**THE ARNEWOOD PRACTICE**

The practice was established in the 1930’s as a single-handed practice working from a bungalow. In 1971 a Health Centre was built and the practice relocated as it had expanded to three partners. Due to the rapid growth in patient numbers space became a problem and the practice moved to a new purpose built surgery in 1999.

New Milton is a small town with a population of about 25,000, semi-urban with some rural areas.

The practice has 13,338 registered patients; with twice the national average of patients registered aged 65+, 75+ and 85+. Looking at a weighted capitation the “Person Weighted List size” is 14,029.

***Practice list size as reported 04.07.2016***

The population is predominately white, with the majority being born in the UK. Over the last 10 years the ethnic diversity has increased with more patients coming from the Far East, India and Pakistan, and also Eastern Europe.

The practice produced a mission statement some years ago: **“Primary Medical Care at its best”.**

The practice remains of the view that the care and support we provide must be patient centred, and the decisions we make must be in the best interests of our patients.

This information pack started as a way of providing information for our expected inspection by the Care Quality Commission. However, it soon turned into a focus for discussion of the many actions the practice has undertaken; sharing the successes, identifying the gaps and developing a number of new initiatives.

The practice has focused on the 5 ***‘Key Lines of Enquiries’*** that are asked about the practice’s services, which are:

* Safe
* Effective
* Caring
* Responsive
* Well led

The narrative on the following pages will hopefully provide some information about how we aspire to meet the needs of our patients.

**PRACTICE STAFF**

There are 11 GPs of whom 8 are partners. This is a training practice and therefore there are often 2-3 GP Registrars in training, along with an F2 (foundation year 2) doctor. The practice is highly committed to education and training, and both 3rd and 5th year medical students also have placements in the practice.

We have one Nurse Practitioner who undertakes a leadership role within the practice and a wide range of duties including home visits, minor illness clinics and telephone triage. In the Treatment Room, there are three Practice Nurses who perform a wide range of duties including wound care, management of long-term conditions and vaccinations/immunisations. Assisting the Nurses, we have 3 Health Care Assistants who also undertake specific tasks such as phlebotomy, NHS Health Checks and wound care. The practice also has an in house Phlebotomist, who runs a weekly INR clinic and co-ordinates the monitoring of Disease Modifying Drugs (DMARDs) and is the only general practice paediatric phlebotomist in the locality.

In June 2015 we started to have 2nd year student nurse placements. This enhanced the nurses’ interest in teaching and self-directed education.

The practice prescribes over 150,000 items per year at a cost of over £2.5m. The number of prescriptions dealt with on any one day is significant. There is therefore one person employed solely to manage prescriptions from 8am to 1.30pm. To help with accuracy, consistency and reduce the risk of errors there are two other members of staff who cover the afternoon prescriptions.

There are 11 receptionists lead by two supervisors. There is a team of “back office” staff whose tasks include scanning, secretarial work, Health and safety, etc.

**PRACTICE MANAGEMENT**

Dr Nigel Watson is the Managing Partner and Chairperson. He works closely with Kelly Anderson, our full-time Deputy Practice Manager.

The Partners attend ‘Partners Meetings’ once a month, some attend executive meetings fortnightly.

We have a number of ‘groups’ where each partner/DPM/NP has delegated responsibilities. These include:

* **Exec –** Drs Watson, Brewer, Kydd-Coutts and Kelly Anderson
* **Finance –** Drs Brewer, Rycroft, Bamford, Walden and Kelly Anderson
* **IT –** Drs Kydd-Coutts, Marsh, Miles, Kelly Anderson
* **Education & Training –** Drs Kydd-Coutts, Marsh, Rycroft, Debbie Taylor and Kelly Anderson.

The practice currently has 3 accredited GP trainers and 2 Practice Nurse trainers. We have 2 GP ST3s and one GP ST2, and during the years have 5th year medical students, student nurses and Foundation Year 2 doctors all for a varying length of time.

The practice considers itself not only a training practice, but as a learning environment. Therefore all GPs, Nurses and some non-clinical staff take part in teaching and also gain from the learning.

Once a quarter, the practice has a session of protected education time. This allows all the staff and clinicians to have joint training, discuss issues and also separate where relevant to the various groups within the practice.

**PATIENT ENGAGEMENT**

Following the introduction of the 2004 GMS Contract the concept of each practice having a Patient Participation Group (PPG) was introduced. The long established Friends of Arnewood Surgery were unwilling to take on this role and therefore the practice sought to establish a PPG. This proved very difficult but we were able to create a virtual group.

Some members were happy to be consulted and would comments and contribute to a number of issues related to development of services, complaints etc.

Over the past 12 months with the wider changes that have been taking place in healthcare locally with Better Local Care and the development of the New Models of Care the practice invited patients to contribute to development of services at a practice level and also more widely across our natural community of care.

A new PPG was established with 9 enthusiastic members and following discussions further members have been sought especially from the younger patients. The practice has now received an expression of interest from 70 more patients who would want to participate in a variety of ways.

**LONG TERM CONDITIONS**

The age profile of the practice accounts for there being more patients than one would expect with long-term conditions:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Number of patients | Practice Prevalence | National prevalence |
| Asthma | 850 | 6.4% | 6% |
| Atrial Fibrillation | 381 | 2.9% | 1.5% |
| Cancer | 298 | 2.2% | 1.9% |
| COPD | 262 | 2% | 1.7% |
| Coronary Heart Disease | 689 | 5.2% | 3.3% |
| Dementia | 132 | 1% | 0.6% |
| Diabetes mellitus | 651 | 5.2% | 5.8% |
| Heart failure | 145 | 1.1% | 0.7% |
| Hypertension | 2,335 | 17.6% | 13.7% |
| TIA and stroke | 437 | 3.3% | 1.7% |

With a high number of elderly patients there are many patients with multiple morbidity.

The practice aims to review patients with a long term condition at least annually, and will then agree with the patient an appropriate interval to the next review.

All patients with hypertension, stroke and TIA, Ischaemic heart disease and diabetes are invited in the month of their birthday for a clinic review with an experienced nurse. Before attending the specialised clinic(s), the patient would have had the appropriate blood tests. Following the review an agreed action plan is given to the patient with general information about what they can do to manage their condition and also some targets for blood pressure, cholesterol etc. They are given a print out with their results and targets.

**URGENT CARE**

Over the last few years the demand for urgent care has increased significantly. With the practice list size growing and the demography of the population, it became impossible to deliver this without moving to a system of *‘Same Day’* appointments and a Duty GP.

Each day there are designated Duty GPs, one in the morning and two in the afternoon (As Monday mornings are particularly busy, we have three). This frees up that GP to undertake urgent visits during that session and also meet the needs of the unexpected problems that might arise. We also have a number of *‘Sudden and Serious’* appointments which are only available to book on the day.

The practice is currently working with two local practices to try an create an acute visiting service for the town. This would focus mainly on the reactive and proactive care of the frail elderly (who form a large part of our visiting workload). The visiting team would have a dedicated co-ordinator, GPs, Community Nurses and establish close links with Social Services.

**OLDER PERSONS**

About 30% of the patients registered with the practice are aged 65 or older, and 17% are aged 75 or older. This is twice the national average. Another major factor is the increasing number of patients who are aged 85 or older. There are significant implications in terms of providing care to housebound patients, and patients with multiple long term conditions. There is a greater focus on the relatively newly recognised long term condition – namely frailty.

**DEMENTIA**

Some years ago the practice recognised that a greater focus needed to be placed on the identification of patients with dementia, making the diagnosis earlier, supporting the individual and carer, and engaging more effectively with the Older Peoples Mental Health Service.

General practice was being criticised for several aspects of the diagnosis and management of this important group.

The criticisms were:

1. The opportunity for early diagnosis was being missed.
2. Drugs that slowed the progression of Dementia we being underused.
3. Too many anti-psychotic drugs were being prescribed to control behaviour.
4. Carers were not being supported.

The practice discussed these issues on numerous occasions, and over a period of time we have tried to address these issues.

We used the Local Medical Committee’s *‘Lunch & Learn’* module relating to dementia with the whole practice team, with the intention of becoming a Dementia Friendly practice. As part of the practice education programme, the clinicians held an afternoon event working with the Older Persons Mental Health lead consultant to help forge closer relationships, improve our knowledge, resolve some concerns and help plan to provide better services for the future.

The Local Authority commissioned a service through the Alzheimer’s Society that placed Dementia Advisors in the community. The practice met with our local Dementia Advisor and decided that to create stronger link and ensure better access for our patients, the service would be enhanced if the “drop in service” had additional sessions based in the practice. This service ran for period of time, but unfortunately the advisors had to stop their clinic due attendance issues.

The CCG has sought support from 3 practices (out of the 54 in the CCG) to work towards becoming a Dementia Friendly Practice and to be prepared to share that experience. Our practice volunteered to be one of the three practices and has been working for the last year to support the CCG in this work. The practice is also part of the Hampshire Dementia Action Alliance and has been lobbying the Town Council to be a Dementia Friendly Town.

Dr Watson has been working as a GP lead with the Academic Health Science Network (AHSN) and dementia champion, to support the wider health economy developing a programme whereby practices can strive to become Dementia Friendly.

**TRANSFORMATION FUND**

The older person frequently has complex health and social care needs that are unmet by conventional services. This is a particular problem for the housebound and those in care homes. The practice has recently had a Care Navigator appointed who will provide a valuable point of contact for patients and clinicians, allow far better access to services offered by the Voluntary Sector and help with care planning. There is a significant overlap with the role of Care Navigator and that of Social Prescribing and we see this becoming one of the same thing.

In addition to the Care Navigator role, we have recently had additional and dedicated GP time funded to focus on enhanced care for the housebound, and those in care homes; especially for those aged 75 or more. This person has protected time to work with the community teams, Geriatricians and the practice. The key part of this role is to review individuals and focus on care planning, medication rationalisation, and enhance the working relationship with Care Homes.

In the past care has largely been reactive with this group of patients, and this provides the opportunity to be far more proactive in the provision of care.

**SCHOOLS**

New Milton is a small town of 25,000 people. It has 3 practices, 7 primary schools and one large secondary school.

We suffered from the usual barrage of requests:

* Johnny needs a letter to be off games
* Lucy has ADHD and the teacher wants you to refer her because it is quicker
* Fred had a cold and did badly in his exams, can we have a letter
* Sarah is missing too much school so the teacher wants you to see her every time she is ill and report this to the Head teacher

The traditional approach has been to write to the school declining their request and stating why we are too busy to undertake this work.

Locally we decided to take a different approach, and arranged a meeting with all the local Head Teachers to discuss our “grievances”.  To our surprise the Head Teachers were fair and reasonable people who were actually quite nice and easy to talk to. None came with a cane, and no punishments were dealt out.

We addressed all the issues above and the Heads broadly accepted and agreed with our concerns.  So almost immediately most requests stopped.

The Heads were concerned about the label of ADHD as they believed that some children were well behaved at school but still were diagnosed by CAMHS as having ADHD when the real issue was parenting.  They were frustrated that the CAMHs service would not listen to them.

We spent some time talking about a pupil who was off school for recurrent minor illness and the impact that might have for their future. This led to The Arnewood Pyramid – Health, Wellbeing and Attendance Partnership.

The practices and Arnewood Pyramid of schools formed a partnership to address poor school attendance levels.  Whilst this is not part of core work and the practices are under no contractual obligation to participate, we have found it useful to work with local schools on health and wellbeing issues, particularly with regard to attendance where it is felt that particular children may be vulnerable.

To that end, the partnership was established so that local schools could ‘refer’ children to their local practice who will confirm whether a child’s absence is appropriate following telephone triage or a face to face appointment.  However, the onus is on the parent to cooperate and to actively participate in the program.  It is only intended for those children and families where there are long term ongoing concerns, where there have been previous efforts to engage with the family and the family is already aware of the initiative.

The Head Teacher identifies the child and family, and meets with them to discuss the situation – so we are only talking about the extreme cases.  In the 3 years this has been running we have only had 4 children put though the scheme.

***PROCEDURAL AGREEMENT***

Before referring a child onto this scheme, Head Teachers will:

* Have had long term ongoing concerns about pupils whose attendance has dropped below 85% with the significant majority of absences being reported as ill health.
* Be able to demonstrate that they have tried to work with the family to improve attendance
* Have engaged the services of Education Welfare Officer as appropriate
* Have referred the case to the School Nurse
* Have met with the family to explain the HWBAP scheme before referring them
* Upon receiving a referral from the school the participating GPs surgery will:
	+ Aim to see the pupil on the first day of illness
	+ Recommend a return to school in the afternoon if it is felt appropriate
	+ Recommend a return date to school if it is possible to do so
	+ Complete the HWBAP pro forma for return to the school
	+ Liaise with the school as appropriate to support the child and family

Following our initial meeting we planned to meet every 3-4 months, which has been useful.

We worked with the schools that planned a “healthy schools week” and got several GPs to go into schools to talk to the children on a range of subjects.  Dr. Watson has been involved in one schools program for the last 3 years.  He thinks he has got more out of it than the schools have!  The children are interested, knowledgeable, attentive and enthusiastic, and appreciate what you do for them. Although, talking to a group of 100 pupils aged 8 and 9 is far more frightening than talking to 100 GPs!

**TEENAGERS**

In most practices this group are hard to reach and are often resistant to engage with general practice; however we do have some advantages. Our population is fairly stable and working; therefore a “family doctor” will frequently see a family over a number of years, so consequently teenagers have developed a relationship with one or two GPs as they have grown up.

Initiative that we have undertaken:

* Work with schools
* Twitter – Practice account – Tweets regularly
* Facebook – Page with a significant number of followers.
* SMS text – the practice uses this facility to communicate with various groups – some teenagers have given their mobile phone numbers – some caution here as some of these mobile numbers are their parents.
* Sexual Health Clinic – now relocated to the practice.
* Free condoms are given out to teenagers.
* Chlamydia testing offered.

**CHILD AND ADOLESCENT MENTAL HEALTH SERVICES**

The practice has partnered with 10 local schools and 6 local practices to bid for a pilot to employ a link working between the schools, practices and the CAMs services. We have been chosen by the CCG to take this forward as this area is deemed to have the highest need, in terms of workload, related to adolescent mental health.

**VANGUARD – MULTI-SPECIALITY COMMUNITY PROVIDER (MCP)**

This was first described in NHS England’s *Five Year Forward* published in October 2014. The practice has been working closely with 6 other local practices, the CCG and Southern Health FT to bid to become a Vanguard Site. Initially there were 269 expressions of interest nationally, however this then reduced to 68, and of which 29 sites were then selected. Southern Hampshire was one of those sites. The idea is to develop a partnership of providers that can work together and deliver primary care at scale.

A brief overview of the project the practice is involved in:

***Community Nursing***

***Stage 1***

Practices’ working with the local community staff is part of a pilot to evaluate the benefits of a common health record. The Practice uses SystmOne as do 2 other local Practices. Community staff working with the three practices has moved to the Community module of SystmOne. The project took 2 years to secure funding and agreement, and was implemented in November 2015. The benefits to patients is that the record will be shared so they will only be asked for information once, which means the practice and community staff can begin to really work together as a single team. We will be producing a single set of templates to share across the locality to enhance the quality and accuracy of data entry.

***Stage 2***

This stage will be to create an extended primary care team that is truly integrated, and would include general practice, community nurses, therapy, mental health and social workers. Funding has been secured to implement a programme of transformation, supported by an external facilitator to enable the practices and community staff to come together under a single leadership. It also provides the opportunity to look at how nursing services are delivered both in the practice and the community, and to look for gains in terms of improved care and outcomes. One example is that we could create a locality based wound care clinic, delivered from one site that involved the practice and community staff with added services to enhance the experience.

**PRIMARY CARE ACCESS CENTRE**

There has been considerable attention on the challenges faced by patients gaining access to general practice. The availability of general practice over a 7 day period, working 8am to 8pm comes with the challenges of increased workload and capacity within general practice. In addition, there is a desire to reduce the pressure of A/E departments.

The practice was part of a consortium of 7 local practices and Southern Health FT that won a bid for the Prime Minister’s Challenge Fund 2.

In September 2015 the new Primary Care Access Centre (called “The Practice at Lymington Hospital) was opened. This is functioning as a branch surgery of the 7 participating practices. We knew that walk in centres have minimal impact on the workload for a practices or A/E. So with our model, patients can either directly book with their practice or at the Centre in Lymington Hospital. The new service also offers some walk in appointments.

The Centre has the ‘*Urgent Care’* version of SystmOne which allows clinicians who are seeing the patient to make their consultation notes in the patient’s electronic health record. This also allows messaging, ordering blood tests and X-rays, and the results will be available to all. Sharing the record will not only improve the quality of the consultation but will enhance the follow up if necessary.

We are now planning to develop the Centre into a Primary Care Access Hub. Recurrent funding has been secured and working closely with Health Education England it will be established as a multi professional training centre. A GP Clinical Lead has been appointed and it expected that FY2 GPs will start being place there from December shortly flowed by nurses, paramedics and GP trainees (ST2s and 3s).

The practice is located next to the Minor Injury Unit (MIU) and close to the ambulatory care centre, the aim is to fully integrate the service with the MIU and establish close working relationships with the ambulatory care unit.

**OAKHAVEN HOSPICE**

Our palliative care patients are supported by the practice working in partnership with the community team and the local hospice. Despite the high quality of end of life care provided by each organisation, it has become increasingly clear that there is a ‘barrier’ between the 3 separate services, and at times it means that communication is not always as good as it should be.

Following discussions, the aim is for the hospice to move from a paper-based system to the *‘Palliative Care Module’* of SystmOne. This will allow the sharing of care plans, avoid the need for asking the same set of questions more than once, and a better co-ordination of visits etc. – all helping to improve the quality of patient care.

**MUSCULOSKELETAL (MSK) EXTENDED SCOPE PRACTITIONER**

General Practice has witnessed an unprecedented increase in workload over the last 5-6 years. In 2008 there were 240,000,000 consultations in general practice and in 2013 there were 340,000,000. This is associated with a fall in GP numbers and increasing difficulty in recruiting new GPs.

There is a need therefore to explore and pilot using different health care professionals to support general practice and add capacity. It is estimated that between 20-30% of all GP consultations are due to MSK problems.

We therefore embarked on a 12m trial to see if a Consultant Physiotherapist could replace some GP appointments and help provide better outcomes. The idea was to offer these appointments as an alternative to seeing a GP. The MSK specialist can take a history, examine and make a diagnosis. They can then offer advice, an exercise programme, request an X-ray of CT scan, and if required inject the joint, advise NSAIDs or refer to Physiotherapy.

To help with the study there has been a template written specifically to help with consistent data entry and extraction, to evaluate patient and GP satisfaction with the service, and to stop advice leaflets etc.

Within 4 weeks of starting the pilot it became clear this service can replace some GP time, although the MSK assessment takes 20min as opposed to the 10min GP consultation. In addition, the referral rate to physiotherapy and orthopaedic outpatients has also reduced.

We hope that having the MSK specialist in the practice will also transfer skills and knowledge to the GPs and Nurses. To help this we have amended the timings so that the MSK clinic allows the specialist time to join the GPs when they meet for coffee. We are also introducing the service in our primary care access centre so we will be able to evaluate whether there is additional benefit for this service to be embedded in a practice.

**ESTABLISHING A SUPER PARTNERSHHIP**

It has become clear that general practice needs to evolve, building on the many qualities that it current has but it needs to be able to operate at scale and fully integrate with locally based community services providing a greater focus on the health of our population.

Over the last few years we have been working towards forming a GP Federation which is now established and has secured a number of contracts including for the Primary Care Access Centre, phlebotomy, Care Navigators and for Frailty GPs.

Discussions have been taking place in New Milton about the potential of merger to form a larger partnership. This was suggested by the older partners but is now being driven by the younger partners.

We has been agreed to form a super partnership involving the Arnewood Practice, Barton Webb Peploe Surgery, New Milton Health Centre and Chawton House Surgery. This will cover a population of about 40,000. There are three other local practices have been invited to join and are currently considering the offer.

**This document provides examples of services that are offered to our patients.**

Appendix A

**Procedure for annual review of hypertension**

As a practice it is agreed that patients with a diagnosis of hypertension should as a minimum have an annual blood pressure check and have their U/Es measured.

Some patients will have this done opportunistically and some may have comorbidities and will therefore have their hypertension addressed in other clinics such as the diabetic or the CHD clinic.

A report is run each month for patients who have hypertension but are not diabetic, have CHD or had a stroke. Then on the month of the patient’s birthday the patient is invited for a review in the treatment room.

In the past this was a two stage procedure whereby the patient attended for a blood test and then returned 2 weeks later to see the practice nurse for a review. This worked reasonably well but had some limitations:

* Patients made 2 visits to the surgery – some not returning for the nurse appointment
* The blood tests were reviewed separately by the GP, and frequently a QRisk2 was not recorded.
* Medication reviews are inconsistent
* Some patients are given a clear management plan but again this is inconsistent.

New procedure from introduced 1st May 2015

A report is produced of those patients with hypertension in the month of their birthday who have not had an annual review and do not have a diagnosis of CHD, stroke or diabetes. They are invited for an appointment with the HCA.

NICE recommends - ***If hypertension is diagnosed offer an annual review of care to monitor blood pressure, provide people with support and discuss their lifestyle, symptoms and medication[[1]](#endnote-1).***

During this appointment a blood test is taken for:

* U/Es – to assess renal function
* Glucose – to screen for diabetes
* Non fasting lipids – to calculate CVD risk

The HCA will also record:

* Height
* Weight
* BMI

An address labels is printed and stuck on an envelope is then given to the clinician who will undertake the second stage of this process.

***Stage 2***

The patient’s notes are retrieved – take to opportunity to “tidy” the major and minor diagnoses.

Review the results for weight, BMI, Cholesterol and BP.

Look for the BP icon on the toolbar top right of the patient’s records and click on this.

Link the entry to the diagnosis of hypertension by using the green flag box.

Click in the annual review box to show an annual review has taken place.

For patients aged 25 – 84 add QRisk2 by clicking on the QRisk 2 icon. For patients with a QRisk 2 > 20% they should be offered a statin, and for those between 10 – 20% a discussion about statins is appropriate.

Suspend the template.

Now look at the left hand clinical template tree and look under Cardiovascular – click on the template – Hypertension – patient results and information. Click on the icon that takes you to the work document for results.

On page 2 the results add the BP, weight, BMI and Cholesterol will have been added. You can add the ideal weight.

Click on Icon - ***Advice given to patient via management plan*** there are a number of pre-set advice statements **(see Appendix B)** – copy the appropriate one into the area on page 2 called “action you need to take”.

Print page one and two of the letter. Put the completed letter in the envelope – you can highlight the advice using a yellow marker pen, if important.

The advice given in the letter should be pasted into the box in the template called management plan.

The medication should be reviewed and reauthorised.

Produced by: Dr Nigel Watson

Date revised: 18th May 2015

Review date: May 2017

Appendix B

**THE ARNEWOOD PRACTICE**

**CARE NAVIGATOR SERVICE**

You have been referred to the care navigator by your GP, Nurse or other health professional.

The role of the care navigator is to ‘signpost’ patients and their carers to access the support and services they may need to enable them to remain safe and independent at home. The service is particularly focussed on vulnerable older people who may have long-term health conditions. It is hoped that the support provided will also help to prevent unnecessary admissions to hospital.

Our care navigator Dawn Walsh is based in the Arnewood Practice. Once she has received the referral, Dawn will contact you by telephone to arrange an assessment of your needs. This may involve visiting you at home. There are various things she can help with and these include:

* Offering basic information and advice about various benefits and allowances and helping you to access more in-depth help with this.
* Helping you to decide whether you would benefit from aids and adaptations in your home and if so, making the referral to adult services.
* Helping you to access support groups services such as befriending, dog walking, gardening, day centres and community social activities.
* Visiting you at home if you have recently been discharged from hospital to see how you are managing.
* Finding out whether you are having any problems taking your medications properly.

Once your needs have been discussed and you are happy with the outcome, Dawn will develop a ‘care plan’ of support and this will be copied to your GP and other professionals involved in your care.

If you need to contact the care navigator, please ring the Arnewood Practice in the usual way.

1. <http://pathways.nice.org.uk/pathways/hypertension#content=view-node%3Anodes-review-annually> [↑](#endnote-ref-1)