Together We're Better: Local Initiative Case Studies

Cannock; Improving Patient Access

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1. Background

This report is one of a suite of case studies developed by The Strategy Unit, in partnership with ICF, on behalf of the Staffordshire and Stoke-on-Trent STP, Together We're Better. The commission was to produce nine descriptive case studies on local, early implementer initiatives that deliver the STP objectives and are intended for wider roll out if deemed successful.

The nine initiatives identified were:

- Stafford Town; Enhanced Care in Care Homes
- Primary Care Integration with North Staffordshire Combined NHS Trust
- Cannock; Improving Patient Access
- Leek; Nursing Home MDT
- Rugeley Network; Partnership Working with Midlands Partnership NHS Foundation Trust
- Meir Locality Care Partnership
- Lichfield; Nursing Home Support
- The Stepping Up Programme
- The Winter Plan Escalation Tool

The case studies were developed following document reviews, site visits and interviews with project leads between March and June 2019.

The purpose of the case studies is to raise collective awareness of these projects and to build a shared understanding of their potential impacts across the STP. Each of the case studies covers the project context, design, activities, outcomes, key successes and lessons learned so far.

2. Cannock; Improving Patient Access

2.1 Project Context

Key information	**Cannock Practices Network:** • 11 practices across Cannock Town[1] • Patient population at the time of the project- 46,705 **Cannock Chase Clinical Alliance** • 24 practices across Cannock Chase • Covering three Practice Networks

In 2014, the Cannock Chase Primary Care Strategy[2] set out Cannock Chase Clinical Commissioning Group's (CCG) approach to developing three locality-based general practice networks: the Cannock Practices Network (covering Cannock Town); Rugeley Network (covering Rugeley practices); and the Villages Network, (practices in the villages surrounding Cannock).

The Strategy identified a range of challenges for practices that it intended for the networks to address, **including making primary care more accessible**. Whilst the national GP Patient Survey reported higher levels of satisfaction in Cannock than the national average, local feedback indicated continued difficulties with getting appointments. There was also an acknowledgment that, **historically, the practices worked in isolation and there was a need for a much more collaborative approach**, to find shared solutions to collective challenges.

Working with the CCG, **the Cannock Practices Network ("the Network")**, which originally consisted of ten practices, identified several issues for the local health and care system that it aimed to address. These included: the difficulties in meeting demand for practice appointments and the related system effects in demand on A&E and the Minor Injuries Unit (MIU) in Cannock Hospital. The 2014 Strategy for example, reported that 40% of patients attending the MIU had needs that would have been more appropriately managed by their GP.

Following a successful bid for £321,000 from the Prime Minister's Challenge Fund, **the Network set up the Improving Patient Access project**. This involved establishing **a central hub** – the Cannock Practices Network Surgery – **offering patients across the Network extended access to appointments**. The Project Team who were responsible for submitting the initial funding application, as well as setup and delivery, consisted of two Practice Managers and an Assistant Practice Manager from two of the Network practices. The work was carried out as part of their normal day job. **The hub went live on 1st of September 2015.**

In February 2018, NHS England and NHS Improvement announced that all CCGs would need to provide "…extended access to GP Services, including at evenings and weekends, for 100% of their

[1] There were initially ten practices involved in the project with a further two practices joining in July 2016. In 2017, one practice merged with a practice in the Villages Network, leaving a total of 11 practices in the Cannock Practices Network.

[2] https://cannockchaseccg.nhs.uk/news-events/documents/84-cc-primary-care-strategy/file

population by 1st October 2018".[3] Being ahead of many, **the Network have been heavily involved in presenting their work and sharing their learning around the country to meet the new national requirement**.

The project ran for three years up until 30th September 2018 at which point, in line with the national requirements, Cannock CCG began to fund the provision. In addition, reflecting increased collaboration between practices during these first years of development, **the Cannock Chase Clinical Alliance was formed in June 2018**. This limited company consists of 24 practices across the three networks, including all the practices in the Cannock Practices Network. **Since the end of 2018, the Improving Patient Access project has been delivered by the Alliance, involving a larger number of practices and under new leadership**.

This short report describes learning from development and delivery of the project by the Network, and in its current form under the leadership of the Alliance. It is based on a focus group with current and previous Project Leads as well as supporting documents that they have provided.

2.2 Project Design

Governance

The Network has a Memorandum of Understanding (MoU) in place and is led by a Chair and nominated Practice Manager who are responsible for ensuring the delivery of any planned work. This included the Improving Patient Access project between September 2015 to 2018.

The Alliance seeks to support collaborative working across practices in the three networks. There is a MoU in place and an appointed management board comprising a GP Chair, nominated representation from the three localities (GPs and Practice Managers) with input from others as required.

The Cannock Practices Network Surgery (launched in 2015) was based within Cannock Hospital. The hospital already had a GP practice within it (GP Suite Surgery) and so two of their consultation rooms were used for the project. The practitioners (GPs and nurses) were drawn from across the Network surgeries and expressed an interest in taking additional shifts at the hub. A new administrative team were also recruited.

Agreements

To allow for clinicians at the hub to see patients and the reception staff at the hub to view necessary patient details, **data sharing agreements were established** between each of the

[3] https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf

practices. **Confidentiality agreements also needed to be put in place** between the hub staff and the GP Suite Surgery, because their consultation rooms were being used and may contain confidential information.

Key enablers

Because the practices had limited previous experience of working together **strong communication, good collaboration and a shared vision were required**:

"We mustn't underestimate the sort of communication arrangements that we had to put in place really to communicate what we were trying to do, what we needed to do and get the support of all the staff within the practice. Not just doctors- nurses, admin staff, you know everybody that worked…in that network surgery…" Member of Project Team

A key enabler was the relationship that the Project Team developing the service had with the Network; they were able to **build trust with clinicians and others**, meaning they developed a high degree of autonomy to make things happen and tweak the model as required during set-up and implementation.

"They trusted us and knew… we were there for them" Member of Project Team

The Project Team provided quarterly updates to practices and made themselves easily accessible to hub staff. This meant that **problems could be quickly raised, and solutions identified**. For instance, even when things had settled down one of the Practice Managers on the team would still visit the hub once a week.

A fundamental component of the project was **having the right people in place**. The project benefitted from having people who had a shared vision as well as people who had the necessary skills and willingness to take ownership and operationally take it forward. For example, people who had practice management support experience:

"The key for me is, this type of thing is additional to what everybody's doing, the day to day stuff that everybody's doing so you really need people who…are prepared to give up some of their time alongside their day job…you need willing people who can see and share the vision…you want people who can roll their sleeves up…and get in there, get their hands dirty and actually make some of those things happen" Member of Project Team

Whilst under the leadership of the Network, the Project Team consisted of two Practice Managers and an Assistant Practice Manager who were at the core of developing the hub on a practical/operational level. These individuals, however, have now stepped down and whilst there is support from another Practice Manager, the Alliance is currently recruiting a new Operations Manager to continue driving the project forward.

Having the right IT systems in place was vital. To work effectively, the project required an IT system that allowed for an appointment made at the local GP practice, to be picked up by staff at the hub. This required being able to view the patient's record, making patient notes, and writing out prescriptions and sick notes. All Cannock town practices were already using the EMIS web system and this was used to develop a new approach. **Close communication was needed with EMIS to develop the required systems as at the time they did not exist**, although there was also a motivation for EMIS to be successful: *"I think they could see the potential benefits for them as well really as a company"*.

As an Alliance, all IT systems have migrated to EMIS Anywhere, allowing remote access to EMIS Web. This was felt to be a more appropriate system ensuring greater patient confidentiality as appointments can only be viewed by the clinician to whom they have been allocated. However, a problem for the hub has been identified as if the practitioner allocated can no longer cover the shift – a risk given that in line with national requirement, appointments can be booked in advance – the practitioner taking the appointment cannot easily access the record:

> *"…old EMIS web system that we had, was just easier to manage from an operational point of view because if anything went, happened, or we needed to look back at a patient, then…I could just go in, have a look, change peoples you know, say it's a new practitioner, you can't do that with EMIS remote, its practitioner specific so that person has to log in"* Member of Project Team

Instead, hub staff are required to manually move a patient appointment from one practitioner to another, taking additional time compared to the previous system.

There are still some teething problems using this new system as whilst practices within the Villages Network are familiar with it, the Network practices as well as NHS 111 who have been previously using EMIS Web, are not. There have been issues around staff still booking in hub appointments using the old system and the hub clinicians then not being able to view the patient record. There is therefore some work needed around upskilling staff to confidently use the new system.

2.3 Project Delivery

Delivery under the Network

Under the Network, the hub ran between 3.30-8pm on weekdays and 9am-1pm on weekends and was covered by doctors and nurses from the Network practices.

Appointments were offered to patients by their own practice when there were none available internally. Each practice had an allocated number of slots available at the hub. Initially, appointments were protected for those who were deemed to be urgent however over time, it became apparent that there were enough appointments for the service to be opened up to all.

As the service developed, the Network gave NHS 111 access to weekend appointments as they were being underutilised; practices would typically arrange same day appointments at the hub so unless a weekend appointment was arranged on Friday, these were not being taken-up. This **collaboration meant that NHS 111 were able to book Network practice patients to the hub rather than signposting them**, and thus adding pressure, to alternative weekend services.

Another key development of the initiative was providing backfill surgeries whereby practices could offer appointments at the hub during normal practice hours (3.30-6.30pm) during which time they would be expected to provide longer appointments (20-30 minutes) to long-term condition (LTC) patients back at their own practice.

Changes to model

Since the Alliance has been leading the service, there have been some changes, in part due to CCG and national requirements (e.g. having pre-bookable appointments).

Firstly, in line with the greater geographical spread of the Alliance and associated increased number of partners, **there is now an additional hub** located in Rugeley which runs three times a week on weekdays and at weekends.

40% of the extended hours appointments are now delivered in-house within each respective practice and the remainder via the hubs. **The number of additional appointments is in proportion to the size of each practice population**. This change in design was due to an understanding that some patients, for example those with limited mobility, may benefit from being seen within their own local practice. However, some staff report concern that this model, alongside the greater number of practices using the hub service, may have resulted in an overall reduction of additional appointments.

The hubs also only operate out-of-hours and therefore there is no longer scope to provide backfill surgeries to allow for longer appointments for LTC patients.

Setting-up the original hub for the Network was described as **setting up a 'mini practice'**. This involved for instance:

- **Identifying and negotiating use of premises:** considerations needed to be made about suitability of the premises for consultations and how easy it was for patients and staff across the network practices to get to
- **Setting up appropriate IT systems** and appointment "books"- see Section 4.2-Project Design for further details
- **Managing staffing:** setting up contracts with the network for each member of staff, delivering staff induction, setting up staff files, setting up rotas for doctors, nurses, administrators, recruiting administrators
- **Equipment:** clinical equipment was purchased and stored within the GP practice with clear communication that this was for use by the hub staff only. The network also negotiated

using the GP suites emergency equipment, ensuring that all staff were aware how this can be accessed and how to call for help within the hub.

- **Payroll:** payroll has been managed by the local GP Federation GP First[4]meaning that an additional person did not need to be recruited

There is a vision to be able to offer additional services as an Alliance. These are yet to be finalised following discussion and agreement with the CCG however early ideas are that they could include investment in flu clinics, smear tests and additional nursing time.

2.4 Project Outcomes

An evaluation was carried out under the Network covering the first three years of project which was designed and led by the Project Team. Overall, approximately 8,000 additional appointments were created per year with 23,148 appointments being booked across the three years (87% booked).

A patient satisfaction survey was conducted across the three years that the service was running yielding a response rate of 23% (4,884 patients). This found the following:

- **99% satisfaction rate** with the way the appointment had been arranged (options were 'not at all satisfied', 'satisfied' and 'very satisfied')
- **97% reporting that they were able get an appointment** at a time that was suitable for them
- 48% reporting that had they not had a hub appointment; they would have waited to book an appointment at their own GP. This would suggest that **a potential 1,812 hours (based on 10-minute appointments) were saved across the practices** over three years thereby reducing pressures on practices
- **Around one fifth (22%) report that they would have gone to MIU or A&E** had they not had a hub appointment suggesting over 2,000 visits had been saved across the three years at each of these services
- 98% reported that they would like to see the service continue

Feedback from patients suggested that the service was beneficial, for instance for those who worked during practice opening hours; or parents with young children who were ill and needed to be seen quickly.

Between October and December 2015, **the number of A&E attendances were found to be 11% lower compared to the same period** in 2014. Similarly, **in-hours attendances at MIU declined by 3% and out of hours by 8%** in comparison to the previous year.

[4] Covers practices across Stafford and Cannock

The Alliance are currently in the first three months of appointment usage and still in the process of recruiting some key staff so do not yet have demonstrable outcomes. They aim to increase patient satisfaction with primary care services and reduce the burden on services such as A&E, walk in centre, MIU etc. as a result of people going there as a substitute to an appointment at their practice.

Nationally, there are seven requirements covering different outputs that need to be achieved[5] and that will need to be monitored:

1. Timing of appointments
2. Capacity
3. Measurement
4. Advertising and ease of access
5. Digital
6. Inequalities
7. Effective access to wider whole systems services

2.5 Project Review

"I got tasked with going around to some of these conferences and for me it was an easy one to sell because it benefitted practices, it benefitted patients, demonstrate that it has an impact on reducing attendances at MIU" Member of Project Team

A key success of the project is that it has increased patient access to appointments and pressures on practices; and self-reported patient data and lower admissions rates suggest it has also reduced demand on A&E and MIU.

On a professional level, the Project Team are particularly proud of how the **staff amongst practices have been able to work closer together to benefit their patients** and their own practices.

A wider success of the project has been that the **practices have gained greater confidence in trying out new initiatives**. For example, the introduction of a care navigator service. This has resulted in receptionists making 1,472 internal referrals (e.g. to nurse practitioner, practice pharmacist) and 237 external referrals (e.g. to the community pharmacist, optician) across 19 Alliance practices thereby saving potential GP appointments.

"Because we'd been successful [with Improving Patient Access Project] and because we'd instilled a bit of confidence I think across the practices about what we'd done, they gave us some license really to

[5] https://www.england.nhs.uk/gp/gpfv/redesign/improving-access/

try other things…the CCG have welcomed some positive news…they've been quite supportive of what we've done…" Member of Project Team

"This all came out of this collaborative working across as a network really and forging sort of a working relationship across practices is that we started to look at trying to do things as a group of practices…carries a lot more weight" Member of Project Team

It was reported that, under the Network, there was a strong sense of **a cohesive group with a shared vision** and trust in the Project Team to set up and deliver the initiative. From sharing their work with others across the country, there was a recognition that this shared approach and understanding is missing in some areas, which may make replication difficult. For instance, there have been challenges with finding sufficient cover for hub(s) or:

"…some areas have got factions if you like that look at things in slightly different ways so we've never had that, they've trusted us I guess, I like to think that's what it is, they've trusted us to do the right thing by them…" Member of Project Team

2.6 Conclusions

Whilst the initial hub service appears to have been successfully implemented with good support from the Network practices, the upscaling of it across the Alliance is likely to bring new challenges. Staff who were key in setting up both the first and second hub have now stepped down and the Alliance is currently in the process of recruiting a new Operational Manager. Ensuring that previous learning is not lost is therefore important and building a new project team that has a "can-do" attitude, the right skills and can instil trust and work closely with staff will be vital.

Feedback from staff suggests that **the Network practices were able to work well together with a shared vision in terms of what they wanted to achieve and how**. Given that the Alliance is still relatively new, **there is recognition that some time is needed to allow for the new group to gel**. However, with a greater number of practices involved, integration, whether that be IT systems, or vision, is likely to be more challenging. In this context, strong, forward-thinking leadership will be needed.

Consistent training will also be necessary given that staff across different practices may be using different IT systems or have different ways of working. Part of this will be making sure that everyone is in "on board" with the project, understands why changes are being made, as well as providing the necessary support and technical training to support a smoother transition.

The collaboration of practices that have previously worked in isolation and, crucially, the success of this initiative has instilled confidence both in meeting the new national requirement and in testing new ways of working. The hub project has paved the way for the wider Alliance to continue being innovative in the way they work.

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