The project to create primary care at scale cannot hope to succeed while substantial parts of general practice are struggling with the basic problem of survival.

NHS England recognised this fact last December when Rosamond Roughton, director of commissioning, wrote to NHS England regional directors and CCGs setting out funding arrangements for support to failing or “vulnerable” practices.

The letter provided details of a £10m rescue package announced six months earlier. It also set out the criteria for identifying vulnerable practices, including those with CQC ratings of “inadequate” or “needs improvement”, and those with below average QOF attainment.

A freedom of information request this March by GP Online revealed the scale of the problem: 811 practices, more than 10% of all practices in England, were considered in need of support.

The money was originally intended as match funding, with the practices matching NHS England’s contribution pound for pound. This provision has already been relaxed in favour of a commitment of practice time in return for funding, partly as a pragmatic response to the fact that the poorest performing practices may often be struggling financially (a point underlined by a BMA report published in May), partly in recognition that unless practices invest their own time in remedial action, any financial assistance is unlikely to result in sustained improvement.

How PCC can help

PCC has developed a support programme for vulnerable practices and is in discussion with NHS England regions about rolling it out.

Other organisations are offering a basic diagnostic service only, but we believe that effective support demands a more robust approach. This should take into account all the issues affecting practices’ performance and the support they will need to develop their own capacity for self-reliance and sustainable improvement.

Vulnerable practices need more than a quick fix

STP plans depend on contracting for new models of care

Sustainability and transformation plans demand a system-based approach to commissioning. They will only succeed if commissioners and providers change both the way they think and change how they approach contracting.

Building on the success of previous innovative contracting events, PCC and Capsticks have again teamed up to share current good practice in a national programme of workshops starting this month. The event uses case studies to allow delegates to explore how learning from other parts of the country can be applied locally.

PCC adviser Phillip Stimpson, says: “Creative use of the contracting process is a critical factor in making new models of care happen. Without bold, robust contracting the theoretical benefits of more efficient, better integrated and higher quality care systems will not be realised.”

Continued page 2
Sally Simmonds, lead adviser for PCC’s practice support programme, says: “CQC ratings and other measures provide a fair indicator where practices are having contractual problems or facing leadership and governance issues, but these often have deeper roots and may be symptoms rather than causes of the underlying problem. “It’s easy to see where there are contractual issues, but the real issues are likely to be around softer skills, relationships, personalities and other factors that may not be obvious or easy to measure.”

**Diagnosis**

PCC has developed its own comprehensive diagnostic, which has been successfully trialled, covering:

- Practice performance
- Premises
- Staffing
- Patient care
- Practice management
- Contractual performance indicators.

The diagnostic includes a SWOT (strengths, weaknesses, opportunity, threats) analysis and recommendations for improvement.

“Our approach recognises that practices may need support in a range of different areas, and we would expect to find different problems in different practices so the support has to be able to flex accordingly,” says Simmonds.

“In some cases, we may be looking at weaknesses in administration, requiring practical, hands-on support. In others, we may need to look at recall rates or referrals and the clinical behaviours behind them. “In all these cases, the diagnostic will provide important clues but the solution has to be to support the practice to make its own sustainable improvements.”

**Recovery planning**

Practices will be able to book further support visits to identify how their issues can be addressed. These will include agreeing plans to address weaknesses in leadership, workforce, training, clinical and administrative processes and resourcing, as appropriate.

But the emphasis will be on speedy, practical solutions, not theory, says Simmonds. “For many of these practices, the alternative is closure and the timescales we’re looking at may be a few months. Once those most at risk have been stabilised, we can help them to think about longer term improvements. For instance, are they making the most of existing sources of funding, such as QOF and locally commissioned services? "Later we can also look at how they work with other practices to reduce costs, increase efficiency and improve the range and quality of care they provide. But to do that they have to be back on their feet. There is nothing to be gained from poor performance and still less to be gained from poor performance at scale.”

PCC is offering its support service to individual practices and to commissioners with responsibility for general practice.

For further information, contact sally.simmonds@pcc.nhs.uk

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**Collaboration service station**

PCC offers flexible support to enable practices to work together more effectively, wherever they are on their collaboration journey. We work with groups of practices considering federation to help them agree a shared mission and identify a suitable legal form. Our experts can also provide support later on with business planning, team training and other aspects of organisational development.

Recent research suggests that some GP federations have stalled either through lack of commitment or because they focused too much attention on legal form too early. PCC can get your organisation back on the road and firing on all cylinders for the next leg of the journey.

For more information, contact: mark.beesley@pcc.nhs.uk
The challenges of supporting patients to become more resilient and knowledgeable about their condition are difficult to crack – and social media can be part of the problem.

Patients often look for information about their condition in isolation, often resorting to Google or joining Facebook groups that have been created by other patients - with no idea of who is providing the content for the discussions or moderating the groups. These can often be more trouble than they are worth, directing people down paths that are not appropriate for them.

To address this issue, healthcare teams at Royal Stoke Hospital have started supporting patients by developing self-care videos and Facebook groups where clinicians can provide accurate, valuable, self-care information to patients in a closed environment.

Part of a person-centred care project launched by the West Midlands Academic Health Science Network across the region, the closed clinical Facebook groups now include atrial fibrillation, multiple sclerosis, asthma and cardiac rehabilitation care and are supported by public facing pages which are used to communicate valuable self-care information to the wider population.

The role of a closed group is to provide much more tailored health advice including common FAQs and information which often forms the majority of the condition related questions asked by patients. These closed groups offer a space where patients can gain real life insights from other patients about living with their conditions as well as useful health advice from the associated nursing teams. These are proving very popular and whilst at the moment the clinical staff are managing the groups, in the long term the ambition will be to provide support within the group from “expert patients” or charitable organisations.

In contrast, elsewhere there are closed Facebook patient groups already up and running that have been created by patients but with very little clinical input. In some, patients are being given misleading medical advice. The closed Facebook groups that we are creating are invitation-only and supported by clinicians, providing patients with a safe forum to meet other people with their condition and peace of mind that any clinical information posted is valid and reliable.

Analysis of the use of these pages shows that 60% of people who are engaging with the medical team via Facebook are over 55 years old, so the potential for getting very useful preventative health advice to an older audience through social media is exciting.

The hospital’s social media project follows similar work in general practices in Stoke-on-Trent over the past two years. We hope to continue to develop the digital infrastructure that we have created to communicate self-care health information into people’s homes via their social media networks.

Dr Ruth Chambers OBE is chair of Stoke-On-Trent CCG

PCC offers an e-learning course for organisations interested in using social media but worried about the potential risks. Managing Risk in Social Media helps you to understand how to handle internal social media accounts and deal with external social media activity which your organisation may become involved in.

To find out more: www.pcc-cic.org.uk/elearning
Outcomes based commissioning may “go against the grain” of how care has been commissioned but will benefit patients, a PCC event focused on care for people with diabetes has heard.

Dr Rupert Dunbar-Rees, chief executive of outcomes data specialists Outcomes Based Healthcare, said the approach could be more straightforward for diabetes because of the clearly-defined patient group, and consensus on which outcomes to measure.

One commissioner attending the event suggested that any benefits of commissioning for outcomes could take up to three years to realise, while financial pressures demand quick results. She added that this was aggravated by the emphasis on outputs, rather than true outcomes, in existing national outcomes frameworks.

Dunbar-Rees said: “There are undoubtedly technical challenges, because it goes against the grain of the way we have worked for 60 years, but we have overcome many of those barriers in diabetes to a large extent. You need whole pathway outcomes to show the benefits properly and make the case for long-term investment.”

“One of the key cases for outcomes is that it is often about improving people’s quality of life – things like being more confident, being able to self-manage and to return to work. These things can’t be delivered by a single care or organisational silo.”

“Reimbursement mechanisms have historically paid for treating complications of diabetes like heart attacks, strokes or amputations, rather than rewarding all the complications that are prevented. Outcomes based commissioning is beginning to change all of that.”

Commissioners and providers need to select the “right blend of quality indicators” around structure, process and outcomes, he suggested.

“Indicators for structures or inputs are easy to measure but they do not always lead to the right processes actually occurring for complete populations. Outcomes that are meaningful to individuals are often important clinically and financially,” he said.

Outcome measures should be developed through meaningful consultation with patients and carers. “You need structured conversations with people with similar needs, but bearing in mind that it is not a precise science, at least initially.”

“Whose outcomes are you commissioning for? How do you involve patients and the right ones? Different areas are using very different approaches such as social media, asking patients to prioritise outcomes by voting for the ones that mattered most to them.”

Dunbar-Rees said some areas are using composite outcome measures, or measures that reflect particular local issues – such as addressing a high number of diabetes-related amputations.

He was one of several speakers to emphasise the importance of clinical leadership in developing outcomes measures.
ensuring senior nurses were no longer spending time writing letters
• A risk stratification tool on a common IT system
• Increased access to a clinical psychologist, particularly for recently diagnosed patients who may be in denial
• When a diabetes patient is admitted to hospital for any reason

the diabetes team is notified and is involved in their care and discharge planning.

Roberts said that the acute trusts are now working together and with community and primary care services in one team to provide patients with a much better quality of life.

“There is evidence of sustainable clinical benefit,” she concluded, while acknowledging that Camden still had significant room for improvement in the national clinical audit for diabetes.

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SIGNIFICANT SCOPE FOR IMPROVEMENT IN NHS DIABETES CARE

Commissioning better care for people with diabetes would benefit both patients and taxpayers, NHS delegates to a PCC event heard this month.

The event, which focused on “outcomes based” approaches to buying diabetes services, comes in the wake of a report from the World Health Organisation that 1 in every 11 adults now have the condition.

Robert Ferris-Rogers, a delivery partner with NHS Right Care, said unwarranted variations in outcomes suggest that services could be improved in most parts of England without any additional investment. Pointing to published data showing a four-fold variation in the level of amputations between different areas, he urged NHS clinicians and managers to see these differences as an opportunity for improvement.

“Spend alone does not equate to better outcomes in diabetes. Only 13 of the 211 CCGs (clinical commissioning groups) were not outliers in at least one of the five diabetes outcomes indicators. Put another way, that means 198 CCGs and their providers have significant improvement opportunities in at least one of the five areas for diabetes.”

Some local health economies, he suggested, hide behind demographic factors such as deprivation and ethnicity.

He urged commissioners and providers to secure clinical leadership and engagement to transform services. They should also make the case for change, Mr Ferris-Rogers suggested, by using readily available data and building a narrative of improvement.

Mr Ferris-Rogers was speaking at an event about outcomes based care in Birmingham organised by PCC and supported by Novo Nordisk.

He pointed to the “substantially better” outcomes for people with diabetes in Bradford compared to their counterparts in Luton, despite the similar demographics of the two areas.

“We need to close the perception gap between clinicians and patients. There is a lot of information out there and some are using it and some are not. We must move away from the old care language of secondary care and primary care. We need a system of care based on what the population needs.”

Mr Ferris-Rogers continued: “You need to look at what optimal looks like rather than blame hospitals or GPs. Resistance to transferring diabetes care services from hospital to primary care is too often based on fear of losing income rather than safety.”

Dr Rupert Dunbar-Rees, chief executive of outcomes data specialists Outcomes Based Healthcare, said commissioners and providers need to choose the “right blend of quality indicators” around structure, process and outcomes.

“Indicators for structures are easy to measure but they do not always lead to the process occurring. Outcomes are meaningful to individuals and are important clinically and financially,” he said.

PCC chief executive Helen Northall said: “Diabetes is an excellent area for outcomes based commissioning as it is well-defined and it is a national priority. With diabetes already accounting for around 10% of the NHS’s budget and the numbers affected set to rise significantly, getting better value for taxpayers is a key challenge.”

The workshops were developed with funding and support from Novo Nordisk, a global healthcare company with more than 90 years of innovation and leadership in diabetes care.

Right Care provides data and tools that enable commissioners to make better informed decisions about how to prioritise investment to get the best results for patients.

Find out more: www.rightcare.nhs.uk
Community pharmacists are working in GP practices across Sheffield following a successful pilot programme.

Using investment from the Prime Minister’s Challenge Fund to improve access to GPs, the scheme releases GP time, improves medicines management and has been welcomed by the mainly elderly patients who have benefited from expert pharmacist advice and interventions.

After initially piloting the scheme in four practices in early 2015, Sheffield Clinical Commissioning Group has worked with local practices to match each with a local community pharmacist.

Although the arrangements and work undertaken are shaped by local needs and their skill level, the project typically sees them working one day a week in the practice and two days in the case of larger practices. With the supply of highly-trained pharmacists increasing, the CCG sees them as a specialist clinical resource that can help GPs and other practice clinicians such as nurses use their time more effectively.

Responding to referrals from GPs and practice staff, the pharmacists’ have largely focused on:

- Dealing with patient queries about medicines
- Medicine reviews
- Authorising repeat medication.

Pharmacists are doing home visits to patients at high risk of hospital admission.

The CCG allocated £730,000 of its £9m PMCF money to the programme, largely to cover reimbursement to the pharmacists’ employers and for locum cover. According to Sheffield CCG medicines management lead, Dr Peter Magirr, the CCG sees the main benefits of the programme as freeing up GP time while improving both the service to patients and the quality of medicines management.

Data gathered on PharmOutcomes suggests the pharmacists’ work so far has released 1375 hours of GP time as 92% of their activity would otherwise have been done by GPs. The pharmacists refer back only 6% of patients to GPs.

The pilot identified that pharmacists sometimes recommend cheaper medicines for some patients and other potential savings – such as patients receiving new prescriptions when they had failed to collect other scripts.

Matching pharmacists with 86 practices and encouraging their employers to see the benefits are among the challenges the CCG has faced.

“The logistics have been challenging because there is no infrastructure to get pharmacists working with 86 practices,” Magirr says.

In most cases pharmacists signed confidentiality agreements and are able to access the full medical record – providing an overview that is itself helpful in medicines management.

“However the improved relationships and understanding benefit both the practices and the pharmacies – not least because they are local and see the same patients. That relationship is key for better patient care. The GPs really value the work that pharmacists are doing in and for their practices.”

While some pharmacists have had qualms about working in a practice, all have found it a positive experience, Magirr says.

“Some of the pharmacists were initially concerned whether they had the clinical sills to work in that environment but it is about reactivating and sharpening skills they have. They have gained great professional satisfaction from using their knowledge, visiting patients at home and undertaking very patient-focused work that is improving outcomes for patients and the patient experience.”

“There’s also a commercial benefit for the pharmacy employer if more patients see the pharmacists as professional clinicians rather than quasi-shopkeepers.”

Contracting for new models of care continued from page 1

"The NHS is not sustainable if individual organisations are winning contracts but the system as a whole is failing. This event explores the practical issues of using innovating contracting approaches to realise the ambitions of the Forward View. Without a change of approach, commissioners will have to make a choice between sustainability and transformation. The real issue is how you deliver both."

The workshop uses examples from Cambridge and Peterborough, Valencia, the United States, Lambeth and Northumberland to illustrate examples of innovative contracting, highlighting the lessons for commissioners considering similar approaches, potential opportunities,
PCC supports scheme to embed clinical pharmacists in general practice

PCC is supporting around 700 GP practices to bring clinical pharmacists into practice teams, as part of a major programme to improve the skill mix in general practice and relieve pressure on GPs.

PCC’s role is to work with the practices as they make the changes needed to embed clinical pharmacists in their new roles and develop the capability to manage further workforce change in future.

The four-year programme recognises the largely untapped potential of clinical pharmacists to provide more frontline care for patients, as well as the need to fill the growing hole in the GP workforce.

Clinical pharmacists will be able to conduct medicines use reviews and play a big part in the care of patients with long-term conditions, for example.

NHS England hopes the programme will relieve current pressures on GPs by enabling practice based pharmacists to take on some of their clinical work, with the longer term aim of helping practices to adapt more readily to changes in the primary care workforce.

Each of the practices that have signed up to the Clinical Pharmacists in General Practice pilot programme will receive funding for part of the pharmacist’s salary for the first three years. PCC will facilitate four development sessions with each practice team to support them to make any changes needed to assimilate the clinical pharmacist role, adapt their working practices and ensure that the changes are sustainable.

Helen Northall, chief executive of PCC, said: “This is the biggest programme of its kind, covering around 10% of all GP practices in England and we are proud to be associated with it. The Forward View underlines what many have been saying for years about the need to make better use of the whole primary care workforce to provide a better service to patients.

“The problems of the GP workforce and the financial and workload pressures on general practice mean we can no longer afford to wait for solutions. This is a bold initiative by NHS England to provide practical support both in terms of funding for practice-based pharmacists but equally importantly in terms of development of the practice team to make the most of the opportunity.”

PCC is one of a number of delivery partners involved in the programme. Others include NHS England, Department of Health, NHS Leadership Academy, Health Education England and Centre for Pharmacy Postgraduate Education (CPPE).

PCC will encourage participating practices to use the NHS Sustainability Model, a diagnostic tool designed to help organisations to identify their strengths and weaknesses during a process of change, and to maintain the gains from improvement initiatives.

Helen Ellis, manager of the PCC team supporting the programme, said: “Our job is to support practices and help them to understand their state of readiness for embedding the role of clinical pharmacist in the existing team.

“There are all kinds of implications whenever you change the workforce mix, including the effect of the change on other staff and how the new members of the team will be regarded by patients. Some practices will have thought hard about that. In other cases, thinking may not have gone much further than whether or not the pharmacist has a chair and a desk.

“The programme is a pilot for the wider general practice workforce, but it’s not a trial. These are real posts and the intention is to make a permanent change. Our role is to support practices to make the changes they need to make to embed clinical pharmacists, but I’m really hoping that they develop the appetite and capability for continual improvement as they are bound to face further evolutionary challenges in future.”

Ellis says that the practices stand to gain in several ways from participating in the programme. “Funding for a senior member of the clinical team may be a big attraction for some initially, but the bigger gains will be around freeing up GP time and bringing the unique expertise of the pharmacist to the package of care offered by the individual practice.

“What we would also hope to see is some evidence that practices permanently improve their capacity for managing change,” she adds.

legal issues and common pitfalls.

“Understanding what doesn’t work is as important as understanding what does,” says Robert McGough, partner in the commercial team at Capsticks, a leading law firm specialising in healthcare.

“Although the legal framework and forms are important, successful examples suggest that other factors have to be in place first. For example all parties need to buy in to the new way of working, behaviours have to change and ideally the solution has to be genuinely co-created.

“When you get into the detail, whether you are talking about alliancing, prime contractor or ACO/ACS/ICOs every example is different. What the good ones have in common is a real shift in thinking from organisation to system.”

This event is relevant for all organisations and staff involved in shaping new models of care and local solutions, particularly those involved in commissioning and contracting. It covers foundations for success, legal frameworks, different contracting routes and when to use them, and accountable care/new care models.

Dates are 8 June (Leeds), 20 July (Birmingham), 21 September (Manchester) and 23 November (London).

Booking details: www.pcevents.co.uk/calendar.
Dawning of the age of self-care

In an era where NHS managers’ desks are straining under the weight of invoices from services and where the printers on clinicians’ desks are churning out more requests for pills and potions for a larger and increasingly older population, one area of the country is asking ‘what is the prescription for the future of healthcare’?

Is it more of the same or something a little different? Could it possibly be a question of handing over a bit of power to the people? And if we imagine doctor-patient relationships working differently, how would that work in practice?

The health and social care economy in Nottingham city is addressing just this issue. As part of a wide-ranging integrated care programme, a pilot is in place to develop the support of citizens’ self-care. Self-care is all about empowering people with the confidence and information to look after themselves when they can, and visit health and care professionals when they need to. This gives people greater control of their own health and encourages healthy behaviours that help prevent ill health in the long-term. For many patients in the pilot area it will mean a distinct change from how things have tended to always be done.

Nottingham City CCG and Nottingham City Council, working alongside Nottingham CityCare Partnership and partner organisations, are running an integrated care programme aiming to provide seamless care and help keep more people healthier in the community and out of hospital. The programme is one of the national integrated care Pioneers sites for NHS England.

The self-care pilot has been launched in the north of the city in an area called Bulwell, and depending on evaluation, will be rolled out across the city. It brings together a large number of projects under one umbrella, all aiming to inform and empower citizens. These include ‘self-care hubs’ in NHS and community venues where people can find out more about local health and social care services, both online and by speaking to staff and volunteers, and ‘community clinics’ where citizens can be assessed for specialist equipment to help maintain their independence at home. Support will be available from volunteers, known as ‘community navigators’, who have a good local knowledge of available services and can help direct people to the appropriate service(s) and to local social and voluntary groups.

The role of care co-ordinators, established under the city’s integrated care programme, has been widened to become public-facing and they too will steer people in the right direction for appropriate care and support. There will be an increased use of specialist health equipment (telehealth) which can monitor aspects of people’s health, for example, blood pressure readings, and specialist equipment for social care (telecare) which can, for example, alert someone if a person has had a fall.

In addition, the pilot is introducing social prescribing where GPs and clinical colleagues can refer people to services which support the wider determinants of health such as joining social groups, taking up exercise, or addressing housing needs, for example. Supporting all of these initiatives is a new website bringing together details of local health and social care services and information on social and voluntary groups. The website, commissioned from a third sector provider, is available at www.nottinghamselfcare.org.uk

Rachel Jenkins, senior project manager for adult integrated care at Nottingham City CCG, said: “Self-care embraces a range of support services – people may benefit from advice about managing their health, having some specialist equipment in the home, or attending a social group like a lunch club. In each case we will work with individuals to identify their needs and what might best suit them. Through initiatives such as this we aim to help keep more people healthier in the community and out of hospital.”

Jo Williams, assistant director health and social care integration at Nottingham City CCG and Nottingham City Council, added: “While the integrated care programme has been established for a few years now, this self-care pilot is being set up and implemented as we speak. It’s multi-faceted, has the support of the voluntary sector, and will hopefully begin to change people’s ideas about how care is best delivered and how we can support ourselves and each other in our community. The pilot will be fully evaluated and we will be happy to share insights gained in due course with any other health and social care economies.”