care be the future of the NHS.

Ben Richardson and Thomas Kibasi are partners and Oleg Bestsennyy is engagement manager at McKinsey & Company
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INTEGRATED CARE

TOGETHER WE STAND

Integrated working is much talked about. What are the key things that will make it reality? By Alison Moore

Integrated care has shot to the top of the NHS agenda. It is seen as offering a way ahead for a cash-strapped system while also improving outcomes for some of the most vulnerable people it cares for.

In June 2011 the NHS Future Forum argued "we need to move beyond arguing for integration to making it happen". This was supported by the King's Fund and Nuffield Trust – which were asked to help support the development of a national strategy on integrated care – and argued that "integrated care must be delivered at scale and pace" across large populations with a concentration on patients with complex health and social needs.

Their plea that integrated care should become "the main business of health and social care" with a focus on the experience of the user has resonated across the NHS with the result that many areas are now looking at providing some form of integrated care for part of their population.

But creating successful integrated care systems is hard and there are pitfalls: done badly integrated care can fail to deliver on its promises and may not save money.

So what is needed to make an integrated system work? Ben Richardson, from McKinsey, believes there is clear evidence that successful models need three building blocks. First, they should focus on a defined segment of the population, second they should make specific changes in how care is delivered to promote co-ordination. And finally they need to underpin these with five key enablers to overcome barriers. Not including even one or two of these can mean that integrated care fails to deliver, he says.

The patients most likely to be focused on are older people and those living with chronic conditions. Oleg Bestsennyy from McKinsey points out that 20 per cent of the population account for about 80 per cent of healthcare costs. Within these 20 per cent will be patients with multiple chronic conditions.

The second building block is multidisciplinary working to co-ordinate care across all the partners involved in a patient's care – primary care, community staff, social care and hospital-based staff.

These staff need to have a common registry of patients. Then these patients need to be stratified according to risk of requiring non-elective admission to hospital. "Any non elective admission is an indication of failure – except in the case of a true emergency," he says.

The packages of care for each of these groups then needs to be agreed, with individual care plans which are created with the patient and their carers. In the most complex cases, particularly around the frail elderly, this may require a proactive approach with intensive case management. This care then needs to be delivered to high standards.

However, Mr Richardson argues that more may be needed. Some patients with highly complex conditions and social situations will benefit from all providers coming together to find new ways of improving their care. Case conferences offer a way to do this – and for different parts of the system to learn from each other and to hold one another to account.

The third building block is a set of enablers. Mr Richardson says: "We know that attempts to implement integrated care are frustrated by perverse incentives, the lack of information flow, organisational boundaries and so on."

He identifies five key enablers:

- Aligned incentives for all the organisations involved, which can be both financial and non-financial. This is likely to involve changing how providers are paid: colleagues in the US suggest changes in reimbursement need to be substantial – at least 30 per cent of provider income needs to be at risk.
- A capitation payment system – with a set amount of money to cover all of the patient's care needs for a year – may be the solution.
- Governance arrangements for joint

CASE STUDIES OVERLEAF ▶

ALAMY

decision-making and accountability, to make the right decisions for the system as a whole. If tens or hundreds of millions of pounds are to be put at risk, changes in provider governance models will be essential.

- Shared information systems which allow clinicians making decisions to see all the information on a patient and to see their own performance in comparison with others. This will also enable effective payment to providers.
- Role models and culture to support the system: without clinical leadership, changes won't happen
- A focus on enabling patients to lead independent and full lives, and empowerment and education to support this.

So what size population works best with this model? It needs to be big enough to benefit from economies of scale. But it would also have to recoup investment in information and IT systems, and management support, suggests Mr Richardson. These costs might be £1-2m a year across a health economy of 500,000 people.

But make the network too big and governance and practicalities – such as organising case conferences – become difficult.

'Make the network too big and practicalities – such as organising case conferences – become difficult'

The "sweet spot" may be to have one integrated care network serving about 50,000 people, he says. This would suggest three or four systems within a typical clinical commissioning group, each serving 10 to 12 practices. Acute trusts would have relationships with perhaps five or six networks.

This does not mean everyone has to sit within the same organisation, although the model can work as an entirely new joint entity bringing together existing organisations.

But integrated care also needs time to deliver. It is not a sticking plaster solution and may take five years to produce the looked-for benefits, he says. In the short term it will need investment in more proactive and responsive care.

Properly established, these systems can deliver significant savings. For example, in Valencia, Spain, care has been delivered for about 25 per cent less than in other comparable healthcare models. The question now is not whether the NHS wants to deliver integrated care, but whether it will be able to use all of these levers to create a system that produces all the possible benefits for the NHS and patients. ●

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INTEGRATED CARE: CASE STUDIES

HOLISTIC GRAIL

Has North West London's pilot project uncovered the secrets of successful integration?

NORTH WEST LONDON INTEGRATED CARER PILOT

The North West London integrated care pilot is being closely watched by the NHS across the UK.

This enormous scheme aims to improve the care for people with diabetes and those over 75 – both identified as vulnerable groups, at risk of hospital admission if their health deteriorates.

The aims of the programme are certainly ambitious: reduce emergency admissions for the groups involved by 30 per cent and nursing home admissions by 10 per cent; and, over five years, reduce the cost of care for those groups by 24 per cent. Although these groups only make up 9 per cent of the total population in the pilot area, they account for 28 per cent of NHS spend – so achieving this level of reductions would have a real impact on NHS finances. At the time the pilot was being devised, the area had identified a significant funding gap in the near future so there was a sense of urgency around change.

So how does the integrated care pilot work? It starts with the registry of patients who meet the criteria in each of the GP practices taking part – but obviously many of those, even though they are diabetic or over 75, won't need the sort of regular healthcare contact that integrated care schemes are meant to provide. Risk stratification – which until recently was hardly talked about among GPs – is important to identify the subset who are most at risk of emergency admissions.

Dr Andrew Steeden, clinical lead for part of the scheme, says: "We don't have the resources to care plan and support our entire population so it is good that we have the understanding of who are the people who need these intervention."

Dr Steeden says there was a conscious decision from the start of the process to concentrate on interventions for these groups which are known to make a difference. He says there is good evidence about what works – Diabetes UK for example, is a good source of information on what great diabetes care looks like. But the interventions also had to be capable of being delivered in "real life".

Some pathways were closely linked to preventing patients deteriorating and needing an emergency admission – for example, there were agreements around quick referrals to hospital specialists for some vulnerable patients.

The position with the elderly patient group was more complex than that for people with diabetes. There were a number of elements identified as making a difference to patients across the board – falls, medicines management, end of life care, dementia assessment and management, supported discharge and continence. Cognitive assessment was key to a number of areas, for example improving compliance with medicines.

Each of the organisations involved in the pilot had to sign up to playing its part in delivering these packages of care. Primary care was to play the lead co-ordinating role but community and secondary care, plus social services, would be involved in many of the care pathways. An integrated management board brought the partners, including the voluntary sector, together and

the legal framework ensured clarity around aspects such as financial recompense and information sharing, as well as accountability.

Care plans were individual and shared with patients and carers. Three or four shared goals were included together with a crisis plan. This moves away from the common problem of parts of the system simply delivering episodic care for the patient without seeing the larger picture of their overall health.

Once care delivery has started there are inevitably complex cases which concern clinicians: these are discussed in multidisciplinary team meetings where changes to the pathway can be proposed and discussed. These are then recorded on the patient's records and implemented. Less serious cases can be discussed in practice meetings, calling in other partners as needed.

There is also a system of performance review to ensure that lessons are learned on an ongoing basis.

But what has made the pilot work so far?

Data at your finger tips: a blood sugar test. Sharing data is crucial to integrated care of diabetics

The answer is a mix of buy-in from organisations and professional groups, and some key enablers. Involvement is voluntary but there has been considerable enthusiasm as the pilot has extended across the area in waves.

Among the enablers is a system to allow shared information. An IT tool has been developed by clinicians which has allowed them to identify patients whose risks meant they ought to have a care plan. If the patient consents, that information is then shared across the system. This system continues to develop with plans for enhanced sharing and a patient portal. Patients are also given a keyfob to show they are on the care plan pathway which they can use to alert hospital staff if they are admitted.

Aligning incentives has been key to the scheme. GPs receive additional payment for the care planning they do – £20 for a diabetic patient and £40 for the over-75s to reflect the additional time they need to put in. They also receive funding for attending case conferences to discuss patients and performance review meetings to conduct peer reviews.

If integrated care works it will also change the way GPs work – less fire fighting and emergency work and more keeping patients well for the long term. They also feel more supported in looking after their patients.

The incentives for the secondary sector may be more subtle. But in a world where the care of long term patients is moving into the community, pilots such as these do offer an opportunity to retain a role in treating them. The acute sector will also benefit from a reduction in emergency admissions which can disrupt the delivery of elective care and may not be fully funded if they are exceeding certain thresholds.

The scheme now covers 550,000 people – shortly to be extended to 700,000 as more areas join. But this vast pilot is broken down into smaller areas covering practice populations of between 38,000 and 68,000 and eight to ten practices. Each clinical commissioning group may have two or three of these. Within these smaller groups, there are regular multidisciplinary meetings to discuss particular cases with representatives from hospitals, primary care, mental health and community nursing. Each practice will put forward a case to be discussed.

Building support for the scheme meant overcoming some original concerns and even antagonism. But the opportunity to provide work within a multidisciplinary team which looked at patients' needs in a holistic way has helped. Providing care which can be seen to have better outcomes and increased patient satisfaction is always a driver for clinicians.

The focus is on proactive care, identifying patients who are at risk of deterioration and ensuring they get the care which will minimise this, and a plan is in place if they do need more intensive care. "Rather than waiting for things to happen, we can start to understand why people end up in crisis," says Dr Steeden.

'Rather than waiting for things to happen, we can start to understand why people end up in crisis'

So what are the outcomes so far? It is hard to be definitive after such a short period but there is evidence that emergency admissions among these groups have fallen compared with similar patients who do not fall within the integrated care organisation – though only by a few per cent. A report in the *BMJ* earlier this year suggested that for the elderly that might be around a 7 per cent reduction but that figure has been controversial, with researchers tasked with evaluating the scheme arguing that more time is needed to see what the outcomes will be. But with the growth in the number of the elderly, even small reductions would be welcome relief for many health economies.

And cost is only part of the potential benefits which include better care and an enhanced patient experience. The evaluation of the pilot will also look at softer indicators such as attendance at multidisciplinary meetings and staff satisfaction.

Dr Steeden says that it is hard to have a proper control group but there does seem to be a real reduction in activity among these patients. And he identifies some additional benefits of joint working for staff. Smaller practices have become very engaged in the bigger system and GPs from them have been coming together in "learning sets". Building this sort of support in primary care may be an early win which will help to push the pilot forward. ●

ALAMY

CHARLIE KEENEY ON AUTONOMY

The NHS Institute for Innovation and Improvement recently held a series of workshops for commissioners, where many clinical commissioning group leads spoke of how the effective engagement of practices was one of the highest priorities on their agenda.

A great deal of focus has been placed on CCGs preparing their authorisation application and then gearing up for their site visit. This has involved a range of strategic developments including agreement of local constitutions, through to the development of integrated plans and commissioning intentions, all led by CCGs. Member practices, and their effective engagement, will play a critical part in bringing the content of these documents to life. Together with the primary care team, member practices are going to be the engines delivering local improvement and so building the capability and confidence of general practice is key to realising this.

The relationship between CCGs and practices has to strike a number of balances right from the outset, as the autonomy that practices have traditionally enjoyed could be seen to be at risk in new accountability or certainly more collectivist arrangements. Alongside autonomy, the insight of practices are just two of many desirable characteristics or attributes that have to be carefully preserved as the new primary care landscape takes shape.

‘Practices will be the engines delivering local improvement’

Across a number of CCGs, over 300 practices in England (and a further 300 in Scotland) are engaged in implementation of the NHS Institute’s Productive General Practice programme. As one CCG lead put it: “This shows our commitment to focusing on the practice environment, provides a great authorisation case study of us all working together closely and has prompted us to think about how we lead and sustain change.”

The Productive General Practice programme is designed to help general practices continue to deliver high quality care while meeting increasing levels of demand and diverse expectations. Its fit with the culture of practice autonomy is often played back to us as critical for building engagement and commitment. For CCGs this growth in on-the-ground capability and confidence around improvement and leading change will be a valuable asset as they embark on development journeys, and take forward large scale change efforts that simultaneously improve patient outcomes, safety and quality, as well as the critical efficiencies needed for delivery of local QIPP plans.

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EFFICIENCY

LIGHTBULB MOMENTS

Alison Moore on a programme that offers GPs a chance to find their own way to a more proactive practice

General practice is going to play an enormous part in delivering the changes that clinical commissioning groups are hoping to prompt in the NHS. Priorities such as better treatment for the growing number with long term conditions and reducing demand for unscheduled care will need GPs and their teams to get engaged and often change the way they work.

But GPs feel under pressure from the daily grind of seeing patients and running practices. Getting them to look at the longer term picture and to find time to think about change is a challenge. But, with the right tools, it can be done.

When the NHS Institute for Innovation and Improvement explored these issues with practices there was a sense of the pressure of work going up and up – but funding not following this. Practices could see that standing still was not an option.

GP Robert Varnam, who is clinical lead for commissioning at the NHS Institute, says: “There’s a sense that general practice is near breaking point. There is a sense of desperation among GPs. We are working just about as hard as we can.

“Most practices are actually committed to the idea that we could do more for our patients, we could do things better and we could improve on what the practice does with the rest of the NHS in some areas.

“The most commonly heard question from practices has been how do we find the time, how do we make the right changes quickly and safely, and how do we get the whole team engaged in it.”

Inevitably, there can be suspicion about new initiatives, which practices see as additional work for them, and there can be a negative reaction to change that is seen as being imposed from above. But this should not be seen as a lack of willingness to change in a way which benefits patient care.

But many clinical commissioning group leaders must be wondering how best can they encourage practices to change. Unlike many other professions and managers, GPs are not trained in improvement methodology.

The NHS Institute has developed Productive General Practice as a way of providing practices with the tools to improve themselves – but without being prescriptive about what and how they do it. Most importantly, it has been developed in conjunction with practices and is designed to meet their requirements rather than those of bigger organisations and different industries.

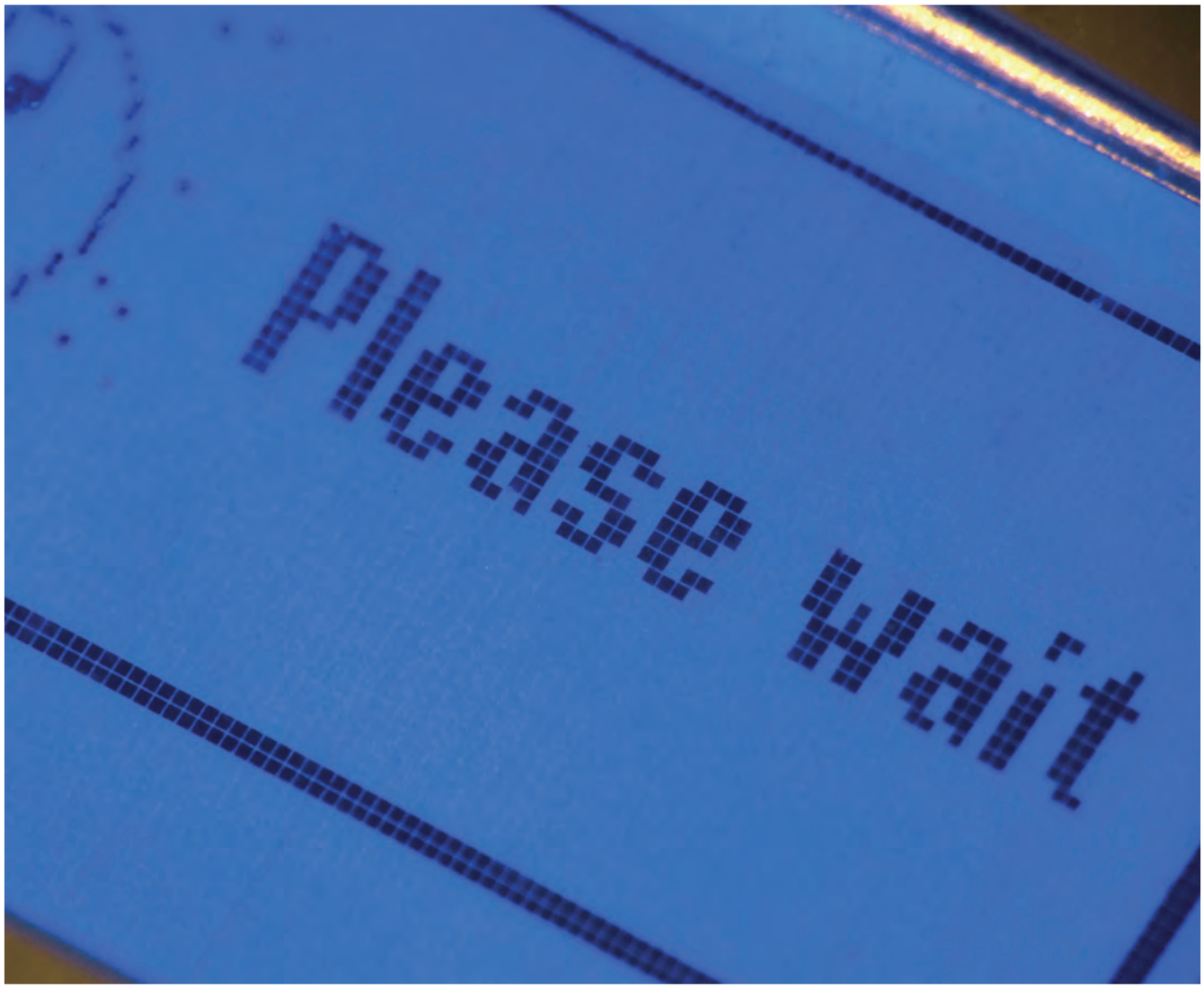
“Practices can just do some of the things they do at the moment in a more efficient and smarter way,” says Sean Manning, programme lead at the NHS Institute. “But the big challenge is realising this will take you so far but could you then do things differently?”

There are simple steps which practices could take to work smarter and save time – things as mundane as ensuring that forms are kept in the same place in each consulting room to help clinicians who are working in several rooms to claw back a little time. And many practices will have made changes to appointment and access systems over the last few years. Dr Varnam says GPs have five ideas a day to make improvements but may feel slightly disappointed when they have tried to implement them and not seen the changes they hoped for.

‘There is a sense of desperation among GPs. We are working just about as hard as we can’

More fundamental changes could involve looking at patients and asking whether a standard length consultation is really what

CASE STUDIES OVERLEAF ▶



ALAMY

best meets their needs and is the best use of a GP's time. Could some be dealt with over the phone, encouraged to self care or access other services? Where does a GP's input add the most value? And given the growing demands of patients with long term conditions how can GPs be more proactive in keeping these patients well and stopping expensive hospital admissions? These are issues for GPs who want to improve care – but they are also key questions for clinical commissioning groups seeking to balance the books and improve quality.

Dr Varnam says one of the strengths of Productive General Practice is that it allows practices to ask these fundamental questions. "Productive General Practice provides the space and some of the tools for practices to move from being just reactive and picking up the pieces to being proactive," he says. "That links with the wider questions being asked not just in the NHS but in healthcare systems across the world."

The modular approach encourages practices to do discrete pieces of work to prepare themselves before making any decisions about fundamental changes. For example, they need to collect data and look at what they are doing now and what are the demands on the practice from different groups of people. There is also advice on how to get patients involved in the process.

When the practice is ready to go ahead, there are modules to help with making decisions on changing administrative functions, looking anew at consultations and improving referrals, among others.

Charlie Keeney, director of primary care and commissioning at the NHS Institute, says that practices feel they are "wrestling the focus back onto the practice" as they work through the programme. "You can see a few lightbulb moments," he says. "There are not many practice-led change programmes which offer a framework such as this." The link with improved productivity is also important for practices, he says. "It links in very well with GP culture and is about building capability and confidence. It is putting the agenda back in their hands."

Some CCGs are signing up to PGP so that all their practices can access it and see it as a way of supporting general practice, which links in with the authorisation requirements. But practices can progress through the programme at their own pace and, crucially, decide on their own priorities.

"We know that to really make these things stick you need that sense of leadership and commitment from the partners in the practice," says Mr Manning.

"The programme enables them to identify the strategic aims of the organisation before making decisions about what and how to change. This means changes are aligned to practice priorities, are more likely to be well thought through and planned, and are therefore more likely to succeed. And, as many practices are finding, the level of staff engagement and participation is leading to better team working and relationships within the practice – a very positive early win." ●

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EFFICIENCY: CASE STUDIES

PUT HEADS TOGETHER

How the Productive process led one Bristol practice to some radical thinking – including a hard look at the value of the traditional face-to-face consultation

CONCORD PRACTICE, BRISTOL

Two years ago a rising tide of patient demand threatened to engulf the partners at Concord Medical Practice on the outskirts of Bristol.

Like virtually every practice in the UK, they were dealing with an increasing number of patients with long term conditions, sometimes transferred from secondary care. These patients' conditions were often very complex with several co-morbidities and, through no fault of their own, required significant input from the practice.

But, unlike many other practices, the partners at Concord decided not just to carry on fire fighting but to change the way their practice operated. "We did recognise that there was a need to do things differently," says Dr Simon Bradley, the lead partner for development and management of the practice. "I don't think general practice will survive without change – not in the shape it is now. I think GPs are under more pressure than they have ever been."

The practice tried to make some changes itself but found they were only partially successful. "We had not been very effective at making the changes that make a difference," says Dr Bradley. "They had not always been followed through, got the engagement of the whole team or been very systematic." When problems were solved in one part of the system, they could have unintended consequences which put pressure on other areas.

A different, more systemic, solution was needed and the practice signed up to Productive General Practice in November 2010. The evidence-based approach of The Productive Series appealed to GPs, he says: "It just became clear from what they were doing in Productive Community Services that it seemed to be systemic implementation of common sense change." Concord became a development practice, helping to refine some of the modules, which meant it has taken longer to get through the process than normal.

"The very first steps were to talk with all the members of the team about what we were thinking of doing, and try to get them engaged," says Dr Bradley. That meant not just the clinicians but also the nursing, reception and administration staff who were feeling the pressure of increased workload just as the GPs were.

This sense of engagement was one of the first positive outcomes of the Productive General Practice approach. "It's one of the areas where we have seen the biggest value," says Dr Bradley. Staff have come forward to champion particular areas, and skills and leadership abilities have come to light. Above all, there is a sense that is not just a GP initiative but one for the whole practice.

The next steps were around data collection so that the practice knew what it was doing before it made any decisions on where it wanted to go and what it wanted to change. "From that point of view Productive General Practice requires commitment and preparedness for you to invest some time in getting ready. There's a definite commitment in time and energy before you even start," he says.

But the value of the data collection phase became clear when it revealed variations in how the practice worked, some of which could be addressed quickly and relatively easily. One of the most striking was the difference in how many consultations nurses were expected to have per session, a position which had grown up over many years and had never been looked at before.

With the co-operation of the practice nurses, a standardised approach was agreed. "The nurses did it themselves, they looked at the activity and decided what the appropriate level of activity was and implemented that," says Dr Bradley. People were willing to take responsibility for how their own areas operated. The practice also looked at how sickness absences were dealt with and introduced a practice-wide approach with the result that overall absence fell. Awareness of the data was a powerful tool to change people's behaviours, says Dr Bradley.

But the most powerful piece of work was still to come. Using the Shaping Our Future Practice module of Productive General Practice, the practice started to look at what the demands on it were, where they were coming from and how they could be met, given the limited resources.

"That really involves stepping back and looking at patient needs in a new light. It is more about fundamental change," he says. Like many practices, how things were done had evolved over time and were not as suited to the current demands as they could be. "Our vision is constrained by habit," says Dr Bradley.

The Shaping our Future Practice module encouraged the practice to put all of this to one side and start designing services with a clean sheet. "We looked at where the increase in demand was and how we could match skill levels to the needs of patients and those demands," he says. "If we don't think about

the opportunities to do things differently we are never going to do it. We obviously had a finite capacity." One of the areas which was putting pressure on the practice was the growing demands of chronic disease management. Like all practices, it had seen this snowball over the last 15 years.

Nurses already carry out much of the work of monitoring and routinely assessing people who have been diagnosed with these conditions. Much of this work is protocol driven and is relatively predictable – patients will need checks at regular intervals, for example. "GPs value comes in dealing with diagnosis and managing complex chronic and acute conditions," says Dr Bradley. 'These are often at the more unpredictable end of patient need."

But if there was a predictable/unpredictable split in patient needs that was best met by different healthcare professionals, there was then a question of how could the practice further identify those needs and ensure that patients got to see the most suitable person.

These predictable patients could then be offered structured care by a nurse, which was both cost effective and freed up GPs to deal with the cases where their skills would be most influential. There's also evidence that patient satisfaction can be higher if nurses deliver this predictable care – and they are able to give more time to patients than GPs.

So the practice started to look at how it could break its patients down into groups with similar needs and customise a service to meet their needs.

Patients with unpredictable needs obviously needed swift access to a GP. But there were other groups who were making significant calls on the practice's limited GP appointments. Out of the 14,500 patients around 400 had long term depression and were being treated with medication. Each of these saw a doctor just over three times a year – more than 1,200 appointments or just over a third of a full-time GP. Many of these appointments were relatively routine reviews of medication and discussion of side effects and could have been carried out by an appropriately trained nurse. In addition, GPs were seeing about 10 patients a week with anxiety.

The solution was to give patients direct access to a nurse with mental health skills who could offer brief interventions. A similar approach is being tried with musculo-skeletal problems – another area where GPs were seeing large numbers of people and where a physiotherapist could be as effective and sometimes more effective than a GP. Direct access to a physiotherapist gave patients a diagnosis, brief interventions to help them self care, if appropriate, and onward referral if necessary.

'The default position is how do you help the patient stay healthy. GPs should be the facilitators of self care'

But other groups needed a different model based more around encouraging them to manage their problems themselves. Mothers with small babies, for example, were frequent attenders at the surgery with minor problems that could be treated at home or with input from a pharmacist such as nappy rash and teething issues.

"We are looking at implementing regular group meetings for new mums to talk about managing minor illnesses in babies to pre-empt visits to the surgery," says Dr Bradley. Some of the ideas are still being worked through.

One "lightbulb" moment for many in the practice was when they stepped back and asked whether the face-to-face consultation was always the best default option. Telephone consultations need not be a second best but could sometimes be the right option for practice and patient. "The default position is how do you help the patient stay healthy," says Dr Bradley. "GPs should be the facilitators of self care."

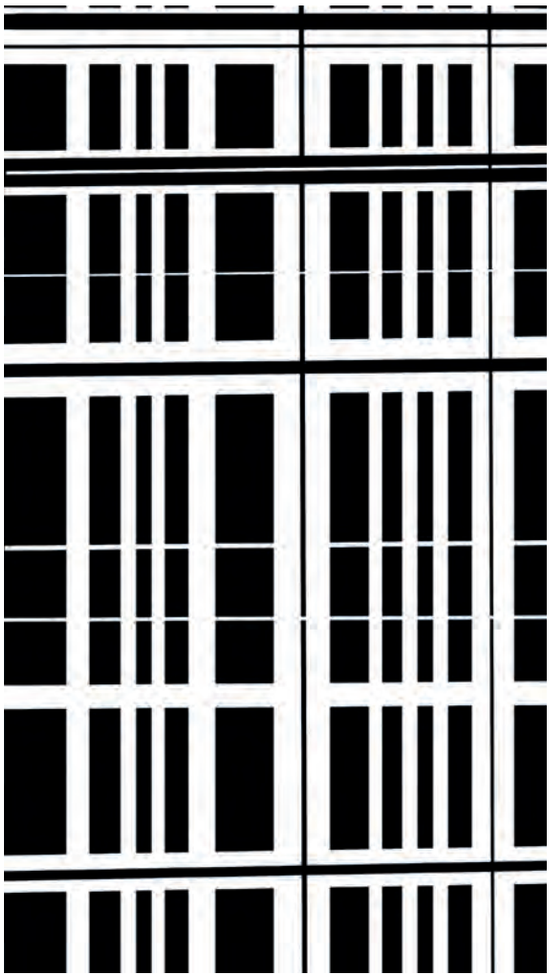
In the long run he hopes this philosophy will pervade the practice and change patient expectations of what they will get out of contact with health professionals. A small start has been buying oxygen saturation monitors for patients with respiratory disease to use at home to determine whether they are in need of intervention.

The practice has been able to make some of these changes because it can act independently, but in some places that independence could contribute to silo working and slow dissemination of good practice. Dr Bradley says Productive General Practice offers a way out of this. But while the practice could have got to these changes itself, he thinks it is unlikely to have done so without the productive approach. "It requires a structure, a determination and a vision of what can be done," he says. "But we are beginning to see the benefits." ●

ESTATES MANAGEMENT

ROOM AND A VIEW

The expert opinion of a 'critical friend' is helping NHS Knowsley make the best use of its estate in a way that fits with its commissioning plans. By Daloni Carlisle



It's one thing to build a building, It's quite another to make the best possible use of it, squeezing out every ounce of utilisation while providing a good service to patients.

With QIPP so firmly on the agenda, NHS organisations are increasingly looking at how to get the best use out of the estate. Too often, though, it is an area with which they struggle, as some forthcoming work by the King's Fund on how the NHS uses LIFT (Local Improvement Finance Trust) buildings is expected to show.

Nigel Edwards, King's Fund senior fellow in leadership development and health policy, says: "The NHS does not have very good estates management strategies in general but there are a lot of good opportunities to use the property better and to go beyond this and start to think about estates planning.

"If clinical commissioning is going to work, you have to make primary care work much more closely with specialists and to have venues in which that can take place."

And this is where estates management moves into planning and taking a strategic view. "A strategic property-based view of the world with imaginative approaches is what we need, with incentives put in place that allows this kind of collaboration between primary and secondary care," says Mr Edwards. Expect some work on this early next year, he adds.

But in the meantime, back at the coalface, there are already people taking this kind of approach, looking at their primary care and community estate and asking: why do we use it this way and could we use it better?

NHS Knowsley is leading the way. In the last decade, it has replaced about 80 per cent of its typical 1960s-built sub-standard primary care and community estate with seven new LIFT buildings. An eighth is about to be delivered and the total investment amounts to some £45m.

Ian Davies, director of strategy and programme co-ordination, says: "This was never just about buildings. It was always about providing the catalyst for transforming services."

It was built with long term commissioning intentions in mind and in particular the shift from hospital-based care to community-based care, he says.

"For example, we wanted buildings flexible enough that we could move our cardiovascular service out into the community and provide a one stop shop with the consultant and specialist nurses on site together able to offer diagnosis and treatment," says Mr Davies.

Such an approach is, by its nature, fluid and earlier this year NHS Knowsley began a pilot with its LIFT partner, Fulcrum Group, to take a more in-depth critical look at whether the PCT was getting the best use out of its buildings – and the opportunities to do it better and improve services.

A team from Fulcrum, which included experts with backgrounds in estates and NHS management, came into one building to carry out a quantitative and qualitative review of how the building is used, how it could be better used, how the existing services in the building relate to each other and what the long term commissioning plans indicate might be needed long and short term.

"I would say they came in as a critical friend and asked lots of 'why' questions," says Mr Davies. "Why is that room being used in a particular way? Why are you restricting its use?"

The team from Fulcrum came up with some recommendations, which the PCT is now working through. For example, they were able to point out that the podiatry clinic runs on a Tuesday but the diabetic clinic is on a Wednesday and suggest that since many patients with diabetes also have foot problems, would it not make sense to run the two clinics together?

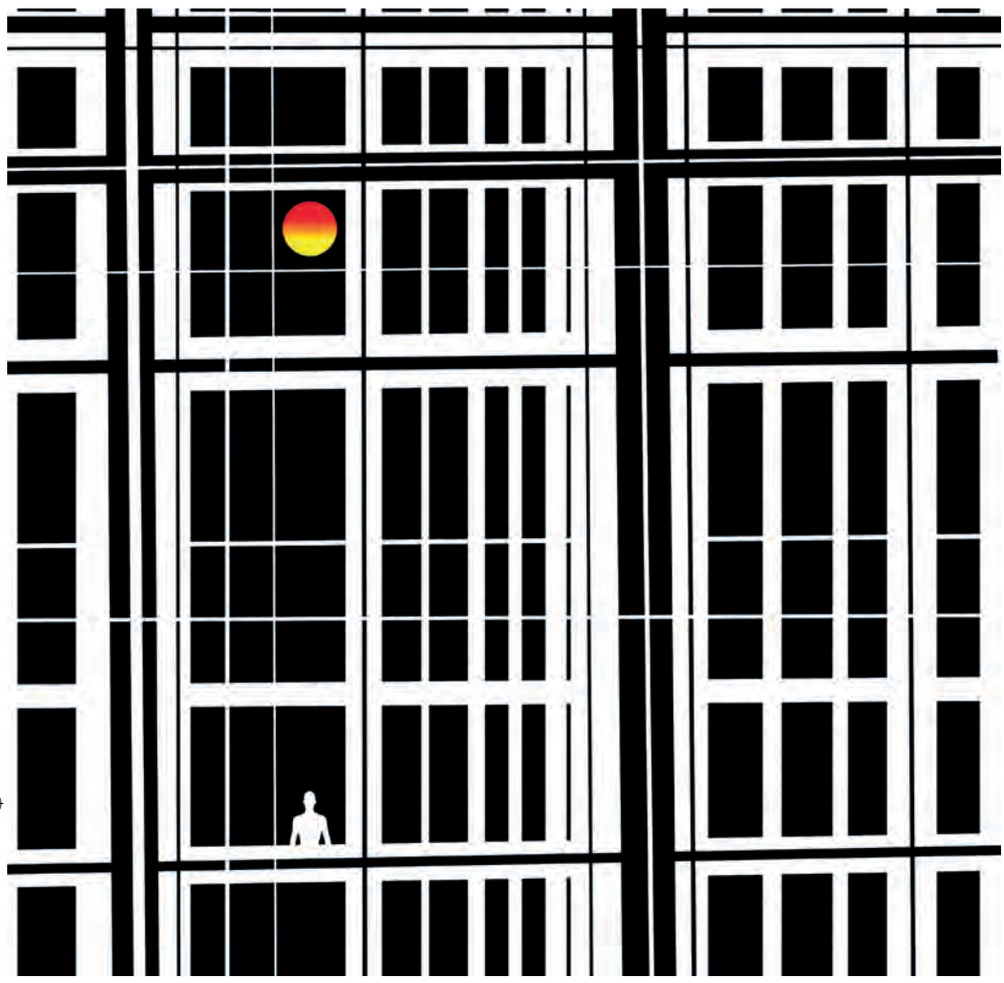
"Yes this is common sense," says Mr Davies. "But they put a lens against our current arrangements and looked at it with fresh eyes. They had been doing some similar work in London and so were able to share that experience and present us with solutions we would not necessarily have thought of.

"So yes, it was building on work we were already doing but it gave us the impetus and a level of concentration we would not otherwise have had."

Some significant changes have been made as a result. Diabetes, podiatry and dietetics clinics where possible can now be provided on the same day in the same place with scheduling arrangements allowing patients a one-stop shop.

"Patients love it," says Mr Davies. Fulcrum were able to point out other instances where two clinics used a suite of three adjoining rooms – but only needed two. This has allowed the PCT to place complementary clinics in the third room, making better use of the suite and freeing up another space.

In another example, it was identified that two existing community dental clinics were poorly utilised but that commissioning plans



‘A strategic property-based view of the world with imaginative approaches is what we need’
Nigel Edwards

wanted to see more NHS dental services provided in an area of high need.

The community dental services have now be rationalised onto a smaller number of sites, making better use of staff without disadvantaging the community in terms of travel as the sites utilised provide good geographical access for the community. The space freed up has been leased to create two new much needed NHS dentists.

“And because the space was already equipped to a very high standard, it was easy and quick to do, taking weeks rather than 12 months as you might expect if you started from scratch,” adds Mr Davies. “These are real win-win solutions.”

It is an approach that the LIFT Council, the representative body for LIFT partners, hopes others will adopt.

Executive director David Pokora says: “We all know that the health service is facing multifaceted challenges and in community and primary care, there is a need to adopt new ways of working. The problem is that when you need to change services quickly, buildings change much more slowly.

“That means there is a need for looking critically at the existing buildings and asking what needs to be done to adapt it so that clinicians can provide better services for patients and populations?”

He argues that the private sector has skills to offer. “We can help deliver your financial and clinical goals and support you by developing the tools and techniques you need.”

Which is just what Fulcrum has done. As a partner in four LIFT schemes in the NHS it has extensive experience of the challenges that PCTs face now – and CCGs and NHS Propco will face in future as it takes charge of all PCT estate from April 2013.

As Adrian Wallace, Fulcrum’s head of strategic asset management, explains: “We think there is room for a more positive, partnership approach to some of the challenges that commissioners face so we have developed the QIPP Opportunities Review.”

This is the methodology developed in part in Knowsley. It has been piloted in one other area in London and was developed with input from senior NHS managers both at practitioner and advisory level.

“It’s about identifying where the gaps are and where there is spare potential to do things more efficiently,” says Mr Wallace.

It starts with a review of baseline data that is already available – such as room utilisation, opening hours, patient numbers and so on. This flags up any vacant rooms or times the building is not open but could be.

Then the team moves on to a gap analysis, looking at commissioning plans and strategic objectives. So, for example, there might be a QIPP objective to reduce falls. The Fulcrum team might identify spare capacity in a well-equipped physiotherapy department that might be used to fulfil this objective.

Finally, the team develop some recommendations for the PCT to consider. In the pilot schemes this has included financial data. “The thing that really grabs the attention is when we point out the cost of empty space,” says Mr Wallace. “This is hard factual information that people often do not know.”

Fulcrum is now offering the QIPP Opportunities Review as a consultancy product.

Back at NHS Knowsley, Mr Davies is clear that working with Fulcrum was the right thing to do. He says: “We have piloted the approach in one of our buildings and we are now taking that learning into the remaining six. We have honed our ability to make better use of our estate and how to feed this into our commissioning plans.”

But, he adds: “This has to be a continuous process and we plan to keep reviewing in detail every six months with a snapshot of use every three months. We have to go further if we are going to see the cost improvements we need.” ●

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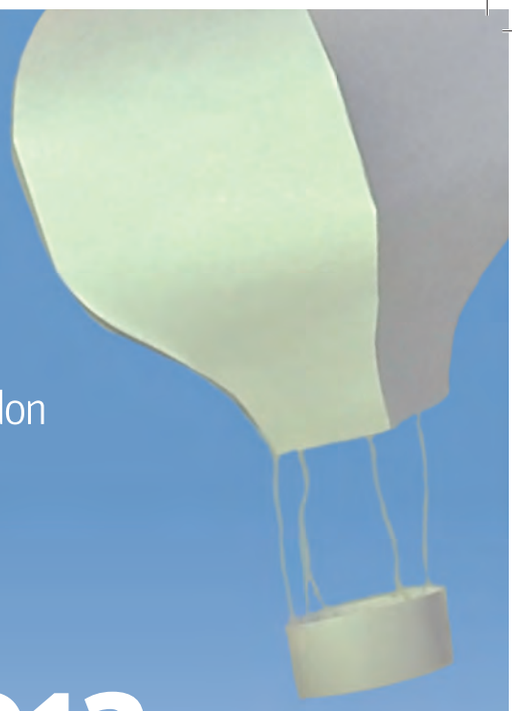

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