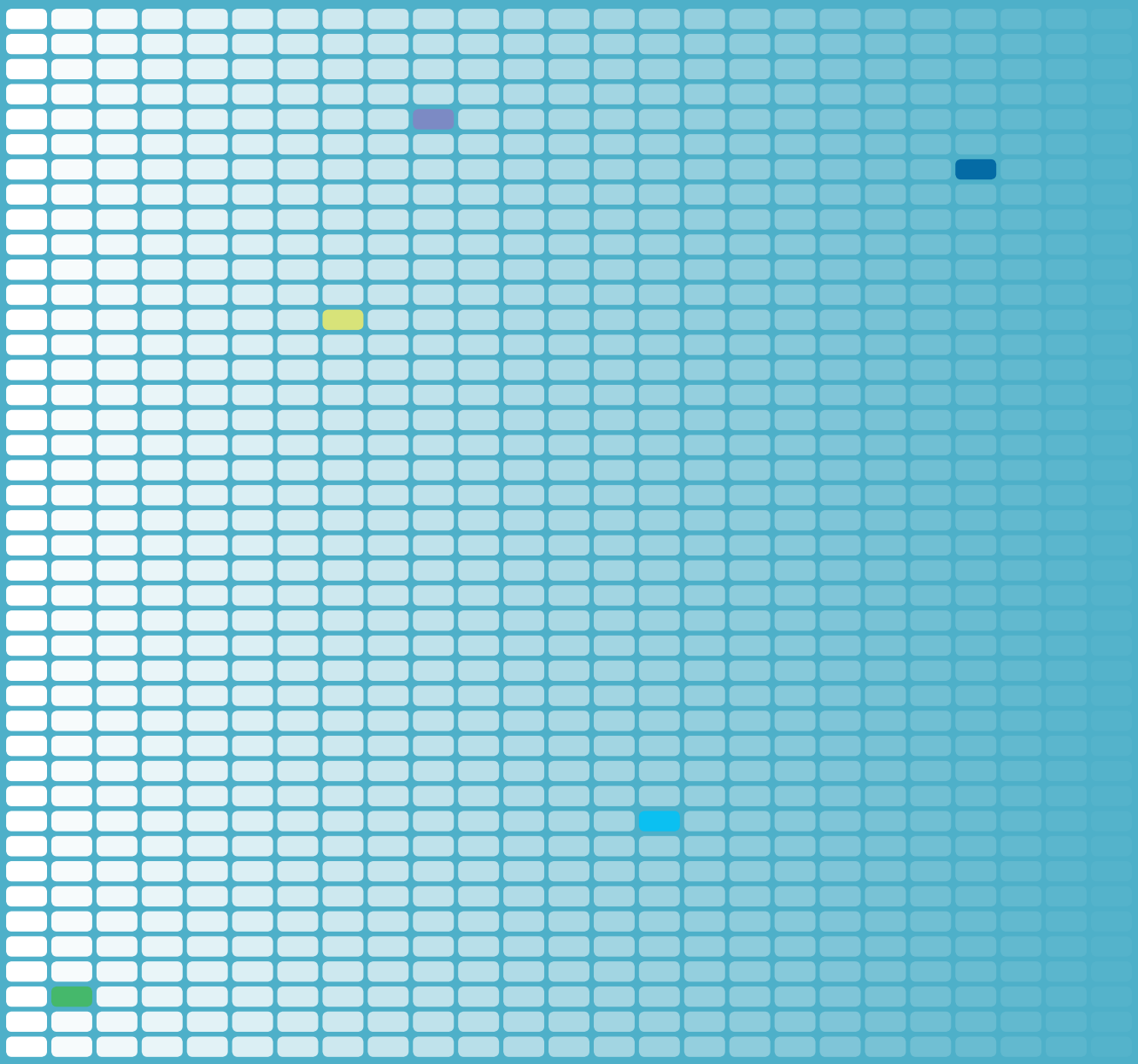
Urgent Care Report



NPCN
National Primary Care Network

Welcome

The inaugural report of the National Primary Care Network

The National Primary Care Network (NPCN) – an informal group of over 500 healthcare professionals from across primary care including GPs, nurses, dentists, optometrist and pharmacists – was launched on 17 September 2013 at its inaugural quarterly meeting.

Each meeting is split into two parts. A discussion forum takes place during the day in which the NPCN's members examine a specific, pre-agreed topic. And in the evening, members take part in a networking dinner, which on this occasion included a welcome speech by Sir David Nicholson, Chief executive of NHS England

This report is intended as a record of the afternoon's discussions. It contains three chapters. The first includes summaries of the presentations that were given by Harry Longman, Dr Shika Pitalia, Dr James Kingsland, and Mukesh Lad. The second sees *The Commissioning Review's* editor-in-chief, Victoria Vaughan, give her overview of the members' reactions and feedback to those presentations. And the last chapter sees Dr James Kingsland OBE – the NPCN's Chair – give his personal view on the day's proceedings.

Campden Health, the publishing and research company behind *The Commissioning Review*, supports the NPCN financially but has no input in the NPCN's discussions.

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INTRODUCTION

Big picture

A summary of NHS England's urgent care review

Urgent or unplanned care leads to at least 100 million NHS calls or visits each year, which represents about one third of overall NHS activity and more than half of the costs. The urgent and emergency care review was launched by Professor Sir Bruce Keogh in January 2013 in response to concerns over rising demand for unplanned care. The review uses a very transparent and engaged approach which aims to:

- Determine patients' priorities when accessing care.
- Build the evidence base to support principles and seek further evidence
- Determine the clinical principles by which urgent and emergency care should be organised.
- Build in public, by contribution, consensus on the key components and the system design objectives.
- Develop commissioning framework for future proposed model options.

Following the announcement, a steering group was established, chaired by director of domain three – acute care, NHS England, Professor Keith Willett, with representation from National Voices, a coalition of healthcare charities, providers and commissioners from across the urgent and emergency care pathway and the wider clinical profession.

The steering group developed the evidence base for change, which identified a number of areas for improvement within the current system of urgent and emergency care in England. In summary:

- More people are using urgent and emergency services, leading to mounting costs and increased pressure on resources.
- Overall fragmentation of the system inhibits continuity of care leading to poor patient experience, duplication and unnecessary use of resources.
- Demographic change means more patients need support to manage long-term conditions to prevent acute exacerbations and use of hospital services, but this support is not always taken up or available. Some patients lack confidence in telephone advice and are likely to pursue a second opinion, which can lead to duplication of service provision.
- Consistent early senior clinical input improves patient flow and clinical outcomes across urgent and emergency care, but significant workforce pressures are making this increasingly difficult to achieve.
- Reduced service provision including fewer consultants working at weekends, is associated with this variation in outcomes for emergency admissions to hospital.
- Urgent and emergency care networks can improve cohesion between services, but there is no consistency in the organisation, scope and functionality of networks across the country.

This steering group also developed emerging principles for the future delivery of urgent and emergency care in England:

- Provides consistently high quality and safe care, across all seven days of the week.
- It is simple and guides good choices by patients and clinicians.
- Provides the right care in the right place, by those with the right skills, the first time.
- Is efficient in the delivery of care and services.

The evidence base and emerging principles were published for an eight-week period of engagement in June 2013 along with system design objectives and possible implementation options.

The evidence base and principles have been revised in response to contributions and additional information received during the engagement period, and will be published in October 2013.

A number of working groups will be established to develop the system components for a future system of urgent and emergency care in England. ●

HARRY LONGMAN

Call me

Harry Longman discusses his patient triage service and how it can help better manage GP workload

Invented and developed by at least 20 practices over a period of 11 years, the core idea of this method is that the GP phones substantially all patients who call the surgery with a medical problem as the first contact.

What has been found repeatedly is that once the initial leap is overcome, it turns out that patients can be managed much faster and more efficiently and the workload goes down. A change in thinking is needed from thinking about supply in terms of slots to thinking about demand in terms of what we predict from patients and when.

The purpose of change can take the form of a question: "How can we help all our patients, all day, every day?"

While most practices would find this impossible running the traditional model – a 10 minute face to face consultation with every patient – we find that with a whole system change, this becomes not only possible but natural.

To outline how it works: the patient calls the practices, details are taken by reception and put on a list, and the doctor calls back to deal with the problem. Typically, 60% can be dealt with over the phone, generating the capacity to see those who need to be seen with an appropriate length of appointment which can always be offered the same day. Other calls, such as for a nurse or administrative query, are dealt with by reception in the normal way.

Case study: The Elms, Liverpool

Dr Chris Peterson described how the system works in his 8,400 patient inner city practice. Launching in April 2012, early months were not easy as staff and patients needed to adapt to change, but the system has been continuously improved over time and now performs with these features:

- Median time for a GP to speak to a patient, within working hours, is 12 minutes.
- Median time to see a patient following a call is 71 minutes and 90% of patients choose to be seen same day. Note that these are all patients, with no distinction needed between routine and urgent.
- Consultation lengths are unchanged at average 5.5 mins for telephone, 11.5 minutes face to face.
- Demand has dropped by 12% over the year, while access has speeded up. This might seem counterintuitive, but shows how when patients are confident in the accessibility of their GP, they rarely waste time with frivolous calls.
- GP workload has dropped 20% versus delivering a traditional system.
- There is no backlog of work, every day begins afresh, but through careful prediction, supply of staff time is well planned.
- A&E demand from this practice is 50% of the Liverpool average.

Patients love the system as shown in patient surveys and local reputation. Fifteen other Liverpool practices are looking at their access arrangements and performance to understand the differences and opportunities.

Nationally Patient Access delivers a programme of change to practices and clinical commissioning groups (CCGs), helping them to adopt and adapt locally the same principles and measure outcomes to refine the system. Before any decision is made, the 'Pathfinder' part of the programme enables the practice to reach an informed consensus (within two weeks) and 'Launch' changes the system so that it is working and evaluated. ●

'…once the initial leap is overcome, it turns out that patients can be managed much faster and more efficiently and the workload goes down'

Harry Longman is an engineer by training and founder of Patient Access with the GP inventors of the method in 2011.

PRESENTATION

DR SHIKHA PITALIA

Acute visiting

Home visits need not disrupt the daily work of a family doctor. New ways of working can reduce emergency admissions

The acute visiting service (AVS) is a simple solution for same day home visit requests. A local community doctor service has been commissioned and is dedicated to providing rapid access for patients at home. Essentially the patient is assessed-to-admit rather than the traditional model of admit-to-assess. All referrals into the service are triaged by a clinician at the practice where the patient is registered. This allows safer referral based on access to full medical notes and soft knowledge of the individual at practice level.

The results have been impressive. Practices using the service have shown a consistent downward trend in emergency admissions. Zero lengths of stay and admission rates for long term conditions have reduced because wherever possible integrated pathways offer alternatives to hospital admission.

Discussions with colleagues and patient groups suggested three main reasons for many emergency admissions:

1. Reduced primary care capacity – GPs were already working to saturation in many practices and so were generally able to spend less than 10 minutes with a patient on home visits. This was not enough time for detailed evaluation of alternatives and frequently resulted in admission as the safest option.

The AVS doctor spends an average of 20 minutes with the patient.

2. Patient and carer expectations – most patients requesting a home visit were genuinely concerned about the seriousness of their medical condition. If the GP could not visit within the timeframe to suit their expectations, then the risk of the patient or carer dialling 999 or attending A&E was high and often resulted in an emergency admission.

The AVS aims for a response time of less than 1 hour for 75% of all requests.

3. Increasingly defensive practice – many admissions are made because GPs felt unable to disrupt planned work for fear of complaints but felt unable to risk delaying attendance for home visits in case of deterioration of the clinical situation. This dilemma frequently resulted in admission as a safer option for the patient.

The AVS doctor offers rapid access and extended time with each patient. As a result integrated pathways and community alternatives to admission can be more easily explored.

General practice has evolved in such a way that to expect practices to deal with planned and urgent care at the same time is unsustainable. The two need to be separated to make each more effective. The AVS allows efficient delivery of urgent care in the community, releasing capacity for general practice to focus on planned primary care.

Aims of the AVS:

- Reduce emergency admissions.
- Improve access.
- Use the patient/carer definition of 'urgent' rather than a clinical interpretation.
- Increase capacity in GP surgeries for planned care – each home visit referred saves on average 30 minutes of GP time. This allows potentially three additional surgery appointments per practice.

Outcomes

The potential savings generated from the AVS are significant with consistent reductions in:

- Urgent admissions.
- Readmissions.
- Zero lengths of stays.

Implementation

Incredibly the AVS was proposed, agreed and implemented within eight weeks. St Helens, Merseyside, commissioners authorised funding taking a measured risk in supporting a pilot in readiness for winter pressure in 2006. Since then the AVS has gone from strength to strength and is now set to be adopted widely as part of the urgent care strategy in many areas.

Despite all the uncertainty and recent changes within the NHS, clinical engagement gained from the success of the Acute Visiting Service has been resolute. Practices trust commissioning decisions based on grassroot experiences.

The AVS has a clear relevance to primary care today and it resonates with GPs, showing them immediate benefits of working together in a way that impacts on their day to day work in a tangible way. Its impact on urgent care has been remarkable and the return on investment is such that it becomes self-funding within weeks of implementation. ●

Dr Shika Pitalia, GP, St Helens, Merseyside

DR JAMES KINGSLAND

The never full practice

Extending practice hours can reduce demand on out of hours care and the need for other primary care providers which can duplicate services

St Hilary Group practice in Wallasey, Merseyside, has successfully bid for a non recurring investment from Wirral clinical commissioning group (CCG) to carry out a year-long project which began in February 2013.

The project aims to increase clinical and administrative capacity in the practice without compromising existing services, and enable the expansion of urgent care provision by the practice.

The practice is now reviewing the local urgent care activity for its registered population (5,200 patients) and will then do the same for the seven practices of the Wirral Alliance consortium (population of approximately 40,000 patients), a sub-division of Wirral CCG.

This assessment will focus on the necessity and appropriateness of contacts and consultations during normal GP 'in-hours' opening in;

- Wirral walk in centres (WICs).
- Wirral minor injury units (MIUs).
- The all day centre ('Darzi' centre).
- GP out of hours (OOHs services - also around the margins of current 'in-hours' GP opening and on Saturday mornings.
- A&E.

Aims

- To give a clear definition of urgent care from a GP provider perspective and provide a 'primary care home' for the registered list and their care needs.
- To assess the potential for extending GP 'in-hours' service and provide a full impact analysis for patients and both clinical and administrative staff in general practice
- Establish the evidence for a change to the current provision of urgent care and assess where this work is already underway in England

Early results

An initial 16 weeks of urgent care activity has been reviewed by the practice with more than 1,000 patient records analysed by six different experienced GPs found:

- Between 75-80% of all urgent (unscheduled) care occurs within current GP contracted hours (albeit across seven days).
- 55% of all A&E activity occurs between 9am and 6pm throughout the week.
- Only 10% of A&E contacts present between the hours of midnight and 6am.
- Of those patients seeking urgent care on Saturdays, two thirds attend between 8am and 1pm.
- 100% of WIC contacts could be managed in general practice; and 40% of A&E attendances could be safely dealt with by the host practice.
- Only one call is now made to the GP OOHs from the practice population (say one call per 5000 population) between 7am and 8am every three weeks.
- Only one call is now made to the GP OOHs between 6.30pm and 8pm every two days.
- There is a high correlation between MIU attendance and need as clinically assessed; there is a high proportion of appropriate attendances – but the majority of these are due to the need for an X-ray assessment of an acute bony injury.

Discussion

The current results are leading the practice to question;

- Current opening hours of the practice and the significant impact on urgent care provision by extending opening from 7am to 8pm during every weekday.
- Re-opening on Saturday mornings between 8am and 1pm would have a significant impact on lowering activity in other local urgent care facilities.
- GP OOHs services could be amalgamated with a WIC type service and downsized if local practices were resourced to provide same day services for their registered lists from 7am – 8pm weekdays and 8am – 1pm on Saturdays To resource this, the CCG would need to support:
- The closure of WICs and other duplicate facilities during the extended opening hours of practices with the redeployment of resources.
- GP OOHs running with shorter hours, less staff and managed by CCG constituent practices.
- Redesign of the A&E contract to alter 'duty of care' for patients with a primary care need and delivery – with a new tariff structure for advice and re-direction of patients back to practice.
- Cash released to invest in general practice extending its service would be in the order of £10 - £15 per head of population with an overall cash release to the local health economy. ●

Dr James Kingsland OBE, Senior Partner, St Hilary Group Practice, Wallasey

PRESENTATION

MUKESH LAD

Pharmacy first

There are 438 million community pharmacy interactions a year. Better use of this profession can ease pressures elsewhere

While many GPs do work closely with their local pharmacist, it's disappointing that our Secretary of State for Health, Jeremy Hunt, is still unwilling to promote a primary care culture that endorses collaborative partnerships between clinical commissioning groups (CCGs) and community pharmacy, allowing us to deliver our full potential.

We're capable of providing cost effective services embedding medicines optimisation within dispensing, managing long term condition (LTCs) and supporting patient self-care.

Timely and accessible help, increased patient understanding and better use of medicines provides invaluable benefit with immediate health improvements. Pharmacy-based optimisation services assist in treatment adherence and delay complications that necessitate hospitalisation. Inappropriate prescribing and additional medication requirements are also identified, reducing errors and waste.

We're promised a paperless organisation by 2018. Access to IT with data sharing across clinical boundaries would finally ensure appropriate arrangements for one patient, one record especially when delivering medicines use reviews (MURs) and new medicine service (NMS).

In his plans for the care of older people, Jeremy Hunt calls for GPs to proactively contact people who don't present at a surgery. As pharmacists see patients more often than the GP team, we're ideally placed to play a key role in the long-term management of patients with chronic disease. Greater primary care collaboration would also lead to better domiciliary healthcare for elderly and vulnerable housebound patients or in residential care.

Targeted trials have already demonstrated positive effects on admissions, mortality, quality of life, and length of hospitalisation, concluding that pharmacist-led interventions can significantly improve patient outcomes. With more than 900,000 people already affected by COPD, pharmacy involvement in this area alone would releasewGPs to take on more diseases currently managed in secondary care and greater management of high risk patients.

> 'Timely and accessible help, increased patient understanding and better use of medicines provides...immediate health improvements'

A recent SIMPLE (signposting, inhaler technique, medication review, peak flow, lifestyle and education) structured pharmacy review of asthma patients saw a 32% reduction in GP visits for asthma-related issues over the study period. Hospital admissions were also significantly reduced.

However, patients and the public don't always see the pharmacist as a first port of call for advice, not just on medicines but also for underlying health problems. This is particularly true for men seeking advice on health issues.

Around 20% of a GPs annual workload is taken up by minor ailments creating 57 million GP consultations costing the NHS £2bn annually.

Funding urgently needs to be identified for a Pharmacy First NHS Minor Ailments Service to support urgent care and out-of-hours provision. Patients need convenient access to advice or treatment for common minor illnesses outside surgery opening hours.

Only half of the two million patients that visit A&E every year need urgent treatment with the rest wanting medical advice or guidance that can easily be provided by a pharmacist first. The cost to the NHS of these unnecessary visits is £136 million.

Action is now urgently needed to underpin new working relationships to offer patients high quality, safe and convenient primary care services.

Policy changes in recent years have moved the pharmacist's role towards being a health care provider advising on the use of prescribed medicines, self-care and lifestyle as well as delivering new services. However, these changes have been introduced in isolation from general practice.

Part of the £3.8 billion integration transformation fund should be deployed at local level to create new and innovative integrated care pathways.

CCGs need to set up working groups with local pharmaceutical committees to explore the many ways in which pharmacy can support the provision of local and conveniently accessible patient care. ●

Mukesh Lad, chair of Pharmacy Northamptonshire Local Pharmacy Committee. Email: mukesh@pharmacynorthamptonshire.co.uk

VICTORIA VAUGHAN

Fixing the urgent care crisis

A wide sprectrum of primary care professionals put forward solutions to ease the pressure on A&E

As winter looms it brings the urgent care crisis into sharp focus. Simply too many people are turning up in A&E and then being admitted to hospital, putting pressure on services and increasing costs in the NHS.

Not all these patients need to attend A&E but they clearly feel there is no alternative. The Department of Health and NHS England need to find a solution to this and clearly primary care is a large part of the answer.

A core representative of the National Primary Care Network (NPCN) including nurses, GPs, community pharmacies, dentists and optometrists gathered in London on September 17 to discuss how the problem is being tackled in their area and what possible solutions could look like.

Telephone triage

This was seen by many as a key way to increase patient access[1] to GP surgeries. Harry Longman gave a presentation on Patient Access, his telephone triage system (see page 3) and Dr Christopher Peterson demonstrated how it worked in his practice.

Dr Steve Laitner, a GP in Cambridge, spoke about his experience with telephone triage.

"There are two paths. Regular patients with an ongoing issue go through to the reception; patients with a new problem go on the GPs list and a telephone appointment is made where they are called back in an average of 12 minutes. That might be followed up by a face-to-face appointment or referral elsewhere.

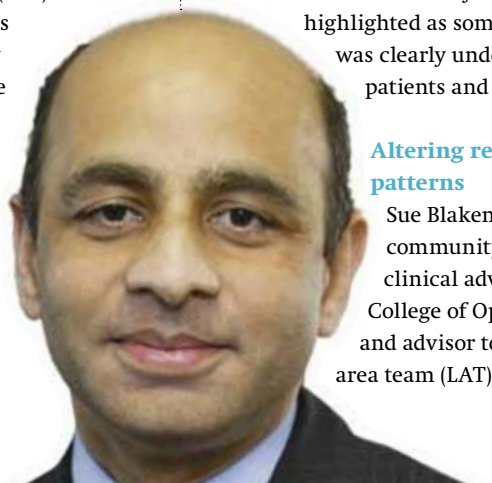
"Demand is finite. We have seen that as you improve access demand does not go up.

"Supporting our practice to be telephone-led has reduced urgent care admissions by 20-40%. By changing the model, which is predicated on face-to-face consultation starting instead with a phone call, improves access. Colleagues in Seattle have shifted channels from phone to email and found they can do more that way."

> The prevention agenda usesproviders like pharmacies to take off some of the stresses and strains by providing immunisations for things such as flu

Dr Amit Bhargava, chair of Crawley clinical commissioning group (CCG), said: "There is a cost implication with telephone triage as it does require front loading. That is difficult if you have a shortage of GPs. I would agree demand is predictable over the days and weeks. Monday and Fridays are the busiest. Doctor First[2] (a telephone triage system) has given us more control over our workload and more GP satisfaction as a result."

Mukesh Lad, a community pharmacist and chair of Northamptonshire local pharmaceutical committee (LPC) said: "Using Doctor First improves access for patients. The only issue is that as it's so intense in the first few hours of the day, it can result in people having a 'jellified' brain. But this can be addressed with appropriate scheduling and changing GP working practices.



Dr Amit Bhargava

"Pharmacy First can also help with minor ailments. We use the outcomes as a tool to analyse where the patients would have gone if they had not gone to the pharmacy and that has been a useful tool.

"Teleconferencing and webcam technology can be used in care homes where there are certain issues with certain patients where GP time could be used more effectively than making a visit."

Patient education

Mukesh Lad commented that patient education should take place with patients presenting at A&E or GP surgeries and would include "having an honest discussion about whether that patient should be there or if an alternative pathway could have been chosen.

"Although we realise that could be quite a difficult conversation, at some point we do need to address this.

"We do need to try and change the psyche of the patients we are seeing."

Moira Auchterlonie, chief executive of the Family Doctor Association, said that patients could be provided with a handbook about what they can expect from the NHS.

The obligation of dentists to see a patient within 24 hours if they are in pain was highlighted as something which was clearly understood by patients and worked well.

Altering referral patterns

Sue Blakeney, community optometrist, clinical advisor to the College of Optometrists, and advisor to the local area team (LAT) in Kent said:

"I'd like to outline what we do locally in Kent to reduce demand on A&E and GP services for ophthalmology referrals.

"There are several schemes which have various acronyms but the most common one is PEARS - the primary eyecare acute referral service.

"This allow optometrists to see patients who either self-present or are referred by GPs with acute conditions, most of which are not sight-threatening.

"The most common eye conditions are things such as dry eye, conjunctivitis and flashes and floaters, which are always a bit of a headache, probably to GPs, but certainly to optometrists because if you get it wrong the consequences are quite serious.

"What I'd like you to do is think about how you deal with optometry referrals.

"Part of the conditions of PEARs is that the optometrists which take part have to see patients within a certain timeframe. Most of the optometrists open on Saturdays and some on Sundays so that will help with seven-day access.

"This is running in Medway and the larger area of Bexley, Bromely and Greenwich.

"In Kent we have the next level up from PEARS as we have two prescribing optometrists in West Kent who see patients with more acute conditions, and they are able to see a higher number of patients without referring them to hospital.[3]"

Paul Hitchcock, director of the Allied Health Professions Federation (AHPF), said: "We could redesign pathways that don't involve A&E - for example, a fractured neck or femur is a fairly obvious thing to spot. Therefore could we not have pathways where the first doctor a patient sees is the consultant orthopedic surgeon who will fix the problem. We know this best practice is happening in some places.

"GPs recognise that patients want to go to their GP practice as a first point of call, not necessarily to see a GP - making better use of the building by employing different professions could help reduce hospital attendance.

"There are some professions, such as physiotherapy, which could benefit from self-referrals. That's a way of working which is very limited at present. It could reduce pressure if people can go where it's appropriate as their first point of call.

Nurse Angela Dempsey, on Enfield CCG governing body, is working on an older person assessment unit to try and prevent issues in the first place by working more closely with patients to keep them well and out of hospital.

> We do need to try and change the psyche of the patients we are seeing

Pharmacy

Stephen Foster, pharmacy national clinical lead for the National Association of Primary Care, said: "There are 438 million community pharmacy interactions a year, that's 1.2 a day and 44 million more than in every other visit combined. We can't underestimate the significance that community pharmacy can have.

Mukesh Lad said: "GPs and pharmacists could run joint surgeries. We know that two out of five patients are coming in for minor ailments; perhaps some of that can be seen by the pharmacist, so more joint working could help in this area.

"The prevention agenda uses providers like pharmacies to take off some of the stresses and strains by providing immunisations for things such as flu.

"Give pharmacists some remit over long term conditions in the community and possibly with home visits."

Robbie Turner, chief executive at Community Pharmacy West Yorkshire, said: "Using community pharmacists in NHS 111 call centres has been done locally in West Yorkshire. We have evaluated it and found it to be really positive and we have avoided call handlers escalating numerous calls to 999 calls.

"We can see the granular detail of the calls coming in. So over the August bank holiday, about 11% of calls were about emergency access to medicine."

Barbara Parsons, head of pharmacy practice at the Pharmaceutical Services Negotiation Committee (PSNC), said: "I'd like to point out that we work with the Proprietary Association of Great Britain (PAGB) to look at the way workloads can be shifted for minor ailments from GPs to pharmacy. The Department of Health has done work on this and found £300 million in savings, so there is a lot of evidence out there. "Also we have looked at the emergency supply of medicines in the NHS as lots of emergency consultations are about people who forgot their medicines."

Paul Hitchcock

Prescribing

Paul Hitchcock said: "From a patient's perspective, very often a patient who gets free prescribing will go to their GP so they can get a prescription so they don't have to spend money in the pharmacy shop.

"We are going to have to redesign how money changes hands if we are going to maximise the use of community pharmacy.

"We could also think about extending prescribing rights to a broader range of clinicians, for example, paramedics, who see many of the more vulnerable people in society who may not be registered with a GP. Prescribing there may help with the pressure on other services."

Jenny Aston, chair of the Royal College of General Practitioners (RCGP) nursing group, said: "If you have an advanced nurse prescriber working with care homes, it's amazing what preventative care you can do. We are working on that pathway in our practice in Cambridge."

Urgent care plans

Dr Agnelo Fernandes, chair of Croydon CCG, spoke about work around risk stratification and anticipatory care in Croydon, where self-care is at the top of the strategy.

They redesigned emergency care with an integrated front-end A&E, with GPs and nurses who now see 50% of adults and 70% of children who attend.

Croydon was one of the first to see proper implementation of NHS 111, and it saw a 50% fall in demand for GP out-of-hours (OOH) services. This allowed them to commission urgent care services rather than an OOHs service. There is also a rapid response team for the frail elderly.

GPs discussed PRISM which is a risk stratification system that uses multidisciplinary teams to have locality-based proactive care, helping to identify patients who may use urgent care more than others early.

Long-term conditions

Katie Simon, service improvement manager at Diabetes UK, highlighted the roles technology, care plans and the Year of Care will play in the future management of diabetes. She highlighted the need for there to be 'someone to call'.

"There is a cliff edge when patients get scared and need someone to call, this could be a GP, a nurse or maybe even a fellow patient or an online expert. There are lots of routes - it's about reassurance and trust."

Harry Longman said: "We have no data about what proportion of demand in A&E is from people who come off that cliff edge with chronic conditions and exacerbations.

"We do have data on GP demand; 60% is acute, 30% is chronic conditions and 10% is acute exacerbations of chronic conditions."

Robbie Turner talked about end-of-life care and highlighted the electronic palliative care record similar to Co-ordinate My Care in London as a good example of innovation in this area which has kept people out of hospital.

He also stressed the need for improved communication between primary and secondary care so there was a shared terminology between the two in this area.

Fiona Clarke, chief officer at South Sefton CCG, said: "In Southport and Formby we have improved end-of-life care pathways and have seen a 12% reduction in the number of A&E attendances."

Training

Jenny Aston focused on training: "We need to look at the importance of the training of nurses in general practice and attracting them into that area as a career pathway, as it's widely variable around the country.

"We are trying to develop that with Health Education England and the local education and training boards to ensure the importance of generalism and health prevention in the provision of care.

"There should be minimum standards for training. For example, healthcare assistants could be on a Tesco checkout one day and in general practice the next.

"We need to have proper foundation training that is generalist in its nature, as they are not prepared for this in a hospital environment. This requires student nurses having properly-funded placements in general practice, which they don't have at the moment."

Fiona Clark, chief officer at South Sefton CCG, said: "We are working with local university for a dual qualification for nursing and social care to meet future needs."

Steve Laitner

Jeanette Martin, the Royal College of Nursing (RCN) regional director for South West England, said: "I'd like to highlight that a lot of care will be delivered by nurses in general practice. I have a background as a practice nurse.

"We are about to realise the retirement bulge in practice nursing and I would suggest it's really important that it is linked in strategically to workforce planning. Currently, not every local education and training board (LETB) is including practice nursing as part of their delivery. They are not thinking about the workforce planning required for general practice."

Self-care

Dr Steve Laitner said: "The Health Foundation is a good resource for information on self-care.

"It certainly does work but it needs to work as part of a system. Giving patients resources isn't enough, they need support and there needs to be services that cater to empower patients."

Durairaj Jawahar, vice chair of Leicestershire and Rutland local medical committee (LMC), said: "A lot of patients know of self-care, but some patients think a small rash is meningitis or turn up thinking they have a brain tumor because they read about it in the paper.

"These patients increase the workload. The front door of A&E is used by people who think going to hospital will get them better care. We need a cultural change. I listen to ministers say they are bringing in 50,000 GPs in the future, but they are not looking at how GP resources are being used. If you have a European model with 900 people on the list and 20 minutes with a patient, I am sure GPs in this country can solve a lot of problems, otherwise, there are resource issues and whatever you do at primary care level will have problems." ●

'There is a cliff edge when patients get scared and need someone to call, this could be a GP, a nurse or maybe even a fellow patient or an online expert'

1. Patient Access. www.patient-access.org.uk
2. Doctor First. www.productiveprimarycare.co.uk/doctor-first.aspx
3. PEARS. model pathways, www.locsu.co.uk

Victoria Vaughan, Editor in chief, primary care, Campden Health

CONCLUSION

DR JAMES KINGSLAND

Final word

Micro commissioning which could be scaled up if proved successful and practice ownership of clinical commissioniong will make a success of the reforms

In 1972, Johnny Nash sang, 'There are more questions than answers', now probably a more apt title for the NHS England document, *Improving general practice – a call to action*. It is not so much a call to action as a description, over the first 11 pages, of the issues challenging the NHS, well known and rehearsed for the last 20 years, followed by 12 pages of questions, many of which were answered in the NHS Act (primary care) 1997. This only reaffirms that there is precious little organisational memory in NHS England.

The National Primary Care Network (NPCN) came together on 17 September this year to provide answers specific to the urgent care crisis in the NHS, and not just from a general practice perspective. Rarely are meetings in the NHS populated by leaders from all four primary care contractor services, community nursing and allied health professionals (AHPs).

The debate and focus on improving care and services in the NHS must be clinically led by people actively delivering the service, as in this NPCN meeting, not by people with a fading memory of a former clinical role or experience; and clearly not from sitting in offices remote from patient contact.

The primary care system of our NHS has been the corner stone for managing demand and containing costs since the inception of the NHS. This has been achieved from a general practice viewpoint through three key and consistent aspects:

1) The practice unit, of variable size and developed to meet local need.
2) Patients registering with that unit for their immediate and long-term care.
3) The independent contractor status which has always conferred a personal advocacy role and the efficiency (financial) of self-employment (in the main) of the general practitioner, pharmacist, optometrist and dentist.

We should not be striking at this corner stone of our NHS in order to fix other parts, which may destabilise the entire system. If urgent care at present is thought to be broken we shouldn't break general practice trying to fix it.

The current reforms have exposed deficits. They have not necessarily created them. Previously rationing through waiting times was the main way to achieve financial balance, which the Blair government largely abolished by significant investment in the NHS. Now that funding has flattened, access and waiting need to be improved by service reform and systematically reducing waste, duplication of service and inefficiency.

Primary care trusts (PCTs) never felt confident or supported in devolving their budgetary responsibility to allow practices to develop their role as commissioners and therefore continued to discourage clinical engagement. We need to understand that the deficits exposed by the current reforms were created by the way NHS services were and are still commissioned. So to do more of the same thing, the same way and expect a different result is largely how Einstein defined insanity.

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We therefore need to do three things to achieve improved patient care through service redesign by good demand management:

1. Finally expel 'clinical engagement' from the NHS vocabulary and talk about ownership of the agenda at practice level (along with the responsibility and accountability this brings).
2. Allow clincial commissioning groups (CCGs) to hold their nerve to see the changes through by devolving budgetary responsibility to all practices in England and focus on demand management instead of rationing.
3. Accept that moving a deficit at local level from say a £10million overspend to £9 million overspend is a success and starts on the road to financial recovery.

If we aspire to deliver more care out of hospital instead of, rather than as well as, what the NHS provides to patients at present, then central to the whole program

of reform is improved and better resourced primary and community care provision. Primary care is the pivotal system by which the public's demand on the NHS can be re-engineered.

What remains vague following the implementation of the current reform program is a vision for 21st Century primary care. Do we know exactly how much of primary care and, in particular general practice, needs fixing and how much entrepreneurial and innovative primary care is actually out there?

This NPCN meeting started to address this for unscheduled care.

The meeting concluded some broad expectations to develop a 'primary care home' including;

- A service that is responsive and fast and provides convenient access to multi-disciplinary teams operating across organisational boundaries.
- These teams, through both their provider and commissioner activity will enable an extended range of quality services and care in the least invasive ways.
- Primary healthcare and wellbeing that is delivered locally, ideally in modernised premises with integrated IT functioning across health sectors.
- The role of a general practice will be to offer a greater choice of services and base these on the needs of informed patients who should expect more from their registration with that team.

Things done at large scale should be cheaper and more effective, hence the idea of federated practices. In practice, starting at scale has often been the problem. Solutions designed with just a big population in mind fail to address the particular problems experienced at practice or locality level.

The bottom-up approach sees clinicians, other professionals and patients sitting down to redesign services and map out appropriate care pathways. The chances of success at this micro-commissioning level are much higher – and the risks of failure are much lower. When we know what works we can scale it up to an appropriate level, which might be a small group of practices, a CCG, groups of CCGs, a region or even the country as a whole.

The NPCN meeting demonstrated good practice examples.

This is not reinventing the wheel but recognising that solutions to local problems must be developed locally and grown organically. The other critical pieces are the networks to link the microsystems and allow them to share experiences, adapt good practice from other areas and enable the free flow of information.

The main role of clinical leaders, healthcare professionals and CCGs is to build the evidence base. The NPCN helps to marshal and shape the case studies and tools that are already being used locally to good effect. It is also developing an online information portal to make it easier for commissioners to find best practice.

The evidence of what works can help show what practical steps primary care can take now to support transformational change. We should draw inspiration as well as information from the best examples from previous vehicles of reform and the actions of individual practitioners (not just GPs) in refusing to let obstacles of the existing system stop them from doing the best for their patients.

For me, this is the key lesson and my top survival tip for the future. Worrying about the unknown is unproductive and ultimately pointless. Concentrating on being the best GP the patient could possibly get, making small service changes, listening to what others are doing and staying alert to the possibilities for reducing waste and improving care – this is and always has been the core business of my practice. If we focus on this, we can deal with management issues as they arise. No-one said that clinical commissioning was going to be easy, but if we focus on the obstacles, the best interests of the patient will be an ever-receding horizon - and remember what we have learnt from previous reforms…. a GP with a budget is worth 10 on a committee. ●