The Big Purple Book

Middleton Demonstrator

Dr Mo Jiva MBE
July 2015

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Acknowledgement

The author wishes to thank the surgery staff from the GP surgeries in Middleton. Without the dedication and enthusiasm of these staff much of what has been learnt would not have been possible. Also we would like to thank all those who took the time to engage with the demonstrator from developing new services to writing articles for this book and all those who have assisted in recording video clips and have committed to recording video clips in the future for the new MiDHaS.uk website.

Foreword from the Director of Commissioning

As described in detail in this document, Middleton was one of six "demonstrator" sites, selected by NHS England as early adopters for aspects of Greater Manchester's Primary Care Strategy. In this context, the project has served both to deliver new and innovative services to the population in Middleton but also to provide a significant source of learning to the whole of Greater Manchester and beyond.

The programme has shown that where local GPs and other professionals work together in an integrated and co-operative manner, there is scope to deliver significant change and development in primary care.

This document provides a full and frank view from the front line of primary care, describing the opportunities to redesign services, as well as the potential risks and pitfalls. The views contained within the report are those of the authors and no attempt has been made apply any external editorial control with regard to its content.

We are grateful to the team who have led and implemented the programme and hope that the work which has commenced via the demonstrator project can continue into the future.

Rob Bellingham
Director of Commissioning (Greater Manchester)
NHS England

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Introduction

What is clear is that the current state of affairs in the NHS is unsustainable. The financial situation cannot sustain the health service for much longer as public demand on the service increases and the nation develops an ageing population with increase in chronic illnesses across many different age groups. With over 60 years of free healthcare at the point of need this country is not ready to introduce privately funded healthcare seen in other countries.

The solution must be in public education, efficient use of scarce NHS resource, new models of care including pathways, collaborative engagement with different sectors across a community including health, social, private, voluntary and many others and also the introduction and implementation of available technology into the healthcare system not to forget additional government investment.

This new opportunity introduced by the Greater Manchester Area Team of NHS England in 2013 preceded phase 1 of the Prime Ministers Challenge Fund and started exploration of new ways of working across large communities with innovation and pushing the boundaries being at the heart of the project. The journey taken by Middleton following a successful bid in 2013 started a rollercoaster ride exploring different models of healthcare in Middleton and kick started an evolutionary change which in the future will provide better healthcare, improved quality of life and easier access to services to the residents of Middleton.

The lessons learnt and systems implemented will be shared with the wider economy to support the borough, the county and nationally to ensure that Middleton does its share to ensure a valued National Health Service retains the founding principles that has been acknowledged worldwide and remains accessible to all across a community.

Dr Mo Jiva MBE
Clinical Lead Middleton Demonstrator

Case Study :

“

I work during the day and travel into Manchester for work. My employer is not understanding when I need to see my GP and so I can’t take time off

”

JE - age 36

1

Background

In 2013 the Greater Manchester Area Team of NHS England requested submission of business cases that proposed new ways of delivering healthcare. At the heart of the project was to explore the delivery of 7 day GP services but to propose other innovations that the local community may benefit from. The timeframe to develop and submit a business case was extremely short and across Middleton there where 2 business cases being developed independently of each other.

The cases being developed sought to address different elements of the patient pathway and once the 2 clinicians realised the existence of the 2 models it made natural sense to combine the 2 concepts and submit as a single proposal with the 2 authors eventually becoming the clinical leads for the Middleton Demonstrator. From the numerous business cases submitted to the Area Team 6 localities across Greater Manchester were finally approved with Middleton being one of the sites.

The criteria as proposed in the Area Team Specification where as follows:

Purpose – In the period to the end of July 2013, NHS England Greater Manchester Area Team Primary Care Commissioning Directorate are finalising the Primary Care Commissioning Plan for 2014/15 onwards. In parallel and as part of the overall process to mobilise the delivery of integrated care, a number of “demonstrator” communities will be identified for specific resource allocation and early implementation.

Criteria – The following high level themes and characteristics for a Demonstrator project/ community have been identified as:

1. Supporting a defined community of 30,000 upwards
2. Integrated approach to delivery i.e. involvement of other agencies, partners
3. Clear, demonstrable link to local integrated care plans
4. Consideration of innovative/enhanced use of technology e.g. shared patient records, web based consultations, telehealth/telecare
5. Robust evaluation process including outcome based metrics e.g. increased satisfaction, reduced A&E attendees, reduced hospital admissions/ length of stay
6. Demonstrating how user access to primary/integrated care can be extended via the model
7. Where appropriate, the project should have the ability to demonstrate savings to enable future recurrent funding
8. Contain an implementation plan with key milestones and delivery plans identified

Within the report the clinical leads will present examples of collaboration, opportunities and barriers experienced.

In the true nature of a pilot we have been open and transparent in sharing our findings. Although there are negative findings presented and barriers experienced with certain organisations, time has allowed refinement of our relationships, modification in the models delivered and definition and implementation of the Terms of Engagement.

This has been the foundation of what will support the delivery of a healthcare model across Middleton delivered on a framework of an open transparent relationships between organisations with collaboration to develop and deliver local services in a cost effective manner.

Quote:

“Yes the medicine is harsh, but the patient requires it in order to live. Should we withhold the medicine? No”

(The Iron Lady – Film based on Margaret Thatcher)

The Original Demonstrator Bid

Middleton is a town within the Metropolitan Borough of Rochdale. The registered GP population of Middleton as of June 2013 was 47936. Middleton incorporates 8 GP practices both GMS and PMS with an additional GP APMS Walk in Centre. The GP software utilised includes both EMIS and Vision, with plans for all the different variations of EMIS to migrate to the web based version EMIS Web by the end of 2013. NHS Commissioner within the locality is Heywood, Middleton and Rochdale Clinical Commissioning Group (CCG) of which all the GP practices across the Borough are members.

Local NHS Hospital Trust is Pennine Acute NHS Trust with the North Manchester General and Oldham Hospital sites being the most frequently visited locations by Middleton residents. Community services including community nursing and mental health services are currently provided by Pennine Care Foundation Trust.

The out of hours period (Monday-Friday 6.30pm-8am and throughout the weekend) is currently commissioned by HMR CCG with BARDOC (Bury And Rochdale Doctors On Call).The APMS Walk in Centre in Middleton has opening hours beyond the core GMS/PMS hours as part of their contractual arrangements which results in public access to primary care services in the evening and weekends.

Throughout the duration of the demonstrator the management at the Middleton WIC decided not to partake and become members of the demonstrator and as a resulted have not experienced, engaged or benefited from the lessons and services created and delivered through the demonstrator. The other 8 GMS/PMS GP practices in Middleton where all members of the demonstrator.

At the time there was no direct contractual link between the local NHS primary care providers and Rochdale Metropolitan Borough Council. With the relocation of public health services from the NHS to the local authority there are now service contracts between GP practices and the Local Authority and the newly established “devoManc” group will strength and establish many more new relationships between the Local Authority, General Practices and the wider community.

Greater Manchester Area Team of NHS England commissioned CLARHC, part of the University of Manchester to evaluate all 6 demonstrator sites across Greater Manchester.

Project Overview

The bid consists of a number of steps: 6 steps to evolution. These included:

1. Public education
2. GP services 7 days a week
3. Virtual Community Ward
4. Local List Server
5. Up skilling local pharmacists
6. Web based consultations

Public Education

Public education is to ensure that the community within Middleton and in surrounding areas registered with a Middleton GP practice where aware of the proposed changes and understand how patient care will be redesigned. Figure 1 is the poster created to present in a pictorial manner a summary of the demonstrator project, this was used for NHS meetings. As the demonstrator evolved the contents of the pilot changed which was linked to the Greater Manchester Primary Care Strategy (figure2)

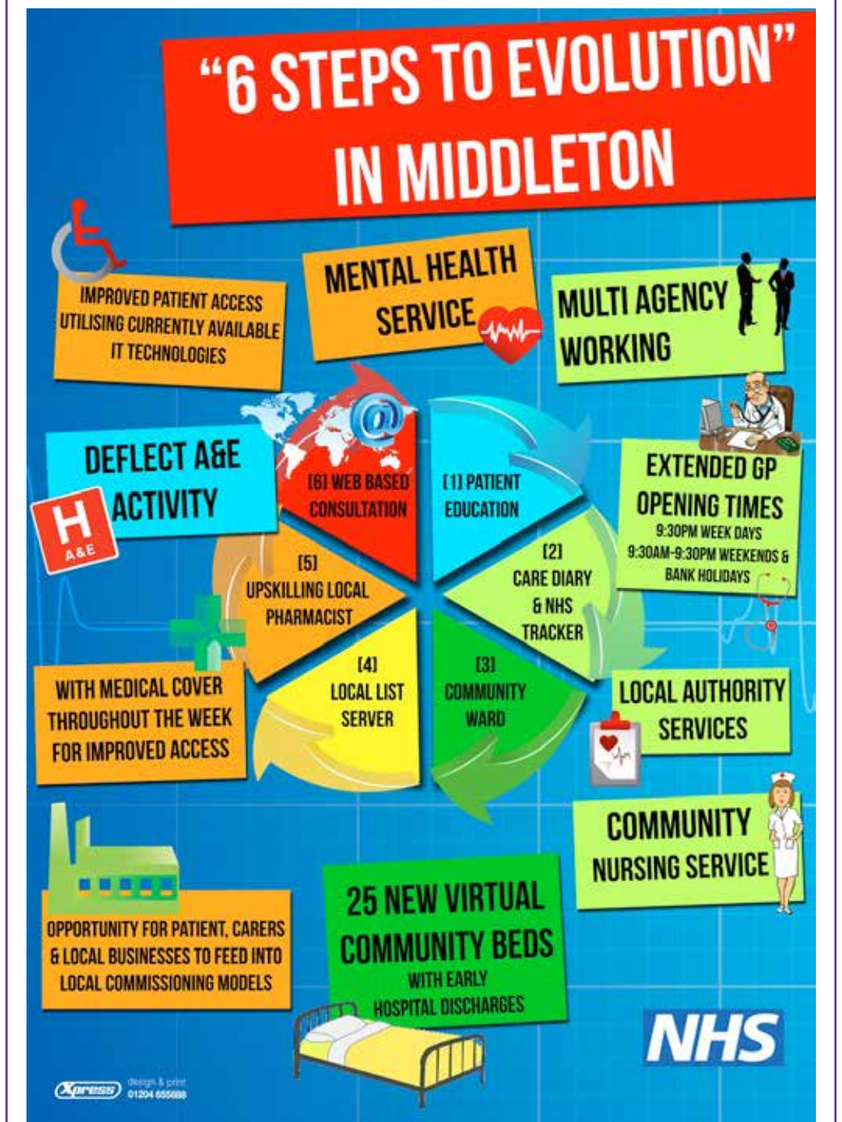
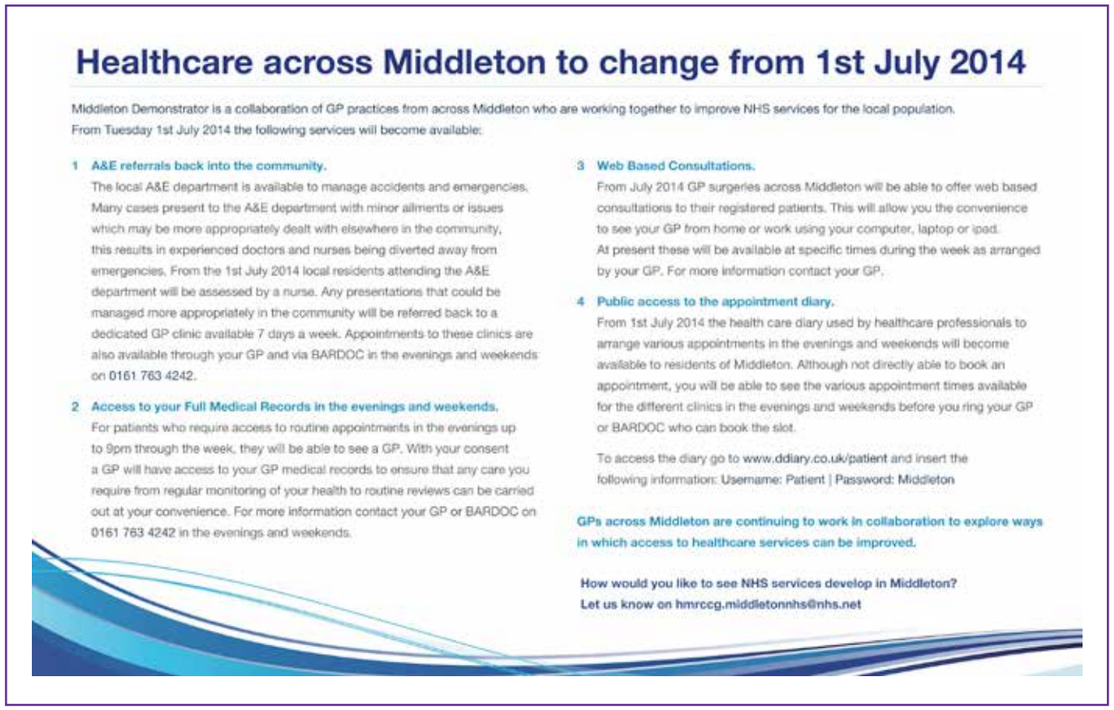


Figure 1

Figure 2

Public education was undertaken with leaflets and posters in GP surgeries and also utilising advertising in the local tabloid, Middleton Guardian. Advertising was undertaken on a number of occasions over the life of the pilot to reinforce the message from the demonstrator to the local public. The work of the pilot was also featured in a Panorama programme on T.V.



Healthcare across Middleton to change from 1st July 2014

Middleton Demonstrator is a collaboration of GP practices from across Middleton who are working together to improve NHS services for the local population. From Tuesday 1st July 2014 the following services will become available:

1 **A&E referrals back into the community.**
The local A&E department is available to manage accidents and emergencies. Many cases present to the A&E department with minor ailments or issues which may be more appropriately dealt with elsewhere in the community, this results in experienced doctors and nurses being diverted away from emergencies. From the 1st July 2014 local residents attending the A&E department will be assessed by a nurse. Any presentations that could be managed more appropriately in the community will be referred back to a dedicated GP clinic available 7 days a week. Appointments to these clinics are also available through your GP and via BARDOC in the evenings and weekends on 0161 763 4242.

2 **Access to your Full Medical Records in the evenings and weekends.**
For patients who require access to routine appointments in the evenings up to 9pm through the week, they will be able to see a GP. With your consent a GP will have access to your GP medical records to ensure that any care you require from regular monitoring of your health to routine reviews can be carried out at your convenience. For more information contact your GP or BARDOC on 0161 763 4242 in the evenings and weekends.

3 **Web Based Consultations.**
From July 2014 GP surgeries across Middleton will be able to offer web based consultations to their registered patients. This will allow you the convenience to see your GP from home or work using your computer, laptop or ipad. At present these will be available at specific times during the week as arranged by your GP. For more information contact your GP.

4 **Public access to the appointment diary.**
From 1st July 2014 the health care diary used by healthcare professionals to arrange various appointments in the evenings and weekends will become available to residents of Middleton. Although not directly able to book an appointment, you will be able to see the various appointment times available for the different clinics in the evenings and weekends before you ring your GP or BARDOC who can book the slot.

To access the diary go to www.ddiary.co.uk/patient and insert the following information: Username: Patient | Password: Middleton

GPs across Middleton are continuing to work in collaboration to explore ways in which access to healthcare services can be improved.

How would you like to see NHS services develop in Middleton?
Let us know on hmrccg.middletonnhs@nhs.net

Figure 3

The messages in the advert above (Figure 3) were delivered through the local press. The key areas covered in this advert where:

1. The introduction of a referral back into the community scheme from the local A&E department (Deflection Scheme)
2. Access to a GP service outside the core GP surgery hours
3. Introduction of web based consultations
4. Public access to the online booking diary
5. Opportunity to feedback to the demonstrator team on any ideas from the community.

These will be discussed further in detail below.

As well as the adverts in the press, leaflets were created to be distributed through GP surgeries in Middleton. Figures 4 and 5 present the 2 sides of the leaflet that was developed.

Figure 4

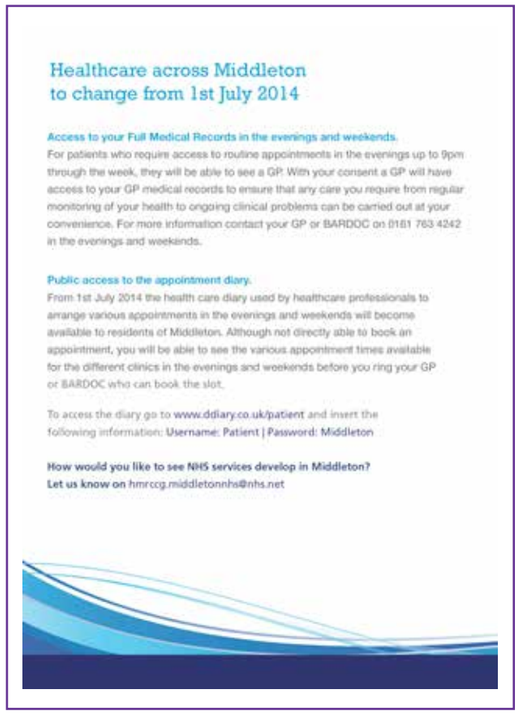


Figure 5

All opportunities to advertise the services was utilised in conjunction with promotion of other services. Further examples of leaflets and posters are presented below.

All too often patients ring their GP and begin a negotiation with the reception staff on what appointments are available and whether they are convenient for the caller. This leads to wasted time for both the caller and the call handler. One of the opportunities provided within the evening and weekend surgeries was the ability for patients to access the online diary and see which times are available on specific dates; this would allow more efficient use of time for both parties.

GP Services – 7 day service

The quote at the beginning of the chapter is from the film "Iron Lady", the story of Margaret Thatcher. Although used in a different context in the film it is relevant to this topic as the thought of seven day working in General Pratice is not openly welcomed by many but nevertheless is a concept that requires exploring if the "patient" or in this context "community" is to live.

Middleton has 9 GP surgeries (including one APMS Walk in Centre (WIC)). All the surgeries other than the WIC are contracted to provide patient care between the hours of 8am to 6.30pm Monday to Friday (Core Hours). Outside this period including bank holidays is defined as the "Out of Hours" period when the GP surgeries are not responsible for patient services. This period is covered by HMR CCG England who commission GP services from BARDOC for the borough of Rochdale.

The nature of Out of Hours care means that the service only delivers care to those who are acutely unwell or have need for urgent access to clinical advice or assessment. Routine healthcare is beyond the scope of the Out of Hours contract and in the absence of access to the patients GP medical record it causes difficulty in providing routine patient care. The demonstrator proposed to extend the period during which patients could access routine healthcare in a community setting beyond the current core hours. In aspiring to undertake this, a number of issues needed to be considered:

1. Do all GP surgeries in Middleton stay open beyond core hours?
2. If we use one site, where will it be?
3. Who man's reception and the clinics in the one clinic model?
4. In a single site model, how do patients get booked into the clinics?
5. How does the GP access the patient's registered GP medical records to ensure that routine care can be provided?

The costing's for the project, demand for routine care in the out of hours for each surgery 7 days a week and the lack of willing manpower to be available in the out of hours period quickly lead to the conclusion that the model needed to be delivered from one site. The GP premises at Peterloo Medical Centre (where the clinical lead for the demonstrator is based) had recently been renovated with a large waiting room, children's play area, breast feeding area, clinical consultation rooms and on site Boots pharmacy made this the preferred venue.

The GP workforce across Middleton is already stretched with core practice work and therefore expecting them to man evening and weekend surgeries was unrealistic in this model. The short nature of the pilot (initially one year) meant that employing staff with all the associated human resource issues was not an option. What was considered was that if the model was successful and became mainstream in the future so that core GP hours where extended beyond 6.30pm and delivered 7 days a week, it would be very likely that the out of hours contract would be reduced financially to reflect the fact that their services would not come on line until the GP surgeries closed late in the evening throughout the week.

This may have impact on the organisation as a whole including the number of GPs they engaged to deliver out of hour's services. The evolution of NHS 111 had already brought new risks to the out of hour's service and the demonstrator was reluctant to make things worse. A decision was taken to engage with BARDOC, they would provide both the receptionist and GP to man the evening and weekend clinics. From the beginning there was a positive approach from the management team at BARDOC to support the evolution of this element of the project. The strength here lay in the fact that the demonstrator could collaborate with an existing organisation who had access to the required staff with all the relevant HR issues addressed. At face value initially there appeared to be no weaknesses or threats. Initially the clinics where set up during the week between 6.30pm-9.30pm and 3 clinics each day on the weekends between 9am-9pm.

The clinics during the weekdays were saturated with bookings from the GP practices in Middleton but capacity at weekends was poorly utilised. This lead to a reduction in the capacity available at weekends by initially cancelling the early morning surgery followed by the afternoon surgery leaving only the evening clinic in place. Initially whilst the demonstrator explored how to access the GP medical records the project used Adastra from BARDOC to supply additional capacity.

Although Adastra allowed delivery of acute healthcare which was already provided by BARDOC in their out of hours contract the project was embarking on winter and the general feeling was to go live rather than await a solution to access medical records which may take us to the following spring.

With 6 EMIS Web practices and 2 Vision practices the demonstrator engaged with the local Commissioning Support Unit (CSU) who provided costing's to create a solution to access all the medical records across the 8 GP surgeries from one venue. Having spent many months looking at numerous options, CSU concluded that this was beyond their abilities.

By now the pilot had engaged with EMIS who introduced the team to EMIS Clinical Services. CSU had provided a valuable role in providing the necessary governance documentation for each surgery to allow sharing of medical records. The demonstrator was invoiced by CSU for the full amount previously mentioned even though they where unsuccessful in providing a solution to accessing the medical records.

The clinical lead for the demonstrator engaged in discussion with CSU reluctant to pay for a service and product that had not been delivered. In the end the Demonstrator offered CSU one of 2 options:

1. CSU gets paid a fraction of the requested amount to reflect the support provided in adopting governance structure to share records and they depart from the demonstrator
2. CSU gets paid the full amount but in return the allocated IT technician working with the demonstrator continued to be allocated to the project and would embark on the steep learning curve that the demonstrator was undertaking at no extra cost to the pilot.

Unfortunately CSU decided to break ties with the pilot and go their own way. This was unfortunate as the pilot was to explore many unchartered technology areas that would provide new future opportunities. CSU where to make a come back later in the process at the request of the CCG in supporting the 2 Vision practices to migrate to EMIS Web which was financially supported by both the CCG and the demonstrator.

Subsequently the demonstrator commissioned EMIS to provide a solution to accessing the 6 EMIS Web practices which was relatively straight forward as there was an "off the shelf" product available in the form of EMIS Clinical Services (ECS). Although ECS would not allow direct documentation into the registered GP's medical record it would allow the GP's medical records to be seen and to record the consultation within the GPs medical record accessed by a yellow bar on the left of the patients consultation screen. This was the best available solution to make progress in delivering routine healthcare in the out of hour's period.

Although the Vision practices initially where unable to offer routine care to their patients in the out of hour's period through the demonstrator, this was rectified once they migrated to EMIS Web. For the future of federated working across a locality there is a necessary requirement for all the GP surgeries to utilise the same GP software which would allow sharing of records but also sharing of clinical staff, secretaries, administrative staff and receptionist. Also this allows economies of scale for audits, searches and research by undertaking locality activity from one site through ECS.

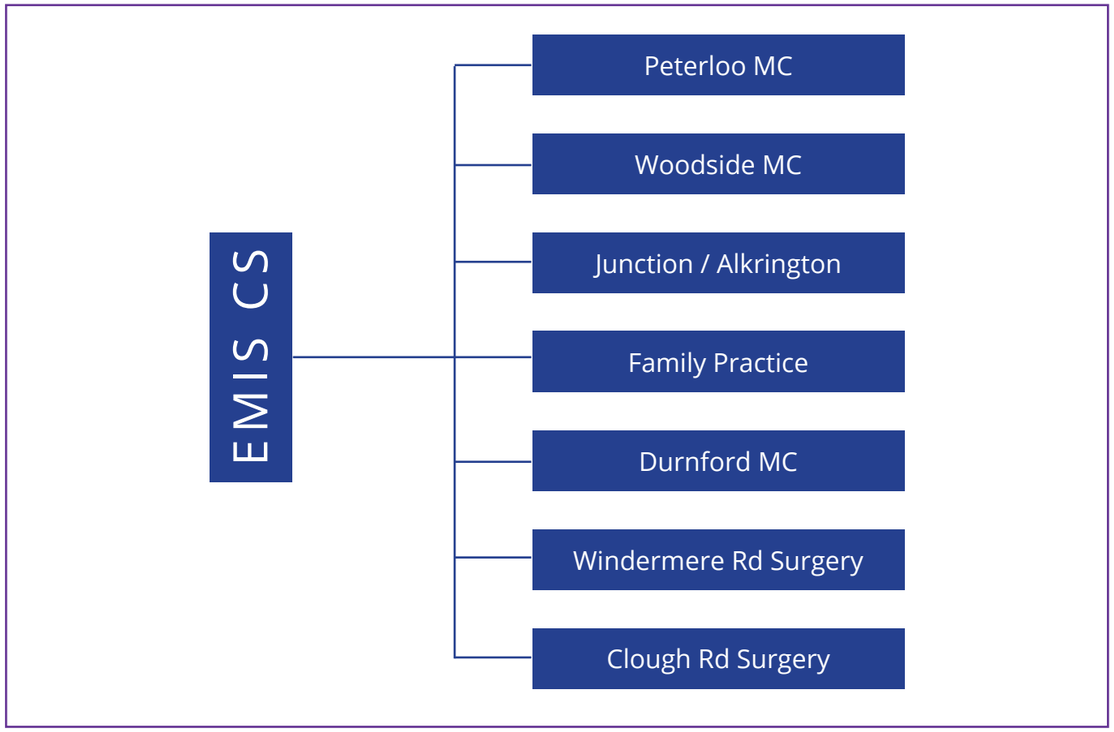


Figure 6

Returning to BARDOC and the reasons for not using the available capacity it appeared that although BARDOC had access to the booking system used by the surgeries across Middleton there was a reluctance to book patients into the demonstrator clinic and preferred to send Middleton residents to the BARDOC clinic outside Middleton. The reasoning behind this appeared to be 2 fold:

1. The call handling staff was a large workforce and not all of them where aware of the existence of the Middleton clinic and so referred to their own clinic outside the locality
2. A call coming in from a Middleton resident at the weekend irrespective of the reason would be categorised as an out of hours call and therefore be bound by the governance and KPI's attached to the out of hours contract meaning that the patient would have to attend their out of hours clinic.

Although it took a while to address these issues, positive engagement from senior management at BARDOC was invaluable in facilitating viable solutions and allowing the demonstrator clinical leads to understand the pressures incurred by the organisation.

There have been occasions when there has been insufficient GP workforce available in the system during the evening and weekends due to a number of other services emerging in the vicinity including a successful phase 1 Priminister's Challenge Fund site in Bury which has had an impact on where a finite GP workforce commit there time. BARDOC has throughout the demonstrator recognised the importance of the demonstrator pilot and only on a couple of occasions over the whole period had to let the demonstrator down resulting in no GP surgery.

A clear lesson from this pilot has been that the more piecemeal activity undertaken by government in introducing various time limited projects that impacts on a finite workforce is likely to destabilise existing services by additional workforce pressures. There is an urgent need for the different systems to work in collaboration for the benefit of the local residents rather than in their own silo's, will "devoManc" provide the solution?

In this single site model, Middleton had 6 GP surgeries on EMIS Web and 2 GP practices on Vision. Having 2 different GP software systems and the vision of the demonstrator to engage with other community and hospital providers meant that we required a booking system that could easily be accessed by all organisations involved. The clinical lead engaged with a local software design company to develop what is now called a DISHI diary (Data Intelligence Software - Health Information diary).

The diary is web based allowing easy access from any desktop computer, Laptop, Tablet or smart phone. Below are some screen shots from the DISHI diary:

Figure 7

The initial login (Figure 7) had site specific username and password for the GP surgeries across Middleton but also for other community service providers, BARDOC and the local hospital.

Figure 8

The one login would allow access to the diaries of a variety of different services as shown in figure 8. Although not all these services went live due to a variety reasons including existing service demands to the short nature of the pilot to justify reconfiguration of services, 4 of the services where explored further with all going live for different periods of time. The 4 services that went live included:

- GP (see above)
- Mental Health
- Pharmacy
- Nurse

On accessing any of the above service boxes the next page provided appointment slots for that organisation (Figure 9). The difference with this diary was the ability to keep the patient details hidden from other GP surgeries due to confidentiality.

As shown in figure 9 a booked appointment would present at the appointment time with the word "Appointment" next to it. Available appointments would be clearly visible and hovering over the time slot would bring up a separate box stating "add appointment", clicking on this box would allow access to a booking screen where patient personal and demographic details including a brief description for referral would be allowed. Service providers such as BARDOC would be able to see all the patient's details to allow them to run a clinic.

As this is a web based system separate to EMIS it did mean that the clinic staff in the evening and weekends had to operate 2 systems during the clinic. The fact that other agencies who do not have EMIS in their organisations could book patients in with a GP outweighed the need for the evening and weekend staff to operate a web based diary and a GP software system.

Providing 24/7 IT support from the software designer and an administrative team meant that the few hiccups around server connections and service lockouts following incorrect passwords where easily rectified with little service disruption.

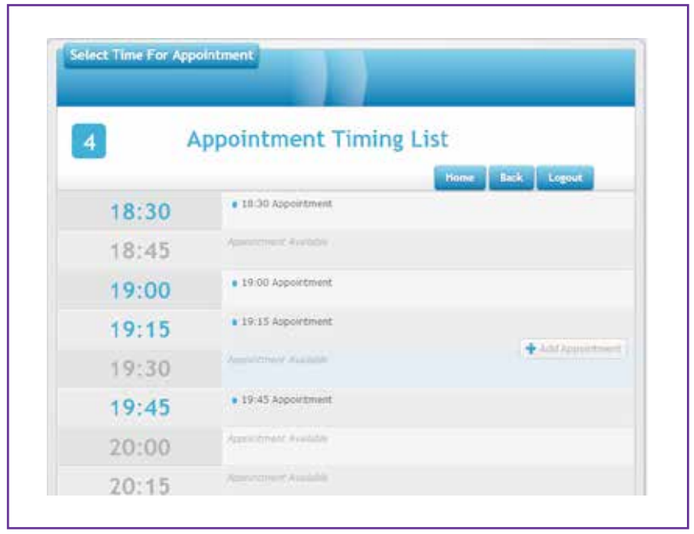


Figure 9

The GP service has been continuous from its inception in 2013 up to the end of May 2015, now lying in the hands of the local CCG who have provided funding up to the end of July 2015 to allow exploration of the 7 day model and the future.

The DISHI Diary has gone beyond Middleton, being personalised and utilised in both Rochdale and Bolton to support the delivery of 7 day GP surgeries.

Unfortunately throughout the period of delivering GP appointments in the evening and weekends the Boots pharmacy on site has remained closed. Initial feedback was that the cost of staffing the pharmacy would be too much for the activity generated from the GP clinics.

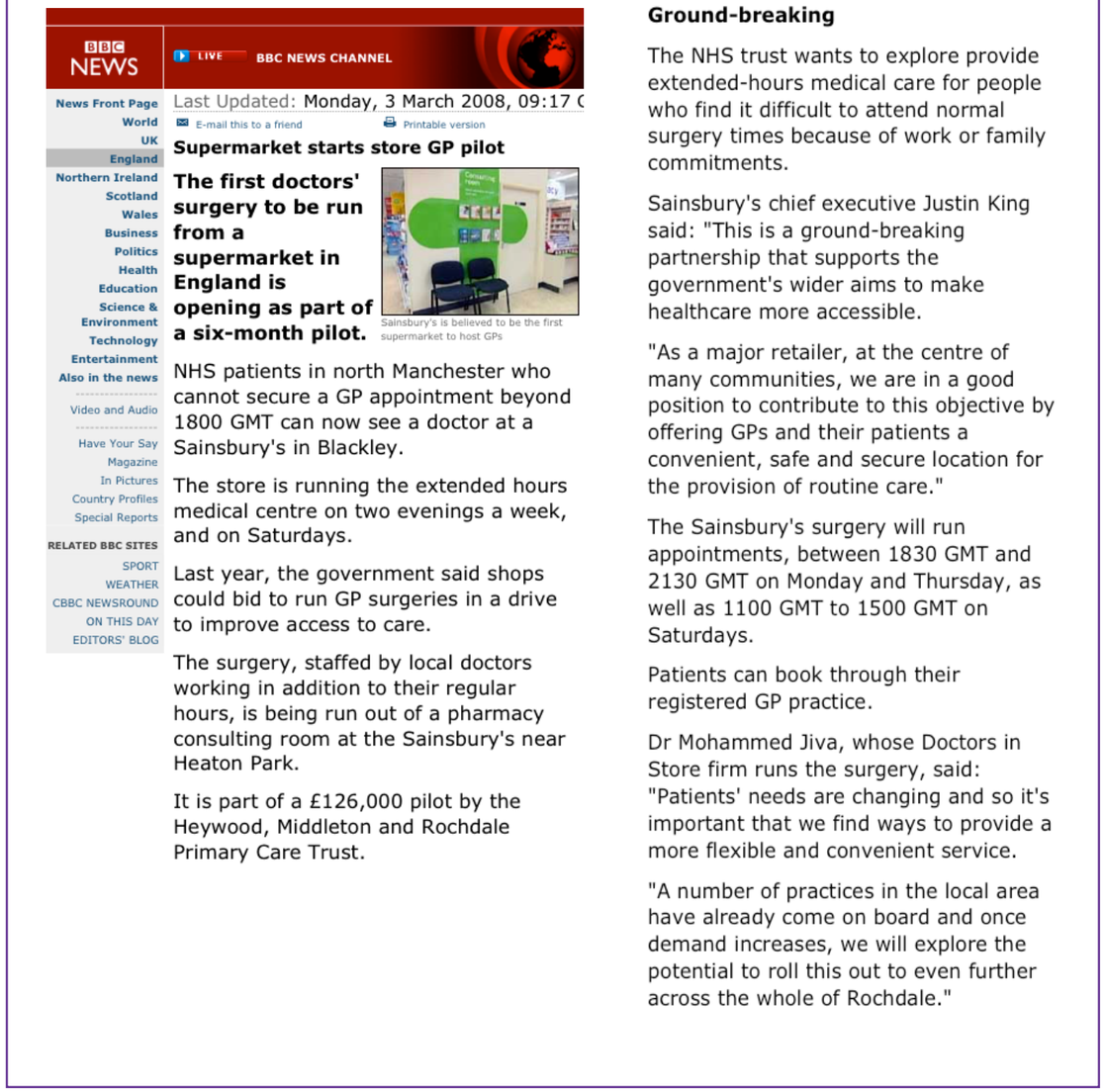
With regard to other services such as phlebotomy to compliment the GP clinic there where a number of initial thoughts:

- During the day patients don't generally get phlebotomy services within primary care setting on the same day, why would they require a different service in the evening and weekend for routine appointments
- If urgent phlebotomy was required in the out of hours period should the patient be attending the hospital either through A&E or direct referral to a specialty otherwise it is likely the sample would go to a "cold lab" which would cause delay in processing the sample and would the referring clinician be available to review the results later the same evening
- Transport to the local hospital laboratory although this issue was addressed by another GM demonstrator at relatively low cost
- Would one evening GP surgery generate enough activity to justify a dedicated phlebotomy service
- Finding a phlebotomist willing to work evening and weekends

For all the above reasons this pilot decided to proceed with GP clinics in the absence of any local phlebotomy services. Any request for phlebotomy where passed to the day time registered GP. Although there will be negative comments from the day time GPs about passing work through to the day services, in light of the short duration of this pilot the project had to keep in mind the limitations of the financial and manpower resource available. If this became mainstream in the future then more robust services to compliment GP clinics would need to be explored.

Other community services such as district nurses where available in the evenings and weekends although not on the same site as the GP clinics, this is an area the pilot explored –see below.

Providing routine healthcare outside GP core hours is not a new concept. In 2008 Dr Jiva started the first NHS GP service based within a superstore (Sainsbury's) within the country. This received both national and international recognition and 5 years on the same store facilitates a venue for local GPs to deliver GP clinics and many dozens of practices across the country have established similar working relationships with their local Sainsbury's stores.



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Supermarket starts store GP pilot

The first doctors' surgery to be run from a supermarket in England is opening as part of a six-month pilot.

Sainsbury's is believed to be the first supermarket to host GPs

NHS patients in north Manchester who cannot secure a GP appointment beyond 1800 GMT can now see a doctor at a Sainsbury's in Blackley.

The store is running the extended hours medical centre on two evenings a week, and on Saturdays.

Last year, the government said shops could bid to run GP surgeries in a drive to improve access to care.

The surgery, staffed by local doctors working in addition to their regular hours, is being run out of a pharmacy consulting room at the Sainsbury's near Heaton Park.

It is part of a £126,000 pilot by the Heywood, Middleton and Rochdale Primary Care Trust.

Ground-breaking

The NHS trust wants to explore provide extended-hours medical care for people who find it difficult to attend normal surgery times because of work or family commitments.

Sainsbury's chief executive Justin King said: "This is a ground-breaking partnership that supports the government's wider aims to make healthcare more accessible.

"As a major retailer, at the centre of many communities, we are in a good position to contribute to this objective by offering GPs and their patients a convenient, safe and secure location for the provision of routine care."

The Sainsbury's surgery will run appointments, between 1830 GMT and 2130 GMT on Monday and Thursday, as well as 1100 GMT to 1500 GMT on Saturdays.

Patients can book through their registered GP practice.

Dr Mohammed Jiva, whose Doctors in Store firm runs the surgery, said: "Patients' needs are changing and so it's important that we find ways to provide a more flexible and convenient service.

"A number of practices in the local area have already come on board and once demand increases, we will explore the potential to roll this out to even further across the whole of Rochdale."

Figure 10 - Article in BBC News in 2008

The New York Times

Business Day SUBSCRIBE | LOG IN

Combining Grocery Shopping With Doctors' Appointments

By JULIA WERDIGIER
MARCH 3, 2008

LONDON — Some Britons can add a visit to the doctor to their shopping lists. On Monday, J Sainsbury, one of Britain's largest supermarket chains, is to become the first in the country to offer a visit to a family doctor in one of its stores.

"There are only so many different types of cheeses and sausages you can offer," said Tim Denison, a member of the Retail Think Tank, a research firm based in London. "This is a logical step for supermarkets that look where to go next to give consumers the efficient shopping experience they want."

The clinics are expected to attract more customers and to give the store an incentive to sell prescription drugs, which have higher profit margins than over the counter medication, Mr. Denison said.

Patients doing their shopping will be alerted via electronic pager when a doctor is available to see them.

The initiative, called Doctors in Store, was the idea of Mohammed Jiva, a 35-year old family doctor in the Manchester area. Dr. Jiva noticed a growing demand from patients to book appointments in the evenings or on weekends because of busy work schedules.

Figure 11 - Article in New York Times in 2008

There is still national concern about government imposition of making GPs work 7 days a week. This is not quite the model proposed as there is a distinction between "your GP" and "a GP" who has access to the medical record. 7 day service can be explored with a number of viable opportunities but there does need to be national clarification for the public that the offer is of routine healthcare 7 days a week with a GP which may not necessarily be your GP.

In reality no NHS GP contract can be imposed as the principal has to sign a contract to be bound by it and therefore each GP will have to carefully consider any future revisions of the GP contract.

As mentioned elsewhere in the report the training time required to provide a newly qualified GP is 10 years. In reality with the variables mentioned in the report relating to too few GPs being created and too many leaving what alternatives are there to meet the manpower requirements to deliver a 7 day service ?

More recently there has been the emergence of a new breed of clinician – The Physicians Associate. In a recent study reported in British Journal of General Practice medical records of 2086 patients presenting for same day appointments at 12 GP surgeries in England over a 4 week period in 2011/12. The study concluded that there was no difference in:

- How many patients had another consultation about the same problem
- Number of diagnostic tests ordered
- Prescriptions issued
- Patient satisfaction

The study also concluded that the physicians associate made more thorough records of consultations than GPs did, 79% versus 48% as judged by a group of independent GPs.

The average time for undertaking a consultation was 17minutes for the associates versus 11 minutes for GPs but when costing where taken into account of £28.14 for associates versus £34.36 for GPs it does make the physicians associate a viable option to explore to complement the existing GP workforce.

Virtual Community Ward

The virtual community ward would allow patients to be discharged early from the hospital back to their own homes with the necessary infrastructure including IT and manpower in place to complete the care pathway initiated within the hospital. To avoid the funding requirements associated with utilising a dedicated building e.g. a community nursing home, this model proposed to use the patients own home which would allow the patient to be in a familiar environment and for family to be close at hand.

The Middleton Demonstrator Pilot was conceived around two pieces of software. The DISHI Diary which was successfully used for booking patients into the extended hours pilot at Peterloo Medical Centre and the DISHI Tracker (Figures 12 and 13) which was designed to follow patients across NHS boundaries. It took many months to reach agreement with North Manchester General Hospital (NMGH) about the use of the DISHI Diary and discussions about the DISHI Tracker did not really

begin until after the Diary agreement. This delayed discussions about the community bed scheme and ultimately we tried to arrange that the bed scheme would begin using the telephone rather than web based technology to keep things simple.

The bed scheme was an arrangement for Middleton practices to provide intensive input to patient discharges in order to facilitate some discharges to be made early to free up hospital beds and therefore relieve pressure on A&E. Numerous meetings were held with staff who would participate in the scheme, clinicians, managers and discharge teams who unanimously held this to be a good idea worth trialing. We set a start date in November 2014 to synchronise with winter pressures, practices were ready and organised waiting to be contacted by NMGH discharge teams but nothing happened.

Further meetings were held and at no stage was it suggested that facilitating early discharges was impractical but no discharge notifications were telephoned through to any Middleton practice. We did explore the possibility of amending the scheme to work with Rochdale Integrated Care and Age UK but there were insufficient funds in the Pilot to resource home visiting by practices, social workers and Age UK staff.

Middleton practices remain engaged to increase the medical and social supervision of patients most likely to attend A&E and require hospital admission. Locally HMR CCG have extended the Unplanned Admissions DES with a locality scheme (LES) preparing and reviewing Care Plans with patients at risk. This is already showing some benefits.

The Demonstrator Pilot is funding the regular visiting of the frail elderly and housebound, creating community beds to prevent admission rather than facilitating early discharges. Certainly the frail elderly are the group most likely to require admission to hospital and yet there are few incentives in the current systems to provide the input they need to remain in the community. This was not always the case. Routine domiciliary visiting of the frail elderly used to be an integral part of general practice that has been squeezed out by other pressures, with outcomes more easily measurable.

It would seem to be the experience and an outcome of this pilot that interventions in general practice to prevent the necessity for hospitalisation are more likely to be successful than moving hospital work into the community. It has been suggested to us that the incentives in the payment by results system mitigate against early discharges and also A&E deflection.

Secondary Care clinicians may be upset about increasing numbers in A&E and increasing numbers of beds blocked by people awaiting discharge but until the current payment system is changed moving work out of hospital into the community will proceed at a snails pace. Perhaps it may be easier and more cost effective to prevent work entering the hospitals

The DISHI Tracker was created on the same founding principles which is to integrate different teams into accessing a single piece of software which coordinated piece care. Figure 12 below shows the table which would record various data allowing patient location and status to be visualised. The different elements of the tracker are:

- Ability to record the patients name, dob, NHS number
- Patient GP
- Choose which hospital they are being seen or admitted to
- Which ward within the hospital they are in
- Date of admission
- The ability to edit various information including the site and ward to allow the ability to track where the patient is
- How long they have been in hospital

The table uses a colour coordinated approach to make the patient status easily visible:

- Grey : Seen in A&E, assessed, managed and discharged home
- Red : Admitted onto hospital ward and under specialist supervision
- Yellow : Has been discharged by specialist service but still on the ward
- Green : Physically leaving the ward

In the back ground there is a stop watch behind each patient which allows the doctors and managers to see how long the patient was at each colour coded stage.

The DISHI Tracker also allows easy audits by using search tools to refine searches from different hospitals to different wards and different GPs.

The tracker also allow specialist to pass on information to the GP through a free text box (Figure 13).

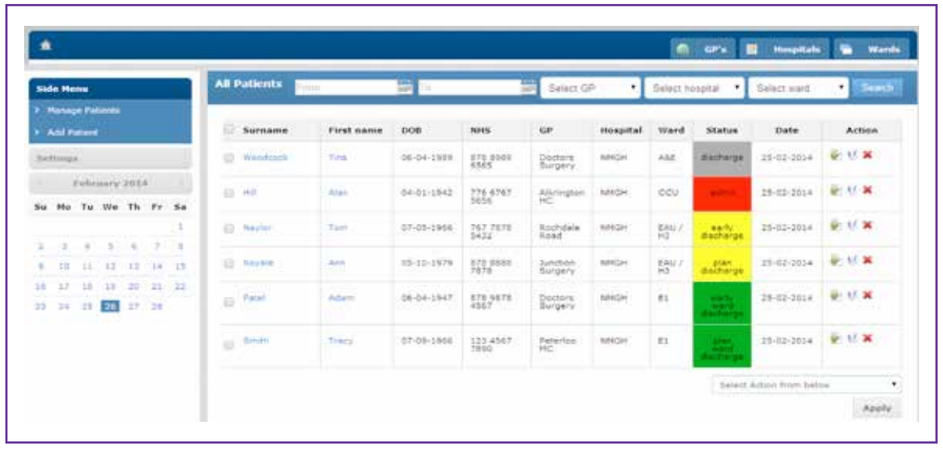


Figure 12

Figure 13

With the diary accessible through the internet it does make patient tracking from inside and outside the hospital much easier allowing capacity planning and bed management during peak period more effective.

This also allows the community staff to monitor whether the patient is still in hospital or discharged. So far the demonstrator has introduced Pennine Acute NHS Hospital Trust to the Tracker with a number of positive meetings from clinicians but bureaucracy unfortunately has hampered exploration and implementation of this software into the acute hospital setting.

The aspiration is that as well as the hospital setting this may be a tool to monitor the status of patients in the community to allow efficient use of the clinical manpower.

More recently the issue of allowing the elderly to die with dignity has arisen. To often the dying are under the care of a single organisation whether this is the hospice, hospital, McMillan nurses or the GP. A dying individual needs review on a regular basis in a multidisciplinary approach.

Although many areas will have Gold Standard Framework (GSF) arrangements in place in many cases the actual reviews are undertaken by one agency. Utilising technology such as the DISHI Tracker would allow various agencies to track all their dying patients whether in the hospital or in the community.

All those involved in the care of the dying can track the progress, location and severity of illness through this web based technology which allows different agencies to access and comment on a variety of issues to ensure other partner organisations are kept informed. This would be a model to share responsibility across different agencies and ensure the dying receive dignity and care during their final stages.

Local List Server

The list server would provide an opportunity for the local residents, carer's and supporters including the business community to post comments and suggestions into the list server to guide the professionals in understanding local trends that may be developing and may need addressing through local commissioning arrangements. This concept has evolved into an intranet vision for Middleton termed MiDHaS.uk (more information later on).

Pharmacy

Pharmacists in and around Middleton provided a great opportunity to support the local clinical community in addressing a variety of minor ailments. Although historically pharmacists have delivered on minor ailment schemes it has been in a solitary fashion. The bid proposed to establish additional training incorporating patient assessment, diagnosis and provide medical cover during the bid period to ensure pharmacists have medical support when required.

This model relied on pharmacist seeing minor ailments but for local GP surgeries to deflect appropriate patients with patient education and triage where necessary to the local pharmacies to obtain assessment and management. In the event that the presentation to the pharmacist is unclear or undiagnosed the pharmacist should be able to access medical advice to address the patient's needs. The patient pathway needed to be simple and uncomplicated.

The demonstrator set up a meeting with local pharmacies to assess the interest in becoming part of the model. Out of 5 pharmacies that attended a briefing meeting 2 eventually expressed an interest in partaking with this project. From the 2 pharmacies, the pharmacist attended a 2 day training programme developed by 2 GP trainers and a GP course organiser. The programme consisted of developing various skills from history taking to assessment and diagnosis. The course also discussed consultation skills. The feedback from the pharmacist is presented in appendix 1.

To simplify the patient pathway, virtual contact was setup using desktop and laptop computers in the pharmacies. Purchasing a Webex license allowed a visual connection between the pharmacies and a GP surgery. Initially the model was to allow the pharmacist to log into webex and setup a meeting but the time required to login and send a meeting request was too long. Also this model would mean 2 Webex licenses, one for each pharmacy. The alternative was for the GP surgery to have the Webex license and generate a meeting with the pharmacy. The pharmacist would text the GP when support is required resulting in the GP generating a Webex meeting:

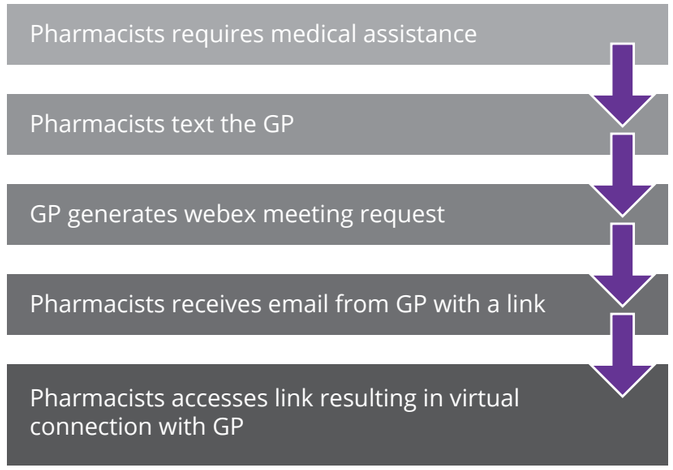


Figure 14

This model works but for a number of reasons was not adopted mainstream for the following reasons:

- The management team within the demonstrator was too small to manage the many different facets within the pilot
- Pharmacists where too busy with their dispensing role to commit to the time required to contact the GP and stay with the patient in the pharmacy whilst the GP assessed the patient. On one occasion the patient's needs could not be addressed by online consultation. The GP accessed the DISHI Diary whilst online and booked the patient in with a GP the same evening to be further assessed and managed; this avoided the need for the patient to return home and contact his own GP to see if there was an appointment available for that day. This simplified the care pathway for the patient.

This model has potential and significant opportunity to reduce patient demand at GP practice level. Further collaboration between GPs and pharmacist to refine the model and streamline the service has the potential to direct the population with minor ailments to the pharmacist with medical support where required.

With the advent of Electronic Prescription Service (EPS) this now allows direct transfer of a prescription to a pharmacy where the patient is being assessed to allow the pharmacist to dispense the medication and thereby simplifying patient care.

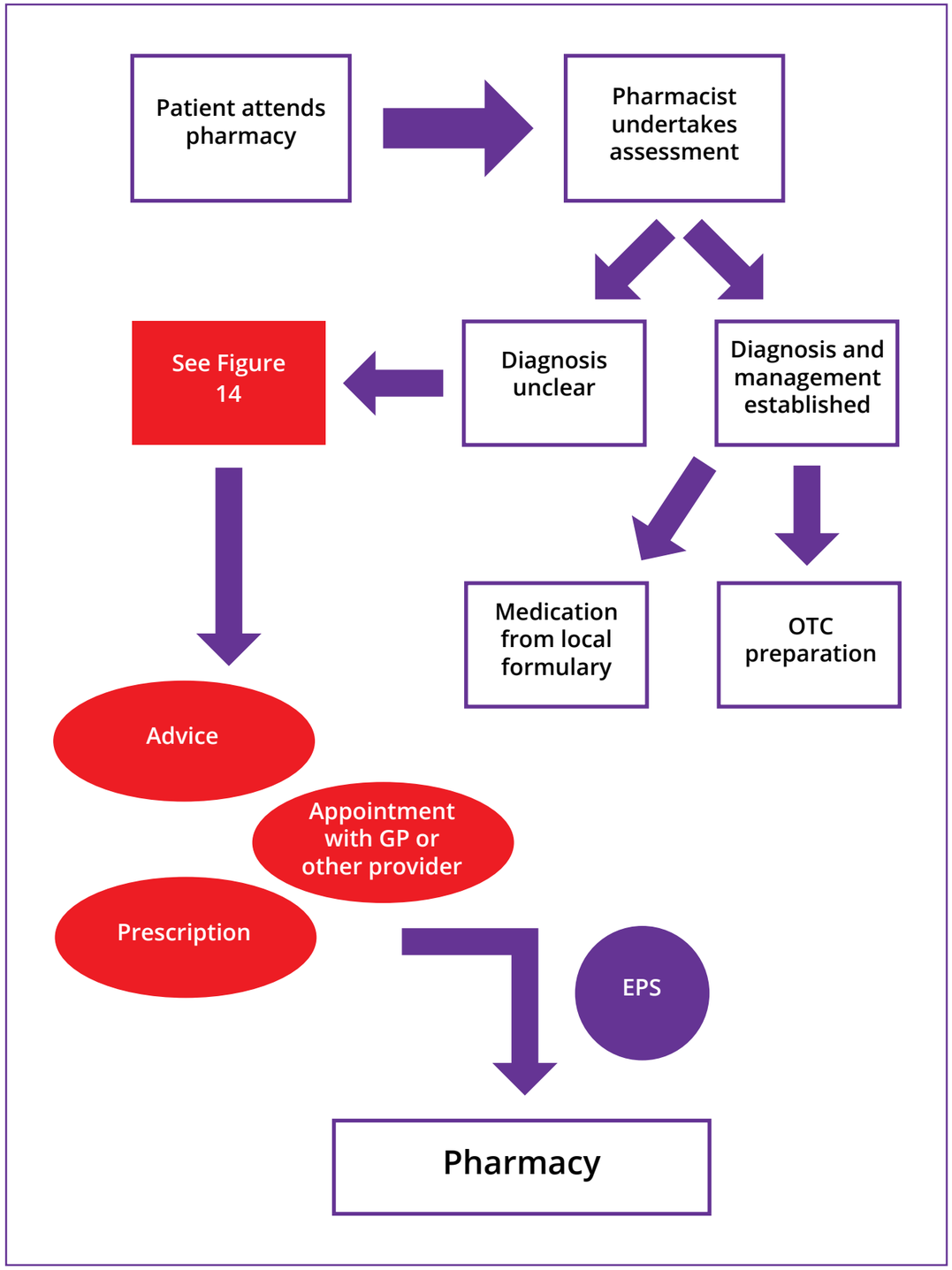


Figure 15

There is appetite within the demonstrator to revive discussions with the local pharmacy community and further explore new opportunities.

Figure 16 - Local pharmacist with GP trainers. Mark from Cisco (on computer and screen) did the webex training remotely from London

The future for pharmacy following the Middleton Demonstrator Pilot

There are numerous ways that community pharmacists and their teams can enhance access to primary care for patients. Some of these have been successfully explored in the demonstrator pilot but there is still a huge opportunity to expand on this.

Better use of the whole community pharmacy team can help to manage demand in GP surgeries so that that GP teams are freed up to care for those patients that only they can manage. This should then enable people to be better managed within their own homes and could potentially reduce hospital admissions.

We already know that more patients visit community pharmacies every day for health reasons than any other health care service and we need to take advantage of this. In particular community pharmacy teams can help patients to stay healthy through the delivery of public health messages. For example, there is a good track record of successfully helping patients to quit smoking and raising awareness of excessive alcohol consumption.

Pharmacists are the experts in medicines and so can support patients to achieve the outcomes they desire from their medicines. In particular helping patients with respiratory conditions to improve their inhaler technique can improve disease control and sometimes allow patients to reduce medicine doses.

We need to raise awareness of the support that patients can freely obtain from community pharmacies such as the medicines use review and new medicines services. Patients have a right to be fully informed about the medicines that they take and these services are an excellent way of achieving this but could be better utilised.

One of the core roles of community pharmacists is to help people to manage minor ailments. No appointment is necessary to have a consultation with a community pharmacist and so patients have easy access often with extended hours. Effective utilisation of community pharmacies for the treatment of minor ailments will reduce demand on both GP and accident and emergency services.

It is clear that pharmacy has a valuable role within the wider primary care team and we look forward to developing this together in the future.

Dr Jane Brown MRPharmS
Chair, Greater Manchester Pharmacy Local Professional Network

Ifti Khan MRPharmS
Local Pharmaceutical Committee Chair, Bury and Rochdale

Dr Keith Pearson
Head of Medicines Management NHS HMR CCG

Web Based Consultations

Webex is a piece of software developed by Cisco. This piece of technology has been used by NHS managers for many years but not broken into the clinical market to support delivery of healthcare. Although Webex is not specifically designed for the delivery of healthcare the product seems more than adequate to deliver the required end result.

The process is via 2 steps:

1. The GP surgery purchases an annual webex license (which is reimbursed by the demonstrator).
2. When required the GP generates a link to the patient via email which once software is downloaded by patient (one off requirement) generates a live face to face clinic.

To get to this stage and have an element of consistency across the demonstrator, the clinical leads engaged with the practices and developed 2 pieces of marketing material:

- Pull up banners for the surgery introducing the service with a different "corporate colour' for each surgery but same text (Figure 17)
- Leaflets that the patients could take with them explaining the service (Figure 18 and 19)

Figure 17

Figure 18

What is GP on Line?

GP on Line is a new innovative way for patients to access a GP without the need to attend the surgery. In many cases a patient is not able to attend the surgery at the times available due to work, family or personal commitments. GP on Line allows patients to utilize their electronic devices to connect to a GP by using the internet and undertake a face to face consultation. To use the service you would need an email address and a suitable electronic equipment (iPad/tablet, iphone, laptop computer or desk top computer with a webcam).

How would the service work?

1.Initially register to use the service by attending the Surgery front desk or go to the surgery website: www.peterloomc.co.uk
2.Ring the GP surgery on the normal phone line: 0161 643 5005 when appointment required
3.Ask for a GP on Line appointment
4.Your email address will be confirmed and an appointment time offered
5.You will receive an email which contains a web link to the GP and a "join meeting" number that you upload when requested
6.You should now be connected to the GP

How can I register for GP on Line?

1. Attend the Surgery front desk and ask to register with GP on Line. Complete the registration form and return to the front desk
2. Go on line and print off the registration form and post to the medical centre – www.peterloomc.co.uk
3. Ring the surgery (0161 643 5005) and ask for a registration form to be posted out to you.

From April 2014 patients no longer need to be a resident within the boundary of the medical centre.

You can register with Peterloo Medical Centre to access all our services from GP on Line to attending the surgery for consultations, minor surgery, family planning services, travel clinic, baby clinic and much more. Only home visits when required will not be provided to registered patients outside the practice boundary but these will be provided by a GP service local to your home

Will using this service cost me anything?

No. This service is provided through a Cisco product called Webex. The license to use the product will be purchased by the GP and so there will be no cost to you (you will need to have access to an internet connection). The service will be received through your device to avoid any audio charges. You may be offered to connect through your phone line for an improved audio reception but this will incur cost and we would advice against this. For the best free reception we would suggest connecting head phones to your device to reduce background noise.

Registration Form

Please register me for access to the GP on Line service at Peterloo Medical Centre. I understand that this is a service delivered through the internet to allow face to face access to a GP.
Please PRINT below:

Name:
Address:
Telephone: Landline
Mobile
Email: (Please Print)

This is the email address used to arrange consultations unless an alternative email address is provided when arranging your appointment.

Sign:
Name:
Date:

To assist your GP in updating your medical records please provide the following:

Height: (Ft / cm)
Weight: (St / Kg)
Alcohol: (iu /week)
Smoke: Never Ex-Smoker
Current Smoker cig /day

Are you an unpaid carer for a friend or relative? You may be missing out on benefits such as a free NHS flu jab

Figure 19

Although currently not live across the locality, each surgery is undergoing training to understand how to achieve the objectives. The surgeries have also been supplied with webcams and small desk top speakers to allow video consultations.

For the demonstrator, the ability of surgeries to come together and select different corporate colours for their banners containing the same information was one of the initial signs that federated working across Middleton could be a reality for the near future.

To fully benefit from this technology the demonstrator plans to explore the ability for the practices in Middleton to:

- Undertake virtual meetings rather than meeting at venues to save time and money
- Explore the possibility of web based interpreters
- Utilise this technology to arrange MDT meetings with various services including hospital specialists
- Use Webex to deliver web based education to other healthcare professionals during mutually convenient times which again avoids the need to travel and can be undertaken whilst having lunch breaks (where these still exist!!)

Nurses or more specifically District Nurses (DN) were commissioned from Pennine Care Foundation Trust locally. From the beginning Pennine Care was supportive of the concept and engaged with the demonstrator to pilot the viability of running a DN service in a room adjacent to the GP clinic within the demonstrator in the evenings and weekends.

With the support of local Pennine Care nurse managers the demonstrator persevered for 5 months to try and utilise the capacity but with no referrals from the local A&E department, GP surgeries or self referrals from patients it was felt to be inappropriate to continue and the clinics were terminated.

The likelihood that the current DN service contract with the CCG in the locality run quite late into the evening and is well established is likely reason for this element of the bid not being as successful as anticipated. Below (Figure 20) is an advert that was inserted into the local tabloid and also converted into A1 size posters for GP surgery waiting rooms.

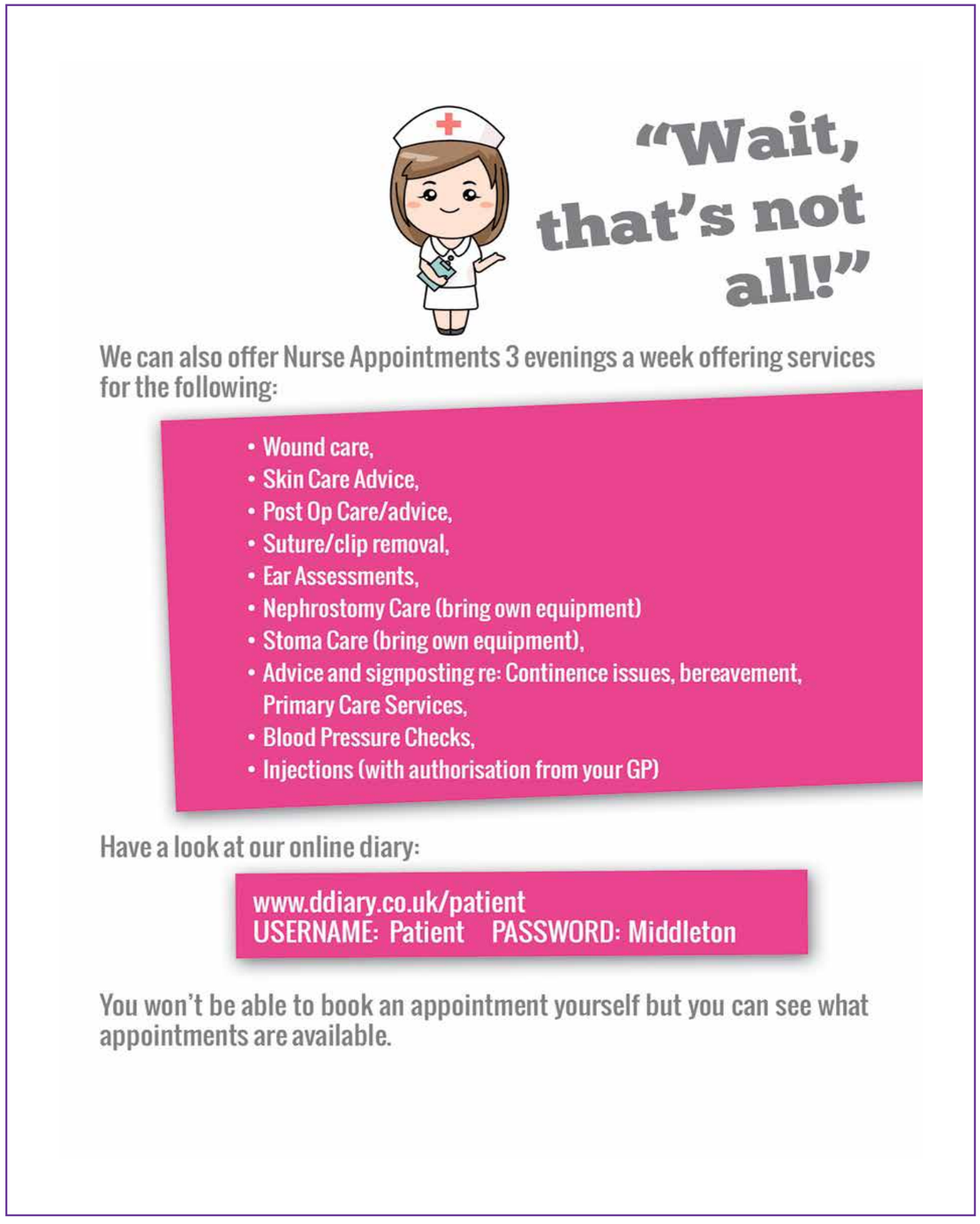


Figure 20 (the other side of this leaflet was figure 4 above)

Mental Health

Mental Health has long been the Cinderella specialty which pervades so many General Practice consultations and yet practices receive so little help to deal with these problems 'in house', which is where interventions are usually most effective.

Junction Surgeries, a practice in Middleton, has over 12 years developed a practice counselling and mental health therapy service, funded by PMS monies, which has been highly valued by patients and doctors alike. This service was increased to provide extended and in hours therapy sessions for all patients within the demonstrator Pilot. Sessions were provided initially 7 days a week, three one hour sessions a day open to all Middleton practices.

All of this was established to improve mental health provision in Middleton which has been inadequate for many years. The Crisis Intervention Service to mental health patients has traditionally had a response time of approximately a week and would routinely be offered in Rochdale not Middleton. The local IAPT - IMPROVING ACCESS to PSYCHOLOGICAL THERAPIES service did at one time have long waiting times but have rectified this by offering mostly group work or self-help advice. Additionally IAPS is restricted to treating only simple mental health problems and is excluded from dealing with moderate or severe mental health problems.

The Junction Surgeries model extended to the Demonstrator Pilot provided same day bookable appointments to see experienced counsellors and mental health therapists able to deal with the full spectrum of presentations in primary care. All of this was overseen by GPs with an interest in mental health. Appointments were available to Middleton Practices and to North Manchester General Hospital Accident and Emergency Department (NMGH A&E). The opportunity to 'deflect' appropriate patients back into GP services was initially well received in principle by NMGH A&E but they have subsequently employed their own GP's in house and no patients were deflected by them.

The extended hours weekday provision was well used by Middleton practices but as explained elsewhere in this report the weekend clinics were underused (similar to GP surgeries) and subsequently discontinued in favour of in hours therapy sessions for suitable Middleton patients, carried out at Junction Surgeries rather than the Peterloo Hub out of convenience. Extended hours evening sessions would always include a risk assessment as well as some initial therapy. Therapists were given the flexibility to offer up to two follow up sessions if appropriate and /or refer back to the GP with advice. Some patients were offered extended follow up if appropriate which might include CBT or EMDR (a therapy for post traumatic shock, e.g. Veterans or victims of abuse).

Some of the therapists have experience of and are comfortable with treating teenagers. Over the course of the pilot 581 appointments were taken up by 186 different patients, 102 availed themselves of further therapy and the majority were either severe or moderately severe depression or anxiety. Many were sign posted to other services such as alcoholics anonymous or citizens' advice. Only three patients were considered on risk assessment to be ill enough to be admitted.

One went to A&E and was offered admission but refused. He came for 12 sessions of therapy after which he declared himself to be better. Just one amongst a number of successful treatments. The other two refused to attend A&E but the team managed to arrange supervision plus family support and intervention from the Crisis Team to produce a satisfactory outcome.
These patients stories underlines that many with anxiety and depression need to be treated, if not in their own surgery, then at least in local and familiar surroundings to achieve the compliance that their treatment requires. A questionnaire followed by a prescription does not deal with underlying issues. An appointment in another town is a bus ride too far.

It was disappointing not to be able to achieve A&E deflection. It is probable that a number of A&E attendances were avoided, certainly the three patients that needed admission but refused plus an unknown number that needed help but who had nowhere else to go, were safely treated in the community. The majority of those referred by practices would otherwise have been a referral to single point of access or referral to A&E or acute mental health service. If this mental health pilot were extended to the rest of HMR PCT then we feel that substantial improvements could be made to mental health outcomes in the borough within a community setting as well as establishing an innovative service not commonly available elsewhere.

The objective of the pilot was achieved in the exploration of the most effective intervention point on the patient pathway which achieved an increase in the numbers and effectiveness of moving therapies out of secondary care into the community. That intervention point is in pre-hospital care rather than post hospital care, a result that we shall see repeated in the Demonstrator report on the Community bed component of the Pilot.

Case Study :

“

I frequently struggle to get an appointment at my GP surgery. I tend to go to my local A&E because I know they will see me

”

HR – age 45

3

Current Demonstrator Position

Having explored the areas above a number of projects where seen to be lost leaders due to lack of uptake. The demonstrator decided to explore new areas to ensure that the allocated budget was used as effectively as possible with exploration of as many concepts as possible to establish possible future service pathways and role of technology. The additional areas explored included:

- A&E Deflection Scheme
- GPs and Opticians (MECS)
- IPads and EMIS Mobile
- Lexicom Digital Dictation System
- EMIS Spirometers
- EMIS TV screens in waiting rooms
- MiDHaS.uk
- Staff Training
- Tea Dance

A&E Deflection

Breaches in the 4hour target in the local A&E department associated with inappropriate community presentations resulted in excessive demands on the local A&E unit. On auditing hospital discharges there were a significant number of discharges within 24 hours of admission. The question of whether fewer patients in A&E associated with more time with each patient was a solution to reduce the number of short stay admissions.

The demonstrator explored how it could support the local A&E unit. The clinical team within the demonstrator recognised the technical issues that the hospital trust faced with our proposal. Middleton was a small part of the A&E department’s activity and to try and redesign the whole A&E department only for Middleton residents was not realistic.

Also at the time the local A&E unit activity was funded through a block contract and not tariff. Any deflection before the patient is booked onto the hospital PAS system would not have a financial impact on the hospital but to try and segregate Middleton residents at reception to bypass the PAS system was an ideal but not realistic. The proposed model in the end became as follows:

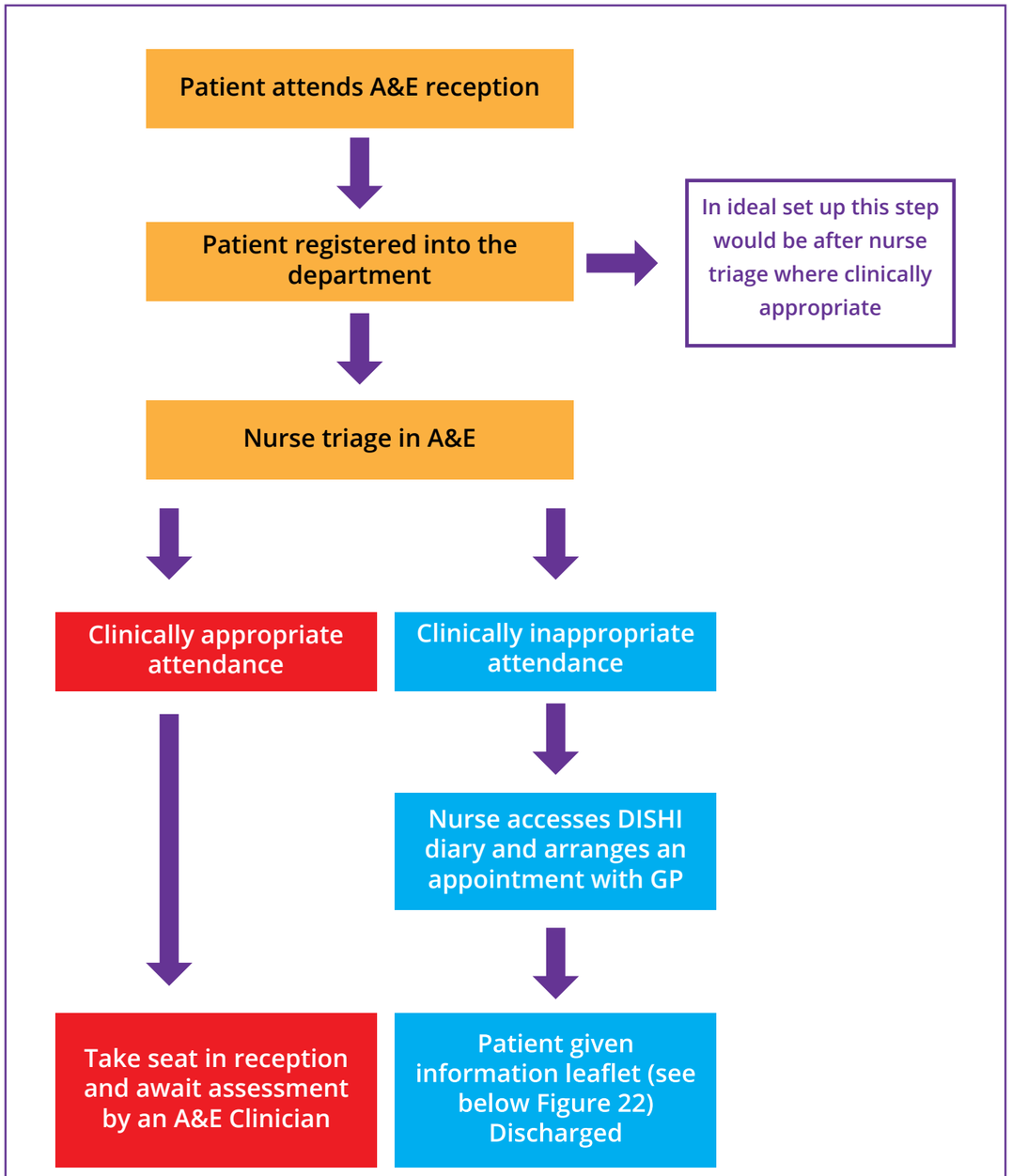
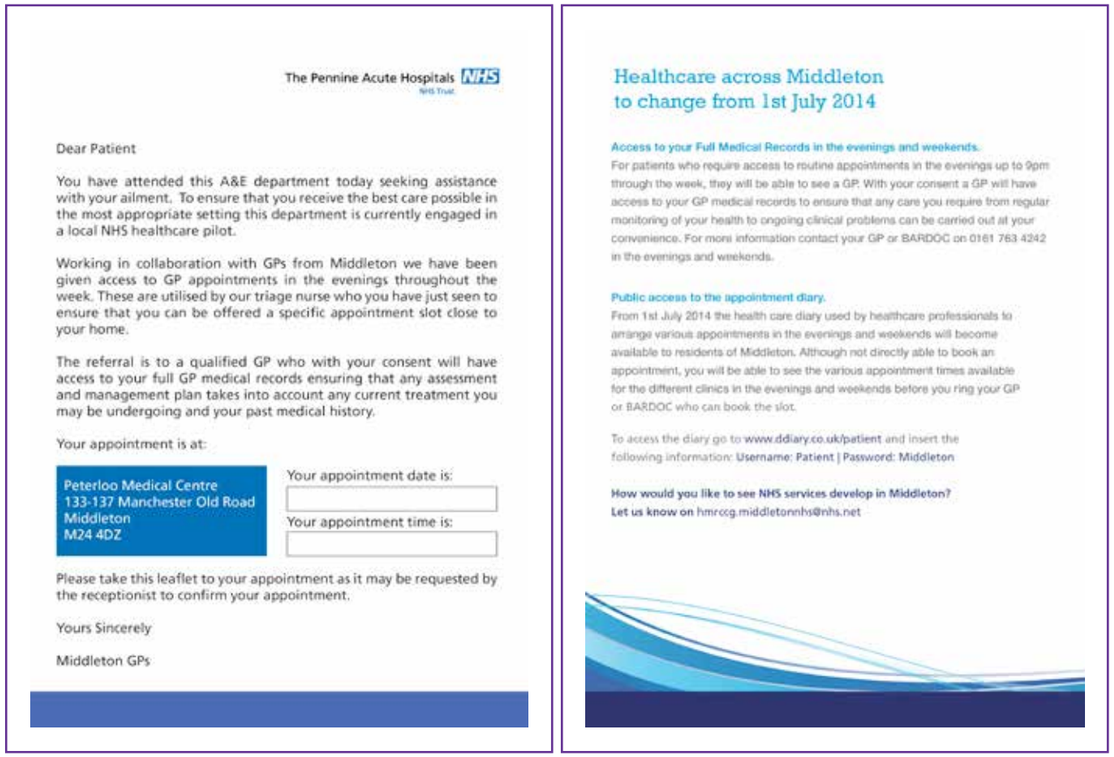


Figure 21



The Pennine Acute Hospitals NHS
NHS Trust

Dear Patient

You have attended this A&E department today seeking assistance with your ailment. To ensure that you receive the best care possible in the most appropriate setting this department is currently engaged in a local NHS healthcare pilot.

Working in collaboration with GPs from Middleton we have been given access to GP appointments in the evenings throughout the week. These are utilised by our triage nurse who you have just seen to ensure that you can be offered a specific appointment slot close to your home.

The referral is to a qualified GP who with your consent will have access to your full GP medical records ensuring that any assessment and management plan takes into account any current treatment you may be undergoing and your past medical history.

Your appointment is at:

Peterloo Medical Centre
133-137 Manchester Old Road
Middleton
M24 4DZ

Your appointment date is:

Your appointment time is:

Please take this leaflet to your appointment as it may be requested by the receptionist to confirm your appointment.

Yours Sincerely

Middleton GPs

Healthcare across Middleton to change from 1st July 2014

Access to your Full Medical Records in the evenings and weekends.
For patients who require access to routine appointments in the evenings up to 9pm through the week, they will be able to see a GP. With your consent a GP will have access to your GP medical records to ensure that any care you require from regular monitoring of your health to ongoing clinical problems can be carried out at your convenience. For more information contact your GP or BARDOC on 0161 763 4242 in the evenings and weekends.

Public access to the appointment diary.
From 1st July 2014 the health care diary used by healthcare professionals to arrange various appointments in the evenings and weekends will become available to residents of Middleton. Although not directly able to book an appointment, you will be able to see the various appointment times available for the different clinics in the evenings and weekends before you ring your GP or BARDOC who can book the slot.

To access the diary go to www.ddiary.co.uk/patient and insert the following information: **Username: Patient | Password: Middleton**

How would you like to see NHS services develop in Middleton?
Let us know on hmrccg.middletonnhs@nhs.net

Figure 22

To assist the A&E triage nurse the demonstrator printed 1000 leaflets as above (Figure 22). This was to reduce the time required for the nurse to explain why the patient was being "referred" to a community clinic with the hope that in due course the patient will become familiar with the community service and access that in preference to the A&E department.

Following a number of meetings with senior staff in the A&E department and demonstrating how to use the DISHI Diary as well as providing a users manual for the diary a provisional go live date was set. One month, two months, 12months, 18months later not one patient has been booked by A&E into the community GP clinic.

Initially 2 appointments every clinic was reserved for A&E to use, after 12months this was reduced to 1 appointment in view of lack of uptake – see Appendix 1 regarding A&E activity. During this period a number of different promotion materials were used including tabloid advertising, leaflets and posters (Figure 23 and 24).

Figure 23

Figure 24

Recently the demonstrator has come to learn that the A&E department has now employed 3 GPs to assist in managing the workload, good idea or not?

We know that having GPs within the A&E department increases the utilisation of available diagnostic services. Also with GPs managing common minor ailments within A&E there is a risk that the local population will utilise the A&E unit to address their healthcare needs sometimes in preference to seeing or having to wait to see their registered GP.

Although at the time the A&E was funded through a block contract (i.e. paid one lump sum irrespective of activity levels) subsequently the financial model was to become tariff based so that the hospital was paid for every patient that attended the A&E department. There is an inherent flaw in the funding of A&E departments and adopting a "unit of activity" tariff does not appear to be the best method in ensuring the patient receives the most appropriate care in the most appropriate setting.

This is a national issue that needs addressing to ensure that patient pathways and patient care remains safe and accessible within an allocated financial envelope. This type of approach to employing GPs in A&E is likely to impact on funding and activity levels available to run an effective 7 day GP surgery (as this is a political ambition).

Although the demonstrator would be keen to pursue the above model further with the local hospital trust it has become apparent that due to the wide geographical footprint of patients attending the A&E unit any pilot would need to be a collaborative venture between a number of different CCG's across Greater Manchester to ensure that the unit can have the same patient pathway irrespective of where the patient resides. The problem with this approach is that it cost's a lot more, involves a lot more bureaucracy and if unsuccessful would require another larger scale change within the A&E department.

GPs and Opticians

Although not directly a part of the demonstrator the MECS (Minor Eye Condition Service) was useful to include in this report as an example of how engaging with other service providers can improve a patient pathway. MECS is commissioned by the local CCG and allows patients to self refer for a number of eye conditions from infections to red eye to a painful eye for any age group. GPs can triage and direct patients to the locally commissioned service for assessment.

Any concerns from the optician can be directly referred to the ophthalmologist with information to the GP for information. This has helped to reduce local demand on GP appointments. See figure 25 which shows the adverts the demonstrator placed in the local tabloid press promoting both GP appointments and the MECS service.

Figure 25

For those GPs interested in ophthalmology this service can support their own learning needs by seeing their own patients but also engaging with local opticians to review more eye related conditions.

Minor Eye Conditions Service (MECS) Report

At around the same time the Middleton demonstrator initiative was being launched, Optometrists in the area were embarking on our own new service. The Heywood, Middleton, Rochdale minor eye conditions service went live on 19th August 2013, after being commissioned by HMR CCG via Greater Manchester Primary Eyecare Ltd, a regional local optical committee provider company.

This was a service whereby Optometrists assessed and managed recent onset minor eye conditions in a primary care setting. The aim was to provide high-quality eye care to patients from suitably qualified clinicians, in a safe convenient and appropriate environment. The benefits of the service would be to reduce unnecessary referrals to the hospital eye clinics and also free up GP time by allowing Optometrists to see eye conditions in well equipped practices. It would also provide easy and speedier access to patients and a quicker route for onward referral where necessary with the added benefit of being more cost-effective to the CCG.

In Middleton there are three local optical practices who participate in the service, with appointments available Monday to Saturday, although Middleton residents are able to visit any of the eighteen service providers in the Heywood, Middleton & Rochdale borough, some of who also provide Sunday appointments. Whilst initially launching the service the clinical lead visited local cluster meetings with GP's, pharmacists and met with the local eye clinics and BARDOC to raise awareness of the new service. All HMR GP's and pharmacists were provided with literature including posters and flyers to display within their practices and the reaction from primary care as a whole was very positive from the start.

From the eight general practices participating in the Middleton demonstrator bid 489 registered patients were seen within MECS service between 1/12/13 and 30/4/15. Out of those, 85 were referred from their GP practice and just 3 from the hospital eye clinic and accident and emergency. It would be assumed that out of the 381 cases who self referred into the service a certain number of those would have presented to general practice had they not have been seen within the MECS service.

84.86% of these patients were managed exclusively within the MECS service and only 12.47% referred onwards to secondary care. 259 cases were deemed urgent from triage and these patients were offered an appointment within 24 hours. There was a 97.96% return rate of the friends and family test questionnaire and 100% reported they were either likely or extremely likely to recommend the service.

The huge success of HMR MECS has increased the visibility of optometry as part of the wider primary care team allowing Optometrists to work collaboratively with local GP's and pharmacists. Whilst the MECS is not part of the Middleton demonstrator site they have worked hand in hand to provide the best care for Middleton patients.

The local optical committee is now in regular contact with the demonstrator team. Middleton MECS practitioners attended the tea dance at Middleton arena and the chair of the local optical committee gave a short talk about the importance of regular eye examinations. We look forward collaborating further with GP's and pharmacists to develop and deliver more local services in a cost effective manner. The MECS service and its collaboration with the demonstrator have shown that optometry can contribute to the new models of care which are outlined in the Five Year Forward View.

Wendy Craven
HMR MECS Clinical Governance & Performance lead

iPads and EMIS Mobile

EMIS has a product (EMIS Mobile) that can be uploaded onto iPads allowing access to the patient's GP medical records through a software app. Although the end product is not the same as the EMIS Web system in clinics (there is an option to have a mirror of the EMIS Web system on a laptop for mobile working but too expensive for this demonstrator!) for now this improved the current position of the GP surgeries.

The iPad allows GP medical records for patients uploaded to be visualised including consultations, medication, allergies but also allow notes to be sent to the administration team and secretaries at the surgery over wifi. Once the consultation is added to the iPad either the information can be uploaded if within a wifi zone or can be stored on the iPad until within a wifi zone before uploading all the consultations onto the main EMIS server.

Installing the Lexicom app onto the iPad allows dictation of any referral letters or messages and forwarding to the secretarial team at the surgery again over wifi. Having the GP medical records and dictation facility on an iPad is a significant improvement on the tradition method of undertaking home visits with pieces of paper and having to wait until the GP is back at the surgery before documenting the consultation and undertaking dictation.

The potential for this element of the demonstrator is significant. Although the surgeries use the iPads for home visiting some of the surgeries are already exploring the use of iPads for a number of other services:

- Practice nurses undertaking chronic disease visits and flu vaccines later in the year
- Junior doctors /trainees undertaking domiciliary chronic disease visits
- Home phlebotomy service with patient records
- Allow regular ward rounds within nursing /residential homes with GP records available and to add consultations during the round
- The future allows for specialist hospital services to undertake home visits having collected iPads from each surgery or by allowing hospitals direct access to GP medical records via EMIS Clinical Services and upload the relevant records directly onto an iPad in the hospital before departing into the community

Each GP surgery decided on the number of iPads required (maximum 4) with the demonstrator paying 50% of the cost of a 16GB iPad and 100% of the EMIS Mobile license. Each license for a surgery allows up to 50 users which makes this very cost effective.

Lexicom and Digital Dictation System

Lexicom is a digital dictation system provider. Already in place at Peterloo Medical Centre and used by all the clinicians this service allows easy dictation following a consultation and transfer of dictation directly to the surgery secretarial staff. As well as the surgery system Lexicom has an iPhone/iPad app which allows a number of different organisations to be stored on the same iPhone. The Local Medical Committee (Rochdale & Bury) uses the same dictation system which allows their Chief Executive – Dr Mo Jiva to dictate letters to the LMC and referrals to his surgery from the same iPhone app by selecting the service from settings.

As part of the demonstrator this product was purchased for surgeries across Middleton for a number of reasons:

- Allows for efficient dictation of letters and prompt typing to ensure there is no delays in patient referrals

- Although at present the dictation is held on a specific server for each practice, the demonstrator has purchased an iCloud option in year 2/3. This will allow referrals from each surgery to be stored in the cloud for the surgery secretaries to pull down the dictation as and when required. In the event secretarial staff from a particular surgery went on holiday or fell ill the GPs would be able to commission time from secretaries at neighbouring practices to pull down referrals from the cloud and type the letters to ensure patient referrals are not delayed. As all the surgeries are on EMIS Web this will support access to medical records providing further information when required.

- In delivering a 7 day GP service the real potential for this technology is in having a smart phone at the surgery where clinics are delivered pre set with all Middleton GP secretarial teams. When a patient requires a referral the GP can select the patients GP surgery from settings in the Lexicom app on the iPhone, dictate and send. The next patient that requires a referral if from a different surgery only requires their registered GP to be selected from settings to send the dictation to their secretary. Although there is concern about extra work being passed to in hours GP staff, as the iCloud option becomes available the evening and weekend clinician can send all referrals to the cloud with the service providers commissioning a single secretarial service to type all referrals. The long term back office opportunity with this technology will be for all in hours and out of hour's referrals to be type by a single secretarial service from inside or outside Middleton. In using the iPhone with Lexicom the surgery where the service is currently delivered has wifi therefore there is no requirement for a phone contract which significantly reduces the cost of having this service available (Figure 26).

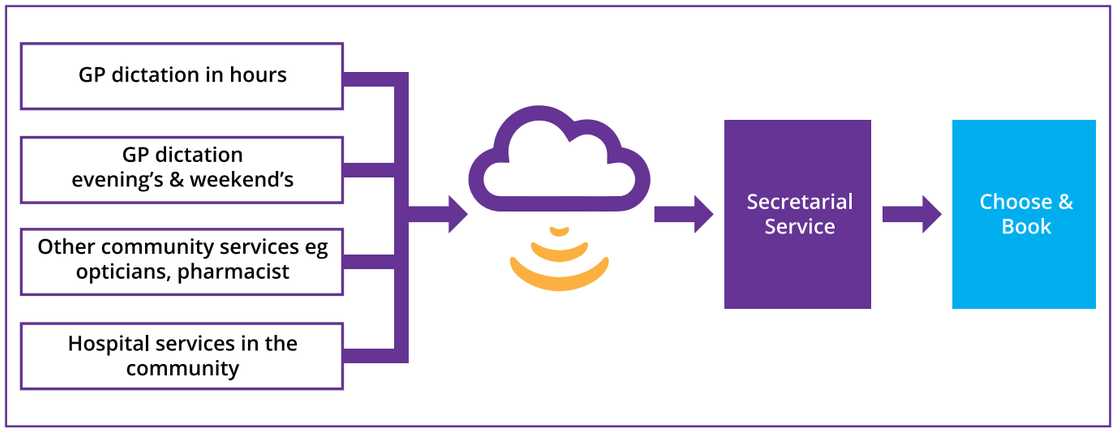


Figure 26

A single secretarial service will improve compliance with local referral pathways.

The demonstrator is keen to continue working with Lexicom to fully explore the potential of currently available technology but also support any new developments which would improve delivery of patient care and also simplify back office function for GP services and other community services e.g. pharmacy/optician referrals dictated into the cloud.

A part of the demonstrator's agenda was to future proof current services and technology currently available. This move in introducing Lexicom into Middleton has not only introduced efficiency into the current system and provided new opportunities over the next few years but also contributes towards the foundations of a federated working model across GP surgeries in Middleton by having a single dictation system which compliments the single GP software system – EMIS Web that is now across the township.

EMIS Spirometers

A small addition to the demonstrator from slippage monies was the replacement of the traditional spirometers in practices with EMIS spirometers. Until now the usual pathway for undertaking spirometry was as follows:

- Patient attends clinic for spirometry (breathing test) with the practice nurse
- Spirometry performed and results printed on a paper slip
- Result on slip scanned onto patient records on Docman
- Results can be viewed only in surgery as Docman not easily accessible from outside surgery
- Spirometer needs regular servicing due to moving elements with the device

The new devices allow USB connection of the spirometer into any terminal in the practice or even a laptop outside the practice. The result is uploaded directly into the patients EMIS GP records allowing easy access from outside the surgery. Allowing other specialist access to the records with patient consent e.g. community respiratory nurses, hospital specialists etc will allow them to see the spirometry results providing more refined management plan and avoid need to duplicate tests. With no moving parts there is no requirement for servicing the device. The demonstrator funded 2 new spirometers for practices with 5000 or more patients and one for those with less than 5000 patients. Moving forward routine healthcare over 7 days for those with breathing problems will be supported with this new addition.

EMIS TV's in waiting rooms (Envisage)

Some GP surgeries use tannoy system, some use LED displays and some provide the personal touch by walking to the waiting room and using the human voice to call the patients into clinics. Some technology is connected to the GP computer systems and some are stand alone.

To build on the EMIS family that the surgeries had embraced the demonstrator decided to invest in EMIS 40" screens (Envisage) in GP surgery waiting rooms. The benefits of this system are:

- Functions as a patient calling system
- Practices can stream health awareness information and communicate important information to the public – works as a health channel
- Practices can design and display their own health messages using PowerPoint or HTML. Inform patients of practice services, DNA numbers, changes in services provided, new services available and so on.
- This product also allows a message uploaded from a central office to be transmitted to all the surgeries in the community at the same time. This will be useful for promoting flu vaccinations, screening programes and changes in services or availability of services across the community. This will not only bring consistency in the message across the GP surgeries but also reduce the amount of time required by each practice in creating and uploading information. The screen

allows both the surgery and locality information to be displayed at the same time by splitting the screen.

- This system could allow transmission of social and healthcare information but also issues around transport, policing, housing and much more which could assist community engagement with the devoManc agenda.
- Could the next step be installation of these screens into other community venues such as council buildings, libraries, shopping malls and so on with health information created and transmitted from a local GP surgery?

MiDHaS.uk (Middleton Demonstrator Health and SocialCare.uk)

The original concept of a local list server to allow communication between local GP surgeries when explored was felt to be quite narrow in its potential. At the time a number of other agenda's where coming to the forefront both at local and national level. Collating all the current issues at the time resulted in the vision of having a local intranet that would address a number of issues.

Although not complete the process is ongoing with a view of going live later this year. MiDHaS.uk was so named as the letters created an acronym for Middleton Demonstrator Health and Socialcare and the demonstrator was able to secure the web domain midhas.uk which would allow access to various services both for the professionals and the public.

The different elements of MiDHaS.uk are:

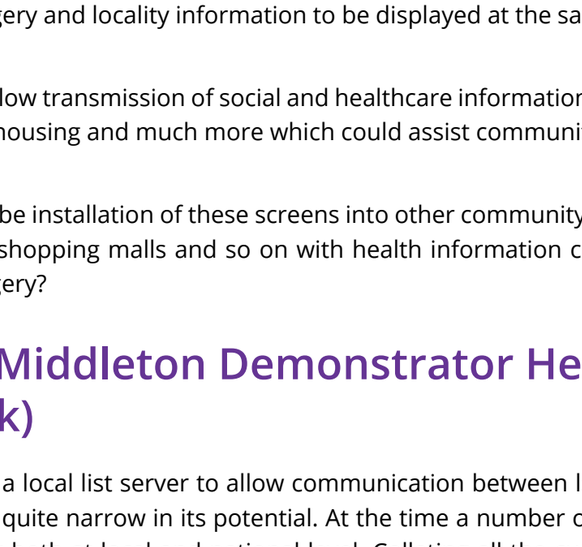


Figure 27

(This is a prototype of the home page for the website, to be further refined following consultation)

- Directory of Services (DoS): this directory will consist of contact details not just of NHS organisations but also Social care, Care homes, Coroner's office, local charities, hospitals, community healthcare services and much more. This will allow easier access for the public to make contact with the right organisation.
- My NHS Records: with all Middleton GP surgeries being on EMIS Web this box will redirect the user straight to the EMIS login page to access their medical records. As this is web based it should be compatible with various devices including computer, iPads, iPhones and other smart technology.
- Referrals, Policies, Guidelines and Newsletters: Recently patient referrals have started taking pressure off GP secretaries. The first patient self referral for treatment was with the local physiotherapy serviced provided by the local acute hospital trust. Since then local GPs have now been able to provide patients with a few different contact details to self refer for mental health problems to weight loss. Moving forward patients need to be empowered to make decisions of where they feel they need to seek support and treatment. To support this process MiDHaS.uk would provide all available self referral forms on one website. Up to now clinicians have been kept informed of local guidelines and policies. Patient's unaware of the thresholds required to initiate medical referral or intervention consult the GP to seek advice. In some cases patients are disappointed due to failure of intervention as a result of local policies and guidelines. Allowing patients to have access to local policies and guidelines again empowers the public to understand when the local services will be able to support their request and when conservative measures may be suitable. This in the long run should stem some of the demand on general practice but provides an opportunity to educate the local population on their illness and the obligations of the local health economy in supporting the patient manage their illness.
- Video Clips: This is the really exiting element of the intranet. The plan is to construct initially a video library of 300 short (10-15minute) video clips. These will be uploaded on to a You Tube platform that will be accessible through MiDHaS.uk. The first step has been the creation of a make shift recording studio at the surgery (see Figure 28)

The video library has been started with a number of recordings including:

- Bowel screening
- Cervical Screening
- Contraception
- Breathing with Chronic illnesses (Yoga techniques)
- Role of the CCG
- Role of NHS England
- Common eye conditions
- And others

This is an opportunity for different organisations to support the development of information material to assist the public in self managing their conditions. This will also assist in the sign posting of individuals to ensure they access the right service at the right time.
The demonstrator would be keen to hear from any organisation that feels they have a message they would like to convey to the public to support them in managing their physical or mental health or may be information on where and how to access Local Authority services or those of any other organisation.

Figure 28 - Recording studio at Peterloo Medical Centre

Guidance to MiDHaS.uk can be found on YouTube at the following address:
http://youtu.be/hWRwW_BaDrI

A completed web clip created on “Contraception after Pregnancy” can be found at:
https://youtu.be/aWysHRAXPtk

Staff Training

To improve patient experience the demonstrator organised half day training for all GP surgery staff across Middleton’s demonstrator practices. The agenda for the session was:

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Agenda

Exceptional Customer Service

A Half Day Workshop

Objectives:	The key objective of this workshop is to enable primary care staff to consistently work towards delivering exceptional customer service while working under pressure. The workshop will provide delegates with an opportunity to enhance their customer service skills in line with patient need and practice requirements.
13.30	Welcome, Introductions and Objectives A Patient Focused Service Definition of Exceptional Customer Service Perceptions & Expectations A Positive Approach - the Importance of Self Talk Overcoming Negativity Saying No in a Positive Way
15.00	Tea / Coffee
15:15	Explaining Policies in Positive Terms Words & Phrases to Avoid Communicating with Patients Dealing with challenging behaviour Action Planning
16.30	Final questions & Close

The event was informative and enjoyed by those that attended.

47 of the delegates filled in a satisfaction questionnaire, results are below:

If the question requires a score between 1 and 10, 1 is extremely poor and 10 is excellent.

Figure 28

Organiser	Middleton Demonstrator	
Date	12/03/2015	
Workshop	Exceptional Customer Service	
Consultant	3 Trainers	
Number of Delegates	47	
Number of Scores	Overall Usefulness	Skills of the Trainer
Average Score – Trainer 1	9.75	10
Trainer 2	7.4	8.1
Trainer 3	9.4	9.9

We asked delegates:

To highlight the most useful aspects of the day.

· All Aspects · Communication with patients & dealing with challenging behaviour · Body language & expressions · Speaking positively and offering alternatives. · Never assume, always listen. Turn negatives into positives · Assertiveness, stories, listening · All X 10 said they found all aspects to be useful · How to answer in a positive way · Trigger words · Perceptions · Challenging patients · How to deal with "difficult" situations · Communications & Listening · Most of them, as they all applied to me · All topics covered were useful · 'Assertive, aggressive & passive' · Enjoyed it all

What changes they would make as a result of attending this course.

· Helping encourage newer members of staff · Always think positively and smile · Try to have a more relaxed and approach able manner · Positive thinking, moral boosting & teamwork · Focus on my tone of voice · Self presentation · Listen more attentively · Be more Assertive · Use of Body Language in a positive manner · Listen to the patients more · Be more aware of peoples expectations. · Better communication with patients

· Staff Training · Try harder to listen · Keep calm · Putting people on hold less · More positive · Try to implement in working day · More aware of what and how I say/speak with patients · Be more positive · Tone of voice and message taking · I have attended this course in the past and already practice what I have Learnt · Try to stay calm. Not to say I am just a receptionist · Try to stay calm with difficult patients · To be more positive · Consistent · Thank you, very pleasant! · Happy to attend this course · Enjoyed the afternoon · I enjoyed the course and meeting people from the other surgeries · Keep calm and smiling · To be more consistent · Listen more closely to what patients are saying

What further training needs the workshop had highlighted.

· Communication · Working together · Concentrating more on tone · Maintaining a positive attitude and staying positive · Positivity and patience in the workplace · Policies · Assertiveness · Positivity and patience in the workplace

Other comments

· I enjoyed it · Enjoyed the session · The trainer was very helpful · Very clear & informative – easy to listen & learn from · Thoroughly enjoyable very useful. All good. · Thank you, very pleasant! · Happy to attend this course · Enjoyed the afternoon · I enjoyed the course and meeting people from the other surgeries

Tea Dance

The tea dance was an opportunity to engage with a target audience leading up to the winter period. The purpose of this element was 2 fold:

- To increase the uptake of Flu vaccines within the locality
- To give something back to the community and promote engagement with local GP surgeries

Tickets were printed and distributed to each GP surgery based on their population size. In total 500 tickets where printed with over 350 distributed to the population as they attended for the flu vaccination or chronic disease monitoring with the practice nurses. Hiring the local sports arena on a Sunday afternoon with an orchestra playing live music, the event was an out right success with over 300 members of the community attending.

Local GPs, nurses and managers attended to support the event (at no cost!) and enjoyed the dance as much as the audience. During the event there was also a short demonstration from a local zumba group and there was a local dance school present to support those with two left feet. The feed back was great. Patients who attended sent thank you cards informing practices that they had joined the local dance school and the zumba group. For an element of the community that struggles with company and physical exercise this was an opportunity to promote what is locally available.

Based on the success of this event the local CCG provided funding for a second event to be hosted at the same venue. Utilising the same format on the second occasion the demonstrator used the opportunity to inform the captive audience of various healthcare services available. Inviting the local opticians, pharmacists, public health and secondary care providers each service provider used 5minutes in between dances to educate the audience. To support the delivery of information the demonstrator commissioned canvas bags, writing pads and pens for the attendees to take away with leaflets from various different services.

On reflection considering how much funding commissioners spend on marketing variety of services and the success of uptake especially screening services there is an argument to be had whether funding should be utilised in different ways by physically engaging with the target audience and grouping variety of messages into one event. Having a cup of tea and cake (provided free) with the local public does not do any harm in them seeing the human side of their GP and surgery staff outside the clinical environment.

Figure 29

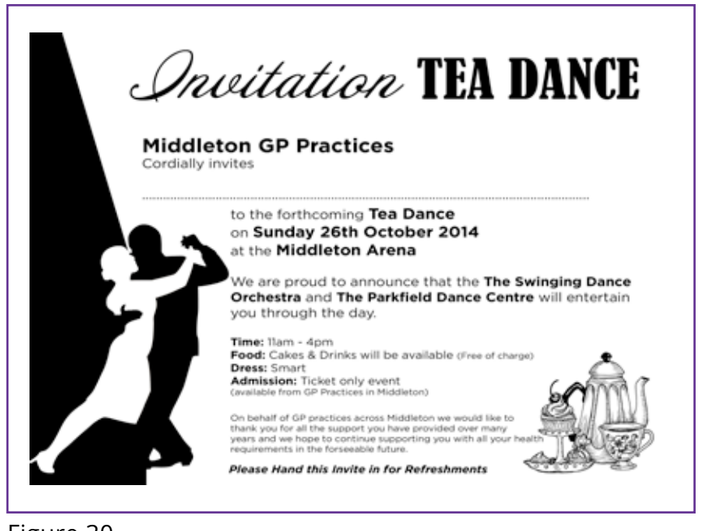

Figure 30

Figure 31 - Surgery staff with Ben in the middle from NHS England

Figure 32 - Dancers enjoying the band

Figure 33 - Canvas bag

Figure 34 - Local Clinicians and staff with Middleton MP Liz McInnes (front centre), CCG Chair Dr Chris Duffy (back row second from right) and Sara Roscoe Senior Project Manager NHS England (back row third from left)

Figure 35 - Band in full swing

Quote:

“Never throughout history has a man who lived a life of ease left a name worth remembering”

Theodore Roosevelt

4

National Health Service (NHS): Elephant in the Room!

What are the issues that the profession is aware of but reluctant to share with the public for the fear of tarnishing the public image of the profession? With adding amounts of stress and tension within Primary Care, GP’s across the country are now willing to be open and transparent with the public to highlight issues facing the service which will impact on care delivered to the population.

On the 21st May 2015, Dr Chaand Nagpaul Chairman of the General Practitioners Committee [GPC] (division of the British Medical Association, BMA) made his chairman’s speech at the National Local Medical Committee’s (LMC’s) Conference at Logon Hall in London. The resulting speech reflected the current issues faced by General Practice across the country and resulted in support from the whole conference through a standing ovation lasting minutes. Below are elements of Dr Nagpaul speech:

“**I open this speech with a heavy heart, at a time when general practice is plunging into the depths of ever deepening pressures.**

The triple whammy of morale, workload and workforce pressures I spoke about last year has become endemic. In September, the Health Education England Taskforce officially declared a “GP crisis” –their words not ours- and the Centre for Workforce Intelligence stated that present GP numbers are “unsustainable…to meet current demand”.

And the latest uptake of GP training schemes was even poorer than last year. The BMA’s biggest ever GP survey of over 15,000 GPs, signals a potential catastrophic time bomb ready to explode, with one in three GPs intending to retire in the next five years, and one in five GP trainees intending to leave the UK to work abroad.”

We're fundamentally paying the price of years of government neglect and progressive defunding of general practice- plummeting from 11% of NHS spend to now less than 8, and with the proportion of NHS doctors who are GPs shrinking from 34% to 25%
And this unashamed starvation of general practice has come as GPs have taken on the greatest growth in volume of care compared to any other sector in the NHS, seeing an estimated 40 million more patients annually compared to 5 years ago, whilst A&E by contrast is seeing 600,000 more in the same period. And practice activity has equally rocketed with Northern Ireland data showing that the number of test results dealt with by practices increased by 217% in a decade and administrative tasks by 115%.

The irrefutable fact is that demand has absolutely outstripped our capacity, and we simply don't have the GPs, appointments, staff or space to meet these escalating demands. And it'll get worse - the demographic change of an ageing population will add further workload, with an estimated 1 million more patients who'll have three or more long-term conditions in a decade by 2018. And the explicit pan-UK policy of moving swathes of care out of hospitals onto an impoverished general practice landscape is a recipe for it imploding under the strain, with already increasing numbers of burnt out GPs and practices handing back the keys to government.

The math's speak for themselves. 16 times more patients will visit their GP surgery today compared to the numbers who'll attend A&E. Each practice closure, each unfilled GP vacancy, each GP working fewer sessions due to stress or each retiring early will hugely reduce GP appointment capacity and a mere 6% reduction in patients seen in general practice would double the numbers attending casualty if they went there instead, and we could be talking not of a 4 hour wait but an 8 hour one. Saving general practice is indeed about saving the NHS.

Last autumn's five-year forward view in England was the first government endorsed publication explicitly using language of the under-funding of general practice, and a specific commitment to transfer resources from secondary to primary-care, and to invest more in general practice itself.

In the pre-election manifestos for the first time it wasn't just about hospitals, but all major parties nailing their colours to the mast to promote the central role of general practice in their future plans, and each trying to outbid the other in the thousands of extra GPs – not other doctors - that they planned to magic up.

And which takes us to today. Now the election is out of the way –I call upon the Prime Minister to jettison the political pipedreams of tomorrow and get real about how we resource, resuscitate and rebuild general practice today. It's absolutely pointless promising 5000 extra GPs within this parliament if we lose 10,000 GPs retiring in the same period

Any New Deal for general practice must start with workload, workload, workload. In the 25 years I've been a GP, it's never been tougher. I started out in general practice all those years ago with 24 hour responsibility, being on call nights and weekends– shackled to my bleep, visiting a patient at 3 in the morning and then back in surgery at 8.30 a.m. few hours later, and yes I also worked seven days. And yet it was easier then, more rewarding and manageable.

The current job has an unsustainable, punishing pace and intensity. We work flat out 12 to 14 hour days without a break, We manage complex patients often with four different chronic problems, trying to condense an hour's worth in the impossibility of 10 minutes, given they were previously seen in four different hospital clinics of 15 min each. We look after seriously ill patients at home who would otherwise be in a hospital bed. We laboriously record a wealth of data on computer screens we're performance managed on.

Add to that the avalanche of phone consultations, hundreds of patient letters and test results daily, each of which could have significant consequences on a patient's health, let alone the rigours of running a practice with increasing regulatory scrutiny and targets. Logic alone tells us we're trying to square an impossible circle, and GPs are voting with their feet, with the BMA survey showing that excessive, inappropriate work and lack of time are the main reasons driving GPs out of the profession, leaving

growing numbers of practices struggling with unfilled GP vacancies. It's no wonder that many young doctors are shunning a career in general practice, since when they experience general practice in their training, far from the myths peddled of lazy GPs working office hours, they see the diametric opposite of doctors overwhelmed from open ended demand, working longer hours than many hospital shifts, and taking work and worries home with them at night and weekends.

"

"

But there's a serious undertone to this. If we carry on the way we are, we're putting not only ourselves but our patients at risk of care that's lacking in quality and potentially unsafe.

And in keeping with my duty of candour, let me today on behalf of the profession blow the whistle that 9 out of 10 GPs state that workload pressures are damaging quality patient care and the new government needs to take responsibility to put this right.

It should start by putting an end to general practice being a one-way valve of workload shift and the backstop for every problem in the NHS and beyond. Today several thousand patients will attend a GP surgery purely for the bureaucracy of the GP re-referring them the minute they miss a hospital appointment, or to chase up a test result requested by another clinician, fill in school absence reports, provide sickness certificates, prescribe medication outside a GP's competence because of hospital budgetary rules, or re-refer a patient to a related specialty because of Trust policy.

I could go on. This results in longer waits to see a GP, since these thousands of appointments are not available for sick patients who need to see us.

It's unacceptable that our goodwill is being exploited in this way, by piling on limitless work onto GPs without any additional funding, while other parts of the system are paid for every ounce of activity. Resources must follow where care is delivered, and this must be a non-negotiable commissioning principle.

"

"

After years of being browbeaten, we must resurrect some empowerment - we do have some control in the way our surgeries run and what work we take on, and as individuals we can exercise choices to do the right thing. That means stemming work that's inappropriate, underfunded and above our capacity, if it's jeopardising our ability to fulfill our professional duty of care for patients.

"

"

And if government claims to have any clue about the plight of general practice, it must halt its surreal obsession for practices to open seven days when there aren't the GPs to even cope with current demands. This would damage quality care by spreading GPs so thinly, and replace continuity of care with impersonal shift-work, and will reduce our availability for older vulnerable patients. And given that government itself believes that the NHS is short of 5000 GPs, let's not even have this conversation until and unless it's created these extra GPs first

We also need honesty about what's affordable within a deficit NHS budget trying to save billions. This must be about managing demand, not stoking it with political profligacy which will take resources away from those that most need it. Nowhere in the world does any nation provide a state-funded routine GP service 8-8 seven days a week, and here our government is pretending we can do more than anyone else with fewer GPs per head than in Europe, while spending less on health compared to virtually all other comparable nations – so please please stop playing games…

"

"

It must also end the punitive overregulation that's strangling general practice- amongst the top five reasons why GPs want to leave the profession. UK GPs are subject to more scrutiny, performance management, and targets than any other nation studied by the Commonwealth Fund - and that's even before the introduction of CQC. It begs the question why England is spending hundreds of millions of pounds on an inspection regime not felt necessary in Wales, Scotland and Northern Ireland.

Practices live in fear and threat, with days taken away from caring for patients to prepare for and endure inspections. The problem is that CQC has mushroomed into an industry of flawed performance management. We managed to get rid of the shameful intelligent monitoring bands, but still have practice ratings without context and circumstance, and which misleads the public with crude proxies that demean the holistic care hard working GPs provide. CQC needs to go back to basics of keeping registration simple, abandon ratings and plough the millions saved into patient services instead.

"And we need a national programme of proactive support from government with dedicated resources for GPs and practices struggling under pressure right now - not after the event when practices are about to collapse. And at a volatile time when any practice can be vulnerable, we need support - not threats or breach notices when practices can't deliver due to circumstance."

"And the public deserve transparency from politicians that we have an overstretched and understaffed GP service, and the limits of what we can physically provide. Just as we've seen a publicity drive to use accident and emergency appropriately, we need a similar national drive to highlight the crippling pressures on GPs, and to signpost patients to use other services where appropriate and to empower patients with strategies of self-care. This requires a complete overhaul of NHS111, which last year referred 5 million more patients to general practice, clogging up our appointments, and with only 15% of patient managed with self-care compared to a 48% previously. This comes as no surprise with a system relying on computer algorithms - not clinicians - to give advice.

Conference, I return to our biggest challenge that we don't have enough GP's to meet current demand. We know that the Prime Minister doesn't have a magic wand to conjure up his 5000 GPs tomorrow. We therefore face a stark choice to sink or swim. I told you last year that I fought to be a GP, and that it defines my life and values. I didn't take on this job to watch my profession drown a death.

Therefore we must have determination, fight and a survival instinct to swim and grab any lifeboat to stay afloat while we rebuild general practice. That means working with any other health professional such as pharmacists who can support GPs in their daily work. We must equally be creative about new ways of working and using technology to ease pressures."

"Conference, we're at a juncture when politicians and policymakers alike are espousing general practice as being central to the NHS's future. We must hold them to their word and boldly stake our claim. I'm not going to government with a begging bowl asking for favours, but with confidence and self-belief that the NHS simply can't survive without us, and to demand that GPs are finally given recognition, respect, and the resources to do our jobs providing holistic care for patients."

"And simply talking up general practice with warm words won't magically increase recruitment and retention - you need to make the job attractive, manageable and rewarding so that existing GPs want to remain working and younger doctors want to become GPs. And this means politicians giving airplay not just too selected clinical leaders, but to see the world through the eyes of hardworking exhausted grassroots GPs who keep the NHS afloat daily, and who I'm most proud to represent

Conference, I want us to be able to tell the future generation of doctors that while general practice is currently at a low ebb, that it has a hopeful future as a regeneration zone and with a central commitment to invest in its renaissance, so that doctors will want to enter our great discipline as I and all of you did.

Only then does the government have the faintest hope of turning the downward spiral of GP workforce into a positive one, and to safeguard the survival of our unique and proud family doctor service that communities depend on. Prime Minister you have no choice. GPs, patients and the electorate will hold you to account for nothing less."

To add to the speech above from Dr Chaand Nagpaul a recent article in the British Medical journal (BMJ) titled “The NHS crisis: are we missing the point?” revealed a number of alarming facts:

- Waits of over four hours in emergency departments were 50% higher in 2014-15 than in 2013-14
- Cancelled operations increased by 32% in a year
- 700% increase in 12 hour trolley waits in a year and a 1800% increase in two years
- A year ago, a quarter of trusts were in deficit. Today 80% are, producing a billion pound aggregate overspend
- Public demand on services is not as high as perceived – over the past decade, emergency department attendances and inpatient and outpatient numbers have risen reasonably steadily by at most 3% a year. The last two years have followed this trend with emergency department attendance only 2.6% higher, and admissions 2.9% higher in 2014-15 than in 2013-14
- Agency staff to back fill hospital attrition cost £2.6bn last year (The SoS has vowed to address this issue)

These facts just add to the urgency of addressing the current state of the NHS.

Dr Chaand Nagpaul this year was recognised for his services to Primary Care by being honoured with a CBE in the Queens Birthday Honours list - Congratulations.

Quote:

“Our wretched species is so made that those who walk on well trodden path always throw stones at those who are showing a new road”

Voltaire

Technology and its role in the NHS

Historically healthcare has been delivered on the basis of offering clinics, clinicians sat at desks consulting with the population and addressing their needs. More recently over the past decade telephone consultations have taken a significant role in addressing public needs by introducing an element of convenience for the patient avoiding the need to travel to a clinic. Now we're in the era of Skype and Webex allowing visual communication with the public with an element of assessment beyond just an audio response. But what does the future hold?

We know that Google has already established its role in information provision within the health arena; it's now not uncommon for patients to attend the GP clinic having researched their ailments with "Dr Google". Using gadgets that count steps taken on a daily basis for the health conscious and various dietary fads that come and go shows a public desire to live healthier lifestyles but the ease with which fast food establishments and alcohol is available is having a detrimental impact on society which eventually ends up at the door of the NHS either through A&E departments or with ailments requiring medical intervention at some level.

Government after government have spent hundreds of millions of pounds on ensuring a variety of portals are available for the public to access healthcare advice. Most of these have depended on a NHS member of staff either a clinician or healthcare advisor to be available to address the presenting complaint. Whether these are in the form of additional GP surgeries, Walk in Centres, NHS Direct or now NHS111, APMS practices, Winter resilience schemes or GP's in A&E they all have one common theme – when the money finishes the service stops. Various projects change the behaviour of the local community on how they access local healthcare only to find that they need to redefine the patient pathway when the original service has been terminated.

The essence of this demonstrator although having 7 day working at the heart as a prerequisite to submitting a bid, has looked to explore how technology can be used to simplify the lives of the community and those that deliver care within it. A clear barrier to progress is the fact that the whole system is "fire fighting" on a daily basis to meet the ever increasing public demand and deliver on the barrage of continuous targets and demands coming down from the government. Very few individuals have the time to look up and recognise the kind of turmoil the system is currently in. Clinicians falling through stress and ill health, the community increasing in number of elderly present and those suffering with chronic diseases not to mention the heavy dependence of communities on the health service to meet all their needs from managing illness to letters for school regarding absence and support with social issues. Investing more millions on "bums on seats" will not provide a sustainable solution with longevity, this approach will continue to rely on heavy future investment from the centre which will come from more taxes on an already struggling society, so what can be done?

Public health and education has a significant role to play but is beyond the scope of this chapter. Technology clearly has a pivotal role. Some examples have been mentioned above from central access to medical records through EMIS Clinical Services to digital dictation systems and iPads. Technology needs to be on both sides of the equation, the health service can adopt technology but the community at large is already utilising technology in their day to day living.

Looking at the technology guidance for wave 2 of the Prime Ministers Challenge Fund the guidance stated that:

"The following provides an indication of the characteristics to consider as part of selecting the technology to support your project:

- Putting solutions in the hand of front-line practitioners and associated staff
- Having the potential to release 'time to care'
- Having proven deliverable benefits
- Having evidence of demand
- Having an established supplier market
- Having the potential to be deployed across a number of clinical workflows and care settings "

When we consider the technology currently available we find school children using iPads for education and social engagement, iPhones and other smart technology to stay in touch with family and friends and today it's very possible that the younger generation spends more time with these smart devices than in front of a TV. If this is the case why does the health service still consider "putting solutions in the hand of front line practitioners and associated staff", why not put it in the hands of the public with remote monitoring by the health service.

Using web based technology can allow specialist within the hospital to reach out to GP surgeries to provide a multidisciplinary approach to complex cases whilst ensuring services are closer to home without the need for the specialist to leave the hospital. This can be extended to translation services that can deliver visual translation services which can appeal to those with difficulty in understanding the English language but also to those that are hard of hearing due to the visual element. Once again this would reduce the need for the translator to travel allowing more consultations from one base which can lead to reducing the tariff for the service.

The latest craze is the Apple Watch. Technology that varies from £299 to £13500 which is customisable with 38 variants and easy to use. Reports comment on this piece of technology as very stylish and wearable. This watch will target the fashion industry as well as the early adopters of new technology. The Apple watch with its NFC chip will allow the public to pay for items with a swipe of their watch and leave their iPhones and wallets in the pocket. Although the swipe and pay ability is not yet available in the UK (available in US) it is a matter of time before this facility becomes available in the UK. This will make the adopters of this form of technology more dependent on the watch meaning more interaction on a daily basis.

The target for the NHS should now be how do we develop relevant Apps that can be uploaded onto the Apple watch that allows both the wearer and their clinicians to monitor the physical and mental wellbeing of the individual. Not all members of a community will be interested in this form of technology and for many the cost of the watch as well as the requirement to have an iPhone to connect to the watch is likely to make this option restrictive. When we take into account the cost of

an A&E attendance, out patient appointment, hospital admission and bed blocking, is there potential for the health service to invest in this technology for those that do not have the means and can we keep patients at home with remote monitoring and early intervention from data transmitted from the watch to a monitoring station. As with all forms of technology advancements and improvements means that any new technology has a limited time span before further new technology becomes available but the old technology becomes cheaper and more affordable and as a national service the NHS needs to keep up to speed with other areas of commerce in how it engages technology in delivering its service.

Apple Watch

Emergence of the Apple watch has allowed the development of a new pilot. GP practice with a registered population list of 9,500 patients will offer 13 - 19 year olds as well as patents with asthma / COPD an email address to contact their GP. The model will work as follows (Figure 36)

The Pilot is planned to commence in August 2015 for a period of 6 months before the initial evaluation this pilot hopes to reduce:

1. Exacerbations
2. Anxiety
3. A&E Attendances
4. Hospital Admissions

Benefits of Apple Watch to support patient services :

- GP can be mobile but still accessible to 'at risk community'
- No need to take smart phone out of pocket with each email
- No need to type responses, dictate into Apple watch and send
- No need for patient to go via practice telephone line which can free up reception time and make more efficient for patient
- This has the potential to prevent severe exacerbations and hospital admissions by GP being accessible throughout the pilot period hours and implement early treatment where required. Better for patient who can stay at home and better for the system as no hospital admission
- Improve confidence of younger population to engage with health services
- Reduce time off work or school by emailing rather than booking a clinic appointment

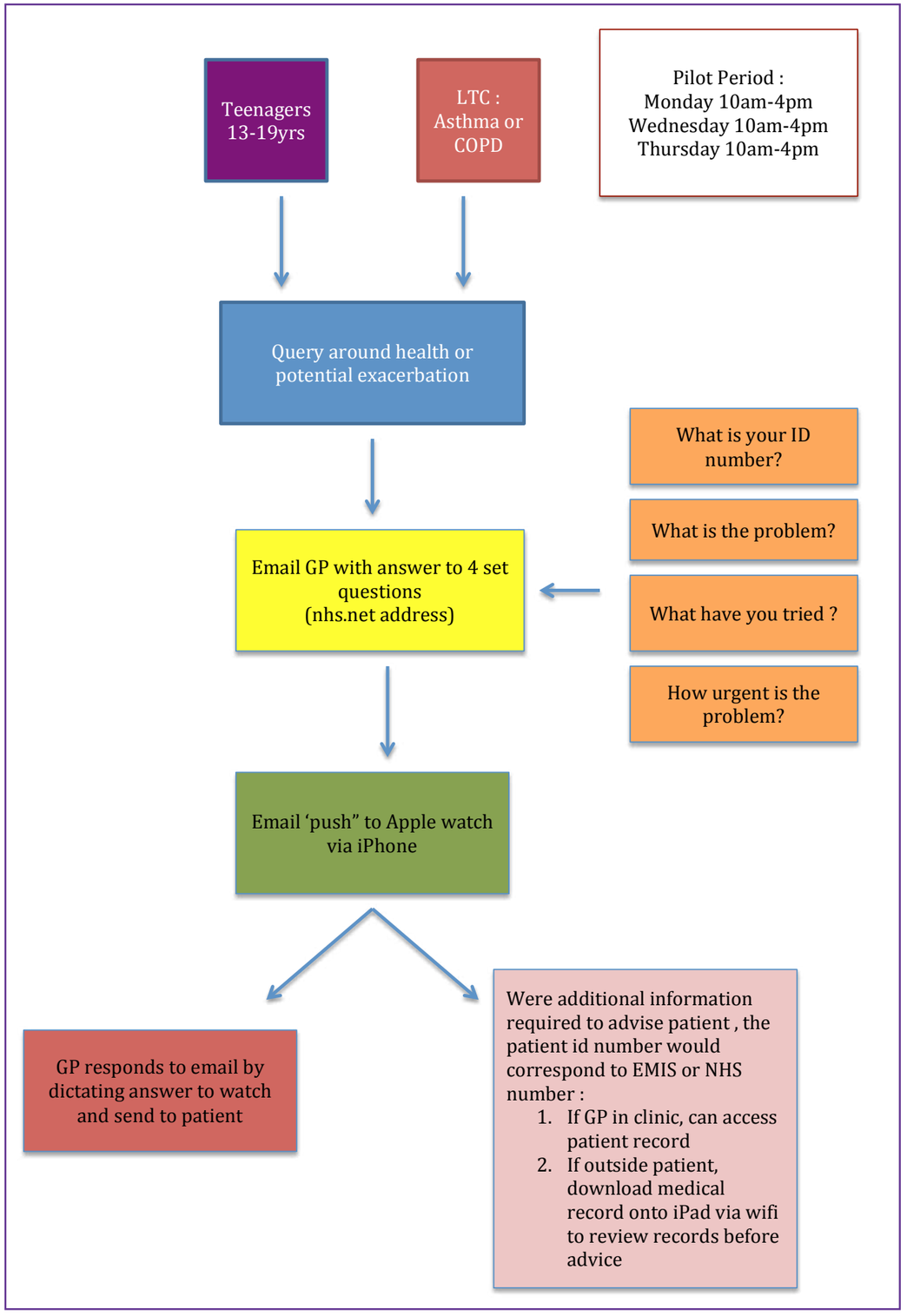

Figure 36

Manchester is now in the limelight with the devolution process but this needs to be beyond the NHS and Local Authorities. Education, charities and the private sector as well as many others need to engage with the agenda to gain maximum benefits. Access to healthcare needs to be beyond the GP and hospital setting. As well as other community venues that currently deliver healthcare services technology needs to bring healthcare specialist into other venues such as schools (beyond a school nurse), libraries, social services environment as well as within local employers premises, this can be achieved today with a TV, webcam and a commissioned healthcare provider.

What the health service needs is a proactive team that engages with software designers at all levels to scope the potential for the proposed new technology in the health service. In the design stage of any new form of technology the question of “How will this technology be used to monitor and improve the health of the nation” should be posed. The health service needs to be conscious of what forms of technology each different sectors of a community are utilising and how can the NHS engage with that community. The current model of NHS purchasing technology and then adopting it into the community needs to be reviewed and the alternative of the health service adapting to the existing technology within the community and engaging with what is available needs exploring.

One organisation that is taking a proactive role in meeting this agenda is the Greater Manchester, East Lancashire & East Cheshire Academic Health Science Network (GMAHSN). With a base in Manchester next to the University, GMAHSN has held a number of meetings with ongoing work which brings the private sector closer to NHS organisations and health care clinicians and managers exploring how collaboration between the private sector and the NHS can deliver a brighter, viable, affordable future for the population. For more information on this organisation go to http://www.intohealth.org

Managing Director of Greater Manchester, East Lancashire and East Cheshire Academic Health Science Network

Greater Manchester Academic Health Science Network provides a platform on which partners can come together to do stuff that delivers value. The platform consists of excellent people with time, resource and knowledge to inspire challenge and to be the glue that brings great partnerships together to deliver creative and innovative solutions that bring wellbeing to our communities and value to our member organisations. We have particular focus and ambition around ensuring the NHS adopts good disruptive research and innovation output at scale and pace, particularly where there is a tight alignment of improvement in patient outcomes and patient safety together with the delivery of cost effectiveness.

We have a programme of work supporting the enhanced use of informatics solutions in the NHS in particular exploiting the sharing of data to promote improved clinical decision making but also to create an environment in which research and innovation can flourish.

We see the Middleton Demonstrator as a great example of pioneering leadership in the use of innovation to improve services for patients. As one of the early four runners of the prime ministers challenge funded practices it has set the tone for how primary care can be modernised to make it more accessible to patients and harness the skills of primary care based staff across the traditional discipline boundaries they work in. There are many good lessons to learn from Middleton and we hope the Academic Health Science Network can play a part in sharing and diffusing this learning with other NHS partners.

Mike Burrows
Managing Director of Greater Manchester, East Lancashire and East Cheshire Academic Health Science Network

Case Study:

“

My mum suffered with a stroke and was taken to our local hospital. Later I found out that another hospital not far from us specialised in management of strokes, I wish she had gone there to receive a full package of care

”

JD – age 49

6

Better Care Fund and Healthier Together 2015/2016

The system is under financial strain and in the June 2013 Spending Round the government created a £3.8bn pot of money called the Integration Transformation Fund which has been renamed the Better Care Fund (BCF). This would allow for pooled budgets between the health and social care services to allow these organisations to work more closely together.

It is an opportunity but carries inherent risks. The £3.8bn is not new money; this amount is aggregated from both health and social care budgets. Guidance made it clear to shift activity from hospitals into the community, hospital emergency activity will have to be reduced by 15%. This would add to existing financial pressures on CCGs. Plans from the BCF must detail how they will provide:

- Protection for social services
- Seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Better data sharing between health and social care based on NHS number
- A joint approach to assessment and care planning and where funding is used for integrated packages of care there should be an accountable professional
- Agreement on the effects of changes in the acute sector

The areas to be monitored on how well the BCF is being used to develop integrated care will be:

- Admissions to residential and care homes
- Effectiveness of re-ablement
- Delayed transfers of care
- Avoidable emergency admissions
- Patient/service user experience

Why is there a need for a BCF?

There is an ageing population with an increasing number of people who have one or more long term condition. These two issues cut across both health and social care. Increasing demand and financial pressures means there is a need to focus on:

- Prevention
- Reducing demand for services
- Making the most efficient and effective use of health and social care resource.

(For more information see The Kings Fund report, making best use of the Better Care Fund – Spending to save?)

Sounds very much the devoManc agenda – see below!

What Healthier Together is and what we do....

Health and social care leaders from across Greater Manchester have been working together to review the services they offer and the way that they are delivered.

They are developing pioneering ways of delivering care in communities and hospitals that are tailored to the specific needs of their local populations and respond to some of the challenges that we face across Greater Manchester.

Over the last couple of years, we have been reviewing health and care in Greater Manchester and looking at how to provide the best care for you and your family under a programme called "Healthier Together".

We want to take out the variations in the quality of care across Greater Manchester. We believe by doing this we can save more lives.

In 2014, we held a public consultation and gave the people of Greater Manchester and surrounding area an opportunity to provide their views and opinions on some of the proposed changes to health and care in Greater Manchester.

A decision about the best option to improve health care across Greater Manchester will be made by the 'Joint Committee' which includes members of Greater Manchester's 12 Clinical Commissioning Groups (CCGs) in Summer 2015. 30,000 responses were received and these will be considered along with data and evidence to reach a consensus on the optimum way to organise hospitals in Greater Manchester.

We need your help.....

We have spent many months meeting people and discussing our ideas which have helped shape our proposals and we now need your help for the next steps of the programme.

This is your opportunity to shape your local health services by advising the programme on what is important to your community and how plans can be put in place in your area. We are looking for patients, carers and members of the community who have experience of either of the following:

- Accident and Emergency
- A planned surgical procedure
- Being rushed into hospital with a serious medical condition

We are in the process of setting up Patient, Carer and Community Advisory Groups across Greater Manchester in the following areas and would like you to join us. The groups will be set up in the following locations:

- North West Area: Wigan, Bolton, Bury and Salford
- North East Area: Rochdale, Oldham, North Manchester, Tameside and Glossop
- South Area: Central Manchester, Trafford, Stockport and South Manchester

If you want to find out more about this opportunity or the programme then please get in touch with us:

Rebecca Patel
Engagement Manager
NHS Greater Manchester Service Transformation

0161 625 7548
rebeccapatel@nhs.net

Quote:

“There are no secrets to success. It is the result of preparation, hard work and learning from failure”

Colin Powell

7

The Five Year Forward View

“We live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese. These changes mean that we need to take a longer view –a Five Year Forward View – to consider the possible futures on offer, and the choices that we face.”

(Foreword - Five Year Forward View)

These areas discussed in the foreword of the document released in October 2014 highlights what is familiar to clinicians and the public at large.

“This document sets out a clear direction for the NHS showing why change is needed and what it will look like”.

Unfortunately many in NHS management have taken this document as the blue print for what services and the models of care that need to be created. Accepting that this document is the creation of the NHS chief executive there are opportunities and potential threats to Primary Care and should be taken in the context of existing local services, public demands and needs and the financial viability of the models proposed with the potential to release efficiency savings. The merits of having statutory bodies such as CCGs with GP practice membership is that local expertise can be applied to the creation of healthcare models that will meet local needs over the forthcoming five years – this document provides “clear direction for the NHS” which many managers interpret as doing as exactly stipulated in the document.

The main areas to address in the document are:

1. Requirement for a radical upgrade in prevention and public health
2. When people do need health services, patients will gain far greater control of their own care
3. The NHS will take decisive steps to break down the barriers in how care is provided

On these three issues there are areas to address:

- On the first issue although prioritising prevention and public health should be a priority there is concern about who and how this agenda will be addressed. General Practice is already over stretched and although the document refers to hard hitting national action on obesity, smoking, alcohol and other major health risks does the government have the ability to take on the large multinationals that financially benefit from selling products that lead to obesity and ill health? This section also refers to helping develop and support new workplace incentives to promote employee health and cut sickness related unemployment. There is a priority to undertake this function within the health service to improve the physical and mental health of those working within the health service to strengthen the workforce (see below - Letter to Prime Minister).
- On the second issue there needs to be clarity on how a member of the public will be assessed to

ensure they have the ability to manage greater care including the option of shared budgets.

- On this final point and reflecting on the results of engagement between the demonstrator and the local acute hospital trust what will happen when one of the parties fails to engage resulting in failure to progress?

The document does state in bold "England is too diverse for a one size fits all" which would provide an opportunity to implement local flavor to models and services created although the same paragraph then proceeds to state "but nor is the answer simply to let a thousand flowers bloom". Although many would argue that a thousand blooming flowers would be a wonderful, fragrant field that would bring both physical and mentally harmony in this model to release efficiency savings there will need to be opportunities to replicate models of care to benefit from economies of scale. This may be an area that devoManc would be suitable to handle as models of care across GM would allow local flavour yet have consistency in services delivered across the county.

The next area shared in the document is the options of new models of care. There are 4 different models shared:

1. Multispecialty Community Provider (MCP) – this is the direction of travel for federated working. This demonstrator has shown how the different community agencies have come together in a short period to start exploring new ways of working but also the contribution and visions from opticians and pharmacist in this report highlights the desire to work together.
2. Primary and Acute Care Systems (PACS) – This would be integrated hospital and primary care provider. With vertical integration this would allow acute hospital trust to run community GP surgeries. There is inherent risk in the lack of understanding of the dynamics of how General Practice delivers on its core responsibility as well as other optional services from enhanced services to public health. The responsibility undertaken by principals and staff within primary care is unparalleled when considering the commitment to complete the job well beyond the contractual hours but also the low sickness rate and passion to embrace continuity of care. There will be areas of the country where GP recruitment will be a significant issue where PACS may be an option but in the vast majority of the country MCP should be the initial area to explore.
3. Urgent and emergency care services will be redesigned to integrate between A&E, GP out-of-hours, urgent care centre's, NHS111 and ambulance services. Maternity services can be lead by the midwives and there would be more support for the frail older people in care homes. There needs to be clarity on what the implications are for organisations that fail to engage and which authority will monitor engagement and impart sanctions where an organisation fails to support development. The example in this report is a clear message on how a local acute hospital can fail to engage with new opportunities within the community which can support activity levels within the evening and weekends by deflection back into the community.

A very welcomed mention in this document is:

"The foundation of the NHS care will remain listed-based primary care. Given the pressures they are under, we need a "new deal" for GPs."

Although there is reference to increase investment in general practice there needs to be assurance of new money into the system and not removal of existing resource to be rebadged and reallocate to general practice. The retention on a list based system will provide an element of stability and continuity to both the profession and the public they serve.

Reference to national leadership and meaningful local flexibility will be a welcomed opportunity to create meaningful models of care that address local need but there does need to be a national programme that supports clinical leadership development with this and other government documents at the heart of training rather than MBA type courses. This report has many examples of innovation and for the lessons and examples learnt from the 2 phases of the Prime Ministers Challenge Fund to be shared nationally would expedite the learning curve for many different parts of the country. One area of caution would be the perception that what works well in one part of the country should be replicated in another part, this has 2 potential issues:

1. Innovative models are created by taking into consideration a number of variables from the local services available to the type of public in the area and the financial resource and systems already in place. A different area will have different dynamics leading to either difficulty implementing the same model or will have additional funding implications.
2. Many aspire to copy what others have achieved. The aim for any area should be to take the best most applicable elements of the model being shared to establish a foundation and ask the question "how can I make this better for my locality?"

There is a need to address public demand, efficiency and funding without which there will be a mismatch of £30bn a year by 2020/21. Failure to address one of these areas will adversely affect the other 2 with the need to release more savings. In a system that is on the brink of running dry there will need to be creation and sharing of guidance which supports providers on where and how to release these efficiency savings. The efficiency savings proposed in the document does appear to be a challenge of unprecedented levels but the NHS Chief Executive feels the targets can be delivered, there needs to be further guidance on how?

The "Five Year Forward View" document and the subsequent document "The Forward View into Action –Planning for 2015/16 " are both worth reading. There are ample great ideas which generate ideas on how agencies can start engaging with each other, with local businesses and the public but there are references to approaches and issues which require addressing e.g. Obesity, smoking and alcohol which will require providers to be more firm and supportive but in a system where clinicians are exposed to public complaints if public wants are not fulfilled there will be hesitation on approaches required to minimise upsetting the patient.

Quote:

“

Reinvent new combinations of what you already own. Improvise. Become more creative. Not because you have to, but because you want to. Evolution is the secret for the next step

”

Karl Lagerfeld

8

Greater Manchester

“devoManc” - Devolution of NHS and Local Authority Budgets

DevoManc is a new initiative across Greater Manchester. The primary aim is to improve the health and wellbeing of the 2.8million citizens of Greater Manchester (GM). This will be delivered through devolution of £6bn of funding from Whitehall down to GM. Having gone live in a shadow form from 01.4.2015 the first year will allow evolution of the model with engagement between different agencies with full devolution from 01.4.2016.

Although the key players in devoManc are the Local Authorities (LA) and Clinical Commissioning Groups (CCG) across GM, the full model will include housing, transport, police and other agencies which impact on the health and welfare of a community.

Initial course of action has been for the LA across GM to come together and form AGMA (Association of Greater Manchester Authorities) and CCG’s across GM. The initial ground rules have been established in a Memorandum of Understanding (MoU) which list the key objectives as:

- Improve health and wellbeing of all residents of GM
- Close the health inequality gap
- Deliver integrated health and social care
- Move care closer to home
- Strength focus on wellbeing with importance on prevention and public health
- Contribute to growth and connect people to growth e.g. supporting employment and early years services
- Forge partnership between NHS, social care, universities and science and knowledge industries for the benefit of the population.

The MoU can be found at:
http://www.agma.gov.uk/gmca/gmca-devolution-agreement1/caring-for-gm-together/index.html

GM is committed to being an early implementer and a test bed for new, innovative approaches of delivering new models of integrated health and social care which reflect the needs of the local population.
(The above has been taken from the MoU for Greater Manchester Health and Social Care Devolution)
So is this a good or bad idea?

We know that a significant part of the £6bn is NHS budget that will be handed down from central government. John Osborne has deduced the need for a “northern powerhouse” that would be lead with civic leadership based not on political parties but on elected mayors, he said “Every northern city needs a Boris Johnson to fight their corner on the world stage”. Elected mayors are central to the devolution agenda and Osborne refers to them as “my red line”, the crucial link in the chain of local accountability. Sir Howard Bernstein (CEO Manchester City Council) has been involved with the devoManc initiative from its embryonic beginnings with close working relationship with Osborne to make the vision a reality. Although the devoManc process is in its shadow form during 2015/16 the reality is that Sir Howard has very likely a vision of how GM will become the “northern powerhouse” envisaged by the Chancellor.

Although many in the NHS may be cynical about the ulterior motive of the Local Authority and its sights on the large NHS budget, for a success stable economy across GM there is a need for strong leadership from individuals with experience, influence and engagement with government. At the heart of a successful venture will be development of open, transparent and honest relationships between the different agencies, the need to engage all stakeholders at some level within the infrastructure and to ensure that the voice of the citizens of GM at all ages is heard and factored into any service redesign. There is already paranoia that the Local Authority are “parking their tanks on NHS lawns” with a view to grabbing the NHS budget but systems and processes need to be in place from those at the top to ensure that reassurances and resolution of any allegations are addressed at an early stage to ensure that progress is made and avoid delays due to disengagement developing from misunderstandings and “Chinese whispers”.

Sir Howard has taken a large gamble on desiring to take full control of activities including transport regulation, strategic planning, housing development, further education, skills training and economic growth. The city would control the £500m apprenticeship budget as well as the £200m housing budget. It would oversee the interface between NHS commissioning and local social services. The elected police commissioner would be out with an elected mayor in by 2017 (shadow form until then). Whitehall has been asked to surrender big budget items such as secondary education, welfare payments and the NHS – Sir Howard has pulled off the impossible and convinced Whitehall to have confidence and devolve the budget. Closer to home Sir Howard has had to convince the other GM council leaders to mobilise this project. Osborne holds Sir Howard in high regards and has worked closely in collaboration to make the devoManc process a reality.

For Manchester to be in such an exciting position with new opportunities that will benefit the citizens of GM both Yorkshire and Birmingham have had to take a back seat. As with many things in government nobody likes to be second and engagement always appears more resistant when the blue print to success has been developed elsewhere. Osborne has referred to devoManc as “the thing of which I think I am most proud”. Far from doing something to pacify a politician the confidence that Whitehall has had in devolving so much to GM requires a level of support and engagement with the process and GM now needs to deliver on its vision if it is to fight off any challenges from other cities who have not been able to seek support from Whitehall at an early stage. Devolving the NHS budget locally with the ability to redesign how and where healthcare is delivered has a high likely possibility of creating a NHS that is very different to today’s NHS. As more cities adopt a similar position with devolution the original vision from Nye Bevan of a NATIONAL Health Service is likely to see its final days with different models across the country delivering the needs of its local populations.

GM public spending is £22.5bn each year but it raises only £17.7bn in taxes. This shortfall of £4.8bn needs to be addressed. Could this be through the devoManc process reducing unemployment and

dependence on state handouts or will the next step be for the Chancellor to devolve powers for the cities to raise their own taxes and target the local businesses and working population? In any service reform from the establishment of CCG's to creation of Foundation Hospital Trust achieving financial balance has been a mandatory requirement to remain free from meddling from the centre, devoManc is likely to be no different and starting with a £4.8bn shortfall will require some quick wins from existing budgets and services before more long term strategies can be created and implemented.

Areas to address also include the way in which the Local Authorities (LA) and Clinical Commissioning Groups (CCGs) function. LA's function in a fashion very similar to many large corporate bodies with a hierarchical structure with a board, chair and chief executive officer. Decisions are made which are passed down to different levels to implement the vision and deliver on targets with accountability lying at board level. CCG's are membership organisations that comprise of GP practices within the CCG boundary. GP practices have no choice in whether they are members of a CCG, if a GP practice refuses to be a member they would not be able to hold a NHS GP contract which allows them to look after the health needs of their registered population. Although CCG's have their boards and consists of director and chief operating officers as well as a GP who chairs the organisations there is a requirement for the board to engage with its members i.e. GP practices to support the direction of travel. These 2 different models between LA's and CCG's will be the same across the country.

The emergence of an elected mayor in 2017 will bring new powers with the position and the future of how these statutory bodies function will need to be reviewed by change in legislation if required. This is likely to bring to life the paranoia of Local Authorities controlling NHS budgets as mentioned above. The only way to address this is to ensure there is strong leadership within the NHS who can represent the voice of all NHS staff and patients. CCG's are a relatively new organisations when compared to the history of Local Authorities. GPs who yesterday undertook clinical work today dedicate part of their week to chair these NHS organisations. In contrast Local Authorities breed and nurture their leaders from ground up, Sir Howard over four decades has risen from a clerk to chief executive understanding his organisation in all aspects and understanding the inner workings of his establishment. As much as the NHS clinicians would like to engage with the local authority on a level playing field it is a matter of fact that there is simply too much ground to cover to develop the expertise and confidence required to manage budgets of such magnitude and to carry the weight of responsibility that devolution has imposed on Greater Manchester. So what should CCG's do?

Fortunately local authorities have little understanding of how the NHS functions. When CCGs emerged public health was transferred to the local authority. The ways in which public health has engaged with primary care has revealed the variation in how contracts are established and monitored between their existence under Primary Care Trusts (pre CCGs) and now under the local authority. There is little understanding of the GP contract and GP services where over 90% of healthcare consultations are undertaken. One of the greatest risks with devolution is to miscalculate the health needs of the local population across GM.

This would not only have an impact on the health of individuals but also have a knock on effect on unemployment, time off work, long term illnesses and increased dependence on the state. The golden opportunity whilst LA addresses their role in devoManc is for CCG's to establish their relationship to each other including the possibility of each CCG carrying a GM health portfolio from finances to governance. The system requires one strong voice representing the health agenda through the portfolio they hold rather than 12 voices each representing their own CCG. Accepting that each CCG is a statutory body accountability will still lie with each organisation, but in a time when GPs are being encouraged to adopt federated working model it may not be a bad idea for CCG's to adopt the same position. There is an Association of Greater Manchester CCGs group but these still function as 12 different bodies in one room, the model needs to be revisited to take on the responsibility that is forthcoming from Whitehall – there is no doubt that resistance amongst CCG chairs will be voiced but future engagement and collaboration with the LA's demands a different model to what the NHS currently has.

A major issue that needs addressing is the infrastructure of the devoManc group. The first meeting of the group held on 23rd April 2015 included the following providers in attendance:

- Stockport Foundation Trust
- Central Manchester Foundation Trust
- Pennine Acute Hospitals NHS Trust
- Pennine Care NHS Foundation Trust
- Central Manchester University Hospitals NHS Trust
- Salford Royal Foundation Trust

In comparison the chair of the Association of Greater Manchester Local Medical Committees was present representing all the clinicians across Primary Care in Greater Manchester. This report is a small reflection of what Primary Care in collaboration with each other can achieve. General Practice is a central member to any new model of care in the community and yet devoManc has 6 hospital organisations compared to one GP in the meeting. Housing, policing, employment, transport and education are all different elements of one community; health is the keystone that underpins the different elements of these services. General Practice over decades has shown to be the most cost effective health care provider in the NHS. For GPs to take a more proactive role in the devolution process there has to be stronger representation on the devoManc group which reflects the key responsibility that primary care will carry compared to acute hospital trusts. At this stage a misconception that is widely held outside general practice needs to be addressed:

- Clinical Commissioning Groups (CCGs) DONOT represent General Practice - Local Medical Committees (LMC's) represent the profession at a locality level. Although GP practices have to be members of CCGs these organisations are statutory commissioning organisations whereas GP practices are provider organisations. Presence of CCGs on the devoManc is essential but they provide a commissioners perspective. There needs to be greater GP representation (and that from other community providers) to ensure a balanced discussion and decision making process.

So what does all this have to do with Middleton?

This is a golden opportunity for different areas of a community to come together to improve the lives of the local community. Looking at both government and private service providers in a community they all have one aim of influencing the activity or behaviour of the community. All these seem to be interlinked like the different links on a chain with sudden change in one service having an impact on many surrounding services. This also has the impact of weakening the chain if the organisation is adversely affected.

Middleton as a township is a proud community with a population of around 50,000. It tends to pride itself on its identity and its history.
The devoManc agenda which is still in its infancy can bring various institutions from the commonly referred to NHS and Local Authority to others such as housing, policing, transport and the private sector into discussions to explore how they can collaborate to review and where required refine existing services to ensure easy access to local services within existing financial envelopes.

Working closer with the larger organisations allows the community to explore a variety of opportunities from recycling existing furniture and IT equipment to establish community centre's and having "work hubs" within GP surgeries and other public venues beyond the unemployment office. This would allow the public to scroll jobs available whilst they wait for other services. Having local employers clarify what they require in their workforce will allow the local community to engage with events to develop the skills to make them suitable to undertake a local job but also support their community once they have settled into their job through education and support. The role of each member organisation will require clarification within the "partnership" and the local public will have a central role in engaging and influencing change.

Work Streams

In order to progress the work involved in reaching these milestones various work streams have been identified. A Programme Board has been established to oversee all the various work streams which cover the following 4 areas;

- Strategic initiatives
- Devolving and Integrating Responsibilities and Resources
- Leadership, Governance & Accountability
- Enabling Work streams

Kings Fund
http://www.kingsfund.org.uk/blog/2015/03/devo-mac-health-social-care-wellbeing-greater-manchester

Unison
http://www.unisonnw.org/wp-content/uploads/2015/05/Devo-Manc-Position-Statement-19-May-15.pdf

Unite - MPU
http://www.sochealth.co.uk/2015/04/25/greater-manchester-devolution-package/

Strategic Initiatives Programme Board (Sponsor: Dr Hamish Stedman, NHS Salford)

- Clinical & Financial Sustainability Plan (Including CSR submission)
- Early Implementation Priorities
- Mental Health Strategy
- Research, Innovation & Economic Growth Strategy
- Capital & Estates
- Workforce Transformation
- Support Services Strategy (overall effiency and joint working developments)

Devolving & Integrating Responsibilities and Resource (Programme Board Sponsor: Paul Bauman, NHSE)

- Resources & FInance
- Primary Care
- Specialised Services
- Prevention & Public Health
- Workforce Training and Development & Support to Challenge Trusts

Establishing the Leadership, Governance & Accountability (Programme Board Sponsor: Liz Treacy, GMCA)

- Programme Board & Infrastructure
- GM Health & Strategic Partnership Board
- GM Joint Commissioning Board
- GM Provider Forum
- Establishing the Relationship with Regulators

Enablers (Programme Board Sponsor: Su Long, NHS, Bolton CCG)

- OD & Leadership Development
- Communications, Patient/Public Engagement
- Information, data sharing and digital integration

Note from Heywood, Middleton & Rochdale CCG Chair

NHS Heywood, Middleton and Rochdale Clinical Commissioning Group became a statutory body in April 2013. HMR CCG commissions – or buys – healthcare services including hospital, community and mental health services, on behalf of the patients and public it serves, in line with the Health and Social Care Act 2012. These are commissioned from a range of NHS, independent sector, voluntary and third sector organisations in order that the CCG effectively discharges its statutory duties and improves the health of the borough's population.

We believe that, as a clinically-led, borough wide commissioning organisation, we have a real opportunity to tackle health inequalities and to respond to the health needs of our diverse community at a very local level.

HMR CCG wants the people of the borough of Rochdale to enjoy longer, healthier lives. We want those who need healthcare to receive it at the right time, in the right place and at the highest quality. This can only come about through skilled and innovative collective action to try to make a difference and to make the best use of the resources we have, based on best practice evidence, and by listening to the people of the borough, engaging them openly in the work of the CCG.

As a membership organisation the GPs from the 38 member practices and their staff are valued partners who are actively encouraged to use their skills, experience and expertise by getting involved and influencing the CCG's work. However Rochdale Borough has poor health outcomes in relation to other parts of the country and also between one part of the borough and another.

So although I feel rightly proud of what the CCG have achieved there is still room for improvement. The opportunity for closer working with Local Authorities provided by the "Devo Manc" deal and the freedom to explore new models of Care delivery as expressed by the NHS 5 Year Forward View offer the chance for the CCG to try and improve the health and lives of people in the Borough in ways not previously possible.

Getting practices to work co-operatively rather than competitively, getting hospitals to work with practices for the benefits of patients rather than in isolation and Health working with Local Authority in a coordinated manner to reduce duplication and get better value for our limited health and Social care budgets are areas that the CCG are already developing and the demonstrator site in Middleton (and the demonstrator project in Heywood) are examples where new innovative working relationship can benefits patients.

We need to embrace the use of technology not only for managing illness but also to enable and empower patients to monitor their own conditions. We are working to develop an integrated clinical record that is accessible by GPs, Hospital and Local Authority staff so patients and their multiple carers have access to a single medical record.

HMR CCG has developed a proven track record of delivering service transformation to improve patient outcomes such as the minor eye service mentioned elsewhere, service quality and productivity, and of reducing inconsistencies in quality, tackling inequalities and remaining within its financial allocation.

We will continue to work with our members, partners and with local people to build local services which are of high quality integrated, safe and accessible.

Dr Chris Duffy Chair, NHS HMRCCG

Note from the Chair of the Association of Greater Manchester Local Medical Committees

The demonstrator projects within the Greater Manchester region have been important in making and changing health pathways in this area.

This book identifies how this has been possible. Going forward we can utilise lessons learned and design a new bold integrated health system within the region with the help of devolved powers and budgets that are unique to Greater Manchester.

We appreciate the work in pioneering the new pathways and look forward to developing them further and extending the reach of the services for patients whilst allowing the voice of the workforce to be represented.

Tracey Vell
Chief exec Manchester LMC
Chair Association GM LMC's
Member of Devolution Programme Board

Quote:

“

The world today has 6.8 billion people. That’s heading up to about nine billion. Now if we do a really great job on new vaccines, health care and reproductive health services, we could LOWER that by perhaps 10 or 15 percent

”

Bill Gates

9

New Parliament - what’s next?

In May 2015 the Conservative government came back into power with a majority vote giving Prime Minister David Cameron a second term in office.
In the conservative manifesto the Prime Minister stated:

“It is a profound Conservative belief that our country is made great not through the action of government alone, but through the flair, the ingenuity and hard work of the British people – and so it has proved the last five years.

We can be proud of what we have achieved so far together, and especially proud that as we have taken hard decisions on public spending, we have protected the National Health Service, with 9500 more doctors and 6900 more nurses, and ensured generous rises in the State Pension”.

The manifesto also states:

“Throughout, we will make sure that if you or your family fall ill, you will always be able to depend on our cherished National Health Service to give you the care you need.”

The Conservatives have committed to:

- Invest an additional £8bn in funding each year until 2020 as well as £1bn to modernize GP surgeries and £1.25bn for mental health over the next 5 years
- Seven day access, 8am-8pm to a GP by 2020 and a guarantee of a same day appointment for the over 75s if they need one. The party will provide £400m in ‘set up costs’ spread over the next five years
- Train and retain 5000 more GPs by 2020
- Mandatory mental health training for all new GPs.
- Plans to extend the Better Care Fund and for GP practices to work with job centre’s, social services and other community services in return for £1bn premises funding. Consider rolling out ‘Manchester-style’ devolution of NHS funding

Although the intentions are plausible there is a major issue – There’s already a significant shortage of GPs to do the existing job let alone facilitate the implementation of new promises. At present 1 in 10 GP partner positions are vacant and 20% of practices are waiting a year or more to fill a GP vacancy. A recent BMA survey shows that a third of GPs plan to retire over the next five years. At the other end medical students are shunning general practice due to morale and workload with 30% of GP training places vacant in the first round compared to only 9% at the same time in 2013.

Although the term for this government is 5years the time to train a GP is 10years. To have a positive impact on the younger population of today to embrace general practice will take the terms of 2

governments and even then there's no guarantee that they will come into general practice or even continue to practice medicine in this country. Conservatives have promised investment of £8bn per year from unprecedented efficiency savings of 2-3% per year which even in more affluent times was a difficult target to achieve. Over the past few years general practice has squeezed the service to make efficiency savings by reducing referrals with introduction of referral gateways and Clinical Commissioning Groups reviewing prescribing behaviour. Various enticements such as golden handshakes are not going to attract GPs in to the professional due to the current state of primary care. The pension reforms have pushed move GPs out of the profession.

Not that long ago GPs contributed 6% towards their employee NHS pension contribution. Gradually this has now more than doubled and the National Pension Age (NPA) being imposed in the 2015 NHS Superannuation pension scheme. All new GPs will be bound by NPA which over the next few decades could gradually increase meaning that GPs (and other NHS staff) cannot retire until they reach NPA which is currently 67. For those in the older pension schemes i.e. the 1995 or 1998 scheme they still have the option of withdrawing part of their pension at age 60 or 65 but for many this will be insufficient to retire on which will force them to continue working up to the NPA. There are real discussions occurring in the younger medical profession on the benefits of being part of the NHS Superannuation scheme and whether available alternatives may allow earlier retirement from the health service.

Even taking into account the satisfaction of treating individuals and families within a community setting there is no doubt that GPs around the country suffer both physical and mental issues as a consequence of the pressures and targets imposed in the current system. Having to plough on into late 60s if not 70s in the future will not provide satisfaction and relaxation for a clinician who will have committed over 40years of their lives to the health service to ensure their community benefits from good mental and physical health.

So is it time to pack it all in, abandon the government and emigrate abroad?

Not yet!

Some have taken this option and moved to Australia and the Middle East for a better quality of life. There is a way to explore options to deliver on government pledges without breaking the system. Does it include 5000 more GPs (even though nobody knows where they're coming from)?
What is transparent at this stage is as follows:

- The government needs to liaise with the medical profession (GPC/LMC's) to explore what can be promised to the public before making national announcements
- Each MP needs to work more closely with the locality and LMC to understand the current pressures in their locality to support healthcare services to meet the needs of their electorate
- Acute provider competition needs to be halted where there is adequate GP provision in the community (through vertical integration referred to in Five Year Forward View). Acute trusts are employing GPs into A&E departments which will not help availability of GPs in the community but will encourage patients with minor ailments to attend A&E instead of community service providers with a financial implications for CCG under a tariff based system
- The hospital tariff based system needs urgent overhaul to support additional resource into the community
- More collaborative working between community service providers e.g. GP, pharmacist, opticians and dentist to support easier access for the public ensuring access to the right service at the right time
- The current APMS contract reviews being undertaken need appropriate financial and manpower support for local GP practices where list dispersal is being undertaken to allow the GP practice to have the resource to absorb the new patients.
- Technology needs to play a pivotal role in allowing easier access to healthcare services and to provide information on self help and illness prevention agenda's
- Avoid multiple schemes that have a resource implication on the same finite available workforce i.e. the same GPs in an area will be torn between the Out of Hours service, Prime Ministers Challenge Fund sites, Extended Opening Hours and other local initiative schemes. In the end the hourly rate in many cases dictates where clinicians work which has a destablising effect on local services.

Middleton demonstrator has delivered 7 day routine GP service for the past 18months but the model has shown areas in the week when demand was too low requiring cancellation of clinics to reinvest resource into more suitable local services. Although 7 day routine health care may still be a government aspiration the availability of services especially over weekends needs review to ensure resource is used as efficiently as possible.

In addition consideration needs to be given to support services from IT to management, booking centre's and 2 week referral offices to be available to ensure care beyond the GP surgery does not stop until Monday morning and any IT related issues in the evenings and weekends can be addressed to ensure continuity of service.

Letter to the Prime Minister

Dr Mohammed Jiva MBE
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Rt Hon David Cameron MP
Prime Minister
10 Downing St
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Monday 1st June 2015

Dear Prime Minister

The Queen referred to the National Health Service working on a 7 day basis and improved access to general practitioners in her speech last month. You have clearly stated your aspirations to see access to general practice increasing to a 7 day service.

Cabinet Ministers and MP's aspire to create change that leaves a legacy. In 1948 a minister by the name of Nye Bevan pushed for the formation of a health service that would be free to all, one that did not leave financial burden at a time of need. Today over 60 years on his name lives on as the minister who improved the health of the nation.

One area needs urgent attention: Staff morale in the NHS

Although national and local government documents refer to patients access and services there appears to be little reference to supporting NHS staff and improving job satisfaction. Investing in New Models of Care, Prime Minister Challenge Funds or practice premises grants are not going to improve morale. A weak primary care front line is a weak foundation to any locality which will impact on all aspects of a community.

Whether the health service embarks on exploring solutions for 7 day GP access or participate in the devolution agenda in Greater Manchester one thing is clear, without a motivated healthy workforce the solutions created will be heartless with little desire to drive the change agenda.

Medical students sway away from General Practice, increasing the pension age with the 2015 pension change has forced GPs to bring forward their retirement plans and those able to retire have jumped ship. Lack of job satisfaction and low morale are keeping clinicians away from front line healthcare. There is also nursing staff, managers and administration/reception staff in general practice who are drowning by imposed bureaucracy and promises made to communities who are expecting more and more from a finite workforce that is already over stretched.

If a government embarking on a new 5 year period was going to create a legacy then it should spend the early years improving staff morale and halting the mass exodus of clinical and non clinical staff out of the NHS. Having content staff with job satisfaction will impact on patient services and satisfaction but also on exploring efficiency savings, service redesign and collaboration with other agencies.

Promises have been made in pre election campaigns and there is no reason why they cannot be addressed but there needs to be consideration given to the pace of change and the processes undertaken to ensure effective use of resource.

This is a prime opportunity for a government to make a significant difference, one that has been previously neglected. Support your NHS staff as well as the public to win the respect of your key workers that run the health service. As you are aware 5 years is not a long time and the clock has already commenced, will there be a motivated primary care work force with job satisfaction at the end of this parliament? Will you leave a legacy that saved the NHS?

Yours sincerely

Mo Jiva

Member of Parliament for Heywood and Middleton

I've been delighted to see this report being produced in Middleton. I know, after working over 30 years in the NHS, just how important healthcare services are to the community I represent.
Some of the earliest cases I dealt with after my election in 2014 were about the availability and management of NHS services and I have worked closely with residents, the Pennine Acute Trust and local CCG ever since.

The importance of integrating services and provision to ensure we get the right balance between best value for money and best care for the patient is vital as we move further into the 21st century. The Middleton Demonstrator pilot with innovative use of resources and technology was a clear signpost of a way to achieve that.

In the coming five years or so, I would like to see the people of Heywood, Middleton, Castleton, Norden and Bamford have access to integrated care from home to hospital with physical, mental and social care working to treat the whole person. I will press for the Department of Health to move away from some patients being allowed no more than 15 minute appointments with carers who may be poorly trained and on zero-hour contracts.

This is a false economy that leads to patients being unnecessarily hospitalised at a far greater expense than that needed to pay for better at-home care. I want to ensure that the current government implements the recommendations of the Francis Report and move away from the hospital-based model of care prevalent in the last century. This Pilot shows that there are ways to make this happen and that they needn't cost extra.

There has been a neglect of the mental health budgets nationally in recent years and I would like to see creative schemes that help us improve prevention, early intervention, and better support for those in need of mental health care.

With a focus on joined-up, integrated work between the clinical commissioning group, healthcare providers and local service users, we can improve health and social care in our community over the next five years no matter who is in government. Co-operation must be the mantra across our services, and not just in health.

Here in Heywood and Middleton, as a party to 'devoManc', we are in a unique position to improve wellbeing across health, housing, education, employment and community. Over 5 years we could revolutionise the provision of services and go from being a pilot programme to the standard model of how things should operate across the country. I'm not saying this is an easy task but it's a good goal to have and something I'll work towards over the course of the next parliament.

Liz McInnes MP
Member of Parliament for Heywood and Middleton

New deal for general practice

When the NHS was set up nearly 70 years ago Bevan recognised that General Practice was special. Despite much opposition he put your independent contractor status at the heart of the NHS, as leaders of the NHS.

And with good reason. Internationally, our primary care system has long been respected and envied. Much of the primary care delivered all over the world today is made in Britain: blood pressure measurement, lung function measurements for asthma, the identification of hay fever or the role of vitamins in nutrition. Today we rank in the top third of countries for primary care doctors per patient.

Even more importantly we get top scores for quality as well. The Commonwealth Fund ranks all major countries on their health systems and it's well known that the UK came top overall last year. Less well-known is that when you dig deeper the areas where the UK amassed many of its marks were on the quality of general practice.

We rank:

best in the world for having a regular doctor who co-ordinates care
best in the world for patients knowing who to contact with questions about their condition or treatment
best in the world for the management of chronic care
In other words a respected, independent US thinktank has made it official: general practice is the jewel in the crown of our NHS.

A jewel we are proud of.

But more importantly a jewel we need to shine brightly because, as I will argue today, the strategic importance of general practice to the NHS cannot be overstated.

Within 5 years we will be looking after a million more over 70s. The number of people with 3 or more long term conditions is set to increase by 50% to nearly 3 million by 2018. By 2020 nearly 100,000 more people will need to be cared for at home.

Put simply, if we do not find better, smarter ways to help our growing elderly population remain healthy and independent our hospitals will be overwhelmed – which is why we need effective, strong and expanding general practice more than ever before in the history of the NHS.

The jewel in the crown?
But the jewel in the crown of the NHS is feeling decidedly unresplendent right now.

The uncomfortable truth is that even though 90% of all NHS contact takes place via GP consultations,

successive governments have undervalued, underinvested and undermined the vital role it has to play. Reforms, always well-intentioned at the time, have often had perverse and unintended consequences.

The 1990 contract imposition introduced more accountability but also started a process that felt to many like de-professionalisation. The 2004 GP contract was meant to increase the focus on prevention, but undermined the personal relationship with patients by scrapping named GPs. The Quality Outcomes Framework (QOF) was meant to provide a better focus on outcomes, but has too often ended up as a tick-box process. All of which suggests Ronald Reagan had a point when he said, "Governments tend not to solve problems, only to re-arrange them."

The result has been a profession where many GPs feel overwhelmed by demand and undervalued by the system, unable to give the comprehensive care they want to, and trapped on a daily hamster wheel of 10 minute appointments that lead inexorably to burnout, early retirement and unfilled vacancies.

That is why a month after the general election I am keeping my pledge to announce the first steps in a new deal for general practice.

Now deals have 2 parties, so I want to be upfront: this is not about change I can deliver on my own. If we are to have a new deal I will need your co-operation and support – both in improving the quality and continuity of care for vulnerable patients and delivering better access, 7 days a week, for everyone.

A new deal on workforce

How we achieve this is complex, and I do not pretend to have all the answers today. But I want to waste no time in making a start with some important elements.

Firstly and most urgently we need to deal with concerns about the primary care workforce.

Since 2010 the GP workforce has increased by 5% with an additional 1,700 GPs working or in training. But at the same time, because of an ageing population and changing consumer expectations, we have seen a massive increase in demand for GP appointments.

As a result, we are delivering an estimated 45 million more appointments every year compared to 5 years ago, but even this has not kept pace with demand. The number of people unable to get an appointment has been rising and public satisfaction with access to GPs is falling. People are simply finding it too hard to see their GP and GPs are finding it harder to give the kind of personal care that is the hallmark of their profession.

So at the election we committed to the challenging objective of increasing the primary and community care workforce by at least 10,000, including an estimated 5,000 more doctors working in general practice, as well as more practice nurses, district nurses, physicians' associates and pharmacists. This will be informed by the important work Professor Martin Roland is doing on workforce mix for Health Education England.

The national picture is not uniform, with wide variations from surgery to surgery in the number of GPs available per thousand of population. Even in my own parliamentary constituency, the availability varies between 0.32 and 1.32 GPs per thousand patients of population even with surgeries only a few miles apart.

We therefore need to focus our recruitment on the most under-doctored areas where the problems are most acute.

So today NHS England is publishing data about clinical staffing levels for every practice in the country. This is not a table of staffing needs, which will vary according to demographic and socio-economic profile. But it does indicate that even in areas with similar profiles the variation is unacceptably large.

Tackling this problem will be challenging, but I intend to leave no stone unturned. Quite simply, at every stage of a doctor's career we must do more to promote the attractiveness of general practice.

First we need to transform the experience which medical students have of general practice. We are changing the focus of medical training so that time spent in primary care is not only compulsory but also a better experience. As part of this, a new pre-GP scheme has been launched by Health Education England which, in its first year, had a success rate of 82%.

Secondly, we need to increase and fill our GP training places. They are going up from 2,600 to 3,250 annually and we are working with the Royal College of General Practitioners (RCGP) on a national marketing campaign to encourage medical students to choose general practice. This points out that general practice is likely to be the biggest growth area of the NHS in coming years with some of the most exciting transformations in care. This campaign started this year with an encouraging 300 more applicants attracted into recruitment as a result.

Next, by working with the profession we will improve routes back to general practice for experienced doctors. An induction and 'returner' scheme for those returning to the profession from overseas or from a career break has been refreshed and now includes support with the cost of returning to general practice. Over 50 GPs have already taken up this offer.

We will also explore with the BMA and RCGP new flexibilities to retain those precious GPs who are nearing retirement but may want to work part-time as they too have a critical role to play.

Innovation in the workforce skill mix will be vital too in order to make sure GPs are supported in their work by other practitioners. I have already announced pilots for new physicians' associates, but today I can announce those pilots are planned to ensure 1,000 physicians' associates will be available to work in general practice by September 2020.

Finally, as well as getting more new GPs, we need to make sure they go to parts of the country where they are most needed. Building on the success of a Health Education England pilot in the West Midlands, we will incentivise a number of newly qualified GPs with an extra year of training and support to develop specific skills needed in areas such as paediatrics, mental health and emergency medicine.

A new deal on infrastructure

Getting the workforce right is critical. But so too is dealing with the challenge of the buildings they work in.

Many of our primary care facilities are simply not fit for purpose. If we are to respond to ever changing and ever increasing demand, we need significant improvements in the quality of our physical infrastructure.

So last year we announced the £1 billion Primary Care Infrastructure Fund, spread over 4 years. Over 1,000 GP practices have now had bids provisionally approved for £190 million of investment in premises this year, backing exciting plans to expand services, house integrated services with community and pharmacy providers, and invest in digital innovation.

These include plans - for example - to allow 2 practices in Waltham Forest to co-locate into a new purpose-built surgery, offering a more comprehensive range of services to patients, including an elderly care facility and a falls clinic. Six practices in Solihull are building additional consulting rooms to increased access to primary care services for patients. While in Crawley, the Pavilions building is being redeveloped so the practice can provide a wider range of services and increased capacity for GP training.

Over the next 3 years we will allocate the rest of this fund to invest in further schemes so that over the course of the parliament cities and towns across the country will see visible signs of improvement in primary care facilities.

This investment will also support digital innovation, where GPs have led the way. Online patient access to summary medical records through primary care rose from 3% to a remarkable 98% over the last year. But we need digital, real time, interoperable electronic health records for the whole NHS, so we will help practices link their patient records to NHS secondary and community care providers and the social care sector.

A new deal on access with a 7 day NHS
While we need to improve workforce supply and infrastructure, we will not solve the problems we face by simply doing more of the same.

In particular, we need to address the issue of 7 day care.

The role and purpose of 7 day primary care is about much more than convenience – it is about making sure precious hospital capacity is kept clear for those who really need it. We have clear evidence from Imperial College London that a lack of access to GPs at weekends results in increases in urgent hospital admissions. As Professor Sir Bruce Keogh develops his new model for urgent and emergency care, we need to make sure general practice plays its part in improving access to routine appointments.

But new models of care should never be one size fits all, and while we must always respect the integrity and accountability through registered lists, different approaches will be appropriate in different parts of the country. Sam Everington says that 20 years ago his stethoscope was his most important device, now it's his iPad. With local flexibility, local knowledge and local clinical ownership comes the prospect of change that is as exciting for the profession as it is for patients - and we want GP partners to continue to be the leaders and innovators in this process.

We can learn from other countries that have made progress in this area, such as the 7 day networks that operate in New Zealand or Alberta, Canada. But important progress is being made here too through the Prime Minister's Challenge Fund. Through it, 18 million people will benefit from improved access, including at evenings and weekends, by March 2016.

This is about a flexible and balanced approach - not that every single surgery will be open in the evenings or at weekends. But at the Watford Care Alliance network of practices patients are offered evening or weekend appointments at their own or a nearby surgery, and for those who can't make it into a surgery an appointment by phone or online, where they see a GP who has full access to their medical record. Dr Mark Semler says, "The Challenge Fund initiatives have demonstrated that – properly implemented – technology has the power and potential to transform the way we do things in primary care. Telemedicine consultations are a powerful tool to assess patients at distance and save GPs large amounts of time."

Other practices are helping to deliver 7 day care by better use of pharmacies. In Brighton 16 GP practices are working with local pharmacies to create 4 'primary care clusters', offering evening and weekend appointments with a GP or pharmacist and giving the pharmacist equal access to GP records. Dr Jonathan Serjeant from Brighton said the pilot has been a "fantastic opportunity for practices to learn to work together…reaching out into their community to work with pharmacists to design, and provide care for people" and "help us understand how to offer more for people in more locations with a different skill mix."

So as we roll out the Prime Minister's Challenge Fund to the whole country, I can today announce that £7.5 million of the primary care infrastructure fund for this year will be used to support community pharmacists with training and appropriate tools.

These new ways of working offer great potential. But what won't work is a return to top-down direction from the Department of Health. Innovation cannot be imposed, it can only be embraced. So please play your part by getting into the driving seat as we move towards more multi-disciplinary working, imaginative use of technology, better coordination with other parts of the NHS and re-imagining roles through federations or responsibility for new integrated community services.

A new deal on assessing the quality of care provided
Additional workforce, £1 billion for infrastructure, support for new models of care - but there is another area where we need a new deal, and that's how we assess quality of care for patients provided in general practice.

Each of us here today, as professionals and as patients, want to see continuous improvement in the quality of care across the NHS. A cornerstone of that improvement must be having the right information to assess quality, conduct meaningful peer-review and support a true learning culture.

One of the founders of quality improvement techniques in health care, W Edwards Deming, said, "In God we trust, but all others must bring data." There has already been a lot of good work by different

groups on developing better data and metrics to assess quality in general practice.

But I have asked the Health Foundation to work with NHS England to do a stocktake of all current metrics, involving a range of stakeholders including NHS England, the CQC, the RCGP, BMA and representatives of patients and the public. This stocktake will review where we are now, and how we can collect and publish better outcomes-driven assessments of the quality of care for different patient groups. This will support the important progress made by Professor Steve Field in establishing the new CQC inspection regime but also address the concerns expressed by many about the shortcomings of some of the data being published.

The Health Foundation will provide an initial assessment for me in the autumn with the first new datasets based around key patient groups published next spring.

Intelligent transparency, though, must have intelligent consequences. One of those is a change in culture – from name and shame to learning and peer review, as championed by Professor Don Berwick in his work on improving safety in the NHS.

Another consequence needs to be much better support for practices identified as in difficulty. So I have today also asked NHS England to work with NHS Clinical Commissioners to develop a £10 million programme of support for struggling practices. This will include advice and turnaround support for the practice itself and help for the practice to work with others to change its business model.

Bureaucracy and burnout

The final area where we need a new deal is not about money or premises or workforce or assessments… but about you. I cannot change the growing numbers of older people who need your help. Nor can I change consumer expectations of healthcare provision that are much higher than 50 years ago. But I can do something about the bureaucracy, paperwork and inappropriate workload that takes up too much of your time and takes you away from patients.

I have already cut the Quality and Outcomes Framework by more than a third and have reduced the reporting requirements linked to enhanced services. But there is more to be done.

So I have asked NHS England to examine how we can reduce bureaucratic burdens on general practice to release more clinical time for patients. NHS England has already surveyed over 200 practice managers and GPs and will be running workshops to determine how to reduce the reporting burden, and will develop practical tools to help GPs better manage the mountain of bureaucracy and paperwork that leads to so much frustration and burnout. I have asked to see the results of that work this autumn.

Your side of the bargain

So plenty of commitments from me. But now perhaps the more tricky part: your side of the bargain.

I am prepared to commit money to this plan – more GPs, more community nurses, more money for infrastructure, help to reduce burnout. The vision for out of hospital care set out in the 'Five Year Forward View' requires more investment in primary care so this is the biggest opportunity for new investment in General Practice in a generation.

But in return I will need your help to deliver a profound change the quality of care we offer patients. Around a fifth of GPs' time is spent dealing with patients' social problems including debt, social isolation, housing, work, relationships and unemployment - yet 50% of GPs have no contact whatsoever with local social care providers.

So we need to empower general practice by breaking down the barriers with other sectors, whether social care, community care or mental health providers, so that social prescribing becomes as normal a part of your job as medical prescribing is today.

We need to empower general practice to deliver an even bigger role in public health. The NHS England 'Five Year Forward View' talks about prevention not cure - and if we are going to change lifestyle choices to improve health outcomes family doctors have a critical role to play.

And we need to empower general practice to take real clinical responsibility for your patients. The guidance being produced by the Academy of Medical Royal Colleges this year will help us understand what this really entails – but for patients it is really very simple: knowing where the buck stops for their NHS care.

Everybody needs to know where the buck stops for their care – and most people would like that to be their family doctor. I want to empower you so that aspiration – treasured by doctors as much as by patients – finally becomes a reality.

Jeremy Hunt

Secretary of State for Health and the Member of Parliament for South West Surrey

Quote:

“

A leader has a vision and conviction that a dream can be achieved. He inspires the power and energy to get it done

”

Ralph Lauren

10

Vision for Middleton and Tomorrows Nation

Does pumping more money into the health service address the current problems?

To answer this question there are a number of other issues that need addressing.

The NHS could be compared to a game of chess. There are the pawns, valuable local community services (pharmacist, opticians and dentist) and charities that have placed themselves in the front line, easily accessible to the public but not valued according to their true potential and have so far been allowed to make small moves around their localities with little power on the board. There is general practice that moves according to services required by government and local commissioners. Jumping around to address core contractual responsibilities balanced with other service requirements including local and national services that pay on hitting targets, this makes general practice the knight.

What many outside the NHS fails to understand is that most NHS GPs are paid £70-£100/patient/year. This fee is the total funding they receive to provide care to their registered population irrespective of the number of phone calls, clinic visits to the GP or any of their staff or number of home visits in a year. This fee necessitates each GP surgery to constantly seek additional NHS services they can deliver to keep their surgeries viable in the long term which means a lot of jumping in all directions. Another significant issue that has arisen in recent years is the balance of variation with the GP medical profession. There are 3 main types of GPs which are differentiated by their responsibilities to the GP surgery they work at:

Principal - A GP that is accountable to the NHS for delivery of the contract they hold to provide NHS services. Their payment is based on a number of variables from the number of patients on their surgery list to the variety of services they provide. There is no guaranteed income; their salary is dependant on how well they deliver services. Their contracted hours in most cases are 8am-6.30pm weekdays but as their salary is dependant on performance and not on hours worked most GPs work well in excess of the opening hours stated to ensure the work is completed.

Salaried - A GP that is employed by a Principal (or another non medical contract holder). Although they can deliver the same clinical services as a Principal they do not have a direct contractual responsibility to NHS commissioners but rather are accountable to their employer through their contract of employment. Salary and hours worked is stipulated by their contract of employment which is usually for long duration of time with a commitment in most cases to one employer.

Locum - A GP that has no fixed commitment to any one employer. They do not have any contractual responsibility to NHS commissioners but will be accountable to the surgery that is purchasing their services which in most cases will be on a short term basis. Locums may work for different employers moving from one surgery to another (sometimes on the same day) to ensure there are enough GPs to continue delivering the clinical services at the surgery. The locum’s salary is based on the number of clinics +/- visits they undertake for a surgery and may work for themselves or for an agency.

Locums have the greatest flexibility as they can decide when they wish to work and when not to.

The above incorporates the vast majority of GPs across the country. A decade ago newly qualified GPs aspired to become Principals who held an NHS contract and owned their GP surgery building or rented premises to deliver NHS services. Fewer newly qualified GPs took on an employee status and fewer still aspired to become locums. Over the past few years the landscape has changed. With the stress, bureaucracy and long hours associated with being a Principal many of the newly qualified GPs are aiming to become locums.

This provides more flexibility with a better quality of life for the individual. GP surgeries across the country are failing to recruit long term GPs (Principals and salaried) as new GPs opt to remain as locums which pays better than either of the other two posts. The long term risk is that without Principals the delivery of patient services will become a commodity delivered by the clock and not on delivery of services and targets irrespective of closing time. Although the government aspires to providing 5000 new GPs it takes 10 years to train a GP and at present there is no guarantees that those desiring to study medicine will come into the community or stay in hospital, what contractual model from the 3 above they will commit to if they embark on a life in general practice or even if they remain within the country following training or emigrate to the sunnier shores of Australia or Canada.

General practice has for over 60 years been the bedrock of the NHS providing over 90% of NHS consultations for less than 10% of the NHS budget but the tied is now changing. The future of general practice and the model it adopts has to now become the key government priority to ensure this country retains a NHS service with all the founding principals introduced by Nye Bevan in 1948 intact. Competition within the NHS, integration of services and promises of new services to the public all have different agendas but without a strong foundation of General Practice the NHS stands to be fragmented and end up compromising the service that the rest of the world admires.

Back to the game of chess:

The local acute hospital trust have played the role of the rook, estates which have been expensive to maintain (castle on the board) and had the potential to make substantial impact both within their organisation but also in the community. With the document Five Year Forward View the doorway has been opened through vertical integration for the rook to move right across the board into the community and run NHS GP surgeries, unfortunately in the same document there appears to be little power bestowed on community services including primary care to take over local hospital estates and services other than setting up competitive services in the community under the model of Any Qualified Provider (AQP) which would only be paid on the level of activity undertaken.

The bishop has to be the private sector who has integrated into the NHS services delivering a service that has delivered spiritual relief in assisting with access targets and moved across the board covering a variety of services from Primary Care to diagnostics and secondary care services but on reflection in some cases has cherry picked what has been delivered leaving the more complex cases to the local hospitals and services. So who holds the 2 most powerful positions on the board? The Secretary of State (SoS) has to be the queen (nothing personal!) able to move in any direction at any pace to influence and where necessary sacrifice both services and staff through health service commissioning and service reorganisations. The SoS is also empowered to protect the key piece on the board, the king. In this game of chess there can be only one individual that can hold this position, the one who if they fell would lead to the end of the game, the king has to be the general public. The whole board is geared to protect and deliver NHS services to ensure that patients are protected and cared for at their time of need. Unfortunately the NHS is much more complicated with many more rules than a game of chess and so far no grand master has emerged who has delivered the Holy Grail for the public that delivers what the politicians offer, that the public desire that the clinicians can deliver all within a finite ever decreasing NHS financial resource.

Within the NHS when considering various providers there are 4 themes or priorities that drives individuals when delivering their services (given that patient care is at the heart of each):

1. Survival - many smaller providers including many GPs go from day to day, putting more than 80hour weeks to keep the service alive and continue to provide local health services. Although priority needs to be to support and ensure survival of these smaller organisations (which patients cherish) there is now a drive to federate services to reduce running costs, release efficiency savings and improve access to services for the public.

2. Sustain a level of living - Many NHS staff continue within the service to ensure that their personal responsibilities can be fulfilled. Whether these are mortgages, loans, educational commitments for their children or to meet the needs of today's financial demands, the necessity to come day after day allows life to continue outside work.

3. Both of the above are genuine reasons that hard working staff will continue to partake in a service that is becoming more and more demanding and which many would say has lost its self satisfaction in undertaking the job they do. The following 2 reasons are ones that may change the way in which future care is provided:

4. Profit - organisations as businesses make profit to provide long term stability and invest in expanding their services. The NHS specifies the fee for a service and therefore any efficiencies within an organisation that releases funding above the running cost is an opportunity to retain a viable business. Over the past year there has been the emergence of a new type of business, one that is willing to either run the back office for a number of GP practices or actually take over the NHS GP contracts for a number of surgeries. Over more recent times there has been the emergence of individual GPs, the "corporate GP" who aspires to take over as many GP NHS contracts with a primary management role rather than a clinical role. In practice there are efficiencies in these models from centralising back office function to providing contingency planning across neighbouring organisations under the same business. With recent large businesses collapsing there needs to be reassurance for the NHS that large models of care have the resilience to adapt to ongoing changes which can vary significantly from region to region. Unlike private business the collapse of a large NHS GP contract that provides primary care services to tens if not hundreds of thousands of patients means a necessity for commissioners to seek additional reassurance. The collapse of one GP practice could be absorbed with additional resource locally but for a number of surgeries under one contract could create serious issues for all NHS services in the locality from A&E to out of hour's services. The availability of community diagnostics and clinical services by groups of NHS hospital specialist who have formed "chambers" outside their NHS contracts

has improved access to services and brought services closer to the patient's home. The next steps could be the collaboration of NHS GPs with hospital specialist and community providers to create legal entities that provide cradle to grave services across the NHS spectrum, something that the Five Year Forward Review may be alluding to. All the above points to the possibility of the traditional GP model of qualifying and committing to a single GP surgery for life and embarking on a career as a vocation seems to be developing large cracks. Although the vast majority of GPs today still commit to the traditional GP model the newer generation of GPs do appear to have a different mindset in what they would like to get out of their profession. With an ageing population and increase in number of patients with long term health conditions it may be that this is a natural evolution of the role of GPs to meet the demands of tomorrow's NHS requirements.

5. Power or Empire Building - the NHS is one organisation and should remain so. Historically local acute hospital services have acted like black holes in absorbing the vast majority of NHS resource within a locality. Primary care clinicians over many years have been aware of the difficulty for various commissioners to withdraw funding from this sector. The influence and power through annual contract negotiations has transferred large sums of money with little hope of withdrawing funds to reinvest in primary and community services. When PCT's split their commissioning role from provider role many Foundation Trust took over community staff to assist PCT's in fulfilling their requirements. Now with opportunities for vertical integration where hospitals can run community GP practices and hospitals already employing GPs within A&E departments there is cause for concern around the potential monopoly that will result in one organisation providing primary, community and secondary care services in the same locality. This in the long term will create issues with commissioners if one organisation delivers all NHS provider services.

Although the above may seem unlikely, when the aspirations of the Five Year Forward View is considered the above becomes a lot more likely.

Taking all the above into consideration what needs to be done?

It does appear that our game of chess is not as straight forward as may be perceived. Through devolution influence on the board can be obtained with greater control on how services are delivered but with it comes the grave responsibility to be able to sacrifice services or impose sanctions on how services are delivered if the efficiency savings required to keep the NHS alive are achieved.

At a local level the following questions need to be explored if today's services are to fit in line with government aspirations and remain fit for purpose to deliver public needs and demands:

1. Existing GP Surgeries: Moving forward how will the GP surgeries in Middleton engage with each other? Will they:

- Continue to function as totally separate entities with their own back office functions?
- Continue to develop on the beginning of what could be a federated model of working where common aspirations are shared and developed with an opportunity to share back office functions in the future? This could be extended to a locality based prescribing formulary and centralised secretarial services to ensure a single referral gateway which would allow consistency in referral pathways adopted. An alternative to centralising secretarial services is to ensure regular training for all existing secretaries across the GP surgeries as a group which would bring common practice and procedures with iCloud technology mentioned previously which would create a virtual secretarial pool. This model also allows neighbouring practices to sub specialise and deliver services for non registered patients through locally negotiated contracts providing more services closer to home. This model is likely to receive the greatest support as is it allows collaboration amongst surgeries but still retain individual autonomy. Through the demonstrator the opportunity for individual surgeries to engage and support the project has lead to a more clearer understanding of each other's issues and allowed an opportunity to support each other from sharing of ideas to financial support through the demonstrator to ensure all GP practices migrated onto the same clinical software and installed a variety of technologies that would lay the foundations of federated working.
- Explore the possibility of a single GP contract across Middleton: Although likely to receive the most objections as it would erode individual practice autonomy, the workforce and services commissioned are changing and this needs to remain on the table as an option to consider in the future. This would replace the current 8 NHS contracts which vary with registered patient populations from 2-10,000 patients with one contract that would cater for the needs of almost 50,000 patients. The fear of impositions and loss of autonomy would be the greatest barriers to adopting this model.

2. How will the GP surgeries engage with the other community service providers?

This demonstrator has shown that various community providers can work in collaboration. With so many different models of organisations from national providers to local small businesses embarking on the possibility of creating a single legal entity is a "bridge too far" but the formation of federated model with a Memorandum of Understanding (MoU) is possible today. There needs to be key leadership drivers identified who will work and engage with the different professions both in and outside the health arena.

3. The role of the Local Authority?

AGMA (Association of Greater Manchester Associations) will provide a direction of travel through the devoManc group. This would be complemented with a local flavor from Rochdale Local Authority. Working in partnership has to be the key to successfully addressing the needs of the community within a finite depleting financial resource.

4. Community services including police, transport and housing?

All central key players in the new vision. Can the local Police Community Support Officers (PCSO) work in partnership with general practice to share knowledge on local vulnerable members of the community? Could PCSO drop in on the frail elderly in the community that GPs have concerns about but not be able to attend on a daily basis? Highlighting concerns at an early stage will allow early implementation of therapy and reduce the need for hospital admissions but also reduce impact on local social care services. Could key messages on housing and employment be shared with the

community in GP waiting rooms and other healthcare venues and in return can key healthcare messages be promoted through various government offices.

5. Role of schools and colleges?

Mentioned further in this report but the needs of the younger population need addressing today but also their role in tomorrow's nation needs to be supported. They will be the providers of tomorrow's health and social care system as well as users of the various services. Schools and colleges need to engage with and be part of an evolution that meets the needs of all members of a society.

To answer the initial question posed of whether pumping more money into the NHS will address the current problems the answer is NO. There is no doubt that funding into the NHS needs to be improved but there also needs to be a review of systems, mindsets, technology and both staff and public engagement to ensure what is invested is used efficiently. Long term the health service is unlikely to be able to continue investing increasing amounts of funding into the system and therefore new ways of working which maximises the resource invested needs to be explored.

All the above is based on individual views and observations in a changing system. There will be alternates that are more transparent to those working in different organisations. An opportunity to allow those that work "on the shop floor" to create tomorrow's system needs to be created which allows anonymity where required yet share their views without the fear of any reprisal if a truly functional collaborative care system is to be developed across the different agencies.

Middleton is on the brink of many new opportunities. The demonstrator has allowed a variety of hardware to be installed as mentioned above and MiDHaS.uk will provide new access to health and social care support. The collaboration between practices has revealed a desire to work together and look for opportunities that provide economies of scale and improve access to services for the local public.

New opportunities to explore include collaboration of all the practice managers across Middleton to review and replace any out dated policies and following a recent meeting to commission Drop Box or purchase an s-drive to allow all policies including CQC policies on a central server. This has the benefit of only requiring one update when a policy changes rather than across 8 surgeries. Along side this there is a view that the secretaries across the township can with additional training become the gate keepers of all referrals created by the clinicians. It's not uncommon when making a referral today to be advised by the secretary of the existence of policies which require additional assessments, examinations or investigations before the gateway accepts the referral. In today's general practice there can be a high turnover of trainee GPs as well as locums who are unfamiliar with the locality referral guidelines yet need to refer.

This will also apply to doctors undertaking evening and weekend shifts in the demonstrator project. Ensuring that all the secretaries are familiar with the referral pathways and guidelines will ensure that referrals are appropriately dictated and typed causing minimum disruption to the referral process.

At a locality level there is potential to explore the opportunity to gain cost efficiencies in back office functions as well as bulk purchasing which has been achieved by a variety groups across the country.

A recent introduction to elevate the quality of services provided by GP practices within the borough is Primary Care Quality Standards. Commissioned by the CCG this local project has 3 levels ranging from surgery opening times to ensuring local screening processes are taken up by the local population to providing both female and male clinicians at every GP surgery. Half day work shop highlighted many new opportunities to progress federated working across the 8 GP surgeries.

So what else can we do?

When exploring the future of devoManc the future of Middleton needs to ensure that the GP surgeries continue to develop collaborative working with other community services but also start establishing locality working with the council, charities, local neighbourhood police officers, housing agencies, unemployment office and private businesses. The future lies beyond either a GP surgery or even a federation of practices, the future lies in multiagency working which results in simplification of existing patient pathways, more effective use of financial resource and partnership working amongst the different agencies. The Holy Grail eventually would be centralised records which contains different sections related to different agency all in one electronic file. There will be a central role for the local public to discuss and promote which services can and cannot be made available in a time that seeks efficiency savings as well as how to disseminate community messages.

Frequently adults establish which services are required and proceed to implement a variety of methods to highlight and deliver the service. One of the most difficult groups to engage with are the teenagers. Also tomorrow's health system will belong to today's teenagers and yet they so far have no input into what they can inherit. To facilitate this process Dr Mo Jiva wrote to local schools in a bid to explore the potential interest in a new project.

The first school to express interest was Bolton Girls School. The proposal is for the existing healthcare system to be presented to a small cohort of students who have an interest in healthcare and may have plans to apply to study medicine or one of the allied health professions in the future. Over a period of time by providing additional insight the vision is that the students will share their views or what a future healthcare system would look like but as importantly how the existing healthcare providers can engage with this target audience.

Dear Dr Jiva

Following our meeting, I hope that the following words will be useful to you.

'As Headmistress of a large girls' school in the North West of England, I have read with interest the proposals put forward by the Middleton 'demonstrator' site for supporting the Primary Care Strategy in Greater Manchester. From my work with the girls at Bolton School, it is clear that there are particular areas in which young people would benefit from changes to the way in which Healthcare is provided. Mental Health issues among the young in particular are a concern for all professionals in the education sector as we see how girls (and boys) can be adversely affected by the society around them. Given that young people's access to the wider world through social media sites is now 24/7, the extent to which they are influenced by images (often enhanced and unrealistic) of others' bodies, faces and lives has grown enormously. The pressure on them to conform to such images is potentially harmful, as is their 'FOMO' or 'fear of missing out'.

At the same time, the ease with which others can contact them, including those with malicious intent, has increased and those young people who are vulnerable to unkind words from others can fall prey to the thoughtlessness of those around them. At Bolton School Girls' Division, we try to provide resources to support our young people, such as a fully qualified medical nursing staff and a Counsellor from the organisation 'Relate', but we know that we can only plug gaps and that the real work is done by CAMHS and other NHS providers. Any way in which the school population's access to health services can be improved would be welcomed by educators.

On the other hand, the benefits of technology can also be a boon to provision for young people. Vlogs and blogs are an ideal way of connecting with them and ensuring that they have up to date information about the issues which concern them. Similarly, the students at my School, as at many others I have known, are very willing to help those less fortunate than themselves and the older girls are very supportive of the younger ones. Positive communication with these young people will go a long way to ensuring that 'peer pressure' is a positive and not a negative force for change. Many of the girls at my School are keen to join the medical professions themselves, motivated by a desire to give back to the community and to care for others. If we can educate them from an early age in how best to do this, we shall be channelling all that youthful energy and enthusiasm have to offer.

Sue Hincks, MA (Oxon)
Headmistress, Bolton School Girls' Division

Case Study:

"I struggle to find someone who will help me with my depression. I get a few counseling sessions for my condition and then get told I'll need to be referred back by my GP because I can only have 8 sessions. I then gradually get worse and attend A&E where I get no help"

MW - Age 28

Summary

Demonstrator Pilots were sensibly established by Greater Manchester Area Team because Healthcare is constantly changing and often bedevilled by unintended and unforeseen consequences. Trialing change on a small scale and expanding after evaluation is a well established and efficient practice now in Primary Care. This is necessary because patient behaviours and sometimes clinician behaviour can be unpredictable at best. We feel that the delivery of healthcare in the township of Middleton has and will continue to benefit for the establishment of the Demonstrator Pilot.

The Pilot has developed on already good working relationships between Middleton practices and upon the innovation of Heywood Middleton and Rochdale CCG. We have benefitted from effective partnership with our local Out of Hours (OOH) provider, BARDOC, who have worked hard to adapt some of their core working practices to meet the needs of the Demonstrator. We have had numerous discussions with a multiplicity of provider organisations and companies, NHS and private. With some there has been synchronicity and benefit and with others increased understanding and awareness, hopefully mutual.

The Middleton Pilot has demonstrated that General Practice has the potential flexibility to implement change rapidly and effectively evolving by evaluation. We have demonstrated the ability to develop new ways of working as well as revisited old and abandoned practices with new insights. We have implemented extended hours and weekend working, whilst applying new and innovative technologies The demonstrator has shown it is possible to change Practice and clinician behaviour in the hope that patient behaviour may also be altered to meet the needs of a modern NHS. Most behavioural studies show that changing patient behaviour is not easy or quick and that transformational change is not possible without altering both patient and professional mindsets. The Demonstrator has made a start, with local advertising, see examples in the report, and engagement such as Tea Dances and canvassing teenage opinion.

Mental Health remains forever the bridesmaid despite the recent YouGov and Mental Health Foundation polls showing that 29% of people suffer from stress, 24% from anxiety and 17% from depression. Depression anxiety and stress remain the most frequent causes for issuance of a Med3 certificate (sick notes) and the numbers of productive days lost per year for these reasons has to be astronomical. Depressed people lack the motivation to complain and sickness benefit payments don't impinge on the health budget so no need to worry. The current panacea is to teach patients 'mindfulness' and can conveniently be taught in groups and on line. Whilst this is useful for stress and anxiety, where depression is a feature it has considerably less value. Mindfulness is a coping mechanism for the motivated not a solution to the problem. That the Demonstrator Pilot has been extended in HMR CCG for the routine medical element but not the mental health clinics tells its own story.

The Community ward scheme is underway and will provide support, reassurance and information to the most vulnerable patients in Middleton. Often housebound with multiple morbidities they are frequent attenders at A&E often requiring admission for a combination of medical and social reasons. There is already some evidence that educating them about OOH provision alone is causing a reduction in their hospital admissions.

We think that the current phraseology 'moving patients care out of hospital' is suggestive of the wrong direction of travel. As we have explained in the report the Middleton Demonstrator Pilot has experienced its greatest difficulties enacting change for patients already under the care of other organisations. Where we have been more successful is in preventing the need for patients to access other health care facilities. We would suggest that the bulk of the funding promised by the government in the NHS Forward View should be spent preventatively in Primary Care rather than reactively in hospital and residential care.

Dr Fred Thomason
Joint Clinical Lead Middleton Demonstrator

Quote:

“

That’s been one of my mantras – focus and simplicity. Simple can be harder than complex. You have to work hard to get your thinking clean to make it simple. But it’s worth it in the end because once you get there, you can move mountains

”

Steve Jobs

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Appendix

Feedback from pharmacist training

The completed feedback forms below are from the pharmacists who undertook the 2 day training programme developed and delivered by the local GP trainers.

Up Skilling Pharmacists

Thank you for attending we would like your feedback please

This session . . .	1 Not at all	2 Slightly	3 Quite a Bit	4 Greatly
Improved my communication skills			✓	
Improved my knowledge on skin conditions				✓
Improved my knowledge on women's health				✓
Improved my knowledge on child hood conditions				✓
Content relevant to my needs				✓
Helped me identify future learning needs			✓	
TOTAL SCORE (add individual grades)				

How could we improve the session/anything that you would hope to be included next week in addition to planned topics?

What did you find useful?

Childhood diseases was good. Slides of photos really helped diagnose the condition.

Any other comments?

Up Skilling Pharmacists

Thank you for attending we would like your feedback please

This session . . .	1 Not at all	2 Slightly	3 Quite a Bit	4 Greatly
Improved my communication skills			✓	
Improved my knowledge on skin conditions			✓	
Improved my knowledge on women's health		✓		
Improved my knowledge on child hood conditions			✓	
Content relevant to my needs				✓
Helped me identify future learning needs			✓	
TOTAL SCORE (add individual grades)			18	

How could we improve the session/anything that you would hope to be included next week in addition to planned topics?

What did you find useful?

- Extra points on certain conditions - eg pulsed itchy we often missed by the others

Any other comments?

Very enjoyable session

Up Skilling Pharmacists

Thank you for attending we would like your feedback please

This session . . .	1 Not at all	2 Slightly	3 Quite a Bit	4 Greatly
Improved my communication skills				✓
Improved my knowledge on skin conditions				✓
Improved my knowledge on women's health			✓	
Improved my knowledge on child hood conditions				✓
Content relevant to my needs				✓
Helped me identify future learning needs				✓
TOTAL SCORE (add individual grades)	Correct		23	

How could we improve the session/anything that you would hope to be included next week in addition to planned topics?

Nothing to improve - This is a great set up as it

What did you find useful?

Very informative and extremely helpful.

Any other comments?

Up Skilling Pharmacists

Thank you for attending we would like your feedback please

This session . . .	1 Not at all	2 Slightly	3 Quite a Bit	4 Greatly
Improved my communication skills				✓
Improved my knowledge on gastroenterology conditions			✓	
Improved my knowledge on Respiratory conditions			✓	
Improved my knowledge on central nervous system conditions				✓
Improved my knowledge on eyes, ears and oral health conditions			✓	
Content relevant to my needs				✓
Helped me identify future learning needs				✓
TOTAL SCORE (add individual grades)			25	

How could we improve the session/anything that you would hope to be included next week in addition to planned topics?

What did you find useful?

Very informative + very helpful!

Any other comments?

Up Skilling Pharmacists

Thank you for attending we would like your feedback please

This session . . .	1 Not at all	2 Slightly	3 Quite a Bit	4 Greatly
Improved my communication skills			✓	
Improved my knowledge on gastroenterology conditions			✓	
Improved my knowledge on Respiratory conditions			✓	
Improved my knowledge on central nervous system conditions			✓	
Improved my knowledge on eyes, ears and oral health conditions			✓	
Content relevant to my needs			✓	
Helped me identify future learning needs			✓	
TOTAL SCORE (add individual grades)			17	

How could we improve the session/anything that you would hope to be included next week in addition to planned topics?

What did you find useful?

Role plays.

Any other comments?

Good overall

Up Skilling Pharmacists

Thank you for attending we would like your feedback please

This session . . .	1 Not at all	2 Slightly	3 Quite a Bit	4 Greatly
Improved my communication skills		✓		
Improved my knowledge on gastroenterology conditions		✓		
Improved my knowledge on Respiratory conditions		✓		
Improved my knowledge on central nervous system conditions		✓		
Improved my knowledge on eyes, ears and oral health conditions			✓	
Content relevant to my needs				✓
Helped me identify future learning needs		✓		
TOTAL SCORE (add individual grades)		17		

How could we improve the session/anything that you would hope to be included next week in addition to planned topics?

N/A

What did you find useful?

Eyes, Referral Points

Any other comments?

Very kind

Service users (patient) feedback

The following comments below where received from patients who completed satisfaction questionnaires:

January 2014:

- Fast appointment excellent service and excellent Doctor
- Very thorough efficient service, best service we have ever had
- Very friendly and helpful
- Really surprised to hear about this and glad to be able to get an appointment when needed instead
- of the usual wait for a workers appointment, hope it gets used enough to warrant a full service
- It's a really good service for somebody who has to work late
- Brilliant service hope it continues
- Very handy having this service close to home hope it continues
- Very grateful for this service, it needs to continue
- Excellent for anyone who works, I would be delighted if this could be available all the time
- Very pleased with the service as I was unable to get in with my own Doctors and needed to be seen quickly
- Great service to have especially with Walk in Centre always full and not being able to get an
- appointment with my own GP

September 2014

- Out of hours, excellent service for me as I work shifts
- Very helpful to have an evening appointment as I work full time
- Good all round service
- Better than my own Doctors
- Good friendly manner would come again
- Very satisfied with the service
- Was not aware of service until today when attempting to make appointment with my GP
- Fast efficient service
- Very good and professional care
- Really happy with the service, great that people who can access service at night really pleased I was able to see a Doctor on the same day.
- Today was excellent
- Fast and efficient just what Middleton needs
- Convenient I would lose income if I had to take time off work

Service provider report

Sometimes there is a reluctance and even a fear for general practices to work together, Middleton Demonstrator has shown that by working together we can:

Develop new services - 7 day access
Engage patients – Tea dances etc
Provide new equipment and training for practices – Spirometers, customer service training
Work together collaboratively – All practices now on EMIS Web
Educate and inform our patients – Intranet, tea dance etc
Develop new and innovative ways of working – web based consultations & meetings, EMIS via ipads

I personally believe that patient education is the key to help us deal with the huge demands we are experiencing across all sectors of health provision. I am personally very excited by the work that Middleton Demonstrator has done regarding developing the Intranet for us and more importantly our patients. Having one point of access for the local directory of services and proving the myriad of informative videos will be an extremely valuable tool to help educate and inform our patients.

This is an exciting and very challenging time for general practice; the demand for our time and resources is almost unsustainable. We have to find ways of working smarter and by working together we can share resources and skills which can only benefit our patients. Locally Middleton Demonstrator has shown us the way forward.

Steve Elsworth
Practice Manager, Durnford Medical Centre
CCG PM Lead

Service administrator report

I have been working for the Middleton Demonstrator Bid in a dual capacity since December 2013.

I have been responsible for the upkeep of the diary, creating appointments and cancelling appointments on the Care Diary and I have also been employed by BARDOC as a receptionist to cover shifts at the Middleton Hub.

The Care Diary has been easy to manage and use by all GP surgeries providing much needed additional Drs appointments when GP practices have been full to capacity. It has also been able to offer convenient appointments for patients who are unable to attend daytime surgeries due to work commitments and saves them the inconvenience of having to take a day's annual leave to visit the GP.

During the pilot I have carried out two patient surveys, January 2014 and September 2014.

January results stated 93% would be extremely likely to recommend the service to family and friends with 84% listing their overall experience as excellent.

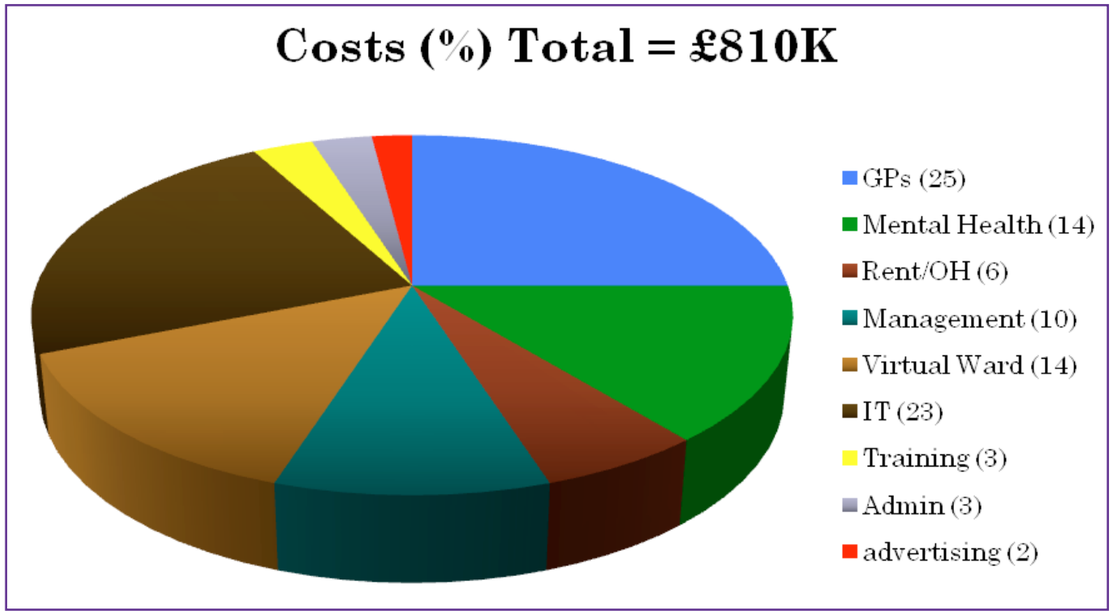
In September 67 % were extremely likely to recommend and 28% likely. 69% listed their overall experience as excellent and 21% as very good.
As I have been able to see the Diary work 1st hand I have been able to see how much there has been a need for evening appointments, and how thankful patients have been for the service being offered.

There are many lessons learnt from the Pilot, as BARDOC have been responsible for providing the service we have sometimes had occasions of Drs not turning up, or turning up late, staff cancelling shifts and BARDOC not checking the shifts are covered till last minute. As the majority of the Drs covering the pilot have been employed by BARDOC as locums, its difficult to get individual feed back on each patient experience with each covering Dr.

It's been a shame that A&E failed to engage in the service, how many of A&E attendances could have been deflected is unknown. I also feel BARDOC could have taken a more active role in signposting the service to patients who have called 111 over the weekends. It would be interesting to know how many OOH calls could have been seen in the weekend clinics.

Miss Julie Dowling
Middleton Demonstrator Administrator

Project finances



Subject	Description (duration 18 months)
GPS	Cost of GPs and reception staff for evening and weekend surgeries
Advertising	Cost of designing marketing material, printing and media costs
Rent / OH	Cost of renting venues for training and meetings as well as cost of overheads (OH) for delivering clinics from a community GP surgery
Mental Health	Costs of mental health workers plus medical cover
Management	Costs of managing all the different elements of the demonstrator including locums for backfill
Admin	Costs of back office administration
Training	Costs of training for community staff and GP surgeries
IT	Costs of commissioning different software, migration to EMIS Web, purchase of hardware and software for surgeries
Virtual Ward	Fund allocated to delivery of the virtual ward project

Project activity levels

Time frame: 74 weeks over 2013-15, weekday evening and weekend clinics

Capacity available over the 74 weeks: n=7224 appointments

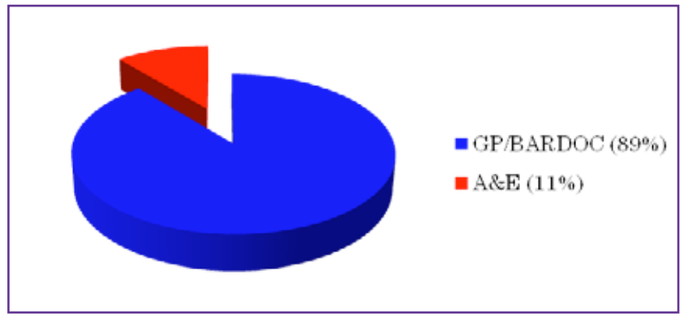


Figure 37

Capacity utilised over the 74 weeks: n = 3371 appointments

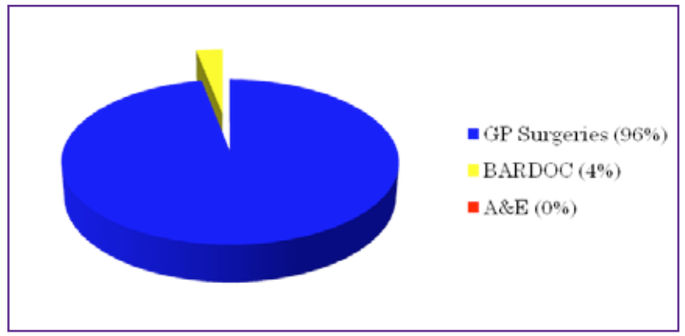


Figure 38

Weekend capacity: n=2072

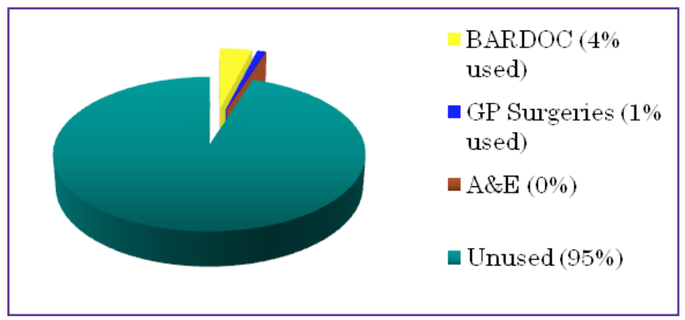


Figure 39

Capacity utilised over weekdays: n=5152

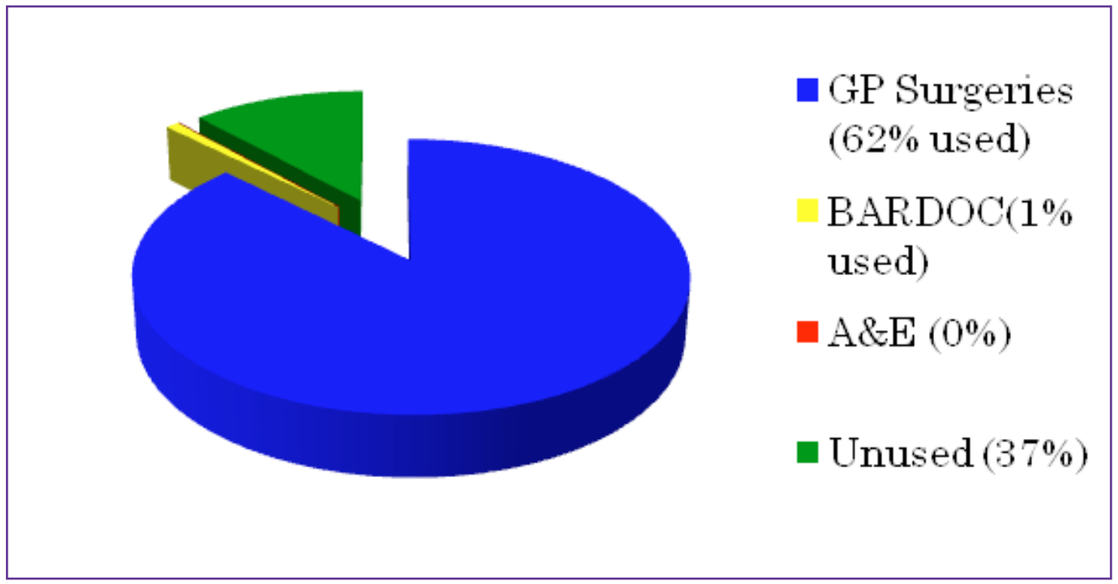


Figure 40

The above charts reflect activity and unused capacity as close as the demonstrator can provide in what was an evolving model. The lack of A&E referrals into the surgeries is accurate but with BARDOC as various internal and external issues were addressed over the time line the activity into the clinics started to improve but still remained significantly less than expected leaving the vast majority of weekend clinics empty.

On reflection although BARDOC has access to the DISHI Diary to book patients into the clinics at the weekend the lack of utilisation of capacity could have been explored in a walk in activity model or having a direct operational phone line at the surgery rather than having to ring the main Out of Hours call centre.

During the week and weekend it is possible that activity levels for BARDOC utilisation may have been higher as the call handlers were using ADASTRA as well to record appointments and in these cases it is possible they may have omitted to record the appointment into the DISHI Diary causing difficulties in producing truly accurate activity levels but the above charts are as close to what the demonstrator team can provide from the statistics available.

Activity levels from Q4 2013/14 to Q4 2014/15

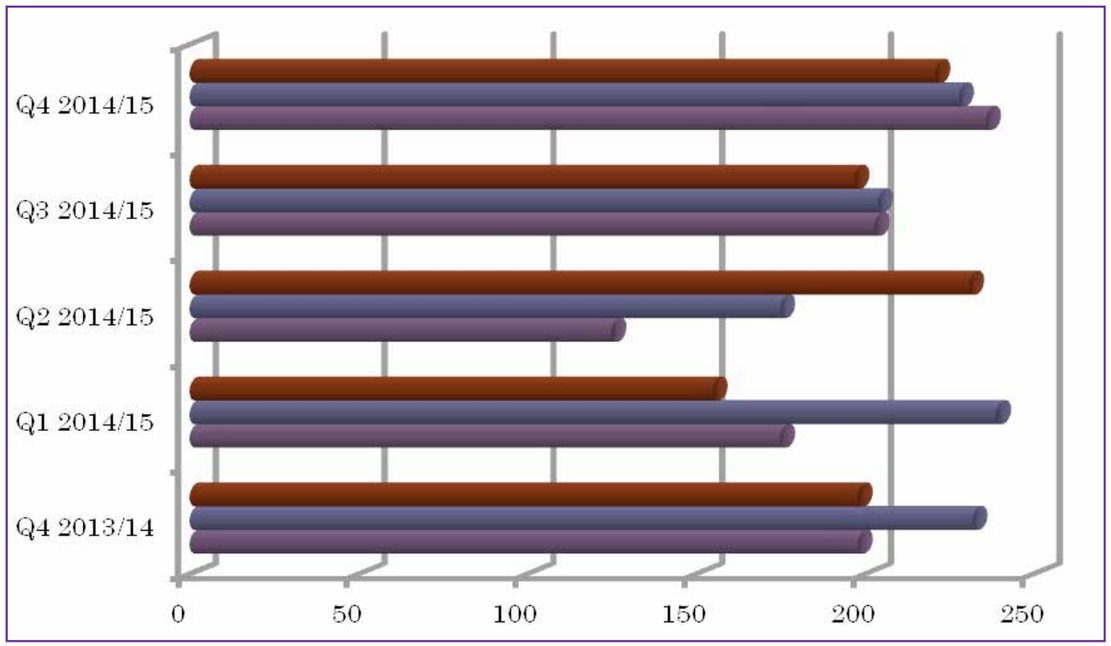


Figure 41

The pie charts above show the capacity utilised within the evening and weekend GP surgeries. The above bar chart (Figure) shows the number of appointments from January 2013 to March 2015. Although the demonstrator at the beginning of the project offered 3 surgeries each day on Saturday and Sunday, this was gradually reduced to 2 surgeries per day followed by one surgery each weekend evening.

The activity levels per month are mainly from activity generated from weekday evening surgeries. The chart shows that both Q4 in 2013/14 and 2014/15 have the expected high demand following the Christmas period as the project is in the middle of winter. Also the chart reveals that over the same period there has been a gradual increase in uptake of appointments which may be due to both confidence of patients and GP surgeries in using the service.

Prolonged delivery of this service may eventually reduce the distinction between in hours and out of hours in the eyes of the public as long as the same quality of service can be offered throughout the period.

Application to become Vanguard Site

As part of the new models of care in the Five Year Forward View, the demonstrator applied to become a Multi Specialty Provider (MSP) to build on the work already described in this report.

Unfortunately the demonstrator was unsuccessful possibly due to the relevant small population size. Many CCGs where approved to further explore new models of care which does now bring into question the role of these organisations as to whether are embarking back on developing provider models. The feedback received was positive and stated:

‘The level of interest in the programme amounted to the team receiving 269 expressions of interest with only 29 sites being taken forward to be a Vanguard site.

In the Five Year Forward View we recognise that every health and care economy in the country has been delivering improvements over the past years but we now need to implement change on a scale that we have not seen before.

Health economies that were judged to be more suitable to enter the first cohort of Vanguard sites used their application to highlight a strong and powerful vision to move away from incremental improvements and describe ambitious changes to the way care is provided in their community. It was felt that your application articulated a very strong vision for change that was appropriate for your local arena and we strongly encourage you to continue along the path that you articulated in your application.

Throughout your application it was clear that you had clearly articulated what you wanted to achieve by becoming a Vanguard. Despite not being successful in your application to become an initial Vanguard site we believe that you submitted a very strong application and were impressed with its overall clarity and ambition. Therefore, we would strongly encourage you continue on your current direction of travel to ensure that you deliver a new care model for the population that you serve, taking into account the initial learning’s from the first wave of Vanguard sites.”

Samantha Jones
Director – New Care Models

Your Ideas:

Middleton demonstrator has shared our pilot and our thoughts on various clinical and political issues. Here are a couple of pages to write down your ideas, what are you going to do to improve the health and welfare of your locality?

Your Ideas:

Contact details

Comments within this report are based on observations through running the Middleton Demonstrator over a period of 18months. In writing this report it is recognised that different parts of the country deal with healthcare in a variety of different ways using manpower, estates and technology to achieve varying levels of success.

There may be elements of this report that support or antagonise personal viewpoints of individuals but it has been written in an open and transparent fashion to ensure any lessons learnt can be shared with the wider community.

Finally, a big thanks needs to go out to the surgery staff from the GP practices in Middleton. They have supported the demonstrator in developing this model to attending on Sunday's to support the delivery of community Tea Dances (for free!!). Without the dedication and enthusiasm of the GP staff in Middleton much of the above learnt would not have been possible and neither would the development of a like-minded approach to federated working be possible without their engagement.

As the clock has started on many of the above innovations, the demonstrator may have a "Big Blue Book" in the making for 2016 to share the results of some of the work that has commenced and will commence later this year.

Dr Mo Jiva MBE
Peterloo Medical Centre
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Middleton. M24 4DZ

mohammed.jiva@nhs.net

In 2013, 8 GP surgeries in Middleton successfully bid for new monies to explore 7 day GP services as well as new innovation to support delivery of healthcare services.

This book written by the clinical lead for the demonstrator reveals the opportunities and obstacles experienced over a 18month period across various sectors from Primary Care to Community and Secondary Care.

There is nothing held back in sharing how the locality delivered on various targets and with input from a variety of other leaders, this book provides food for thought for those who want to explore the boundaries of healthcare.

The Author

Dr Mo Jiva qualified in 1994 from Liverpool University. Having undertaken his house job at the Royal Liverpool University Hospital he moved to Bury to undertake 3years of Vocational Training to embark on a career in General Practice. In 2000 Dr Jiva joined Peterloo Medical Centre as a partner where he has remained in full time general practice for the past 15 years.

During this time he has held other positions including Medical Director, Clinical Governance Lead and national medical advisor to Sainsbury's plc. He currently holds a position of Chief Executive Officer of Rochdale and Bury Local Medical Committee and Clinical Lead of Middleton Demonstrator. In 2014 Dr Mo Jiva was honoured with a MBE for services to General Practice.

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The **Big Purple** Book