In collaboration: PCC and NHS Networks

August 2013

Commissioning EXCELLENCE

Patient voice is still not heard says survey

Only three in ten believe their local healthcare economy is good at listening to the views of patients. So says a survey of 844 healthcare professionals representing commissioners, providers and the voluntary sector.

The survey by Primary Care Commissioning (PCC) and People Matters Network found that only 31% rated local healthcare economies "good" or "very good" at listening to and acting on the voice of the patient. The figure rose to 58% for CCGs (143 CCG staff took part).

Julian Patterson, marketing director of PCC, said: "CCGs appear much more confident than other organisations, but is that a cause for celebration or concern? One of the main findings of the Keogh report was that we need to be much better at acting on the experience of patients. If six in ten CCGs think we're already doing a good job they may not be prepared to try harder."

The survey also found many organisations (55%) struggling to measure the effectiveness of engagement programmes. Similar numbers admit they need help in using feedback from patients and the public to inform commissioning and to improve existing services.

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Croydon recruits allies in urgent care revolution

Croydon Clinical Commissioning Group's (CCG) efforts to reverse the rise in emergency department (ED) attendances have taken the form of a coalition of local health care providers.

Having inherited a significant financial deficit and with high rates of ED attendance, emergency admissions and readmissions set against low levels of patient satisfaction, the CCG developed a strategy for transforming the whole system – starting with redesigning emergency and urgent care.

Although the opening of an urgent care centre (UCC) at the entrance to the ED provided the foundation, the CCG has sought to gain the active support of a battalion of partners – from GPs to pharmacists and the local ambulance trust.

Dr Agnelo Fernandes, the CCG's assistant clinical chair, said: "You do need to change the mind set of clinicians as well as patients. It has not been plain sailing to begin to deliver transformational change – sometimes you do need disruptive innovation when you are changing the whole system rather than papering over the cracks.

"Professionals don't always understand the role of other professions and of managers in an integrated system. Managers need to think strategically and that can be difficult because of pressure to deliver targets such as the four hour waiting time."

Such creative tensions were perhaps at their peak with the commissioning of the UCC, run by Virgin Healthcare, which opened in April 2012. However, its position at the front of the ED, together with streaming by "experienced receptionists with nursing support", has brought about some dramatic changes in numbers and costs.

Fernandes suggests there has been a 40%-50% decline in the number of adults attending the ED, with the decline even steeper for children at between 60% and 70%.

"The urgent care tariff is about half that of the ED so in terms of savings that is a very important contribution to our QIPP savings," says .Fernandes. He declines to provide a figure but the CCG does have to achieve a net QIPP saving of £14m this year, having already achieved £38m efficiency savings in the previous two years.

Almost simultaneously with UCC change, the 111 system was introduced in Croydon. The CCG took advantage of the coincidence to redesign GP out-of-hours arrangements.

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HELEN NORTHALL

Primary care: the journey starts here

"The key to engaging CCG members is to help them realise that they have a mutual interest in active participation."

The journey starts with primary care: this is not just true for patients, it is true for clinical commissioning groups (CCGs).

The relationship between the CCG and its member practices is one of the main factors for success. To get the added value from clinical commissioning it's vital to engage with members, but turning already pressurised members into commissioning partners is a challenge for many CCGs.

Our work with CCGs around the country suggests that while CCGs have different priorities, they have a common interest in forming strong relationships with their members. Getting members on board is not just about making life easier in the short term, it's also about building the foundations for better local care.

There are four reasons for CCGs to engage with their members:

- They are the main source of clinical expertise and understand what is important for patients
- They bring the whole care pathway view, having information from multiple sources to identify quality issues and spot what needs to change
- General practice is one of the main channels for building patient participation and public support for change
- High quality primary care underpins the CCG's commissioning ambitions and CCGs have the opportunity to play a leading role in its development

No membership organisation can survive without providing benefits to its members. The key to engaging CCG members is to help them realise that they have a mutual interest in active participation. Understanding and taking part in the CCG will help them identify how to develop their own businesses, possibly working with other practices to form bigger provider entities and share resources.

Being an active member may also increase their ability to respond to procurement processes, allow them to realise their clinical ambitions and improve services for local people.

PCC is supporting a number of CCGs to engage with their members, helping them to understand the basic principles of commissioning, procurement, contracts and funding flows. We are supporting groups of CCG members, or localities, to consider how they can work together and with other CCGs to improve access to services and to review locally commissioned services.

We can also work with general practice associations or groups of practices to look at aspects of practice development or federation.

Where there are local issues of primary care quality, unwarranted variation and poor provision, the CCG is the organisation with the best hope of solving them. They may not hold primary care contracts, but the contract is in any case a blunt instrument and a tool of last resort.

Mutual interest and strong relationships are the keys to improving primary care. CCGs that position as local leaders of primary care and enablers of change can make it happen.

Making the primary care connection

PCC is an independent not-for-profit organisation with strong links to the NHS.

Until recently an NHS organisation, PCC is now a social enterprise providing development and support services to CCGs.

We run workshops covering some of the core commissioning topics including procurement, negotiation and contracting and bespoke sessions to enable CCGs and their members to work together on commissioning plans, solve local problems and form stronger working relationships.

We also run e-learning courses and provide other online resources, including NHS Networks, a free collaboration, news and networking service used by more than 80,000 healthcare professionals. Commissioning Excellence and our other newsletters keep commissioners and primary care providers up-to-date on all aspects of policy and practice.

Our national adviser team includes experienced facilitators and experts in NHS funding, commissioning and primary care development. PCC advisers also provide rapid responses to queries about technical, regulatory and contractual issues via an online helpdesk.

As well as CCGs our customers include NHS England area teams and local authorities, allowing us to facilitate the relationships on which commissioning success depends.

For information about PCC services for CCGs contact peter.bullivant@pcc.nhs.uk.

www.pcc-cic.org.uk
www.networks.nhs.uk

Croydon recruits allies

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AGNELO FERNANDES

Fernandes says: "GPs and nurses provide care at the urgent care centre. The UCC and 111 service developments gave us the chance to change the GP out-of-hours contract and as a result reduced activity to the GP out-of-hours service by half. It did what it is supposed to do: integrating 24/7 GP out-of-hours provision to the urgent and emergency care services by a whole system approach."

The re-design has also included:

- Each consulting GP reserving two urgent care same day appointments on a Monday
- Alternative care pathways agreed with the ambulance trust – including treating more people at home without transfer and taking patients directly to the UCC rather than to ED
- Rapid access triage and treatment in ED to improve ambulance turnaround times
- "Pharmacy first" and "'Talk before you walk" promotional and education campaigns.

However, Fernandes says emergency and urgent care should not be seen in isolation. Other changes, such as risk stratification in all GP practices and the local adoption of the London "Coordinate my care" model for end of life care registers, are intended to improve patient care more generally. By providing more coordinated and integrated care, however, they are expected to ease the burden on urgent and emergency care.

Fernades says the early successes in Croydon reflect a belief in the equal importance of clinical input to commissioning and high quality local management.

"To have big changes you need people who know what they are doing, focused on better patient outcomes rather than just process, exploiting different levers and incentives across the system, and who take calculated risks to make a real difference."

"Professionals don't always understand the role of other professions and of managers in an integrated system. "

CCGs and hospital pull together on Bradford DVT pathway

Two Bradford clinical commissioning groups (CCGs) hope to save around £500,000 annually after developing a new pathway that means most diagnosis and treatment of deep vein thrombosis (DVT) takes place in primary care.

The new pathway is also improving patient care and outcomes.

Dr Matthew Fay, a GP and long term conditions lead for NHS Bradford City CCG and a key figure in developing the new pathway, says the radical overhaul was driven by clinical recognition that local performance could be improved.

He says: "We were getting clear and consistent feedback that the existing DVT pathway was poorly understood and there was poor compliance from both patients and clinicians, which increased the risk of poor treatment outcomes. The new pathway will save money, improve the patient experience by ensuring they avoid unnecessary hospital admissions and deliver better health outcomes."

Evidence suggested most non-complex DVT patients could be managed at home by a GP.

The CCG is working with its neighbour, Bradford Districts CCG, in implementing the pathway.

Historically most Bradford patients with suspected DVT were admitted to hospital for diagnosis and, if confirmed, treatment. They were monitored after discharge at anticoagulation clinics based in secondary care.

Now GPs follow a pathway that sees them assessing the patient and using a blood test to gauge the likelihood of DVT – and going on to treat and manage patients where the DVT is confirmed. The pathway has been adapted for use by the acute trust's emergency department.

Secondary care remains responsible for diagnostics and haematology services for high risk patients – such as pregnant women.

Patient information group Anticoagulation Europe advised on clarity of language and acted, Fay says, as a critical friend in providing the patient perspective.

Recognising that the changes would have a big impact on their acute provider, the team evaluated the likely impact on income flows and activity and turned a potential negative into a positive.

Fay says: "We recognised the need to avoid destabilising services that would see activity move to the community – such as the medical assessment unit (MAU) and coagulation clinics and also to ensure that radiology and the haematology service were ready for additional activity. This actively engaged hospital clinicians, building an effective partnership that we have used to manage issues that come up in implementing the pathway."

He adds that the process was given added momentum by the desire to fully implement recent clinical guidance from the National Institute for Health and Care Excellence on venous thromboembolism and a relatively new drug, Rivaroxaban.

In its first month the new pathway ensured 81 patients avoided admission to the MAU, saving £26,000.

However the CCGs are expecting the pathway will deliver annual savings of more than £510,000. Although there will be additional costs in prescribing Rivaroxaban and D-dimer testing and radiology scans, these will be more than offset by saving £600,000 in MAU admissions and £140,000 by moving anticoagulation out of secondary care for most patients.

Fay concludes: "This pathway would be easy for other organisations to adopt and adapt to local circumstances. It means many people who otherwise would have been diagnosed and treated in secondary care are receiving all their treatment in more convenient locations with at least equal – and arguably better – outcomes."

For more information email **matthew.fay@bradford.nhs.uk or clare.smart@bradford.nhs.uk.**

GP TRAINING INJECTS COMMON SENSE into MSK pathways

Training GPs in musculoskeletal (MSK) medicine could save the NHS millions of pounds a year by cutting rheumatology and orthopaedic referrals, an evaluation of a three day education programme has concluded.

The study focused on the referral patterns of 17 GPs funded by the former Hastings and Rother Primary Care Trust to undertake the training in early diagnosis and management of MSK disorders. A large proportion of the training, which is delivered by the British Institute of Musculoskeletal Medicine (BIMM), is devoted to injections - for which the GPs receive a directed enhanced service (DES) payment.

Dr Tom Saw, an MSK and sports medicine physician and BIMM tutor, said: "A patient with an MSK condition often has a difficult, fragmented and confusing journey through the NHS. MSK conditions are also expensive for the commissioner as GPs face a choice of referring to an extended scope physiotherapist – with typical waiting times of up to 18 weeks – or into secondary care."

BIMM asked GPs who attended the Hastings and Rother roadshow to record changes in their referral patterns three months and six months after completing the training. It also sought information on the number of injections they administered for MSK conditions.

The data suggested that in six months the 17 GPs avoided 226 referrals to secondary care – which equates to more than 450 in a full year. In the same period, the GPs also administered 266 MSK injections that they could not have delivered before the training – which equates to 532 over the course of a year.

The local cost of one outpatient appointment and injection was £278 for orthopaedics and £375 in rheumatology.

Saw told Commissioning Excellence that the data did not include information on how many patients were eventually referred to secondary care and what the costs for each patient treated swiftly by a GP might eventually have been. However, he said the savings were clearly significant and should be explored further.

"With so many variables and incomplete data it is difficult to put an exact figure on the savings. However even after allowing for the £43 DES payments to the GPs for injections and the cost of the training, we estimate that the figure could be close to £100,000 per year per group of 20 or so trained GPs.

"Around a quarter of GP appointments involve MSK problems but these conditions do not receive much if any time in pre-registration training. This is about upskilling GPs who can share their learning with colleagues and improve patient care while saving money by diagnosing and treating common conditions in primary care. It would be good to have more analysis of the potential savings but CCGs should be building this approach into their MSK pathways."

Kell urges commissioners to make a reality of integration

An increasingly fragmented system of commissioners and providers makes the development of integrated and patient-centred care more challenging, a clinical commissioning leader has warned.

Steve Kell, co-chair of the NHS Clinical Commissioners leadership group, said that if the new commissioning arrangements are to deliver, all parts of the system need to work together.

Addressing Commissioning 2013, Kell said: "Monitor as a regulator has a lot of information about our local hospital that is not shared with us. We are still fragmented: integrated provision takes a long time; integrated contracting will take even longer. We need to talk to each other."

With the government's comprehensive spending review for 2015/16 announced soon after the conference, NHS Clinical Commissioners welcomed the focus on integration of health and social care but warned that the money to fund it would be diverted from commissioning other services.

Urging NHS England to work with the voluntary sector when commissioning specialist services, Kell voiced doubts in his talk about primary care commissioning capability.

"The importance of getting primary care right is so high but I have concerns about NHS England around contracting. We need to engage primary care as members and commissioners and commission the right service in the local community."

Emphasising the need to involve the public and patients, Kell said: "Francis has shown that communication is very important and we need to be open and transparent when we have a local issue. When we talk to the public about reconfiguration we have to be clear about whether it is a cost issue or a quality issue."

The NHS and its partners could learn from the airline industry's handling of safety issues, Kell suggested. He pointed to that sector's practice of issuing immediate warnings to airlines about any safety concerns with regard to a particular model of aircraft.

In NHS Bassetlaw Clinical Commissioning Group, which he chairs, life expectancy varies nine years between postcodes – a statistic that highlights the importance of public health in delivering outcomes.

Integrated care teams in practices help east London treat the 'whole patient'

Integration based on sophisticated risk profiling of patients, particularly those with long term conditions (LTCs), has started to deliver results for health services and their patients in east London.

Dr Jagan John, a GP and clinical lead with NHS Barking and Dagenham Clinical Commissioning Group (CCG), said that risk stratification provided the data that shaped the development of an integrated model of care for at risk patients and new integrated teams of health and social care professionals based in practices.

Addressing the recent Health and Care conference, Dr John said that services for people with long term conditions across four north east London boroughs were marked by relatively poor patient satisfaction levels and outcomes and excessive unplanned admissions and secondary care activity.

"Our vision was coordinated care with improved clinical outcomes and patient experience. There was clear evidence that patients who needed the most care were not getting it at crucial points in their journey. If you intervene earlier you can prevent and reduce costs but we also wanted to create a system that would work in the future, one that was sustainable. That would be our legacy as frontline staff."

The CCGs (including Havering, Waltham Forest and Redbridge as well as Barking and Dagenham) used the Link Well platform to integrate care data from across health and social care. They videoed interviews with patients with long term conditions to ensure staff understood the need for change from the patient perspective.

The result was integrated care teams based in GP practices.

The teams include:

- Community matrons
- Care coordinators
- Social workers
- Occupational therapists
- District nurses
- Learning disability workers
- Mental health professionals.

Dr John said: "We went for a co-located model because there is a lot of benefit in having teams in the same room and practices working together. Some old GPs say that they had this system years ago so we are effectively going back to a system that GPs felt was beneficial."

Emphasising the importance of social care to the new model, John said: "Our social care team changed all their processes - they challenged health and said 'we are prepared to change our structure to fit in with this'."

The model of care is now being delivered by a coalition of three CCGs (Waltham Forest has moved to a similar grouping in inner east London), 200 GP practices, three local authorities, two acute trusts and a community provider.

Dr John pointed to outcomes including:

- Year-on-year reductions in length of hospital stay for patients with LTCs ranging from 8%-12% across the three CCGs
- Fewer admissions to residential care and a reduction in safeguarding referrals
- Over 2000 patients now have multidisciplinary care plans that are accessible virtually by a range of professionals and the patient/carer
- More timely care packages, including direct referral to social care
- Coordinated care by multidisciplinary teams that has improved the patient experience and reduced wasteful duplication
- A nominated care coordinator for every patient to coordinate personalised care.

He said the work had made clear that a new funding model is needed for larger community teams now undertaking some work previously carried out in secondary care. This is influencing the work of the national programme to develop a LTC "year of care" funding model.

Referring to an unexpected improvement in staff retention, Dr John said: "The workforce has been inspired by the team approach and they feel supported and want to work in that team environment. Most importantly, we are dealing with the whole patient and not just their diabetes or mental health problem."

PATIENT VOICE IS STILL NOT HEARD

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The attitude of clinicians and "community owned and designed engagement" were identified as the most important factors, though IT systems for collecting and analysing patient feedback and social marketing expertise were also considered important.

Patterson said: "Clinicians are going to start some of the important conversations about health and the NHS, but many of the answers will be found in the community. The attitudes and actions of individual patients and communities will have a greater impact on health and wellbeing in the long run than anything that doctors can do.

"CCGs need to be thinking beyond engagement as an end in itself and about their role in enabling communities to be stronger advocates for health and better at describing the services they need from the NHS."

Results of the survey:

Issues identified by the survey will be debated at a free event for CCG leaders on 3 September in London with speakers from NHS England, patient groups, National Voices, the NHS Alliance and an award-winning social media group. Building public support for change is for CCG board members and senior CCG managers with responsibility for patient participation.

Book your place:
www.pccevents.co.uk/pcc/696

Booking enquiries:
events@pcc-cic.org.uk

DIARY DATES

All you need to know about primary medical services contracting
6 August, Leeds

NHS England area teams and other staff with responsibility for managing primary medical care need to understand the fundamentals of contracts and contracting. This workshop gives a comprehensive overview of contract types and how to use them, including processes for monitoring performance and compliance.

http://tinyurl.com/l4wlv8r

CCG summit: building public support for change 3 September, London

Engagement should be part of everyone's job description and woven into the fabric of commissioning, not treated as a low-priority business process. But with CCGs struggling with urgent financial problems and crises of care, getting patients and the public involved in commissioning may seem like a luxury. This event illustrates how good engagement underpins CCG ambitions to change services and how without it CCGs will not have the evidence on which to base commissioning plans or the support of local populations to enact them. With speakers from NHS England, Healthwatch and patient groups as well as leading practitioners.

http://bit.ly/17TDlMm

Procurement masterclass
5 September, London

An interactive half-day workshop to address the implications of the new NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013. Delivered by PCC and Capsticks.

http://tinyurl.com/kugzzfr

Emergency preparedness and rapid response
27 September, London

This workshop will enable delegates to consider their role and responsibilities in responding to emergency situations and the broader impact these situations may have on their teams and organisations as a whole. Duncan Selbie, chief executive of Public Health England will provide an update on the national position and arrangements in place including local health resilience partnerships.

http://tinyurl.com/mkjxu8d

HWBs: vital links to local government – pity about the politics

Health and wellbeing boards (HWBs) provide space for difficult but necessary clinical discussions and vital links to local government, the only GP to chair one claims.

But the experience of GPs also suggests that local politics are a less welcome feature of the new boards.

Dr Joe McGilligan, chair of East Surrey Clinical Commissioning Group (CCG) and co-chair of Surrey Health and Wellbeing Board (HWB), argues that the boards provide "a safe place to have difficult conversations – including discussions about decommissioning".

"We were in shadow form for two and a half years. There have been rows and difficult conversations but we still come together to meet and understand each other. We have to fight people off who want to join because it is seen as the place to sort things out but it took a change in the law for us to do it [closer working between the NHS and local government].

The boards, based in local authorities, have assumed new significance in recent months with shadow health secretary Andy Burnham proposing they be handed major commissioning responsibilities, relegating CCGs to an advisory role.

McGilligan, who is thought to be the only GP chair of an HWB, said the boards represented a step forward on the joint strategic needs assessments that councils and their public sector partners have produced for around a decade. The assessments played little part in commissioning and clinical decisions, he said.

The squeeze on public sector spending and growing demand for health and social care mean those involved had to make the boards work: "We have used all the silver bullets and picked all the low hanging fruit, we have done the easy things," McGilligan said.

With the boards now expected to produce health and wellbeing strategies, McGilligan told the Health and Care 2013 conference that most people now recognise the impact on health of employment, housing, education and crime.

However, McGilligan acknowledged that working with local government also meant dealing with local politics.

As well as party political differences, McGilligan said there were sometimes tensions between different tiers of local government.

He continued: "On something like delayed transfers you can get buck-passing and when councillors are involved you start to get questions like 'what is truth?' It is hysterical how you get dragged down a rabbit warren all the time."

Steve Kell, co-chair of NHS Clinical Commissioners leadership group and vice-chair of Nottinghamshire HWB suggested at the same event that the boards "are not there yet" in terms of structure.

"I have just had a complete change of membership within my HWB [due to local elections] and the real challenge is to get them to take decisions without politicising things".

An early assessment of the impact the boards had in shadow form suggests that members should "lead through influence rather than authority in order to effect change". Published by the Department of Health, the NHS Confederation and the Local Government Association, the report was generally positive about their impact and potential but highlighted challenges.

The report urged HWB members to "advocate and mobilise support for change – even where that is initially unpopular (and) adopt new behaviours and relinquish some power where necessary".

The report is available from **http://tinyurl.com/q9pyll9**

NHS URGED TO WORK WITH THIRD SECTOR to avoid cancer 'nightmare'

Voluntary groups and a commissioner who has twice received treatment for cancer have urged commissioning organisations to make more use of the voluntary sector in developing pathways for the disease.

Charles O'Hanlon, formerly associate director for delivery at Newham Clinical Commissioning Group (CCG), said that the biggest difference between his two battles with cancer was the involvement of the third sector.

Addressing the Health and Care 2013 conference, O'Hanlon, who is still in commissioning, said buying services from the third sector did not signal a loss of faith in the NHS.

Pointing to recent research suggesting that by 2020 nearly half of people would have cancer at some point in their lives, he said smaller voluntary organisations in particular could play a vital role in supporting cancer survivors as they live with the symptoms and after-effects of the disease and treatment.

"This is not about a poor NHS but a partnership for healthy lives. Some of the smaller voluntary groups do not have money for next year. The NHS, which is in a relatively stable position, could help them by developing long term partnerships."

Failing to support cancer survivors would turn "the new normal into the new nightmare" which would be much more expensive for the NHS, he warned.

Sharing the platform, Macmillan Cancer Support chief executive Ciaran Devane urged CCGs to "commission for pathways and populations – not for activity".

"Commissioning decisions need to be based on people and evidence locally," he said.

That evidence, Devane suggested, should include:

- Epidemiology
- Outcomes and experience
- Effective service solutions and
- Health economics.

Commissioning tied to a tariff would not work, he said.

Marie Curie Cancer Care chief executive Jane Collins said her organisation had proved that high quality palliative care could be provided by the third sector working in partnership with the NHS. She pointed to the Greenwich Care Partnership (see box) where her organisation works with a local hospice and the NHS to ensure more people with terminal illness die in their preferred place of care.

"This is not about a poor NHS but a partnership for healthy lives. Some of the smaller voluntary groups do not have money for next year. "

Case study: palliative cancer care – Greenwich Care Partnership

An end of life care service involving two voluntary groups and a community trust commissioned by NHS Greenwich CCG has allowed more people to die in their preferred place of care - the main indicator for palliative care.

Initially commissioned in 2011 by the former Greenwich Primary Care Trust on a two year "test and learn" basis, the Greenwich Care Partnership is based at Greenwich & Bexley Community Hospice, the prime contractor. Marie Curie Cancer Care and Oxleas NHS Foundation Trust provide services on a sub-contractor basis.

The service was re-commissioned in May after proving it could provide effective care in the community for people nearing the end of life.

Just seven months into the pilot, 14% of deaths among its patients took place in hospital – compared to 63% in previous years. Some 57% took place at home or in a care home and 22% in the hospice. Most people prefer to die at home if possible.

The integrated community service offers:

- Inpatient and day hospice care
- A 24 hour rapid response nursing service with a round-the-clock contact number
- A care coordination centre
- Key workers assigned to coordinate each patient's care and ensure effective communication between professionals and services
- An end of life care register.

Local GP and CCG chair Dr Henry Wahba said: "The pilot scheme worked well to demonstrate the importance of a scheme like this to ensure patients in Greenwich are able to die with dignity in the place that they choose. The rapid response service…means that Greenwich residents are able to access this care 24 hours a day, 365 days a year so that wherever the patient is they and their families and carers have support available."

The CCG agreed a £629,000 contract for 2013/14, a figure arrived at after studying the cost of acute and community provision before the pilot began.

Refreshing new start for primary care alcohol services

A GP-led service treating patients with alcohol misuse disorders in primary care has increased the numbers receiving treatment, improved outcomes and reduced pressure on expensive consultant-led services.

Wandsworth Clinical Commissioning Group (CCG) commissioned the Fresh Start service after a 12 month pilot. During that time the service outperformed the alternative option of a local enhanced service (LES) on both outcomes and cost-effectiveness grounds.

Each of the three Fresh Start clinics has a fulltime specialist nurse who is supported for one session a week by a GP with an interest in the management of alcohol misuse disorders. The operating principles are drawn from those used in specialist services.

Alcohol illness and injury is thought to cost the NHS more than £2.7bn a year in hospital admissions, emergency department attendance and primary care – but nationally only around 6% of dependent drinkers access structured treatment each year.

Fresh Start offers planned alcohol withdrawal within an agreed structured treatment plan.

Patients can self-refer or be referred by their GP or a range of public and third sector agencies.

GP Johannes Coetzee led the pilot and continues to lead one of the three clinics.

He says: "Patients with alcohol dependency are often reluctant to seek treatment through their own GP but a primary care service that offers anonymity increases uptake.

"Patients usually present in crisis when seeking help. Long waiting times are a barrier to treatment. The Fresh Start clinic has increased capacity within specialist services, allowing them to work with patients with more complex needs. We see patients in the Fresh Start clinic within seven days of referral where previously patients had to wait up to 18 weeks to access treatment."

A pre-pilot audit also revealed high levels of relapse when patients were treated in mainstream GP practices.

Using the operating principles developed by specialist services, the Fresh Start pilot recorded:

- 57% abstinence at three months
- 50% improvement in mental wellbeing scores
- A significant improvement in alcohol-related health problems (measured by recognised markers of dependency)
- Waiting times of seven days (compared to an average of 13 weeks at the time for the consultant-led community alcohol team).

With GPs previously referring many patients to the more expensive specialist services, the service has delivered cost savings and cut waiting times for both the primary care and specialist services.

Richard Wiles, health and drugs policy manager with Wandsworth Council's public health team, said the target patient group would feel more comfortable accessing a service in a primary care setting. Previously, the former community alcohol team's location in a psychiatric hospital would have been particularly off-putting to some patients.

Wiles said: "The Fresh Start model has proven itself to be clinically superior and more cost-effective compared to other models of treatment such as the former LES. GPs often treat patients for alcohol misuse because there is a lack of choice. This service builds on GP enthusiasm and skills and extends choice."

Commissioners failing diabetes patients, charity says

Commissioners are piling extra costs on the NHS and harming patients by failing to commission separate care and services for the two types of diabetes, a national charity has warned.

Bridget Turner, director of policy and care improvement with Diabetes UK, accused commissioners of "failing to get to grips" with type 1 diabetes.

Addressing a recent conference, Turner said: "Education and commissioning need to reflect that type 1 diabetes is different. While it makes up only 10% of diabetes cases, it has a big impact in terms of care and complications (such as blindness and amputations). There is something going on when so many people with type 1 diabetes are missing out.

"We feel commissioning has not got to grips with type 1 diabetes."

Warning that the already massive NHS spending on diabetes, around £10bn, would continue to rise, Turner urged commissioners to involve diabetes networks and other patients and carers in service redesign.

She said that by investing more in patient education and prevention, commissioners could save money by reducing the £8bn currently spent by the NHS on treating diabetes complications – while improving the lives of thousands of patients.

Only around half (54%) of the three million people living with diabetes in the UK have the nine regular checks they need to manage their condition. The checks are recommended by the National Institute for Health and Care Excellence (NICE).

Turner's comments came a few weeks after her charity published a review of the early work of 50 health and wellbeing boards that warned many are failing to prioritise diabetes.

Half fail to mention diabetes management in their joint health and wellbeing strategies, documents the charity argues heavily influence commissioning decisions across health and social care. With around 850,000 undiagnosed cases in the UK, the charity says the boards should be promoting health checks to improve early detection and make early diagnosis a priority in their joint strategic needs assessments.

PCC PRIMARY CARE COMMISSIONING

Commissioning Excellence is supported by PCC and NHS Networks. Contact julian.patterson@pcc.nhs.uk or visit www.pcc-cic.org.uk and www.networks.nhs.uk