Putting QIPP and Francis at the heart of commissioning support

Implementing QIPP and the Francis report and the need to help commissioners drive transformational change emerged as the key themes of a brainstorming event about developing effective commissioning support.

Organised by the NHS Commissioning Board (NHS CB) with clinical leaders from NAPC, the NHS Alliance and the Clinical Commissioning Academy, the two day accelerated solutions event (ASE) was attended by 50 leaders of NHS and independent commissioning support services (CSS) and over 20 board members of clinical commissioning groups (CCGs).

The event’s outcomes will help shape the commissioning support strategy being presented to the NHS CB for agreement in May.

Bob Ricketts, the NHS CB’s director of commissioning support strategy and market development, told PCC that throughout the event QIPP, the Francis report and the need for transformational change drove discussion and thinking.

Adapting Bill Clinton’s unofficial 1992 presidential election campaign slogan, Ricketts said: “It really is a case of ‘It’s QIPP, stupid!’ and that is the area that everyone needs to focus on. If the board’s CSS strategy is to be worth doing it has got to have a focus on those things that will help CCGs and CSS providers deliver QIPP. Without QIPP everything else is peripheral.”

He continued: “QIPP and the Francis report need to be at the centre of everything commissioners and commissioning support services do. “We need transformational change rather than minor improvements in contract negotiation or procurement. This is about wholesale service reconfiguration, major pathway redesign, improving outcomes and ensuring that variations in quality are addressed in both primary and secondary care, learning the lessons from the Francis report.”

Participants also explored how commissioners and CSS providers could be equipped with the skills and expertise required to deliver such change – as well as the transactional, commissioning-focused activity.

Ricketts said: “There was recognition that we need to help commissioners and providers shift from the transactional to the transformational. They will still need to contract for services efficiently, but given the importance of delivering major service change and driving up quality, we need to increase substantially the skills and expertise available in the system to help commissioners transform services.”

Continued page 4

‘ICONIC’ CONTRACT helps cut bureaucracy

Flexibility and simplicity characterise the new NHS standard contract.

Its creators have sought to address criticism that past versions have been unnecessarily complex in structure, content and language.

The new web-based “e-contract” is also one of the first of an anticipated slew of digital initiatives in line with the health secretary’s plans to reduce bureaucracy and eliminate paper from the NHS.

Responsibility for the contract now lies with the NHS Commissioning Board, which published the final version last month.

The NHS CB views the 2013/14 contract, which is to be used for the commissioning of all NHS health and clinical services apart from primary care, as having landmark status for two reasons: it will be a key enabler of safe but innovative commissioning and it will be the first NHS standard contract to be published and available for use in electronic form.
The new NHS standard contract should free commissioners from the fine print and leave them to get on with the real job of commissioning, according to Morgan Cole, a leading law firm specialising in the healthcare sector.

Morgan Cole partner Gayle Curry welcomes the focus on outcomes and the reduction in complexity and legal jargon.

“Contracts in the past have tended to be quite complicated. People took to filling in the forms rather than thinking strategically about what they are trying to achieve for services.”

Time spent developing a service specification, preferably with significant input from senior clinicians, will be well rewarded, Curry says.

She warned against twin trends of recent years: the inclusion of dozens or even hundreds of local quality requirements or other provisions that contradict the main contract clauses in the ‘documents relied on’ annex to the main contract.

“Because of the perceived clunkiness of the standard contract in the past people have tended to try to change certain terms by including side letters attempting to vary standard provisions in the ‘documents relied on’ annex to the main contract.

The DH’s standard contracts team believes that it has succeeded in producing a standard contract that will make it easier for commissioners to specify key outcomes. Now it is up to commissioners to select the right outcomes.

Involving potential providers as well as your clinicians will make that easier, Curry suggests.

“There is an increasing emphasis on outcomes in this coming year. Commissioners will need providers to help develop the service specifications, particularly the key inputs. Commissioners who try to develop their specifications themselves will lose out on the innovative thinking many providers can bring to bear,” she says.

While commissioners should be clear about their local expectations around quality, Curry cautions against including excessive local quality indicators.

“In our experience, it is not unusual to see 250 or more local quality requirements. That is too many: how can you manage a contract like that?”

Further tips and key elements of the new standard contract

• In response to stakeholder feedback the new contract has stronger provisions on TUPE to clarify the responsibilities of each party in expectation of TUPE applying on a change of provider
• Clinicians should attend some contract management meetings to provide frontline and patient feedback to providers
• The CQUIN process has been simplified – Curry emphasised that CQUINs are more effective when there not “too many local goals that dilute the value of each incentive”.

Erewash CCG helps practices face the business implications of NHS change

Membership development is critical to clinical commissioning groups’ (CCGs) success. CCGs stand to make obvious gains by helping practices understand their role as members and have a role of their own to play in supporting practices’ development and awareness of the changes in the health care system.

PCC is working with CCGs to deliver workshops aimed at supporting their member GP practices as they face the challenges and opportunities presented by the NHS reforms.

Erewash CCG identified such support as a practice development priority and recently hosted one of these workshops for GPs and practice managers on the potential impact of the changes on practices.

Helen Rose, the CCG’s lead for primary care development, said: “Our development work is trying to get the practices to understand what is going to be different now – the fact that the CCG and (the NHS Commissioning Board’s) local area team are very different bodies and have responsibility for different commissioning activity.

“The local area team will be more distant than the primary care trust (PCT) was and they will be more grounded in national policy rather than local partnership. Previously the practices knew a commissioning manager at the PCT.”

During the workshop PCC development manager Peter Bullivant guided participants through the new commissioning and regulatory structures and organisations before highlighting the factors that could threaten practices’ income. He also outlined the various procurement routes that commissioners could take - including Any Qualified Provider and competitive tenders and the possible impact of different approaches on practice income.

Through tick boxes and dropdown menus on the e-contract system, supported by guidance, commissioners will be able to select and apply to their own contract those of the service conditions which are applicable to the particular type of provider and range of services being commissioned. The system will allow commissioners to populate the schedules to the particulars with their own service specifications and other locally-agreed content.

The third part of the contract – the general conditions – will remain as standard, containing terms and conditions applicable to all NHS contracts.

Despite the new contract’s digital credentials, the entirely paperless contract is not here quite yet.

Savage says: “What we can’t do is bypass completely the legal niceties to create the contract. Once the contract is agreed, all commissioners and the provider will need to sign it, but will be able to do so remotely – their signature pages can then be scanned into the system so electronically there is record of everyone signing it and the document would then be dated and printed.

“In due course the e-contract system will allow, for example, contract variations to be agreed and incorporated electronically. The board hopes to develop the functionality of the system to encompass procurement and negotiation processes and contract management.”

In line with the thrust of health policy, the contract is intended to promote innovation and focus on outcomes.

Savage said: “We were being told by commissioners and providers that the contracts of 2012/13 and previous years were seen as unwieldy and not sufficiently flexible to accommodate all the models they would like to see providers putting in place. The new contract should be perceived very differently.”
Collaboration as important as competition for CSS providers

Commissioning support service (CSS) providers are increasingly recognising that they need to collaborate as well as compete.

Bob Ricketts, the NHS Commissioning Board’s (NHS CB) director of commissioning support and market development, told PCC that although the organisations would be competing to provide services to commissioners, the sector as a whole would benefit if they shared information and experience on issues such as implementing new clinical pathways and service transformation.

“That is what happens in other sectors,” he said.

Ricketts was speaking after a two-day accelerated solutions event (ASE) for CSS providers and CCG board members. He said: “By the end of the event many providers were recognising that there are things you compete on and things you need to collaborate on. There was a very mature debate around that.”

He said the event also highlighted that commissioning support units (CSUs) needed to develop strong, but flexible and responsive relationships with CCGs.

“A theme running through the event was the need for CSUs to stay in touch with individual CCGs and offer bespoke packages of support that meet their particular needs. Effective account management, tailoring their offer to individual CCGs, will be essential.”

He continued: “What was really good was that CCGs were involved in setting out their needs and being very clear about what they wanted from CSUs and from CSS more generally.”

To deliver a full range of support services, Ricketts said, CSUs will need to rapidly form partnerships with a wide range of partner organisations, including Primary Care Commissioning (PCC), professional bodies, independent providers, consultancies, legal firms and the voluntary sector.

“Forming relationships with voluntary groups and NHS organisations will make for a richer offer to the CCGs seeking help with a range of problems,” he said. “It will also help them face the challenges not only of current QIPP ambitions but what comes next in QIPP II.”

The event was organised by the NHS CB as part of the engagement activity around the development of the CSS strategy.

PUTTING QIPP AND FRANCIS AT THE HEART OF COMMISSIONING SUPPORT

Continued from page 1

Ricketts continued: “To deliver the best outcomes for patients we need excellent commissioning by great commissioners, and they in turn need to be supported by excellent and affordable CSS. However, both in terms of the provision of such services and the market for them CSSs are still at a very early stage of development. That meant that the big challenge we faced at the event was how can we ensure that every commissioner will be able to access excellent and affordable support. For example, procurement processes will need to be simple and fast as some CCGs need access to transformational support right now.”

One suggestion at the ASE event for helping CCGs discriminate between support providers was a Trip Adviser-type website to help commissioners choose between CSS providers.

Challenging messages also came from the national commissioning development director Dame Barbara Hakin, the National Association of Primary Care chair, Dr Charles Alessi and Dr Shane Gordon from the NHS Alliance.

The NHS CB is eager to engage CSS providers and CCGs on the outcomes of the event and how they should shape the next draft of the board’s CSS strategy. A summary will be available from 4 March on the board’s website.
CCGs and their member practices need to work together if the clinical leadership envisaged by the NHS reforms is to materialise. The relationship is potentially a two-way street with CCGs benefiting from clinical engagement with the commissioning strategy and practices benefiting from the support of their peers in the collective effort to improve primary care.

Inevitably the process of forming relationships and proving the potential of the new organisations is more advanced in some areas than others.

Carl Ellson, a GP and chair of South Worcestershire CCG, says: “We have 32 practices in our CCG but we have four localities. Each locality has a GP lead and practice manager lead and they meet monthly with us. This is making for better commissioning and releasing the benefits of that. It is making them better providers without putting them in a privileged position (for bidding for locally-commissioned services).”

Ellson hits on the dichotomy at the heart of the CCG/practice relationship.

GP practices, despite making hundreds of micro-commissioning decisions each day by writing prescriptions or referring patients, are seen as providers within the NHS. Yet they are in reality now members of organisations which will be commissioning many community-based services. Practices working alone, in federations or as broader provider organisations might wish to provide those services to augment their core list funding from the NHS Commissioning Board.

Ellson’s CCG is encouraging practices to consider the new business opportunities available to them in the new commissioning regime, while warning about the risks of regulatory challenge if the procurement process is not scrupulous and fair.

He says: “We are educating them informally about the options available – such as federating or forming a loose alliance to compete to provide services. Primary care needs to adjust to a new climate and protect itself by winning new contracts so it is future-proof.”

Ellson’s CCG is encouraging practices to consider the new business opportunities available to them in the new commissioning regime, while warning about the risks of regulatory challenge if the procurement process is not scrupulous and fair.

Helen Rose, Erewash CCG’s head of membership development, says: “In our first year as a CCG we have done quite a lot in terms of looking at clinical variations in referring and admissions behaviour. Sorting out variations will free up resources to deliver back to primary care and to commission new service that practices can bid for.

“Also, we need to remove those variations and show that practices are performing to a high standard if we are to justify taking services out of secondary care. We are trying to take more diabetes services out of hospital and some of those, for example prevention, will probably go to primary care while others will be put out to tender and practices will be able to bid for those.”

With just 13 practices Rose acknowledges that getting practices to buy in to this sort of performance management is probably easier in Erewash than some other CCGs but she says that the new clinical leadership of the commissioning body can encourage GPs.

“With the CCG GPs are leading in the sharing of information and benchmarking against each other on referral behaviour, admission rates and prescribing. We get them all in the room and they accept it as long as we are not just looking at one indicator and it is a transparent process.”

Rose argues that such engagement is in the interests of the practices and patients.

“We have 13 (GP) members sitting on the group and they are the keenest ones. By playing a role in the CCG, practices can be the ones deciding what services will be commissioned and the activity that can be provided in the community. That could give the appearance of conflict of interest but the CCG is quite clear that having care closer to home and integrated systems is in the best interests of patients.”

For a longer version of this article: http://bit.ly/VT7Tat

See Opinion, page 12.

PCC provides workshops, e-learning and facilitated development to support CCGs and their members: http://www.pcc-cic.org.uk/ccg
In the years before the credit crunch and the resulting economic turmoil, discussion about housing tended to be more about chains than networks.

However, long after the property market crash, a network formed in 2002 within the Department of Health continues to play a key role in improving specialist housing for older people and forging links between the sector and healthcare.

The Housing Learning and Improvement Network (Housing LIN) now has 48,000 members and since its departure from the DH in 2011 has developed sufficient commercial and membership support to survive as an independent entity.

There is growing recognition within the NHS of both the role housing plays in public health and how an integrated approach to specialist housing can reduce or delay demand for expensive health and social care – including emergency admissions and visits to A&E.

Housing LIN director Jeremy Porteus is amongst the sector leaders working with the NHS Commissioning Board to develop a compact of understanding. It will highlight the health outcomes of close relationships between clinical commissioning groups, housing providers and developers and commissioners of specialist housing with care and support.

Porteus says. “There is mounting evidence, accepted in the government’s housing strategy, that providing people – especially older people – with housing that is appropriate to their changing need for care and support can reap a dividend for NHS and social care commissioners.”

That evidence includes an independent evaluation of the DH’s extra care housing fund which the Housing LIN administered on the department’s behalf. The fund encouraged local authorities and primary care trusts to co-ordinate local partnerships to develop extra care housing in their areas.

The DH fund awarded £227m to those local partnerships, which helped attract another £1bn from other funding streams such as the private sector and equity release, to develop over 80 new extra care housing schemes.

Successful bidders were required to use the Housing LIN to network to share their innovation and experiences with unsuccessful bidders.

The 19 schemes evaluated in 2011 were among 6,000 new units of extra care housing built while this particular DH fund was running – increasing by 20% the total stock of such housing in England. It is hoped that a new DH fund, of up to £300m, can build on this success over the coming years.

“Extra care housing models are based on self-contained flats owned or rented by people whose care needs are met around the clock, through flexible care and support packages that can be adapted as people’s needs change,” Porteus says.

The University of Kent’s Personal Social Services Research Unit evaluated the DH-funded schemes and found that residents of extra care housing schemes:

- Had better mental and physical health than their peers – reducing demand for health services
- Were less likely to move into residential care
- Had lower death rates than people in residential care.

The network has now joined forces with the charity Elderly Accommodation Counsel and two local authorities to develop a tool to be launched this month (March). The tool SHOP@ helps local authorities work with CCGs and other partners to establish the likely level of unmet demand for specialist housing over the next 20 years.

Such data can inform decisions about both public and private sector investment in a range of specialist housing options for older people and other vulnerable adults.

The tool grew out of another Housing LIN resource, Strategic Housing for Older People, jointly published with the Association of Directors of Adult Social Services. That resource emphasised the need for greater partnership working in planning, designing and delivering housing that older people want.

Porteus concludes: “With the arrival of health and wellbeing boards, CCGs and other health commissioners should now be well-placed to see housing as a key part of public health and, for older people, a factor in promoting independence and reducing expensive crisis interventions.”
The Housing LIN has around 48,000 professional members – a figure that has grown since it spun out of the DH in 2011. Around 34% work in acute and primary care, 28% in adult social care and the remainder in housing.

It describes itself as a ‘learning lab’ for professionals in England involving in planning, commissioning, designing, funding, building and managing housing, care and support services for older people and vulnerable adults.

The network’s members communicate both virtually and through regular regional meetings.

However, as a cheerleader for integration, the network has helped promote the prevention benefits for the NHS and social care of well-designed specialist housing. Such housing also allows older people to retain their independence.

The network is seen as a leader in generating and promoting new thinking in specialist housing.

The network’s director, Jeremy Porteus, has been a key figure in the development of key reports – including several by the All Party Parliamentary Group on housing and care for older people.

It has influenced guidance on assistive technology to support people with dementia and helped develop new design standards to raise the quality of purpose-built housing for older people.

By providing access to expert advice the network has actively helped local partnerships secure funding for the development of specialist housing.

Porteus says that the network’s reach across sectors and professional boundaries means it does not follow any particular process map or organisational development model.

“We know that different sectors and professions have different languages and cultures so we like to keep it simple – but effective,” he says.

You can visit the network and join at www.housinglin.org.uk

Paediatric palliative care network drives improvement

Healthcare networks appear to be particularly effective in improving patient care and professional performance in clinical areas that “attract people on a mission”, an academic has concluded.

Professor Elizabeth West, director of research at the University of Greenwich, was speaking after surveying members of the West Midlands Paediatric Palliative Care Network.

The network, which was formed in 2000, now has around 80 members – half of whom agreed to take part in West’s survey. She found an active network with meetings typically attended by 30-40 people and several sub-groups that have produced significant clinical resources. These include advance care plans and guidelines.

Her findings included:

- 91% of respondents said they had acquired new ideas, information or evidence about paediatric palliative care from the network
- 74% said their practice has changed as a result
- New funding routes opened up, partly because of the strength and credibility of the network and partly because of better information flow
- 89% felt membership of the network brought them more influence with practitioners, commissioners and policymakers
- 79% of members felt they were better placed to represent service users through network membership.

West said: “We constructed our survey based on what the policy documents were saying were the important contributions that network forms of governance could make. We were quite surprised at the very positive comments members made about what difference the network made to their clinical performance, sense of efficacy and their ability to represent patients and their families.”

She attributed much of the network’s impact to the commitment shown by its leaders but said members generally were committed to the development of their specialism.

“Paediatric palliative care and cancer attract people like that who are really people on a mission,” West said.

She called for more funding for research into the impact networks had in less high-profile areas of healthcare.
Helping people with long term conditions to take control

Two practices in Carlisle are implementing a more holistic approach to the treatment of patients with long term conditions.

The practices are carrying out annual comprehensive and patient-centred assessments of patients who have cardiovascular conditions – considering in depth each condition the individual has. The reviews are also provided for patients with diabetes: during the Diabetes Year of Care pilot programme, collaborative reviews emerged as a key factor in developing patient-centred care. The pilot outcomes highlighted the role of patient education and self-care.

Carlisle GP Alan Edwards, whose practice is one of those implementing the new approach, said he was inspired by a talk from the former diabetes national clinical director, Sue Roberts, who established the Diabetes Year of Care pilot project.

Edwards says: “She talked about the changes made in diabetes care which put the patient at the centre. There was less focus on just one or two interventions a year and telling the patient how their condition was going. The patients were more involved in their own care.”

The Carlisle locality of Cumbria Clinical Commissioning Group (CCG) commissioned care pathways manager Katy Gordon to work with three practices to coordinate and implement the new holistic review system for patients with several cardiovascular conditions. One of the practices subsequently dropped out of the initiative because of unrelated issues.

Gordon says: “Patients with five, six or even seven conditions were receiving different reviews and checks throughout the year. That meant a lot of duplication. This new approach puts the patient back at the heart of the review with the nurses looking at the individual and their health. For example, with a holistic review clinicians can look at all their medications together and how they might interact.”

With improved management of the patient’s care the commissioners anticipate a reduction in primary care consultations, A&E attendance and emergency admissions. However, with the first round of holistic reviews only beginning nine months ago data confirming those expectations is not yet available.

Edwards, a partner with St Paul’s Medical Centre in Carlisle, says: “It is too early to talk about outcomes but the hope is it will reduce admission rates further down the line. We decided to fund Katy’s post because we recognised that with increasing numbers of patients with chronic diseases we had to do something.

“We are wanting to do more planned work and as a result have less unplanned work.”

As well as developing a new holistic template for the reviews, clinical skill levels and the impact on the practices’ workload were considered.

Gordon says: “It was important to put the foundations in place. That meant developing a template for conducting reviews for a range of cardio-vascular conditions such as TIA, coronary heart disease, diabetes, atrial fibrillation, heart failure and hypertension.”

“This is a major change for staff who have not been doing such reviews before and there has been skilling up amongst nurses. We had to look at whether the nurses were equipped with the skills and the knowledge to deliver such reviews. Each practice looked at how their staff could best be supported together.”

District nurses have also undertaken additional training to ensure that patients unable to leave home have access to the holistic reviews and the patient-centred approach.

In some cases health care assistants, two of whom have received additional training, prepare the groundwork for the review – taking bloods, recording some details and making a preliminary note of possible lifestyle reviews and goal-setting to be followed up in the nurse consultation.

Goals and aspirations set during the review reflect the patient’s own ambitions as well as clinical measures. For example, says Edwards, a patient might aim to be able to walk to collect their newspaper.

Gordon says implementing the new review system requires the full commitment of the practice leadership.

“There has to be a functioning team and commitment from the partners. You also need one GP who will support the nursing team. It is clear that one size does not fit all and there has got to be flexibility so it can be shaped to how the practice works.”

This project has also involved the development of personal health action plans for people with long term conditions. This is a vital element of encouraging self-care. Part of the plan contains core information about the individual’s health problems and needs while the rest of it has generic condition-specific information.

Gordon says: “This approach makes it easier for the patient to use these plans and it cuts down on duplication.”

The packs were refined after feedback from carers and one of the GP’s involved in the pilot is planning to research the impact of the plans.

“We are looking at the personal health action plan and how that links in with the review,” Gordon says.

It is intended that the model will be adapted and applied to other long term conditions – work has already begun with patients with respiratory conditions.
Three primary care practices in Leeds are seeking to improve the clinician-patient relationship to make consultations more effective for both the individual and the health professional.

The project brings together several interventions including a written appointments guide, volunteer practice health champions and the analysis of transcripts of real-life recordings of consultations in their practice.

NHS Leeds is coordinating the initiative, which also extends into secondary care with similar approaches to improve the patient experience at the two emergency departments of Leeds Teaching Hospitals NHS Trust.

Project lead Rachel Porter says the Right Conversation at the Right Time (RCRT) initiative partly grew out of Health Foundation-commissioned research around the doctor-patient dynamic which was published in the summer.

The report, When Doctors and Patients Talk: Making Sense of the Consultation, by Gill Ereaut, a linguistics consultant, and health and social care systems consultant Martin Fischer, looked at the anxieties faced by patients and clinicians. This included evaluating what they called the invisible structure of the consultation which can affect the relationship and the effectiveness of the conversation.

Ereaut and Fischer have helped shape the Leeds project alongside clinicians, other staff and patients.

Ereaut says: “This has very much been co-produced with the patients, managers and clinicians all the way through. We developed a prototype of the appointment guide for example after initial discussions and then changed it several times after trial and feedback.”

Porter says: “The inspiration came from research but there was already a general view that the patient experience and patient-centred care are so important but consultations are not always done very efficiently. We wanted to focus on the relationship rather than behaviours on either side.”

One practice from each of the city’s three clinical commissioning groups (CCGs) is taking part – as well as the acute trust’s emergency department – and Porter believes the learning could be used in other care settings. The project is being funded on a pilot basis by NHS Leeds with support from the CCGs, using money from a budget to deliver transformation change.

Sam Forbes, business manager with the Robin Lane Medical Centre in Pudsey, Leeds, says that all the practice’s clinicians had consultations taped and analysed to help understand current practice.

Forbes says: “There could have been a lot of resistance but they could see the benefit for their own clinical practice. Even the process of going through it has made people think about how they consult and their communication.

“This is not about telling clinicians how to consult but getting an agreed framework around principles of how to consult.”

He said that with consultations now more effective the project was helping to reduce demand for follow-up appointments.

Ereaut explains that the recorded conversations allowed her team to discuss with clinicians the elements that made for, as she puts it, smooth or bumpy consultations.

“We were looking for patterns. If a patient has several concerns and clearly expresses them at the start then that ensures they are heard but the GP is in charge of how the time is used. That makes a consultation quite harmonious.”

Dr Jonathan Adams, a GP partner at St Martins practice, says that seeing the transcripts of recorded consultations in the feedback workshop was startling.

“It shows how complex consultations are – you see the information that is involved when it is written down like that. The linguists are very good at showing how the conversation ebbed and flowed. There is a whole science about the consultation.”

For his own consultation style, Adams says the recordings reminded him that consultations had a beginning, middle and end – and highlighted how he could be more effective in the latter stage.

“For me personally I have learned a lot about how to wrap the consultation up in a good way. You have to summarise the process and what has been agreed and what happens next.”

Breeda Columb, A&E matron at St James University Hospital, said that the recording and analysis of clinical discussions with patients complemented existing training.

“There is lots of training around communications but this project is about looking at the expectations of the patient and the doctor or nurse. We need to listen and respond to the patient’s expectations – it might flag up that we might not be the right place for them and that we are unable to provide what they want.”

See related story p11
GPS’ HOTLINE TO CONSULTANTS helps cut referrals and admissions

A new mobile telephone service linking GPs to consultants for immediate advice is reducing inappropriate referrals while building relationships between local doctors in the south-west.

Consultant Link, using specially-commissioned software, has been developed by GP Care – a GP-owned provider organisation. Consultant Link is designed to allow a GP to call a number connected directly to teams of hospital consultants. It has been successfully trialled with a team of cardiologists at University Hospitals Bristol NHS Foundation Trust.

The system scans the consultant list to find a doctor available to take the call on his or her mobile.

The GP, often with the patient still in the practice, is able to discuss with the consultant the most appropriate response to the individual’s symptoms given their medical history. Calls are only made where the GP would have otherwise referred the patient to outpatients or as an emergency admission.

GP Care chief executive Roger Tweedale says that feedback from both primary care and consultants is extremely positive, reinforcing the statistical evidence from the pilot that the system is reducing the number of inappropriate referrals.

“We looked at existing advice and guidance services but they were all based on emails or letters and the written word is open to misinterpretation as well as being time consuming and slow,” Tweedale says.

The system has been piloted in Bristol since October and is now available to patients from South Gloucestershire and North Somerset clinical commissioning groups (CCGs) as well as those covered by Bristol CCG.

Activity has grown steadily each month with 54 calls received in January.

Since the service started, referral or admission was avoided in 56% of cases, 13% resulted in a diagnostics request by the GP and 31% led to referral or admission to secondary care.

Tweedale says: “GPs often need a quick piece of advice but they are unable to get it so they refer a patient. The feedback from both GPs and consultants is that inappropriate referrals and emergency admissions are down. Also, where a referral is appropriate following a Consultant Link call then it is a ‘warm’ referral with the consultant team ready to receive the patient in the right clinic.”

The CCGs pay a fee for the service to cover development, service infrastructure and day-to-day administration costs. However, Tweedale says that with a current national tariff of £210 for a cardiology outpatient appointment, the system only has to prevent referrals in some 10%-15% of cases to achieve real savings for commissioners.

The discussions with the consultants also provide GPs with case-related training.

The software provides each CCG with its own dashboard to monitor the use and outcomes of the service.

Bristol GP Simon Bradley used the service to seek advice on treatment for a patient with palpitations and an irregular ECG scan.

“I did not know whether I should make an urgent referral to outpatients or ask for an emergency cardiac admission. I got through to a consultant cardiologist in less than 15 seconds and we agreed a decision on how to manage the patient while they were still in the building.

“The key thing is you get straight through to a senior grade doctor during the actual consultation. Previously you could spend half the consultation waiting for the hospital switchboard to answer and then get directed on to an answer phone. If you did speak to the emergency team you would often speak to a doctor less experienced than yourself and they would err on the side of caution.”

GP Care now plans to extend the service to other specialties - with gynaecology, paediatrics and general medicine the next likely options. The organisation also plans to include specialists from other hospitals so that GPs receive advice from their local consultant teams.

The software has been developed to allow practices to shape the list of specialists according to their own preference as the system expands.

An important secondary benefit already being delivered by the system is the rebuilding of clinical relationships tested to destruction by the arrival of the purchaser/provider split in the NHS over the last 20 years.

GP Care chairman and GP Phil Yates says: “We are using technology to go backwards in a positive way. So many of the comments we are getting emphasise that it is good for GPs and consultants to be talking to each other again. Payment by results and practice-based commissioning polarised the two sides. Then the ‘dear colleague’ letter of choose and book further reduced personal contact.

“This system is producing better quality referrals and improving relations between primary and secondary care.”
How the system works

- The system is available 8am-8pm on weekdays although GPs are encouraged to use it at times consultants have agreed they are more likely to be available – 8am-9am, 12pm-2pm and 4-5pm
- The CCGs, acute trust and GP Care have agreed a protocol outlining the circumstances in which GPs should use the service to avoid inappropriate calls
- The service scans the list of consultants available that day, calling each in turn until the call is answered
- The percentage of calls that are answered by consultants is in the high 90s but in other cases calls are diverted to GP Care whose staff offer to arrange a call back from a consultant
- Most calls are answered within 60 seconds and the conversation typically lasts two to three minutes
- A digital record of the full conversation is sent to the practice and attached to the patient notes to ensure an accurate clinical record and provide medico-legal protection to the GP and practice. The paperless system makes it easier for consultants to take calls
- The consultants have the option of rejecting the call if it is not convenient – each mobile has been adapted so a call from the service has a distinctive ringtone.

THE RIGHT CONVERSATION
at the right time in A&E

The Leeds project (see page 9) is extending into the city’s two emergency departments.

With longer waits much more likely in A&E than in any GP practice, the role of the volunteer patient champions is a little different from their practice counterparts. The project looks beyond the consultation at the wider context in which conversations take place. Staff and patient feedback has led to further workstreams aimed at improving the physical environment, signage, and provision of information about waiting times.

Iain MacBrairdy, urgent care business manager, says feedback from patients was an important factor in the decision to revamp the physical environment of the waiting area.

Staff, volunteers and the RCRT project advisers spent two days looking at the department from a patient or carer’s perspective and talking to those in the waiting area.

MacBrairdy says: “On the observation days we did quite a lot of talking to patients as they waited and getting their comments on what constitutes a positive experience.”

Matron Breeda Columb said: “We needed external eyes to see things as we are used to working there every day. We are looking to make high-impact but low-cost changes first and are looking at the signage and more comfortable chairs.”

Those more comfortable chairs will be arranged in a way that encourages conversation between the people in the waiting area if they want to chat. The less talkative will soon find they have access to magazines, books and a TV.

The waiting experience could also be improved by the emergency department champions currently being recruited. It is hoped they can be matched to particular patients in some cases.

For example, a volunteer who has experienced domestic violence will have an empathy with a patient injured by a partner. Sometimes, McGregor says, the victim is afraid of talking to officials or the police. In such cases the volunteer might not only tell the patient of local crisis services but offer to accompany the patient.

However, McGregor says, the volunteers will often be using their empathy and communication skills to simply support anxious people sitting alone.

“One role is just to be there. Often in A&E what people need is a chat with someone with some understanding of health and a sense of empathy. The volunteers will offer them a cup of tea or in other cases reassure them that they are in the right place if they are anxious about whether they should even be there.”

MacBrairdy says: “A lot of the negativity in emergency departments is because of waiting. Patients do not know where they are in the system and what they should be doing.”

Columb explains that colleagues are working with the IT department to see how patients can be kept informed of likely waiting times and any added delays due to the arrival of serious emergencies.

“We have a lot of that information at the click of a button and we are looking to see how we can share that with patients through a smartphone app with a barcode so they can see their own information.”

A longer version of this article: http://bit.ly/13tgNin
Engaging their member practices is the biggest problem facing CCGs as they open for business on 1 April.

In a survey by the GP newspaper Pulse this month engagement was member practices was the second highest priority for CCG leaders after reducing emergency admissions and ahead of managing budgets. (It might have been number one if a quarter of the quality premium were not tied to cutting admissions.)

Without the active support of practices, none of the other CCG ambitions identified by the survey, including improving patients’ experience of care, reconfiguring hospital services and reducing prescribing costs will stand any chance of success.

There are five reasons why CCG-practice engagement is crucial:

First, without the involvement of GPs in making and delivering commissioning plans, “clinical commissioning” is just a label. CCGs were designed to succeed where other commissioning organisations have failed: making the collective wisdom and judgement of clinicians an integral part of the commissioning system, giving GPs an executive role in decisions about health investment rather than a seat on a sub-committee.

Second, the quality of primary medical care, like NHS care across the board is uneven. Nine out of ten patient journeys start with a visit to a GP. There are 300m GP consultations every year. This is the front line of the NHS and it has to be as good as possible, but there are considerable variations in quality, safety and value for money.

Third, whether or not GPs take active roles in the CCG, they are small-c commissioners on a huge scale making referral and prescribing decisions with enormous consequences for the welfare of patients and for NHS finances.

Fourth, primary care as a whole has to develop if service reconfiguration is to mean more than keeping money out of the budget. (It might have been number one if a quarter of the quality premium were not tied to cutting emergency admissions and ahead of managing budgets. (It might have been number one if a quarter of the quality premium were not tied to cutting admissions.)

Fifth, GPs can play a major role in preventing ill health and reducing health inequalities without which demand will continue to rise.

Strong as they are, none of these arguments will secure the co-operation of GPs. This is because nobody has yet explained how life as a GP is going to get any better as a member of a CCG. Nobody has made it clear what benefits the practice unit or the provider business gets from supporting the strategic development of the CCG. The interests of the practice and the CCG are disconnected or worse.

Practices need incentives to engage with the CCG. This does not mean more cash – easy QOF points, shares in the quality premium or promises about protecting income from enhanced services or PMS contracts – though successive governments can share the blame for confusing bonus schemes with proper incentives. The answer is to help GPs address much more serious underlying concerns about the future of their profession and the viability of their businesses.

A survey of 2,700 GPs by Wessex LMC earlier this year paints a picture of a demoralised and disaffected workforce.

- 67% of respondents said their practice would struggle to remain viable
- 93% of GPs reported that their working day had become longer in the last three years and 45% said it was much longer
- 94% reported their work had become more complex
- 48% of GPs said they would be considering alternative options for earning a living or taking some form of retirement.

The survey demonstrates why GPs may not be lining up to do their bit for the CCG. One more statistic is very telling: only 2% of the GPs in the Wessex survey were confident that the CCG could provide the leadership “to make primary care more sustainable”.

CCGs will have their work cut out to change this perception, but they must try because their success depends upon it. They will need to demonstrate that the interests of the CCG and its members are not opposed but aligned, that understanding the new commissioning system and taking an active part in it will be good for business (or critical to survival), that quality improvement is not a euphemism for performance management but a way to avoid it, and that only co-ordinated collective action can address the problems of growing demand and shrinking resources.

Part of it will mean a change of language with messages geared to the interests of the individual practice as a provider rather than as a conscripted and unpaid commissioning consultant. It will also mean running the risk of conflicts of interest. CCGs have yet to work out how to help members become “more sustainable” without crossing the line. There are many areas where the interests of the CCG and the practice can be happily combined. CCGs need the cottage industry of medical practices to grow into bigger, more efficient entities capable of running the sorts of services they want to commission. Economic pressure, demand, economies of scale and the ambition of GPs to grow their businesses (or at least keep them viable) are pushing practices in the same direction.

The benefits of working together may be unclear and even those CCGs already engaging effectively with members foresee difficulties ahead, but the consequences of a do nothing and go it alone approach are painfully obvious.

PCC support for CCGs: www.pcc-cic.org.uk/cccg

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