The working of a primary care network in Wirral: experiences thus far

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In January 2019, the NHS Long Term Plan was published, setting out ambitious improvements for health and care services over the next 10 years (NHS England, 2019a). To support with transformation, sustainability and increasing demand, the plan places a significant emphasis on integration and dissolving boundaries between organisations. The plan describes the need for a cultural shift between health and care partners by wrapping around each other and moving forward as one system. These actions are to ensure that the population receives the best standards of preventative, anticipatory and unplanned care.

The NHS Long Term Plan encouraged sustainability and transformation partnerships (STPs) and integrated care systems (ICSs) to develop and implement their own strategies to execute local actions. This was to improve their services and population wellbeing while identifying the specific needs of the local community with place-based care (NHS England, 2019a). Primary care networks (PCNs) have since evolved, with a neighbourhood network of services coming together as a collective with a joint budget. PCNs have the potential to benefit patients by extending the range of services and care on offer to them and by helping to integrate primary care with wider health and community services at scale (Baird, 2019).

Wirral is an asset-rich area with a large number of services and organisations from the NHS, private and third sector. Previously, health and care partners lacked knowledge and understanding of all the services available locally, which often led to fragmented care, gaps in communication and frustration among professionals. The Healthier South Wirral (HSW) PCN was established following the NHS Long Term Plan, and it brought together seven GP surgeries, an integrated health and social care community trust and the third sector. HSW serves a registered population of 49 500 people. This PCN has a diverse geographical area, with both deep pockets of deprivation and areas of affluence, thus bringing unique challenges to health and care professionals in daily practice. Monthly meetings within HSW were commenced with the immediate focus on building relationships, improving local health outcomes and increasing staff satisfaction through quality-improvement projects. This was well-supported by the Primary Care Wirral GP Federation, which enabled the PCN to work at scale and begin to innovate.

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Workshops

In addition to the monthly PCN meetings in the Wirral neighbourhood, leadership workshops were held. It was acknowledged that local partners needed to know and understand each other with much greater depth before they could move forward as one system. The HSW workshops were a creative space that supported staff with appreciative enquiries. They provided protected time for health and care professionals to discuss and reflect on practice together. This enabled people to think more laterally about what services are on offer to the local population. Some professionals were already familiar with each other, but the workshops enabled them to refocus and reconnect as a unified local team. Time to reflect as a group is an essential requirement of any high-performing and successful team, especially when team members come from varying professional backgrounds and have varying experience (Cream, 2016). From multiple group exercises and

ABSTRACT

In order to meet the unique needs of local populations, health and care providers need to come together as a collective. A model of integration in line with the NHS Long Term Plan will support transformation, sustainability and meeting the increasing demands on the NHS. Due the complexity and variety of services in care communities, it is vital that organisations and the third sector acknowledge and understand one another with greater depth. Primary care networks (PCNs) support this by dissolving organisational boundaries, with services wrapping around each other and moving forward as one system. This article describes how one PCN in Wirral committed to appreciating each service's roles. By engaging regularly in different ways, members of the PCN were able build on professional relationships. The refocusing and reconnecting regularly as a collective team enabled a more streamlined approach to proactive, place-based patient care while providing professionals with improved working relationships, skill-sharing and increased job satisfaction.

KEY WORDS

◆ Integrated care ◆ Primary care networks ◆ Streamlining ◆ Skill-sharing ◆ Care co-ordination

BJCN_2020_25_7_PCNs_CJ.indd 353 25/06/2020 16:06

reflections, a common theme emerged from all services about the collective opportunity to learn together, empower the community and co-create a better system. Interdependence was embraced, with diverse teams knowing they could complement and support each other's roles. Shared, evidence-based learning and the creation of a more dynamic, unified workforce began to evolve with a person-centred approach specific to Wirral's communities.

Further to the Wirral-wide workshops, HSW also proactively brought professionals together to explore each other's roles and identify strategies to improve care for service users. A workshop in July 2019 had 35 attendees networking and reflecting together. It was a safe space for a conversation of equals, to build on plans for the future for safe care and excellent co-ordination. This HSW workshop led to the creation of locally enhanced methods to share information, skills and knowledge, and to improve multidisciplinary team (MDT) working for the most complex patient cases. It also supported a joint approach towards education and development, with opportunities for professionals to shadow one another in practice.

In September 2019, acute, community and primary care nurses facilitated a chronic obstructive pulmonary disease (COPD) education session. The acute care nurses provided up-to-date clinical education incorporating both diagnostic and pharmacological updates for the HSW practice nurses, nurse practitioners for older people and community matrons. In turn, this provided a space for reflection and clinical supervision for the staff attending while also raising awareness of the services and care on offer in Wirral.

In November 2019, another HSW workshop combined a dementia-awareness session and yoga class to support staff resilience and physical and mental wellbeing. The ongoing commitment to regular face-to-face networking strengthened relationships and enhanced appreciation of each other's roles.

Patient engagement event

A healthy lung patient engagement event was held in September 2019 at a community health centre, with over 50 people attending. It involved the author, secondary and primary care specialist nurses, a substance misuse team, social prescribers, a smoking cessation group and Age UK Wirral.

This event was advertised via text and flyers to the population served by the PCN. Patients attending the health centre to see their GP that day were also encouraged to engage with professionals and access the resources on offer. Attendees' ages ranged from 3 to 83 years. Expert advice was provided to most of the patients requiring management for asthma and COPD. Some seven adults registered an interest in commencing the smoking cessation support programme.

Age UK had the opportunity to recruit volunteers who expressed an interest in supporting with veteran groups and befriending services. They were also able to signpost some older people to community groups and activities specific to their interests and needs. The social prescribing service played a key role, too, providing important housing and benefits advice to many of those attending.

Professionals gained enormous job satisfaction in being proactive in their roles during this event, as well as engaging in valuable skill-sharing and further networking opportunities within the PCN.

Integrated care co-ordination teams

Wirral is divided into four health and social care hubs, and each hub has an integrated care coordination team (ICCT) that is aligned with a PCN. The ICCT is a multidisciplinary team comprising health and social care professionals and the third sector. Community, primary and secondary care can refer complex patient cases to the ICCT, which will enable people to be reviewed with an MDT approach to their care. Referrals are varied, from frail, isolated people living with dementia with a risk of falls and self-neglect, to patients with poorly controlled long-term conditions, such as COPD, with a history of crisis admissions. ICCT review and care enables vulnerable people with complex conditions to be as independent and healthy as possible while living in their own homes. It also enables robust, proactive crisis admission avoidance plans to be implemented.

Each ICCT has a locality meeting once a week, where people on the caseload are discussed with an MDT view. Every member of the professional team brings a valuable perspective, opinion and suggestion to resolve complex care needs. These are high-energy meetings and provide an opportunity for learning and development in every case. Weekly, structured MDT discussions are instrumental to the implementation and delivery of high-quality support and care in the community setting.

Patients will stay on the ICCT caseload for a maximum of 6 weeks, being reviewed by relevant professionals or members of the third sector. After this time, it is expected that patients would receive supportive, ongoing care in place or their health and social complexities would be stabilised.

Following HSW's workshops and networking opportunities, the HSW ICCT saw an increase in the number of complex patient referrals by 20% in 10 months. This was particularly from GPs and practice nurses, with their improved understanding of this service within the locality. There was also an increased attendance by professionals at weekly meetings. This has enabled HSW to be particularly proactive in complex case management of its most frail and vulnerable patients. Data from July to December 2019 indicated a decline in hospital attendances by 1.7% in comparison to 2018. Although this is a marginal reduction, it is anticipated with the continued successful development within the PCN and ICCT that hospital attendances should continue to decrease with improved, proactive, joined-up care.

Physician associates

In the past year, five physician associates have been introduced in HSW GP practices. Physician associates are generalist health professionals trained to a medical model who work alongside GPs and the wider MDT. Physician associates provide medical care in an enabling role, bringing new talent and a varied skill mix to MDTs. In general practice, they work within a defined scope of practice, offering patients a comprehensive review and examination while developing appropriate personalised treatment and management plans. This role may also be found in acute care settings, such as the emergency department and in patient wards. Posts such as the physician associate can support with the new operating model proposed for workforce planning

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and transformation as part of the NHS Long Term Plan (NHS England, 2019b; Royal College of Physicians, 2020).

HSW physician associates have been a valuable addition to the MDT and weekly locality ICCT meetings. These professionals have facilitated consistent weekly face-to-face contact with the GP surgeries, discussing complex patient cases and offering a varied perspective and opinion to community care and admission avoidance plans. The physician associates can also bring new patient cases to the locality meeting weekly, asking for advice on complex cases they have seen in practice that week. In-depth holistic assessment by physician associates is an integral part of review and is particularly valued in MDT discussions.

COVID-19 response

The evolution of the HSW PCN enabled and supported its response to the COVID-19 pandemic. Wherever possible, there was a shift to remote patient consultations. GPs, community nurses and social prescribers connected regularly via virtual meetings for professional support and education, as well as to discuss patients. It was immediately identified that the community trust nurses and GP practices had similar registers of frail, vulnerable people who needed to be contacted and supported in the safest manner possible. To avoid duplication between services and to maximise the impact of any patient contact, caseloads were shared and alerts were put on patient electronic records to state which professional and service was leading on that person's care during the COVID-19 pandemic. There was a strong emphasis on making every contact with a patient count and to minimise any necessary human traffic through patients' homes.

HSW set up a COVID-19 hub at a local leisure centre car park. This enabled people who were confirmed to have or suspected of having COVID-19 to drive through an assessment area and be examined in well-ventilated pods. In a large sports hall at the leisure centre, socially distanced education on patient assessments was facilitated by a GP for physician associates and community matrons. Community trust staff also attended this hub once daily for socially distanced face-to-face communication with the GP surgery staff about patients, local capacity, home visits and COVID-19-positive patients in the practice population.

Due to the strong foundations of professional understanding and appreciation for each other, the transition into working differently due to COVID-19 in the community setting felt supported and well-coordinated. The familiarity between GP surgery staff and community nursing enabled professionals to adapt and evolve in these challenging times.

Conclusion

The work of HSW PCN was recognised nationally. NHS England's Primary Care Lead, Nikita Kanani, visited the PCN in the summer of 2019 to learn about how it was building better professional relationships and improving the local population's health and care.

The quality of professional relationships is paramount in enabling organisations to move forward as one system. Services need to be integrated if high-quality care is to be provided to patients. It is highly unlikely that one cohort of professional staff can meet all the needs of a complex population alone. It is essential that services are knitted together further for the sustainability and future success of the NHS. PCNs can support this concept by being a diverse and supportive neighbourhood team. Moving forward, they can enable care to be delivered in a more effective, specific model. Place-based care can be better built around smaller groups of professionals operating locally to meet the unique needs of their own communities. It can also facilitate an improved focus on care and shared teams rather than activity and contracts. Regular contact and interactions have been pivotal for the success of the HSW PCN. It may appear to be a simple concept with workshops, patient-engagement events and virtual meetings, but it is the simplicity of having this regular interaction and excellent understanding of each other's roles that supports the PCN's innovation in the ever-changing landscape of a complex health and care system. **BJCN**

KEY POINTS

- Models of integration can support with transformation and sustainability of the NHS, as well as with meeting the demands on the service
- Primary care networks can enable professionals to meet the unique needs of their local population
- Effective multidisciplinary team working is facilitated by appreciation and understanding of each other's roles
- Health and care professionals benefit from refocusing and reconnecting as a collective team
- Investing in the improvement of professional relationships enhances patient care and job satisfaction.

CPD REFLECTIVE QUESTIONS

- What individualised care and services are specific to your geographical area of community practice?
- What activities could strengthen professional relationships?
- What factors of the primary care network model can further support community nursing services?
- How has COVID-19 changed multidisciplinary team working and community care?

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