INVERCLYDE
HSCP
Health and Social Care Partnership

AGENDA ITEM NO: 2

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**18 August 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/51/2016/BC**
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Subject:	**INVERCLYDE NEW WAYS OF WORKING**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board of the range of work underway across Inverclyde in relation to the New Ways of Working pilot.

2.0 SUMMARY

2.1 General Practice is under considerable pressure as a result of increasing workload and workforce shortages. It is recognised that one of the major concerns in the health and social care system at present is that few of the professionals involved are truly working at the 'top of their licence', i.e. many are engaged in a significant proportion of tasks/activity that could be more effectively done by others.

2.2 The role of the General Practitioner and other professionals in Primary Care in future must be able to make best use of the unique experience and skills of each.

2.3 In order to improve outcomes, GPs need to be freed up from activities that do not require GP involvement and other health and social care professionals require to become more accessible.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the range of work in progress, and consider the potential future delivery of Primary Care and consequential resource implications.

Brian Moore
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4.0 BACKGROUND

4.1 In September 2015, Inverclyde HSCP was approached to consider the opportunity to work in partnership with NHS Greater Glasgow and Clyde, the Scottish Government and the British Medical Association (BMA) to explore new ways of working and inform the development of the new GP contract.

4.2 An unprecedented combination of pressures has resulted in the continued delivery of Primary Care in its current format no longer being tenable. Pressures driving change include demographic changes; increasingly complex health care needs; workforce shortages; financial demands and public expectations.

4.3 By changing the role of GPs, it is expected that we will improve recruitment and retention and strengthen the crucial role of General Practice and Primary Care within the wider health and social care system.

4.4 The revised role of the GP is envisaged to be that of a senior clinical decision-maker in the community who will focus upon:-

- Complex Care in the Community
- Undifferentiated Presentations
- Whole System Quality Improvement and Clinical Leadership

Complex Care in the Community

GPs will spend a greater proportion of their time delivering care to patients with multiple co-morbidity, general frailty associated with age, and those with requirements for complex care, e.g. children or adults with multiple conditions including mental health problems or significant disabilities. The system will be focused on knowing its population and assessing where there is potential to achieve better outcomes. Each Practice would therefore need to be supported with adequate information to proactively identify this cohort of patients, and to then work with others to devise an appropriate care plan to ensure that these patients receive the optimum care and support.

One of the main aims of this change in approach/focus is to reduce the avoidable time spent in hospital by patients with complex needs, where this is appropriate. It is broadly agreed that where care at home is desirable and adequately supported, it is better for patients. GPs spending more time on patients with complex needs would help to ensure that admission to Acute care should only be to achieve a specific outcome, or for an assessment or treatment that could only be provided in a hospital setting.

GPs will also be involved in establishing protocols for community teams on how to manage patients with complex needs and develop anticipatory care plans for these patients in order that they can be cared for in their own homes for as long as possible. As the expert generalist in the community, GPs will also support these community teams when any expert GP input is required.

Undifferentiated Presentations

Seeing patients who are unwell, or believe themselves to be unwell, has to remain a core part of General Practice as it is the basis for learning the clinical skills required of a generalist and is expected by patients. However, GPs are a limited resource and their capacity to see patients is finite. There will, therefore, need to be a balance found between access to GP appointments, access to other health professionals where that is more appropriate, and encouraging patients to seek self-care where appropriate.

The new model of care, with everyone working to the top of their licence, will require

other health professionals to be more involved in meeting immediate patient needs. Working alongside GPs they need to be able to efficiently assess and treat patients, within their clinical competence. It will be essential that they are able to complete episodes of care without recourse to the GP on a significant number of occasions. Yet, GPs must retain oversight of the service and must maintain longitudinal patient contact to develop and maintain the skills that are required to manage complex care.

Practices should act as a "patient gateway" to ensure that patients are being adequately streamed to the most appropriate service. Patients should experience contacting the Practice, either in person or remotely, as a way to obtain advice on how best to have their needs met most efficiently by the service. GPs should oversee and manage the process to ensure it is effective and that streaming of patients is clinically appropriate.

Whole System Quality Improvement and Clinical Leadership

GPs must have regular protected time to be able to develop as clinical leaders, with the intended outcome that they become fully involved in assessing and developing services intended to meet the needs of their patients and local communities.

As senior clinical decision-makers, GPs will assess the overall performance of their own Practice, Practices within their cluster and the wider community team, with a clear focus on outcomes of relevance to patients leading to suggestions for improvement that will, in turn, be evaluated by them and others. This will require GPs to have influence to direct change within the wider health and social care organisations. Indeed, it is doubtful that health and social care organisations can be successful without the significant involvement and engagement of GPs in this meaningful way.

Whilst it is recognised that many GPs may not currently see themselves attracted to broader leadership roles and responsibilities, each will need to be involved in improvement activity in both their Practice and the wider system, as any significant improvement in patient outcomes is only likely to be achieved if every senior clinician is engaged in these activities at some level.

5.0 CURRENT POSITION

5.1 Following initial engagement sessions led by the Partnership, NHS Greater Glasgow and Clyde, the Scottish Government and the BMA, all 16 Practices in Inverclyde signed up to participate in the pilot.

5.2 Feedback from these sessions, complemented by a wider multi-disciplinary session (including Practice Managers (PM), Practice Nurses (PN), Pharmacy, District Nurses (DN), Allied Health Professionals (AHP), Public Representatives, Third Sector and Housing colleagues), clarified areas to address into 3 broad categories:-

- Communication
- Operational
- Transformational

Communication and Operational

From the sessions it became apparent that there was not widespread or consistent awareness of the full range of services available within Inverclyde or, indeed, how to access these. There was also frustration at some issues in operational systems which were resulting in delays and inefficiencies in day to day working. Work has been ongoing in these areas to fully identify the issues and explore how to address these whilst also communicating across teams to improve understanding and up to date knowledge of all services within Inverclyde.

Transformational

Transformational work has focused upon a number of Tests of Change, identified by the Primary Care workforce as areas where realignment of activity could achieve the aim of releasing GP capacity:-

- To develop a reliable and responsive Community Phlebotomy Service; implementation of a pre-bookable service that would run in parallel with the existing service. Five local GP Practices are involved in this pilot to evaluate the impact on GPs and Practice Nurses in terms of releasing capacity. The impact would also be measured for existing community phlebotomy, treatment rooms and district nursing services.

- Addressing early intervention and prevention for people with long-term conditions. Implementation of Activity of Daily Living (ADL) smartcare system to increase self-management of non-acute conditions, direct patient access to some items of aids to daily living, timely access to Occupational Therapy (OT) for those patients at high risk and reduce dependence on GP Practice services. We envisage that 6 local Practices will be involved in this Test of Change.

- To provide first point of contact for assessment, diagnosis and initial management of Musculoskeletal (MSK) conditions in a GP Practice setting. This test will take place in 3 GP Practices in the hope that patients requiring early interventions in acute MSK conditions will access the right person at the right time. It is envisaged that this model will reduce the patient journey, reduce GP referrals to MSK, reduce the need for longer courses of physio treatment and use Secondary Care services effectively.

- Exploring opportunities for working differently to maximise the nursing potential within Practice and Community setting. Test the role of Advanced Nurse Practitioner (ANP) based on learning from other areas. This test is in preparatory stages working with local PNs and Community Nurses to determine current roles and opportunities for working at an advanced level. Work is also underway to develop local Health Care Assistants and determine the way forward with this role in Practices.

- Manage home visits more effectively by testing implementation of telephone triage. One GP Practice will be involved in this test, with support from one of our experienced PNs, as will other key professionals. This test will then focus on responses to home visit requests to determine which patients could be safely managed by other members of the Primary Care team.

5.3 Other Areas

- Pharmacy – each Practice has been allocated additional support to shift the balance of pharmacy workload from GPs to Pharmacists. This will take shape in various formats depending on Practice need; examples are: acute/special prescriptions, clinics, medication advice and medication reviews.

- Older People – developing how older people are assessed and supported within Acute and the community is underway, including the introduction of early Comprehensive Geriatric Assessment in Inverclyde Royal Hospital and consideration of how Community Geriatrician support can enhance care for older people in the community. This supports New Ways by providing access to the right person/support at the right time in the right place.

5.4 Complementary Workstreams

In addition to the tests of change, the work is underpinned by a number of

complementary workstreams, all within direct GP involvement:-

- Patient and Carer Involvement – recognising that to move workload from GPs to a range of other professionals, a key element is to inform the public of the need for change, utilise their input to understand how and why they access services and to begin to redirect to other services, we are working closely with Your Voice to engage with patients and carers.

- Education and Communication – in redesigning services locally, we have researched to understand how some of the issues we are facing have been addressed elsewhere, rather than perhaps trying to reinvent the wheel from scratch. The existing Continuing Professional Development Group is using this to programme this year's work, through formal Protected Learning Time events and more informal network communication.

- Data and Outcomes – clearly in utilising the methodology of Tests of Change, to understand the impact upon activity, we not only need to know what activity changes but also what activity was happening as a baseline. We are endeavouring to build this in at the outset of each piece of work, supported by the expertise of colleagues in Public Health and Information Services Division. This is an area of particular challenge as, unlike activity in Secondary Care, much of Primary Care activity historically has not been vigorously recorded.

- Quality and Leadership – given the pivotal change to embed a qualitative approach to Primary Care, a range of initiatives are underway. Facilitated sessions for GPs, PMs and PNs have commenced in 4 locations, sharing basic tools and techniques for Quality Improvement and using the time to identify common themes/areas for improvement. In addition, access to Quality Improvement Workshops at a Board level has been provided for some key individuals, with local workshops planned for PMs, PNs and any other interested parties. Over the course of the next 12 months, 5 groups will commence working together following a national facilitated programme, Collaborative Leadership in Practice. This will be delivered locally in 4 geographic clusters and with the fifth supporting the work to improve pathways for older people between Primary and Secondary Care. The Collaborative Leadership work is key to widening the New Ways work beyond purely healthcare staff, and will include Social Workers and Homecare Team Leads in particular, with the key aim of improving understanding of how roles impact upon each other and can change to meet the needs of our population more effectively.

6.0 PROPOSALS

6.1 The challenges leading to the development of the New Ways of Working project are complex and multifactorial. Careful monitoring is underway to monitor the impact of change and, in particular, the ability to move activity between services and/or professionals encouraging all to work to the top of their licence. Inverclyde is not unique in testing models of change, with some of the initiatives already tried in other areas and, indeed, we have learned from this. However the scale of change, across professions, with all Practices involved is not replicated elsewhere, giving us a unique opportunity to progress a longer-term strategy of transformational change. To assist in reviewing the impact and overview of the project, researchers from the Scottish School of Primary Care at Glasgow University have been commissioned by the Scottish Government to evaluate progress.

6.2 Of particular note to date has been the level of engagement and willingness to participate we have secured from the local GP community, against the backdrop of the whole purpose of the project, i.e. increasing demand for their services.

6.3 Going forward, a key issue will be finance. To date, the money supporting the project has been on a one-off and non-recurring basis. Support secured, both directly financially and support in kind, such as the Collaborative Leadership Programme, has been considerably in excess of what we would have secured on a solely population base. However, if we demonstrate the benefits of moving activity, inevitably the need for recurring resources will arise and the IJB should consider this in the light of any available monies for allocation.

7.0 IMPLICATIONS

FINANCE

7.1 **Financial Implications**:

Funding in the region of £385,000 on a non-recurring basis has been allocated.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
Health and Community Care	New Ways	2015-17			

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments

LEGAL

7.2 There are no legal issues within this report.

HUMAN RESOURCES

7.3 There are no human resources issues within this report.

EQUALITIES

7.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

8.0 CONSULTATION

8.1 There has been ongoing discussion with the Staff Partnership Forum.

9.0 LIST OF BACKGROUND PAPERS

9.1 None.