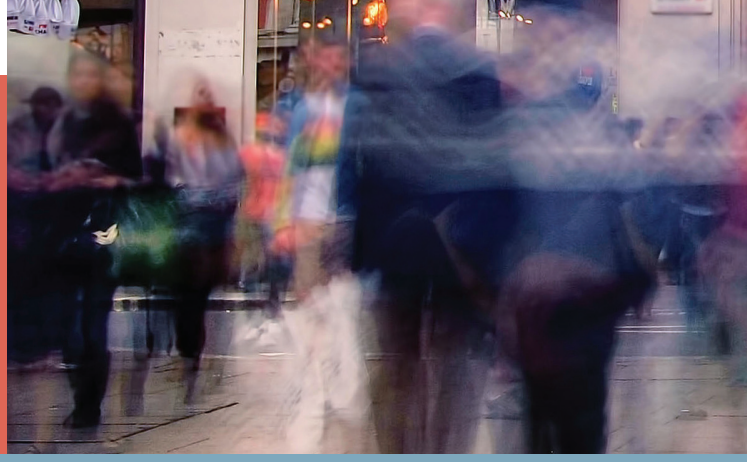
October 2019

PCC insight
Informed is ahead



PCN support is also a collaborative business

NHS England has firmed up support arrangements for primary care networks, with the publication of revised guidance for the networks on how to buy the right support.

The support prospectus is designed to help PCNs to identify appropriate sources of third-party expertise to help them to get PCNs up and running fast. It helps them to focus on each of the domains of the "maturity matrix", and it anticipates the network dashboard, the assessment tool that will be used to show networks' progress against the seven new service specifications.

The support programme is backed by a £42m fund this year with the promise of continued development funding in subsequent years.

Helen Northall, chief executive of PCC, says: "We welcome the concrete steps NHS England has taken. Guidance on how and where to get support is vital if PCNs are to fulfil their potential. What is also helpful is that it is working hard to map support requirements to clear success criteria.

"However, the expectations heaped on PCNs are huge and the pace of change will be rapid. Developing good relationships with member practices is an essential first step as is getting the governance right so the clinical director has clear decision making parameters. Meeting the network service specifications – such as reducing health inequalities – will be challenging. Collaborative working will also be hard. Most networks are still working on their own relationships, let alone making overtures to community services or the voluntary sector.

"Support providers like PCC have also faced up to the fact that we also need to work collaboratively to provide the full range of support that the networks need. We're working with CCGs, with LMCs, commissioning support units and with STP/ICS areas. We can also call on our national associate network for project management, extra capacity and specialist expertise."

Northall cites PCC's work with Cheshire LMC as an example of the range of support the company provides. It included running an event for all practices in Cheshire and Mersey to discuss the issues posed by PCNs in the run-up to the July start date, support for individual PCNs and a development programme for the area's practice managers.

"We're also working with Wessex LMCs to establish a PCN clinical director network," she said. "PCNs can't deliver what's expected of them without the time and resources to establish strong foundations."

Northall identifies four reasons PCNs and commissioners may wish to look to PCC for help:

- Highly-regarded leadership programmes for clinical directors and practice managers, including coaching and mentoring
- Our track record in providing support to stabilise under-performing practices (NHS England identifies stabilising general practice as one of the main roles of PCNs)
- Our experience in providing PCN development support
- Inclusion on the Consult 18 procurement framework, making it easier to work with us.

Download an overview of our PCN support: https://bit.ly/2mUpmEz

Case study: Tackling mental health in general practice

By Karen Garry

People experiencing low-level mental distress, such as bereavement or anxiety, make up a significant proportion of patients seen in general practice. Often there is little a GP can do beyond medication to support people with mental health needs, especially if they do not meet the threshold for referral to secondary care mental health services.

Harley St Medical Practice in Stoke-on-Trent had a long-term ambition to address this gap in service and, when a GP left the practice, they took a leap of faith and appointed a mental health practitioner, Deborah Glendinning, to work full-time in the surgery.

There was no template for the mental health practitioner role. The practice manager, Yvonne Bell, was not sure exactly what the new role would entail, but she knew what she did not want:

- A case load
- Traditional therapy
- A crisis role
- A replacement for IAPT, access services or secondary care
- As another way to monitor patients as systems were already in place.

Glendinning is a mental health practitioner with 20 years as a CPN lead nurse in adult services and in primary care settings. She is experienced in assessment, care co-ordination, working with senior mental health clinicians and other professionals. She has training in cognitive behavioural therapy (CBT), pyscho-social interventions and family work.

PCNs advised to take charge of the integration agenda – before it takes charge of them

GPs acknowledge that scale (usually meaning "bigger") is a factor in the sustainability of general practice. Few dissent from the logic of a primary care unit serving a population of 30,000 to 50,000, which is now folklore. Delegates to a recent PCC event heard that while there is nothing like a bit of unsustainable pressure to create consensus, we should not squander the opportunity.

Nils Christiansen, managing partner with primary care law firm DR Solicitors, told a recent PCC event exploring options for practices in this new climate: "Unusually for the NHS everyone is speaking the same language. We are seeing that new money for primary care is being tied to the partnership model but at scale. That is because primary care at scale is now a requirement – not just an option."

"While that brings definite advantages, there are also potential problems – working at scale is not a magic bullet. You need a plan to realise the benefits. We've seen things go pear-shaped and bigger does not always mean cheaper or better. Small practices tend to have smaller problems, while problems in a merged practice, super-partnership or primary care network (PCN) could become so significant that they become a risk to patients."

Christiansen believes four models will dominate: PCNs, federations, super-partnerships and integrated care providers (ICPs).

Christiansen said: "It's important to remember that the models can co-exist, but you will want to keep structures as simple as possible so look to remove things that are not working or contributing – such as a federation which has no contracts."

He suggested that organising around PCNs is likely to be important. This could mean practice mergers within PCNs, or a combination of PCN and federation – in which the federation develops over time into a supplier of services to the PCN, including practical assistance with tax-efficiency – whether through advice, corporate arrangements or legal structures.

"A VAT costs sharing group could include the PCN core network practices and be a limited company which would incur shared costs on behalf of the practices. Since the PCN members would be the shareholders the company would look a lot like many GP federations but would avoid the well-publicised VAT risks associated with PCNs.

"This could well be the way that federations and PCNs are going to play together in future, but there are still some important issues to consider such as pensions and contracting."

Christiansen warned that integrated care provider (ICP) arrangements could pose a threat to practices, particularly where acute trusts see the advantages of running primary care.

"If GP practices don't take the lead by developing and providing primary care at scale through the other three models then others will lead through an ICP."

"In this context, super-partnerships often have a problem because they do not map well onto the geography of PCNs. There are a few super-partnerships which are members of ten or more PCNs. You do wonder how that will work – if you assume that the future is going to start with PCNs.

"In choosing a model you should decide what you are trying to achieve – whether that be cost reduction, role specialisation, shared investment, sharing best practice, integration, a seat at the table, developing new services or reducing risk to practices and their partners.

"However, think of the geography of PCNs and try to build everything else round them. While practices are not being forced into PCNs they are being strongly encouraged and you have to assume that all new money for primary care will come through that route."

Case study: Tackling mental health in general practice

By Karen Garry Continued from page 1

Glendinning works as part of a multidisciplinary team in the practice. For an hour each morning she takes triage calls from the care navigation team. If needed, she offers people an appointment or she may signpost them to the practice social prescribing link worker with whom she works closely or, occasionally, to the secondary care access service.

She supports people over the age of 16 with no upper age limit, including older people with mental health problems that can be managed in primary care.

Glendinning provides 30-minute appointments to give people time to talk through their issues or concerns. She listens to them and helps them gain insight to the problems they are experiencing. She assesses their needs, encourages them to reflect on what has worked for them in the past and uses the CBT framework to give people tools and techniques to manage their feelings and cope better with stressful situations.

Patients are encouraged to focus on things they can do for themselves but if they require medication Glendinning sends a request through the task system for a GP to check her recommendation against the patient's physical health and agree treatment.

In general, Glendinning books people in for a follow up appointment in two to six weeks' time , to check in with them and offer encouragement to keep going.

Five months in, the practice has seen many benefits from the mental health practitioner role.

- A third of GP appointments have transferred to Glendinning and GPs are referring patients to her
- People have quick access to a mental health specialist in the surgery; they do not have to wait three months, for instance, to access support with bereavement
- Quicker access means quicker results and helps to prevent issues escalating into more serious illness
- Glendinning is picking up people with undiagnosed attention deficit hyperactive disorder (ADHD) and autism spectrum disorder (ASD). One patient now diagnosed with Asperger's syndrome has been able to come off long-term medication completely
- She is helping people with stress and anxiety back into work.

Yvonne Bell, practice manager at Harley Street, says: "A lot of people with mental health issues were coming in every week. Now they have a proper mental health assessment, they are managing better and have achieved really good results."

Karen Garry is an adviser with PCC

Running a successful patient group: top tips

Mike Etkind is chair of a Buckinghamshire patient participation group (PPG) that has teamed up with others in the area to form a primary care network-wide patient group, thought to be one of the first in the country. He says there is no one-size-fits-all approach to setting up and running a successful PPG. Here he offers some tips for PPGs, GPs, practice managers, PCNs and CCGs

1. GPs and practice manager need to be on board. They need to be encouraging and not see a PPG in tokenistic terms or just a drag on resources. GPs are in a good position to identify patients who might be capable and willing to serve on the PPG.

2. The practice should encourage the PPG to take the lead in running its own business. A PPG in which the agenda is led by a practice manager is far from ideal. If a PPG is led by the patients, a GP and practice manager should attend at least some of the meetings. The ideal is a sense of partnership.

3. A virtual PPG alone is insufficient and may be little more than a fig-leaf for compliance with contractual obligations to engage with patients. On the other hand, it is important for a PPG committee to have a means of taking soundings from fellow patients, because committee members tend to be self-selecting and often demographically skewed to older people with time on their hands. A virtual email group is a very useful way to extend the reach of the PPG to involve or at least inform the wider population. The surgery can help kick things off by writing to all patients asking if they are willing to be contacted by the PPG from time to time, making it clear what to expect and by including a similar question in their new patients pack. We have 400 patients who have opted in to receive emails from the PPG in a practice population of around 3,500, which means we are reaching more than 10%. Take care to get the frequency of communication right. Bombarding people with requests for information is a turn-off, but they will forget about you if you don't stay in touch. We have just notified those on our email group that we may contact them up to four times a year, a rise in frequency that reflects increased activity in primary care particularly as a result of primary care networks. We also included the option of unsubscribing so as to comply with GDPR (the legislation that governs, among other things, how we use people's personal data to keep in touch with them).

4. Communication is very important. It's a means of keeping fellow patients informed, of getting their views, and a way to recruit more members. So while PPG committees need to focus on issues relating to the operation of their surgery, they also need to put in some effort getting their infrastructure in place and decide what are viable means of communication that are not only practical but also have a good chance of reaching and engaging fellow patients. A newsletter in paper form stuck in a pouch somewhere in the waiting room may look good, but may only be read by a very small number of patients. This may be where a CCG can help with advice on comms channels and technical assistance, including GDPR.

5. Some PPGs will always function better than others. It largely depends on the patients who put themselves forward: how capable they are; how enthusiastic; whether they adopt a constructive approach or see themselves as solely there to criticise and complain and do little of positive value. The capability and commitment of committee members will also affect what the PPG takes on: for example whether it organises events with speakers or confines itself to a patient representative role. Don't forget it's ultimately about people and that PPG members are volunteers.

6. It's essential to try to build a good relationship with the GPs and practice manager. My approach has been to say that we are here to help you and recognise you are very busy and don't want us to take up your valuable time unless it's for a good reason. Secondly, we do have a role as a critical friend giving you a patient perspective, but a critical friend is one who is supportive as well as commenting constructively where necessary. We approached the PCN with broadly the same message.

7. It never goes amiss if the GPs and practice manager occasionally compliment the PPG volunteers and acknowledge their contribution.

8. PCNs will provide an opportunity for PPGs to support one another, so if some are thriving and some not, there is scope for mutual help. Of course it could be over the coming months and years that PPGs largely operate at the PCN scale and are less common for individual surgeries, but that's in the future.

9. If the CCG is running network meetings for PPGs, make sure that the PPGs get a say in the purpose and agenda for the meetings. They should be more than just events where the CCG downloads what is happening. I'm talking about co-production.

10. Make the meetings enjoyable and keep on smiling. Provide biscuits.

Wanted: clinical directors for driving job

by Helen Northall

Helen Northall

Clinical directors will need to look in many directions at once if the high-speed journey of primary care networks (PCNs) is to succeed.

Although many see their main job as focusing on what's happening outside – improving services for the PCN population, working with other providers, making the best use of the resources in the area – it's equally important that they ensure that all the member practices are on board, and are not just coming along for the ride.

That means ensuring that the line taken by the clinical director has been agreed with the member practices, that all the practices are fully signed up, that there's a clearly articulated vision that all share and that the progress of the strategy is kept under regular review. Network agreements – the written agreements between members about what they can expect to contribute and gain from membership of the network – provide a contractual framework for the relationship, but no more than that. The culture – how things are done around here – will take time to develop, and that can only happen if all the members are invested in the enterprise.

At the same time the clinical director needs to have eyes on the dashboard – how are our finances, what impact is the PCN having on the local system, are we making best use of our workforce and premises? Workforce poses particular challenges. Some roles are new, or new to general practice, and will need easing in with care. What impact will it have on the wider practice team, on workload, on the experience of patients? What about the experience of the individual concerned? Is it a rewarding job? Do they have the support they need to do it?

What is the clinical director doing to ensure that they are building a team around them with knowledge of finance, IT and governance issues needed to build an organisation that can act as well as think "at scale"?

Successful clinical directors will be those who realise quickly that theirs is a leadership and enabling role. Running a PCN is too big a job for one person. The clinical director will need to mobilise all of the resources at their disposal including practice managers, clinical leads and existing talent in the network.

Where there are gaps, they will need to decide how to fill them.

Here's the formidable list of things clinical directors will need to get to grips with in year one.

- Relationship management, starting with member practices but moving on to form strong links with community and voluntary sector providers. While the stability of the network is vital, so is early evidence that PCNs are more than general practice networks. Forming upward links with the STP/ICS will be important too
- Assess the population health needs of the network. This will need a review of all the available data, and needs to take into account immediate and future pressures in the system and local commissioning priorities
- Workforce mapping. While funding is being made available for PCNs to bring in new roles, the bigger task is to review workforce across the network as a whole looking at how the collective workforce of current and future network members could be best deployed to improve local services. How can reconfiguration be achieved through collaboration? What are the HR implications of managing the network workforce?
- Premises strategy. Delivering an expanded range of services to a bigger population will require suitable premises. Does the network have the right premises at its disposal? Are they in the right place? Do they need modernising? What assets do they own collectively? Could they be used differently to get a better result? Are improvement grants and other local funding available? Who do they need to talk to at NHS England or the CCG to get support for the premises plan?
- Understanding where the gaps are will be as important as identifying your assets. Not all of them will be addressable straightaway. Be realistic about those you can fill now, those that can wait until later and those that are beyond your control. They may include people, skills, finances, premises, IT, knowledge and are certain to include missing relationships
- What will your new workforce do? Although PCNs are not obliged to employ additional workforce, many will be keen to take advantage of the funding incentives for new roles – starting with clinical pharmacists. Each of these will come with a role description, but it will be up to the networks themselves to flesh these out to become jobs that provide value to the network and its patients. Left to their own devices, new staff will develop their own roles, but as we've seen from our work on the clinical pharmacists programme, the most successful integration happens when the clinician and their new employer work together to align the new role with the needs of the organisation and its patients.

Checklist for new PCN drivers

1) Drive the bus – taking a route most people agree with to a destination everyone wants to reach
2) Keep the passengers onboard – deal with inevitable delays, disappointments and the occasional disagreement among members
3) Be clear about the destination based on the health needs of the population and the wellbeing of the staff and organisations in the network
4) Keep an eye on the dashboard – how much fuel is in the tank, how far have we come, what's showing red?
5) Keep an eye on the road – what obstacles are up ahead, how do I get round them, who could help and what direction is national policy suggesting?

It's a daunting list and a tall order for clinical directors in the two days a week they can be reimbursed for under the network DES.

It may be tempting to skip some of the preliminaries and just get stuck into the practical tasks. For some this may include their vision for the PCN. Of course the 1200 networks have already spelt out their "vision" in their initial applications for PCN status, but it needs to be something that everyone in the network fully understands and signs up to. It should be a source of motivation and energy to tackle the many operational challenges networks face. It will need to be frequently communicated and checking from time to time to make sure it still has meaning.

On its own a vision statement or strapline is unlikely to be memorable or effective. What are the stories you tell that paint a picture of where you want the network to be? Do they show how life will be better for patients? Do they promise a brighter future for staff? Is it realistic and imaginable? Will it survive changing circumstances? Is it something you can communicate in two minutes? Who are you sharing it with? Everyone you need to influence – practice staff, network partners and system leaders – needs to be convinced by your vision, and convinced that you can deliver it.

It's equally important that clinical directors believe themselves. They have a challenging future ahead and just a few weeks into the job clinical directors need to set realistic objectives and make some quick, easy wins to establish trust and credibility.

PCC provides coaching, leadership development and other support services to PCNs. Contact enquiries@pcc-cic.org.uk for more information.

Training the primary care network leaders

by Helen Ellis

Helen Ellis

PCC is offering leadership development support for those setting up and becoming involved in primary care networks.

The move to network working means that leadership needs to focus multi-directionally - leaders need to think beyond their own organisations, build new partnerships and work closely with their peers in other parts of the health and care system.

As individuals are increasingly obliged to look beyond the boundaries of their own organisation for answers they will need to develop new capabilities. Influencing, negotiation, coaching and change management skills may be needed both to support their own organisations to take part in the evolving system and to nurture relationships with partner organisations.

We have supported leaders to develop their own skills and to get the best from all those they need to work with.

Our Confident Leader and other development programmes have an emphasis both on self-reflection and on listening skills. These have a positive impact on teams as they feel more respected and more fully engaged. There is plenty of evidence to show that engaged teams are more effective and have higher morale – and that this in turn leads to improved patient care.

William Greenwood, chief executive of Cheshire LMC, commissioned PCC to provide leadership development for local clinicians. Afterwards he said: "Excellent service throughout and value for money. Excellent pre and post session communications; good after service support via their online portal; willingness to share resources; flexibility to meet attendees needs on the day. They have expert subject knowledge and we will almost certainly be using their services again this year and in the future."

Our trainers use a coaching style and work in an open and honest way to ensure maximum trust and engagement so that our sessions are authentic and inclusive. We use proven methods and leadership theory but with an emphasis on applied learning – the acid test it that after any session, participants are able to see immediate benefits whether in improving working relationships, solving problems or removing obstacles to progress.

We believe in creating the space for people to learn from and share with one another, while learning new skills to improve system leadership.

We understand the pressures on leaders to do the day job, which make it easy to neglect development, so we ensure that your sessions are meaningful, relevant and never a waste of your time.

Our programmes, for leaders and for practice managers:

- Promote understanding of leadership styles and how to improve personal performance
- Develop the skills and strategies to work successfully in newly formed or developed partnerships
- Explore new ways of working across an integrated delivery system
- Provide skills and strategies to manage personal resilience while supporting system change and transformation.

The programmes include expert sessions on influencing skills, assertiveness, communication, managing conflict, courageous conversations and managing change and are a blend of theory and model-based learning and group work applicable to the delegates' situations.

We can work with small and large groups and offer executive coaching to individuals as well as peer support, self-coaching and group coaching.

Helen Ellis is head of personal and team development for PCC.
To find out more about our support for individuals and organisations contact enquiries@pcc-cic.org.uk

Physios hope to make first contact with PCNs

Jamie Bell

When primary care networks receive new funding for expanded multidisciplinary teams next April, physiotherapists will be one of the new roles they may want to bring into the team.

Jamie Bell, clinical and commercial director of Total Physiotherapy, believes that physios should be high on the list of priorities for PCNs, as they can have a potentially huge impact on GP workload.

His company's six physiotherapists have provided a varied number of weekly sessions to around 15 GP practices and federations for more than three years.

Inevitably he has encountered a variety of challenges – and successes – along the way.

He will be sharing these at a PCC event in Manchester next month which will explore how PCNs can make best use of the additional roles funding they will receive to fund some of this expansion in clinical expertise. Bell is one of four clinicians who will be telling their stories at the event.

Bell told PCC Insight: "I do hope the PCNs will open up opportunities for first contact practitioner (FCP) services in particular. They get excellent feedback – not least for being more flexible than many NHS services by providing, for example, evening sessions."

He cautions that networks need to be realistic about what level of service a first-contact physio can provide.

"We found that GPs need to be clear that if a physio or physio provider is commissioned to provide a first-contact service then that is not a replacement for the secondary care services where patients receive three to five treatment sessions. We will be taking the burden off GPs by assessing patients rather than providing intensive or complex treatment.

"Most of the patients we see have very basic conditions such as tennis elbow. The PCNs need to think about what MSK pathway they want to put in place but I can't see many practices wanting the physios they contract in to be doing joint injections."

At the other end of the spectrum however, Bell says, reception staff often need to be encouraged to offer patients swift access to a physio where that is appropriate.

"The challenges are usually around the training of the reception team: they need to screen the symptoms or patient presentation and direct them into the FCP service if that is appropriate. Once they have got to grips with that they are usually very positive because they enjoy being able to offer patients rapid access to a physio rather than a longer wait to see a GP."

Bell urges clinical directors to investigate current physiotherapy provision and build relationships with independent sector providers.

"I hope PCNs will open up opportunities from April and help practices use FCP services because they are embedded in a lot of places. We have had quite a lot of anecdotal positive feedback from various sources and patient feedback is excellent."

New workforce, new challenges

If primary care networks fail, the long-term plan will also fail. To succeed, PCNs need to get the workforce right. That means more staff in a wider variety of roles.

NHS England has recognised this by developing a five-year directed enhanced service (DES) payment scheme for PCNs, which are being encouraged to expand their workforce beyond the traditional practice-based roles.

PCC and primary care specialist law firm Hill Dickinson are running webinars and events to explore workforce considerations for PCNs and their member practices.

During a recent webinar, Amy Millson, a legal director in employment at Hill Dickinson, explained: "The DES funding will allow practices to share clinicians such as pharmacists, physiotherapists, physician associates, paramedics and social prescribers.

"PCNs that were established by 1 July this year will receive funding for those additional clinicians through to 2024."

However, she cautioned, the changes come with challenges – including questions around employer liability, clinical management and access to the NHS pension scheme.

All such issues, including agreement about the day-to-day management of additional staff, should be covered in a network agreement complete with a workforce schedule. The employment contracts that networks use may also depend on the PCN structure they have adopted.

Issues may arise after new staff are in place. These include the risk of creating a two-tier workforce with different line management arrangements, policies and procedures. Such inconsistencies could expose PCNs and member practices to claims of discrimination.

Emphasising the primacy of leadership, culture and integration, Millson said: "They are key to your practice but what happens when your practices come together? You and your partners will need to develop a leadership structure and strategy. They will decide how key decisions are reached. Do votes need to be unanimous or simple majority? Do all the partners in member practices have a vote or is it just one per practice?"

She also cautioned that unless NHS England extends the DES, PCNs will be faced with particular challenges in 2024 when retaining the additional clinicians/workforce from practices' own funds may be unsustainable. At this point, redundancies may be necessary and consultation with the PCN workforce would be essential. Employment tribunal claims might also follow.

Our next event on the expanding workforce and employment law is in Manchester on 15 October.

A good CHAT boosts quality and saves money in dementia care

A nurse-led service aimed at providing more care for care home residents with dementia outside hospital has produced big savings and improved patient care – winning national endorsement from NHS England.

As well as providing expert care to the residents, the Enfield Care Home Assessment Team (CHAT) supports and trains care home staff – giving them the confidence to respond to the residents' needs and to enable easier access to healthcare services when needed.

Having started as a pilot in four care homes in 2011, CHAT now supports 41 homes across Enfield and the neighbouring London borough of Haringey. The acronym is appropriate given the opportunity for communication that the team provides. Its membership draws together mental and physical health expertise – including community matrons, geriatricians, a consultant psychiatrist, mental health nurses, occupational therapists, a phlebotomist and pharmacists. The sense of integrated care is underlined by close partnerships with primary care, frailty networks and a tissue viability service.

While they work with individual residents, the team's contribution is magnified by the provision of follow-up education and on the job training to care home staff. That is vital given that an estimated 80% of care home residents have dementia – and most of those have at least one other morbidity.

The Barnet, Enfield and Haringey Mental Health NHS Trust's decision to establish the service was partly driven by demographic projections. The number of people over 65 with a dementia diagnosis in Enfield is expected to rise from around 2,000 people in 2018 to nearly 5,500 by 2035.

The implications of those projections for the local health economy were stark.

Between 2014 and 2017 A&E attendances and hospital admissions involving people aged over 65 with dementia rose by 18%. The proportion of those over 65 with dementia also rose in the same period.

The trust reckoned that many of these episodes of care could be managed within the care home by staff trained in managing end-of-life care pathways. From the start the service aimed not just to reduce hospital contacts but to improve end-of-life care, allowing more people to die in their preferred place of death – usually, for care home residents, the care home.

The CHAT team's involvement begins with a holistic geriatric assessment of a resident in the care home. The professionals either provide the care and treatment identified in the assessment or signpost the care home staff to appropriate support.

The impact in terms of both care quality and budgets has been significant. Improvements include:

- 35% fall in A&E attendance and non-elective hospital admissions – compared to a 23% increase over the same period among people over 65 who don't live in care homes
- A 9% reduction in hospital costs – nearly £600,000 – compared to a 34% increase in the general population of over 65s
- A 7% reduction in the number of falls leading to A&E attendance or hospital admission
- Most (99%) of residents dying in their preferred place of death
- Nearly 40% of residents having their medication reduced.

It is estimated that nearly 8,500 hospital attendances and more than 8000 GP call-outs have been avoided.

An additional benefit is that the team have trained more than 7,500 care home staff and managers in 59 subjects.

As the service has grown, so have the benefits – including reduced workload for the community mental health team, partly as a result of closer working with physical healthcare nurses.

Bringing together commissioners and a range of clinical providers under one service umbrella has also driven investment. Health Education England funded the employment of a community matron to lead on training.

As trusted assessors, the team's community matrons have reduced the number of delayed discharges from hospital. With the matrons on call, some care homes are now accepting weekend admissions.

Occupational therapy led vocational clinics get people back to work sooner

Royal College of Occupational Therapists

Saving GP and practice nurse time is a key priority in primary care, particularly for those appointments that could be more appropriately dealt with by other professionals.

The Royal College of Occupational Therapists has set up new clinics in Southampton and Pembrokeshire. These are giving patients with physical and/or mental health problems the option of attending vocational clinics led by occupational therapists.

These avoid taking up appointments with GPs who might not be best qualified to help. It also means they can get better advice about return to work, typically reducing their time off work. This benefits employers as well as the individuals concerned.

Over 340 patient and employer contacts made in a six-month period have saved thousands of pounds for local employers due to reduced sickness absence rates.

Some of the occupational therapists have been seconded from local NHS trusts so there are not any direct costs for the GP surgeries. The growth of primary care networks could make similar schemes attractive.

According to estimates by the Department of Work and Pensions, up to 10 million GP appointments – or more than 3% of all appointments – are for fit notes.

While some doctors are happy to provide advice and support to help people stay at work, many feel it is a low priority. Yet demand for fit notes is increasing. There is growing evidence by numerous organisations including Public Health England that employment is one of the most important determinants of life expectancy and quality of life.

Genevieve Smyth, who is leading this work for the Royal College of Occupational Therapists, says: "When we think about prevention it needs to start with working age adults. We currently have the highest employment rates on record but also a fast-growing part of our workforce with long-term health conditions. Many of these people will not have immediate access to occupational health and the first place they go for help is the GP surgery. Our new services put occupational therapists in the right place at the right time to give people the practical help they need to stay in work."

Occupational therapists provide self-management advice and suggestions for workplace modifications so patients are able to return to work sometimes weeks sooner than they would otherwise. This means less repeat appointments for ongoing GP fit notes and, better health outcomes for the individual.

Not only have the clinics been supported by the GPs and practice managers, practice staff have used it in a personal capacity to maintain their health and wellbeing to stay at work in pressured GP surgeries.

A GP, who is also a service user, said: "I have found the service very useful. I've struggled with dyspraxia and ADHD symptoms for as long as I can remember.

"I think people assume medics get special treatment but the reality is it's hard to access support when we need it particularly around mental health. Having some practical space to work things through has been beneficial particularly in terms of the time management and organisation.

"While things are stressed across the NHS, I reach saturation point quicker and this has definitely helped me stay in work and I'm a lot happier as a result. Most of it has involved some acceptance and good sense really but when you're busy saying it to others sometimes you lose sight of it yourself."

The role reimbursement scheme, which incentivises primary care networks to employ professionals in non-GP roles that relieve pressure on practices and improve services to patients, does not currently include occupational therapists. The Royal College of Occupational Therapists believes that this is a missed opportunity arguing that more and more commissioners would like to be able to include occupational therapists in practice teams.

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