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Prime Minister's Challenge Fund Pilots:

Innovative workforce Solutions

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Brighton and Hove

In Brighton, **pharmacists have been integrated into the primary care model to alleviate pressure on GP capacity**; patients can be referred to a named pharmacist if deemed more appropriate than a face to face consultation via the GP led triage. Pharmacists can gain access to medical records and in some cases prescribe medication.

Community navigators have also been recruited from the voluntary sector to be present in practices and **offer links to alternative local solutions for those patients with complex needs outside the remit of primary care**. Patients are either identified by practices themselves or referred to a community navigator through GP triage. This is intended to reduce pressure on GP capacity.

A number of **administrative tasks are being redirected away from GPs to be undertaken by other members of staff**. This has involved mapping new workflow pathways and training up administrative staff to undertake this work that will hopefully reduce non-clinical pressure on GP time.

Darlington

Darlington has established an **inter-practice clinical advice project**. This enables clinicians to request peer advice on the care of a patient in three specialist areas: gynaecology and women's health; ear, nose and throat (ENT) and cardiology. The aim of this project is to improve the quality of referrals to secondary care. Three clinicians deliver this project, each focusing on one of the three specialisms. Each clinician has a session (four hours) per week to respond to requests from GPs across the 11 practices. The GPs that are delivering this service have been identified as having interest, extended knowledge and additional experience in one of these areas.

Derbyshire and Nottinghamshire

Nottingham North and East CCG are **employing advanced nurse practitioners to deal with some of the less complex patients** usually seen by a GP: an audit of calls by two practices in the CCG showed that approximately 50% of patients did not need to be seen by a GP. A follow up audit across nine practices showed similar findings. In using advanced nurse practitioners, the pilot wants to free up GP time to help manage complex care patients better.

Devon, Cornwall and the Isles of Scilly

This pilot contains three CCGs, all are conducting different innovations.

NEW Devon CCG

The Beacon Medical Group (practice population 33,000, 4 sites) are piloting the provision of a **mobile GP**, their role is to cover house calls Monday to Friday (9am-midday). This is to ensure that house visits can start early, and not be pushed back till after morning surgery resulting in reduction of avoidable admissions.

The Beacon Medical Group is employing two **healthcare assistants (HCAs) to provide regular phone calls to all patients defined as 'at risk'**. The pilot is initially contacting patients with COPD who will be at risk during the winter months. The purpose of the call is not to provide a medical consultation but is designed to be an early warning indicator that the health of a patient may be worsening. If the HCA has concerns about a patient, an appointment with the GP will be arranged. It is hoped the proactive calling of patients will help prevent admission to hospital.

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In NEW Devon, as part of the Beacon Medical Group, **pharmacists will be providing support to the mobile GP and HCA** to assist patients who have polypharmacy. In the eastern and northern localities of the CCG, patients will be encouraged to seek advice and treatment from community pharmacists. St. Levan surgery (practice population 6,600) will employ a **pharmacist over a period of six months to provide polypharmacy review through face-to-face and telephone consultations**. Pharmacists will be able to **provide a repeat prescription service** and it is hoped this will reduce need for a GP appointment or OOH service.

South Devon and Torbay CCG

In the coastal area (4 practices, frail elderly population of 800), **community teams** including district nurses, therapists, social workers and the voluntary sector provide **seven day a week care** to frail elderly patients. The pilot hopes this approach will free up GP capacity and increase access to clinicians.

To protect the capacity of GPs and A&E, **community pharmacists will become the point of contact for patients** who require emergency medication and patients who arrive at a GP surgery or A&E from outside the area. In addition, community pharmacists will be providing a **repeat prescription service, minor health advice** and patients will be encouraged to go to their pharmacist and thus free up clinician time.

Cornwall CCG

In three community hospitals (Bodmin, Liskeard and Camborne) minor injury nurses have been up-skilled and are providing seven days a week 8am-10pm extended access appointments. The nurses have all had refresher training and will also be developing the range of minor illness services they offer during the pilot. Although the sites were in operation before PMCF, the additional funding has freed up existing nurse capacity through the funding of administrative support. It is hoped **increasing the capacity and capability of nurses** will reduce demand for GP appointments and avoid A&E attendance.

Herefordshire

This pilot has **employed a link nurse; their role is to ensure that patients are discharged quickly from hospital and that appropriate holistic care plans are in place** for their return home. They will identify barriers to discharge, seek to challenge or address them. It is hoped that by using a nurse in this capacity, patients are discharged quicker and that once at home, patients have appropriate support and therefore reduce the likelihood of re-admission to hospital or further GP contact.

Morecambe

In responding to the emerging high volumes of weekend demand for phone triage component of their '8-8 service', the pilot has adapted the resourcing of their service model. Initially the 8-8 service was delivered solely by GPs and supported by reception staff. However, from the 10th January 2015, the **GP providing this service has been supported by an Advanced Nurse Practitioner** (initially contracted for 6 hours on a Saturday and 4 hours on a Sunday). This skill mix allows phone triage appointments to be allocated according to complexity. Where appropriate, it also provides some capacity for patients to be called into the practice for a face to face consultation following the phone triage call. As well these benefits of skill mix, it is considered that this provides a more affordable solution than incorporating additional GP sessions to the service.

Slough

Some of the **GPs within this pilot have been given a degree of autonomy** in how they use the additional appointments, allowing them to decide the most efficient use of their time. For example, one GP has been **visiting patients in hospital** who are due for discharge to prepare for primary care and there has also been **targeting of patients for extended hour appointments who are known to have a high DNA rate**. Feedback from the first wave of patient surveys has been very positive.

Slough is also implementing **self-help groups; led by GPs but co-produced with patients** to support patients to take more control over their own health and by default pro-actively reduce pressure on primary care. The pilot is working closely with the voluntary sector (through SCVS) to ensure groups link up with provision already available
South Kent Coast
This pilot has implemented a **visiting Paramedic Practitioner service**. This includes home visits undertaken by a dedicated Paramedic Practitioner, between the hours of 11am and 6.30pm Monday to Friday. The new service provides unscheduled primary care to patients who are unable to travel to see their GP; the Paramedic Practitioner is trained to independently provide definitive care that does not require the intervention of a GP or doctor. The aim of the service is to minimise the disruption of home visits to GP surgery schedules, and to reduce the number of A&E attendances. Bookings must be made by a GP. Following the success of the service, there are now plans to offer the service on Saturdays and Sundays. Anecdotal feedback provided by patients to their GPs has been positive.
West Wakefield
The pilot is trialling extended access to physiotherapy, this service enables **patients to have direct access to physiotherapy assessment instead of GP appointments** as the first contact for minor musculoskeletal problems. It is hoped this will provide a more efficient and streamlined service for patients and free up GP time.
Workington
Workington appointed two **chronic obstructive pulmonary disease (COPD) nurses** to work part time. The COPD nurses have been given the top 2% 'at risk register' list from practices as part of the Local Enhanced Service. These are COPD patients classed as severe/very severe risk of admission. The COPD nurses have written to or rung each of these patients and have arranged to do a full patient assessment. They will then support the patients with ongoing reviews. The COPD nurses provide home visits and care home visits as well as clinic based appointments. It is hoped this will reduce demand on GPs and prevent avoidable hospital admission.