GP FORWARD VIEW IN ACTION AWARDS

Award categories: Please tick those you wish to be put forward for :
1. Primary Care Workforce Innovation – successful changes of skill-mix or cross-practice staffing models ✓
2. Primary care workforce innovation – best example of developing the role of unqualified staff working in primary care
3. Primary Care workload – Quick Win award – the best easy to implement change that really made a difference
4. Primary Care workload – best example of successful working with the voluntary sector to improve support to patients and reduce workload pressures in the practice
5. Primary Care workload – successful implementation of a change to reduce demand by enabling more self-care ✓
6. Infrastructure award – best example of using technology to improve access for patients or support self-care
7. Infrastructure award – best example of creative use of accommodation/space to deliver patient centred care
8. New models of care award – merger of the year – best example of changes in service delivery achieved through a successful merger
9. New models of care award – best example of adoption or spread of 10 High Impact changes
10. New models of care award – best example of support offered by a primary care provider organisation to improve resilience
11. Turn-around award – creating a sustainable solution which has averted service failure
12. Collaboration award – best example of win/win solution for patients achieved by joint work between general practice and pharmacy
13. Collaboration award – best example of win/win solution for patients achieved by joint work between general practice and an NHS provider organisation ✓
14. GP Forward View Clinical Champion – individual nominated by peers for articulating a local vision of how GPFV will deliver sustainable primary care in their local area
What stage are you at? (please tick) Early stage discussion ☐ Developing pilot ☐ Implemented ☒ Evaluated ☐
What problem are you trying to solve? **Challenge identified and actions taken: Who – what – why – how – when** **Examples of good practice that you would like to share?** In South Somerset, in common with many parts of the South West, we faced the linked problems of soaring demand for healthcare and rising costs at the same time as a staffing crisis in general practice and other parts of the system. The Symphony Programme was set up in response to this as a collaboration between South Somerset GP Federation (19 practices), Yeovil District Hospital, Somerset Partnership NHS Foundation Trust and Somerset County Council. It is led by a Programme Board which is chaired by a GP and includes four elected representatives from primary care (3 GPs and a practice manager partner) as well as the GP Associate Medical Director of Yeovil Hospital, who is also a local GP. Yeovil Hospital has four representatives including the Chief Executive, and there are also representatives from Somerset Partnership, Adult Social Care, the voluntary sector and Somerset CCG. There is a small programme team hosted by Yeovil Hospital led by a dedicated Programme Director and we are one of the nine national Primary and Acute Care System (PACS) Vanguard sites. Other parts of the programme have focussed on developing new organisational forms: one to support primary care (Symphony Healthcare Services has been established as a subsidiary of Yeovil Hospital to allow practices to integrate

where they wish to); and another to hold a capitated, long term outcomes based contract for the whole population in a joint venture between primary care, Yeovil Hospital and other partners.

Together we have analysed our population, joined up the data, developed new integrated care models and new organisational forms to support primary care. This application focuses on the new integrated care model which has primary care at its core.

The integrated care model has several objectives:

- Improving support for patients and their families with long term conditions
- Developing a sustainable staffing model and way of working in primary care
- Improving the working lives of staff
- Shifting resources from expensive acute care to primary care and prevention through avoiding admissions and other secondary care activity
- Enabling a long term sustainable financial model for the health economy as a whole.

The model has three tiers: Complex care for the small number of patients with the most complex conditions (tier one), enhanced primary care which supports practices to take a much more preventative and proactive approach to their patient list by expanding the practice team and introducing health coaches (tier 3), and the new tier two service to support patients who are becoming increasingly complex but do not need the full resources of the complex care team. This sees patients managed within primary care but with support from the complex care team.

All three tiers are focused on supporting people to understand and manage their own conditions, link into the voluntary sector locally and navigate the healthcare system through a team-based approach where different professional groups operate at the top of their licence.

Health coaches are now in place in 13 practices, with a further five commencing by Christmas. By then 52 health coaches will be in place – a significant boost to practices. We are also piloting MSK practitioners seeing patients in practices without seeing a GP first, diabetes virtual clinics where a consultant from the hospital visits the practice and discussed the most complex diabetes cases with the team so that changes can be made to medication and management, and hot respiratory clinics where practices can obtain an urgent opinion from a specialist nurse without attending an outpatient appointment. The next priorities are pharmacy support and mental health support workers.

GPs now work in a team with their health coaches and other staff members, who meet daily or several times a week in “huddles” where the whole practice team discusses the patients they are most concerned about, agrees what actions are needed and who will do what. The team is also able to put together information about patients which can enable them to spot problems early on.

The health coaches work with people to help them develop confidence to manage their conditions, as well as ensuring that any liaison with other services is effective and coordinated. Patients can contact the health coaches directly, and often will see a health coach or other member of the team instead of a GP, freeing up the GPs to focus on the most complex patients.

Three complex care teams are now in place to support the most complex tier one patients. Patients are referred to the teams by practices or consultants at Yeovil Hospital and the teams become the first point of contact for those patients. The teams include key workers, who are the main liaison point and support patients and their families through the care planning process, as well as carrying out some health coaching and ensuring families are linked into other sources of support. Care coordinators (nurses) are responsible for developing a single person-centred care plan, and providing clinical input, and the team is led by Extensivist doctors – GPs or consultants who are focussed on managing complex multi-morbidity. One of the teams is based in Yeovil Hospital which has allowed excellent relationships to be developed with the secondary care consultants, which means that advice can be accessed without an outpatient appointment, and the team lead the discharge planning when patients need to be admitted, reducing length of stay.

The new East Team, which is collocated with Somerset Partnership community teams, is working with the practices in that area to develop the new tier two service. This sees care coordinators attending practice huddles and supporting the staff in practices with care planning, training and advice. Extensivist opinion can be easily accessed when needed and the complex care team can take patients onto their caseload for short periods when needed. This will allow the complex care team to become embedded in primary care and create a wider team.

Which High Impact Actions, to release time to care, are most relevant?

1. Active signposting ☒
2. New consultation types ☒
3. Reduce DNAs ☐
4. Develop the team ☒
5. Productive work flows ☐
6. Personal productivity ☐
7. Partnership working ☒
8. Social Prescribing ☒
9. Support self-care ☒
10. Develop QI expertise ☐

Which area of the NHS England General Practice Forward View is the best fit?

1. Workforce ☐
2. Workload ☐
3. Practice Infrastructure ☐
4. Care Redesign ☒

What changes have you made? *(e.g. changes in staff, systems, processes, communication)*
I have described the changes made in the section above.

What happened: Impacts and Outcomes? What process did you undertake to achieve this? What did you learn? What benefits or drawbacks have occurred as a result of these changes? How could this approach be replicated? Were there any ideas/changes that didn't work? What was particularly successful?
(Characterise and describe what has happened, define the elements in an open manner)
At present we have 42 health coaches in place across 13 practices with five more coming on board by Christmas. In the period April to June 2016 these health coaches helped 1600 people in a combination of short interventions and longer term health coaching. The complex care teams have had over 300 referrals, and as at the end of June had actively worked with 223 patients and their families.

We are tracking the impact on hospital admissions and this is being formally evaluated by the Centre for Health Economics ay York University and the South West AHSN. It is too early to say with any certainty, but the early signs are showing an encouraging reduction in the admission rate of those patients who have been part of the complex care service (tier 1), which has been running for just over a year now. A graph is attached which shows the admission rate for all patients within the complex care service. This rises steadily for two years ahead of entry into the service, then reduces over a twelve month period after entry into the service. However, this data is based on small numbers of patients without a control group so carries a health warning. A full evaluation with an academic partner is commencing shortly.

As the health coaches have only been in place since November in four practices and May in the remaining 9 (tier 3) it is too early to be able to observe an effect on hospital activity in the data at this point – these benefits are forecast to be longer term as the health coaches are working with less complex patients with the aiming of helping them to manage their conditions as well as possible and avoid exacerbation and admission in the future.

Anecdotal evidence of avoided admission and improved care is strong, however, and I have attached some case studies as examples to demonstrate this. We are also receiving lots of feedback that the new model is making a major difference to practices, as illustrated by the following quote from a GP in South Somerset:

> "I have no doubt that they have reduced admissions and referral failures. They have improved working life for all at the surgery. I believe I have gained an hour a day at least, in addition to some sanity!"

Further quotes from GPs are attached with the case studies.

The care model has been developed by working groups led by GPs on the Programme Board, and has evolved considerably over time. It has taken some time to establish the complex care team as practices had concerns about governance, communication, impact on practice finances and about "handing over" some of their patients. Through joint working, and in particular the introduction of the health coaches in practices and expanding the practice teams, these concerns have been addressed, and the new tier two being developed in the East will enable complex care to become fully embedded in primary care. GP leadership combined with the resources of secondary care have been crucial along with a willingness to reflect on feedback and adapt the models over time, and this process will continue. We are very happy to share our experiences and learning along this journey.

Next steps Fully developing the tier 2 service and expanding this to the rest of South Somerset. Introducing health coaches into the remaining 5 practices by Christmas. Introducing pharmacy and mental health support. Commencing formal evaluation. Closer working with community teams and social care.
Tips for adoption Engagement of primary care at every stage of conception and design. Strong clinical leadership from primary care – our Programme Board has four elected representatives of primary care and a further GP who was Yeovil Hospital's Associate Medical Director. The workstreams are led by primary care. We have lots of experience and documentation we would be willing to share.
Relevant documents/templates/examples *(Embed files or share separately)*
Case studies and feedback from GPs are attached. There is also lots of information on our website www.symphonyintegratedhealthcare.com.

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Who will be attending the event on 14th October 2016 /or able to collect award on your behalf if successful:

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Consent for publication on the Models of Care Portal:
Signed: Jeremy Martin

Date: **24 September 2016**

Please submit to andrea.melluish@nhs.net by 25th September 2016