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Personalised Care Team External Referrals Pilot Report

February 2024

Summary

Following a consultation process facilitated by Kera Consultancy Services Ltd, involving Action Learning Sets (ALS), and representatives from all Hartlepool and Stockton Primary Care Networks (PCNs) and Service Providers, a pilot was launched in October 2023. The pilot tested the concept and process of standardising the referral process into Personalised Care Roles.

Initially, stakeholders representing all PCNs participated in cause-and-effect analysis to understand the problem they were retrying to solve using a Fishbone Diagram[1]. SMARTER aims[2] were developed to test the proposed change(s) to the referral process, through A Plan Do Study Act (PDSA) cycle[3]. A single referral form with a clearly defined pathway was created to direct the referral to the PCN team responsible.

Six referral sites were recruited to take part in the pilot. Referral sites were offered a presentation about Personalised Care and a demonstration on how to use the referral form. All referrers participating in the pilot were asked to complete a short survey after each referral to gather referral data and feedback on the process.

The data has shown that the pathway reduces burden on general practice's resources and supports the patient to reach the appropriate team directly. Unexpected benefits have arisen to include improved information gathering and appropriateness of referrals, as well as improved system level access with stronger partnerships and communications between Personalised Care and local partners.

A Phase 2 extension of the pilot is therefore proposed from January to June 2024.

Evaluations from the ALS sets showed that 100% of PCN representatives felt the sessions were 'very good' or 'good' with quotes including "this meeting group has been a good use of our time and we have positive outcomes for patients".

[1] Cause and Effect (fishbone) https://www.england.nhs.uk/wp-content/uploads/2021/12/qsir-cause-and-effect-fishbone.pdf

[2] Developing your aims statement https://www.england.nhs.uk/wp-content/uploads/2021/03/qsir-developing-your-aims-statement.pdf

[3] PDSA and the Model for Improvement - https://www.england.nhs.uk/wp-content/uploads/2022/01/qsir-pdsa-cycles-model-for-improvement.pdf

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Rationale

To improve access to Personalised Care Roles across the three PCNs in Hartlepool and four PCNs in Stockton, by clearly defining and streamlining the referral processes available to patients and professionals. Within the ALS, the team used the NHS Model for Improvement to provide a structure for the pilot[3].

Group discussions allowed the representatives to identify what they were aiming to accomplish:

- Reduce the variation in access to Personalised Care
- Improve access to Personalised Care Roles
- Increase collaborative working at scale across all seven Personalised Care Teams

Existing barriers identified during consultation:

- Referrals across many of the Personalised Care Teams have been largely restricted to internal referrals only (Primary Care Staff)
- Teams accepting external referrals are aware of multiple, historic, and out of date referral forms in circulation in the wider community.
- External referrals received via multiple non-approved routes, creating opportunities for referrals to become lost or bounce around between different PCN Teams
- Patients wanting to self-refer have been advised to self-present and be triaged by their GP practice, impacting on telephone, administrative and clinical resources.
- Primary Care Networks and their respective service providers are still not widely understood which creates confusion for patients and potential referrers.

Concerns/ Risks

PCN representatives and Personalised Care team staff expressed concern with:

- Capacity to accept additional (external) referrals and becoming overwhelmed.
- Personalised Care Teams collaborating at scale.
- Sufficient momentum to complete the pilot and if ongoing data was required to demonstrate impact to keep ensure continued engagement.
- Knowing if change(s) were having a positive impact on Primary Care

To measure the impact of the referral pathway on Primary Care resources, including time and cost savings to clinical and administrative time, outcome measures were integrated into the referral process.

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Results and Outcomes

Six organisations agreed to be a referral partner in the pilot. These included: *Stockton Adult Carers Service, Change Grow Live, North Tees and Hartlepool Foundation Trust (Waiting Well and DNA project), Let's Connect, START, IMPACT (IAPT service for Long Term Conditions)*.

A total of 12 referrals and accompanying surveys were completed between October and December 2023 *(Figure 1)*.

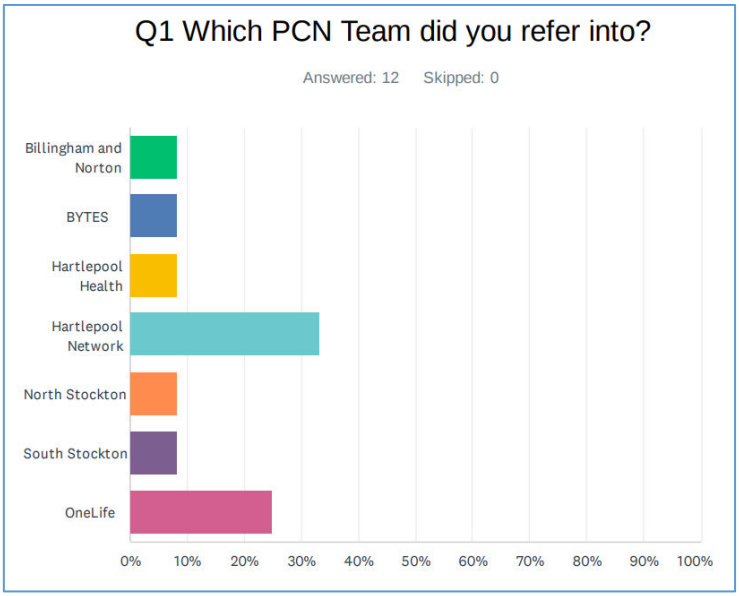

Figure 1

Referrers found the form either 'Very Easy' (83%) or 'Easy' (17%) to fill in.

Most referrers (92%) described the length of time taken to complete the form as 'Relatively Short', as opposed to 'Too short' (0%), 'Too Long' (0%) or 'A Long Time but Acceptable' (8%).

None of the referrers had difficulty getting the form to the right PCN team *(Figure 2)*.

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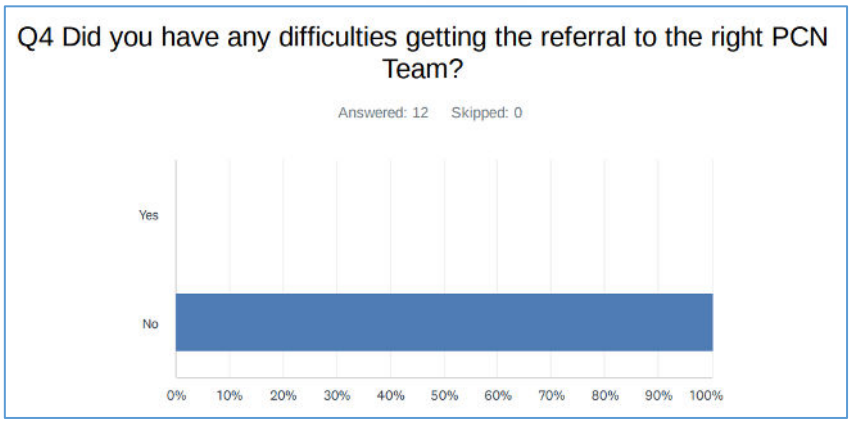

Figure 2

Referrers were asked how they would have otherwise supported the patient to access this support without the use of the referral pathway. The survey results in *(Figure 3*) showed that most referrers would have used a route involving other touchpoints or resources at the patients' registered GP practice.

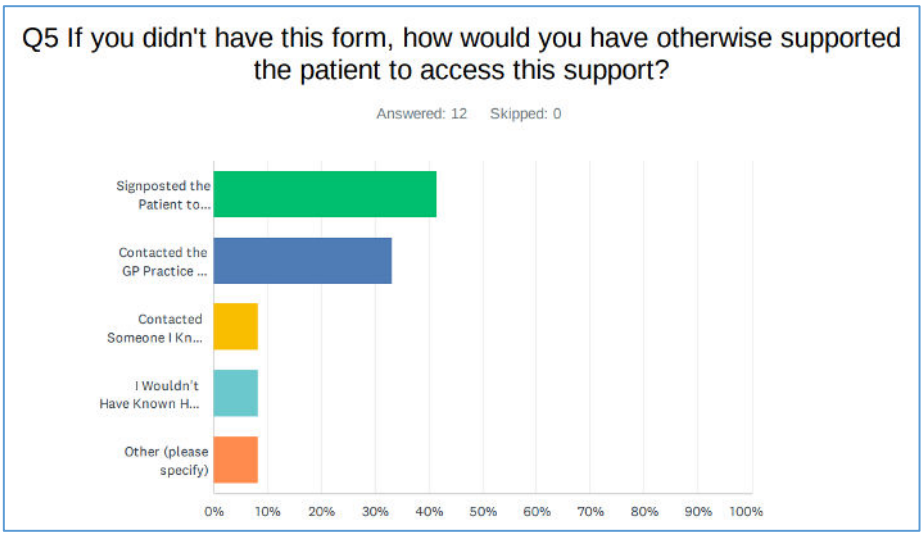

Figure 3

For example: signposting the patient to speak to their GP Practice (42%); contacting the GP Practice themselves on behalf of the patient (33%); or, *'Send a letter to GP practice requesting they review client'* (8%). The data indicates a potential for reduction in demand for GP appointments and will make it easier and quicker for patients to access the help they need from primary care tackling the 8am rush in line with the Primary Care Access Recovery Plan

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(PCARP)[4]. If the pilot process is adopted, this data indicated that 42% of the personalised care appointments can be directed to the link workers, care coordinators or health & wellbeing coaches rather than being directed to request a clinical appointment first.

8% would have used an unofficial route via someone they know that works in the service.

8% expressed they would not have known how to support the patient to access support.

Personalised Care Team Feedback

Personalised Care Teams had not received as many referrals as they originally thought they would via by the pilot, contrasting earlier concerns around capacity and being overwhelmed. Staff felt that the layout of the form provided them with more information than they would normally have in a referral which has been helpful. The referrals were overall deemed to be more appropriate.

Representatives explored what changes could be made to make further improvements and the consensus across the PCNs to explore the option to be expanded for self-referrals to support the Integrated Care Board's (ICBs) 2023/24 Operational Planning Guidance[5] by produce a standardised self-referral form for patients to access via their surgery website for direct support from the Personalised Care team, without the need to see a clinician first was agreed.

Outcome

The data shows that the pathway improves access to Personalised Care Roles, allowing patients to reach the appropriate team directly and more efficiently, saves time and resources in GP practices, and reduces pressures on Primary Care.

Surprising and welcomed benefits of the pilot have provided Personalised Care Teams, some of which are still in the early stages of establishing their roles and understanding their limitations within Primary Care, to develop their Personalised Care service offer. Through better connections and communication with the wider system, and teams receiving more appropriate referrals with rich and useful information included, as well as the opportunity to work and collaboratively with others, they are able better able to integrate and help meet the huge scale ambition of changes in General Practice.

[4] Delivery Plan for Recovering Access to Primary Care https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/

[5] Integrated Care Board's (ICBs) 2023/24 Operational Planning Guidance PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf (england.nhs.uk)

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Recommendations

- Expand the referral pilot into Phase 2, widening the opportunity to other services and stakeholders in a gradual manner – January to end of June 2024.
- Review Phase 2 with Personalised Care Team representatives from each network in July 2024.
- Continue to ask for referrer feedback and data but at their discretion instead of after each referral as per Phase 1.
- Create a shared tool to keep track of the services involved with the scheme so that new versions or updates of the form can be communicated effectively.
- Use National Social Prescribing Day on 14.03.2024 as an opportunity to share learning on the approach taken.

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Appendix 1 - Personalised Care Team Referral Form

Please use this form to submit referrals into Primary Care Personalised Care services in Stockton and Hartlepool.

These services can include **Social Prescribing Link Worker**, **Health and Wellbeing Coach** or **Care Coordinator** provision. Please be aware that:

- These are **non-clinical** and **non-urgent** services.
- While all practices have access to **social prescribing**, other roles can vary.
- You will need to know the **GP Practice** of the person you are referring to ensure it reaches the correct team *(see page 3 of referral form).*

Examples of Inclusion Criteria	Exclusion Criteria
• All ages** • Bereavement support • Care navigation support • Connecting to groups for activities • Employment/Training support • Finance/ benefits/debt advice/cost of living • Food bank • Housing problems • Lonely or isolated • Low level mental health needs • Migrant/refugee/asylum seeker support • Parenting / family / carer support • Relationship problems • Smoking cessation • Support to manage long-term health conditions • Accessing exercise and healthy eating support *** Some referrals for under 18's may be referred onto targeted youth support organisations if necessary.*	• Clinical/ medical needs • Safeguarding concerns - *where referrer believes there may be safeguarding concerns* - *active investigation ongoing* • Severe mental health condition *(under secondary care)* **Patients with medical needs should contact their GP practice directly or 111 as appropriate.**

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Date of Referral:	Click or tap to enter a date.
Service Requested (if known):	Choose an item.

Name of referrer	
Job Title	
Department	
Address of organisation	
Contact Number	
Contact Email	

Patient Details

Forename		**Address**
Surname		
Preferred name		
NHS Number (if known)		
DOB		
Contact Number(s)		
Consent for referral ☐		**Consent for us to speak to referrer ☐**

Reason for referral

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Risks
Please let us know any risks associated with the patient. *Drug/alcohol abuse, active safeguarding investigations, self-harm/ suicidal ideation*
Service involvement
Please let us know which professionals and services this person is already working with. *For example: social worker, hospital service, voluntary service, mental health support service, care provider etc.*

Name of GP	
Please select the patients' GP Practice and PCN from the drop down lists below:	
Hartlepool:	Choose an item.
Stockton:	Choose an item.

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Please send completed referral forms to the email address of the appropriate PCN team

Hartlepool	
OneLife PCN	Bankhouse - hstccg.a81007@nhs.net Chadwick - nencicb-tv.A81011@nhs.net Havelock Grange - nencicb-tv.a81031@nhs.net
Hartlepool Network PCN	nencicb-tv.hartlepoolnetworkpct@nhs.net
Hartlepool Health PCN	nencicb-tv.a81044splwteam@nhs.net
Stockton	
North Stockton PCN	nencicb-tv.nspcnsplw@nhs.net
South Stockton PCN	nencicb-tv.stocktonsouthpcnexternalrefer@nhs.net
Billingham and Norton PCN	nencicb-tv.bnpcnsplw@nhs.net
BYTES PCN	sprescribing@middlesbroughandstocktonmind.org.uk


HARTLEPOOL
North Stockton
Primary Care Network
Stockton Primary
Care Network
Billingham
& Norton
Primary Care Network
BYTES
Primary Care
Network
One Life Hartlepool
Primary Care Network