Report of the **GP Services Workstream**

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Contents

1. EXECUTIVE SUMMARY

Somerset's new health and care strategy 'Fit For My Future' has a clear structure, starting with population need, then looking at pathways of care, and only finally considering settings of care. This is to make sure we focus on patients not organisations, meeting needs not service requirements.

However, because GP services are so important, and because decisions are needed now on transformation and workforce, it was agreed that an in-depth look at GP services would be undertaken as early as possible.

This is the report of that work. In summary it found that:

- The people of Somerset need and value local, high quality GP services
- There has been a significant loss of GP workforce in Somerset- we now have far fewer GPs than we did in 2013
- In general, GP services are still providing a good service, but
- The service is under extreme pressure
- There are wide variations in waiting times, continuity of care and other indicators of clinical quality
- Several important aspects are in decline, in particular continuity of care
- Many practices are innovating new approaches, but the spread of innovation is uneven
- General practice in Somerset is not currently able to play the role of foundation in a modern integrated care system
- The Somerset system will not be able to meet the needs of the population without resilient, flourishing GP services
- Urgent action is now required to deliver national and local priorities.

This report contains wide ranging recommendations for action. These are summarised below:

1. Population Health There are significant opportunities for more to be done in general practice to promote population health. The commissioners should identify these opportunities and include them in their commissioning intentions, recognising that investing in additional capacity to improve population health will deliver a significant return on investment.
2. Self-help and self-care General practice could be a significant contributor to population health messages. There is also a pressing need to divert or avoid activity in general practice in order to secure a resilient and sustainable primary care provider sector. This should include making good quality online information and advice available on every practice website, promotion of self-care resources and greater use of community pharmacy.

3. Access

Reasonably timely access to GP services is an important feature of a well-functioning health system. Some practices have demonstrated how understanding and investing in demand management, capacity planning and workflow/organisation can transform the experience of patient access and lead to better population health management. We need to help every practice to provide good patient access, working to a shared ambition between providers and commissioners. Commissioners need to invest in a model of general practice which offers reasonably timely access as standard.

4. Continuity of care

Continuity of care is a key variable in emergency admissions. It is an area which should be of the greatest interest to the system. A symposium including providers, academics and commissioners should be established immediately to develop plans to retain and increase continuity in Somerset. Commissioners should explicitly commission for continuity, and this should be reflected in their commissioning intentions.

5. Variation

Across a wide selection of measures there is a significant level of variation - we need to understand and focus on variations in outcome and on the measures that matter most. Clinical evidence should be at the heart of our approach.

6. Workforce

Comprehensive action is required to improve the primary care workforce situation. A ten-point plan for primary care workforce in Somerset has been developed. This describes a feasible programme of action over the next five years. This should be adopted and implemented immediately.

7. Organisation of general practice

In order to meet the needs of patients and deliver national policy requirements there is a need to organise GP services in the most effective way. We believe the term 'organised primary care' is a more accurate term than 'primary care at scale'. By this we mean that:

- Population health management is delivered optimally
- Clinical care is delivered in a consistent way for all patients and carers
- There is a high level of continuity of care for the whole population.
- Workforce is managed to make the most of scarce and precious resources
- Access is managed so that all patients receive a timely and responsive service.
- A wide range of services are delivered at a local practice level and at a 'neighbourhood' level covering 30,000- 50,000 people.
- There is a co-ordinated provider organisation/s providing a wide range of support to practices- everything from business efficiency to removing partner

liabilities

Transformation funding should be used to develop ‘organised primary care’ in Somerset.

8. Leadership and change

It can be hard to make change ‘stick’ in primary care. We need to support leaders who can inspire peer-led improvements, fostering ‘joy at work’ through a constant focus on improving things, inspiring positive team climates and having an orientation to work collaboratively with others. Comprehensive leadership development support is crucial, particularly for GPs and Practice Managers who find their roles rapidly changing.

9. Investing in GP services to support the whole system

More could be done in general practice but further investment is needed to achieve this. We should continue to invest including targeting health need and those variables which we know are related directly to system costs, such as continuity of care A bundled practice contract is vital to deliver a consistent service to patients.

There should be clear articulation of service expectations by commissioners and effective contract management within an overall context of trust and shared interest.

The CCG should take full responsibility for commissioning GP services from NHS England as quickly as possible.

None of this will happen without strong, purposeful leadership that facilitates the right motivations and behaviours to enable successful change. The resources required, in time, people and money cannot be underestimated. The scale of the challenge confronting us is vast. But the prize justifies the effort - to create a highly effective health and care system, supporting the people of Somerset to have the best possible health outcomes. This can only be realised by having a strong foundation of general practice.

We hope that our work will be of assistance in developing the overall strategy for health and care services in Somerset for the coming years.

2. INTRODUCTION

Somerset's new health and care strategy 'Fit For My Future' has a clear structure, starting with population need, then looking at pathways of care, and only finally considering settings of care. This is to make sure we focus on patients not organisations, meeting needs not service requirements.

There are six pathway workstreams:

- Population health and wellbeing
- Urgent and Emergency Care
- Proactive Care for People with Complex Needs
- Maternity and Children's Services
- Planned Care
- Mental Health and Learning Disabilities

And each of these pathway workstreams is considering its subject in totality, from prevention, self-help, community resources-primary care through to secondary care. Each workstream will have implications for the future of GP services in Somerset.

However, because GP services are so important~~,~~ and because decisions are needed now on transformation and workforce, it was agreed that an in-depth look at GP services would be undertaken alongside the six pathway workstreams.

Following an initial data-gathering and scoping exercise, we posed the following questions which we expected to be able to answer through this work:

- Patients are very clear that they value a local GP service with continuity of care and reasonable access. How can we provide this to a dispersed rural population and with a limited GP workforce?
- What should be the role of general practice in population health management? How could we organise and contract for optimal primary and secondary prevention of disease. Would this be easier to deliver at larger population level?
- How can we ensure that clinical care is delivered in a consistent way for all patients? Should unwarranted variation be identified and reduced through a peer-led, collegiate quality improvement approach or through contractual specification?
- The research evidence is very clear that continuity of care is strongly related to system cost, for both emergency and elective care. How can we maintain and even enhance the level of continuity available? Is team-based continuity of care the answer?
- How should we utilise the very limited workforce available to best effect? What skill-mix model can be agreed between commissioners and providers so that a pipeline of newly qualified staff can be organised? What are the

preferences of GPs and how can we use this knowledge to increase recruitment and retention?

- Access is important to patients. We know that approximately 20% of general practice consultations are clinically urgent and need to happen on the same day, but that about 50% of patients would prefer to be seen the same day, and when offered a service model which routinely offers a same day service that rises to about 80%. Waiting times at Somerset practices range from less than one day to several weeks. What is a reasonable and deliverable aspiration for access?
- General practice already delivers a wide range of services at a local practice level. How should we sustain these services and increase the scope of what is delivered locally?
- We currently spend 10.2% of the NHS budget in Somerset on general practice. Are we targeting this funding in a way that delivers optimal benefits for the population and the healthcare system? Do we need to increase funding and if so what benefits would accrue?
- Where are the greatest opportunities for one-off investment through transformation funds in general practice?
- What should our approach be to developing practice networks at a 30-50,000 population level? Should we see this as the basis for integrating community and primary care services at a local level?
- How can we promote GP leadership and innovation in a challenging environment?

In addition to the questions above which the GP element of the strategy is seeking to answer, there are significant questions for the other workstreams which have impacts on general practice. These include:

- For urgent care, the opportunities and impacts of Urgent Treatment Centres in particular, as well as the other policy requirements for Integrated Urgent Care, Urgent Treatment Centres, Direct Booking from 111 into practices and Integrated Front Door at our two A&E departments
- For long-term conditions, the opportunities and impacts of a proactive care approach
- For planned care, what opportunities exist to re-provide large amounts of activity in community settings, possibly through contracting at scale with a GP provider organisation.
- For mental health, a more integrated approach to primary and secondary care delivery.

This report describes our work in seeking to answer these questions. Our findings are positive. Although GP services in Somerset are under real pressure, there are many positive aspects. We found the leadership, innovation and understanding of population health benefits that are required in order to start a renaissance in general

practice in Somerset. There is a firm foundation of evidence which we now need to take action on, working together as a community of commissioners, providers and patients to improve GP services for everyone.

There is no doubt that if the right leadership, time and financial resources are brought to bear, we will succeed in this.

3. PUTTING THE PATIENT AT THE HEART OF EVERYTHING WE DO

Patients have given us a strong and consistent message; they value a local, personal general practice team with continuity of care and timely access. It is incumbent upon us a system to respond to these perfectly reasonable wishes.

Further, the research evidence bears out the validity of these desires, for example showing that continuity of care reduces secondary care utilisation, longer appointment times deliver greater enablement of patients, and that local availability of primary care services reduces population mortality.

However the commissioning of GP services has not kept up with changing population trends and aspirations. As a society, we are increasingly orientated towards rapid online access to goods and services and an expectation of same-day access. There is also an increased utilisation of services which is demonstrated by a steep rise in GP appointments per person, approximately 15% between 2010 and 2015 (Kings Fund, 2017). Although satisfaction with GP services is still relatively high - 85% of patients describe their experience as good or very good (Ipsos Mori, 2017) - the trend is downward. Overall, younger patients are less satisfied with the service they receive from GPs than people aged 35 years and over. Across a wide range of measures 18-34 year olds have satisfaction levels often half that of older people, and sometimes far worse. Younger people far prefer walk-in centres, many of which have closed in recent years. Evidence also suggests younger adults are more likely to turn to A&E when they cannot secure an appointment with the GP. (Citizens Advice, 2014).

A rapidly ageing population increasingly living with complex multiple conditions also adds to the demands for GP services. The Kings Fund (2017) found that the share of clinical staff contacts taken up by patients over 85 increased by 16 per cent, from 3.6 per cent to 4.3 per cent (a 28 per cent increase in total contacts).

Although most funding for GP services in Somerset is weighted according to the Carr-Hill Formula to take account of age and deprivation of practice populations, there is more that could be done to address health inequalities through GP services.

These changing demands have impacted heavily on a model that is still commissioned and provided largely in a traditional way with ten-minute face to face GP appointments and a service model that consists primarily of General Practitioners, supported by some ancillary staff. Funding has not kept pace with demand and the overall share of NHS funding for GP services has reduced since 2010.

It is therefore little wonder that some patients are concerned and frustrated with the GP services available to them, and that some practices are overwhelmed and feel unable to cope with demand. Increasing numbers of GPs are seeking to retire early or are leaving the profession because of ill-health (Sansom et al, 2018).

In Somerset, we have a very mixed picture. Some practices are amongst the highest rated by patients in the whole of England. In some places all face to face appointments take place on the same day. We have national exemplars in holistic care for people with complex needs. Some practices have no difficulty recruiting and retaining GPs. In other places, patients are waiting four or five weeks for an appointment and practices are unable to recruit to vacancies. There is a risk in Somerset, as elsewhere, of practice closures although much concerted action has been taken to avoid this.

General practice offers four main benefits to the population and the healthcare system:

1. Person-centred, not disease specific care
2. Lifelong, not episodic care
3. A comprehensive set of services delivered locally
4. Care co-ordination for people whose needs go beyond the general

Co-ordinated action is now needed by commissioners and providers to ensure that these benefits are not lost, but are in fact enhanced. As the needs of patients are increasingly complex, it is vital that we take a thorough look at how patients' needs are responded to.

The needs of patients are at the heart of this strategy and will be at the heart of our work as we seek to deliver improvements in GP services in Somerset.

4. NATIONAL POLICY REQUIREMENTS

The challenges of modern day general practice are being felt up and down the country, this is evidenced by the number of GP practices in England reducing by 671 in a four year period (2013 – 2017[1]).

NHS England reacted to the general practice decline in April 2016 with the publication of the General Practice Forward View (GPFV), a document full of commitments delivered through an extra £2.4 billion a year to support general practice by 2020/21. The document pledges to improve patient care and access, and invest in new ways of providing primary care.

The GPFV includes help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to speed up transformation of services.

NHS England structured the support package under five key headings; Investment, Workforce, Workload, Practice infrastructure and Care redesign. Under each of these headings are a number of commitments to discharge at either a national and/or CCG level. The full list of commitments made in the GPFV can be found in appendix A.

CCGs are mandated to implement the commitments of the GPFV through the NHS Operational Planning and Contracting Guidance published jointly by NHS England and NHS Improvement.

The first guidance document setting out the requirements on CCGs was published in September 2016, with a refresh planning document published in February 2018. Below is a summary of the national policy requirements on CCGs for 2018/19.

Workforce	Delivering their contribution to the workforce commitment to have an extra 5,000 doctors and 5,000 other staff working in primary care. CCGs will work with their local NHS England teams to agree their individual contribution and wider workforce planning targets for 2018/19. At national aggregate level we are expecting the following for 2018/19:
	CCGs to recruit and retain their share of additional doctors via all available national and local initiatives;
	'600 additional doctors recruited from overseas to work in general practice;
	'500 additional clinical pharmacists recruited to work in general practice (CCGs whose bids have been successful will be expected to contribute to this increase);
	An increase in physician associates, contributing to the target of an additional 1000 to be trained by March 2020 (supported by HEE);

[1] https://www.gponline.com/number-gp-practices-drops-650-four-years/article/1436925

	Deliver increase to 1,500 mental health therapists working in primary care.
Investment	Investing the balance of the £3/head investment for general practice transformation support. This is a non-recurrent investment designed to stimulate development of at scale providers for improved access, stimulate implementation of the 10 high impact actions, and secure sustainability of general practice.
Networking	Actively encourage every practice to be part of a local primary care network, so that there is complete geographically contiguous population coverage of primary care networks as far as possible by the end of 2018/19, serving populations of at least 30,000 to 50,000.
Estates and Technology	Investing in upgrading primary care facilities, ensuring completion of the pipeline of Estates and Technology Transformation schemes, and that the schemes are delivered within the timescales set out for each project.
Sustainability and Resilience	Ensuring that 75% of 2018/19 sustainability and resilience funding allocated is spent by December 2018, with 100% of the allocation spent by March 2019.
Time to Care	Ensuring every practice implements at least two of the high impact 'time to care' actions.
Provider development initiatives	In all practices, delivering primary care provider development initiatives for which CCGs will receive delegated budgets, including online consultations.
Improving Access	Providing extended access to GP services, including at evenings and weekends, for 100% of their population by 1 October 2018. This must include ensuring access is available during peak times of demand, including bank holidays and across the Easter, Christmas and New Year periods.

5. RESEARCH EVIDENCE SUMMARY ON EFFECTIVE GP SERVICE MODELS

Introduction

It is often said that general practice is the 'jewel in the crown' of the NHS. There is little explicit disagreement with this, but the fortunes of GP services as a sector of the NHS have ebbed and flowed considerably over the last seventy years. For a number of reasons relating to workforce, demand, morale, finance and politics, general practice as we know it is facing an existential challenge. We can no longer assume that GP services will just be there. Equally, the evidence requires us to ask some hard questions about the role of GP services in a modern integrated health and care system. These include variation in clinical practice and the organisation of general practice to deliver optimal outcomes.

The purpose of this brief paper is to inform those questions with the evidence from literature as it currently exists. There are some surprising gaps in our knowledge but also some strong messages which will help us to set the course for GP services in Somerset in the coming few years.

Key messages from the evidence base

There is a wide range of research evidence, spanning the effectiveness of primary care as part of national health systems to small scale studies at individual patient level. Interestingly there is little that is easily available to commissioners by way of systematic review which would help to answer the kind of questions that now face us in Somerset. However the main health think tanks including the Nuffield Trust, King's Fund and Health Foundation, The Royal College of General Practitioners, organisations representing patients' views and the British Medical Association have all published extensively on GP services in recent years.

It is important to note the context for GP services; they are not an island but a fundamental part of any modern integrated health-care system. For this reason we need to be clear about the inter-relationships between GP services and the wider system, particularly when identifying opportunities for GP services to do more. As Imison et al (2017) state in their overview of evidence for STPs seeking to shift care out of hospital;

"Many initiatives we examine place additional responsibilities upon primary and community care, at a time when they are struggling with rising vacancies in both medical and nursing staff, and an increasing number of GP practices are closing. Addressing these issues is a necessary precursor to success."

In the absence of a full systematic review, there are a number of very significant pieces of work including a joint report by the King's Fund and The Nuffield Trust,

commissioned by West Midlands SHA in 2012 (Smith et al, 2013). It described the challenges facing general practice and proposed a set of key design principles. As it was written by a highly authoritative team of academics and policy experts and has not been superseded by more recent research evidence it can be treated as valid evidence for our strategy. The report states that no one model of general practice organisation will fit the bill; local context is important. However the study makes clear that extending the scale and scope of GP services is vital. The study proposes a set of clinical and organisational design principles. These are reproduced below:

Clinical design principles

1. GP services must be characterised by early senior clinical contact
2. Systematic use of technology to improve access for patients
3. Minimum number of separate visits
4. Access to specialist services at convenient locations
5. Continuity of care **and** rapid access are important
6. Proactive, population based care
7. Care for frail older people tailored to their specific needs
8. Patients are supported to identify their own goals and manage their own health

Organisational design principles

1. Care is delivered by a multi-disciplinary team
2. Forms of clinical encounters respond to the needs of patients
3. Practitioners have immediate access to common diagnostics, guided by clinical criteria
4. A single electronic record is available to all providers
5. Data on quality and outcomes is available openly and in real time
6. There is professional management, expert leadership and organisational development support.

The approach above is reinforced by The King's Fund (2018) in a review of innovative models of general practice seeking to respond to the crisis:

"We set out five attributes that underpin general practice: person-centered, holistic care; access; co-ordination; continuity and community focus. Models that focus on access at the expense of other attributes may not provide the most effective and comprehensive care for patients." (Baird et al, 2018)

Further detail on key messages from the wider body of literature is set out below.

Population health management

Hypertension, tobacco, alcohol misuse, high body mass index and low physical activity are the leading risk factors for illness and disability in Western Europe. Many of these risk factors are amenable to intervention by a range of actors at national and local levels, including health services.

General practice, with its registered list of patients, has untapped potential to engage in a more proactive approach to improving the health and wellbeing of the local population. Such a focus is essential if the NHS is to meet the challenges of responding to rising rates of chronic illness at all ages of the population, during a time of financial austerity.

There are already examples of GPs engaging in work to improve access, outreach and management of both their chronically ill patients and those who are still healthy. Interviews with GPs, practice managers and other staff by the Nuffield Trust (Chana, 2013) reveal both an appetite for further change and a multitude of ideas about how such visions might be realised.

Successful projects also depend on imaginative approaches to deploying staff, and better use of existing data in order to fully leverage the unique knowledge that staff in general practices have of their individual patients, their families and their local communities.

The evidence examined by the Nuffield Trust (Chana, 2013) suggests that good-quality data and risk stratification tools will be essential to support this task. Routine data on smoking, body mass index and other lifestyle indicators for patients who do not normally come into contact with their GPs represent the biggest challenge. Policy-makers will need to enable investment in data collection, alongside innovative approaches to payment systems and contracts, which will enable practices to take consistent action.

Research shows wide variation in common procedures in general practice such as influenza vaccinations (e.g. Dexter et al, 2012) but also highlights the danger of using crude uptake as a performance measure. As is so often the case, a much more sophisticated approach to the use of evidence is called for (Health Foundation, 2017).

As part of the national review of the Quality and Outcomes Framework, Forbes et al (2017) conducted a systematic review of the impact of QOF which found that the QOF was associated with a modest slowing of both the increase in emergency admissions and the increase in consultations in severe mental illness (SMI), and modest improvements in diabetes care. It was unclear whether any of these associations is causal. No clear effect on mortality was found. The authors found no evidence that the QOF influences integration or coordination of care, holistic care, self-care, or patient experience. The review concluded that the NHS should consider

more broadly what constitutes high-quality primary care for people with long-term conditions, and consider other ways of motivating primary care to deliver it.

We understand that this evidence has been taken into the national discussions on the future on QOF. Further detail on how an evidence-based approach to general practice quality will be implemented through contractual arrangements is expected shortly.

Access to care

The international evidence on access to primary care is strong, and demonstrates significant reductions in population mortality where primary care services are available (Starfield and Mangin, 2010). The research literature is not clear on whether the current decline in access which is demonstrated by the national GP patient survey (Ipsos Mori, annual, last published July 2017, CCG summary results at Appendix B) is driving increased emergency admissions.

Fleetcroft et al (2016) did find an association between hospital admissions for asthma and access to primary care although were unable to show that the association was causal.

Cowling et al (2018) found that there was a slightly lower rate of admissions in patients who reported it easy to secure an appointment, but no relationship with patient experience overall.

Continuity of care

A significant body of evidence points to the benefits of continuity of care.

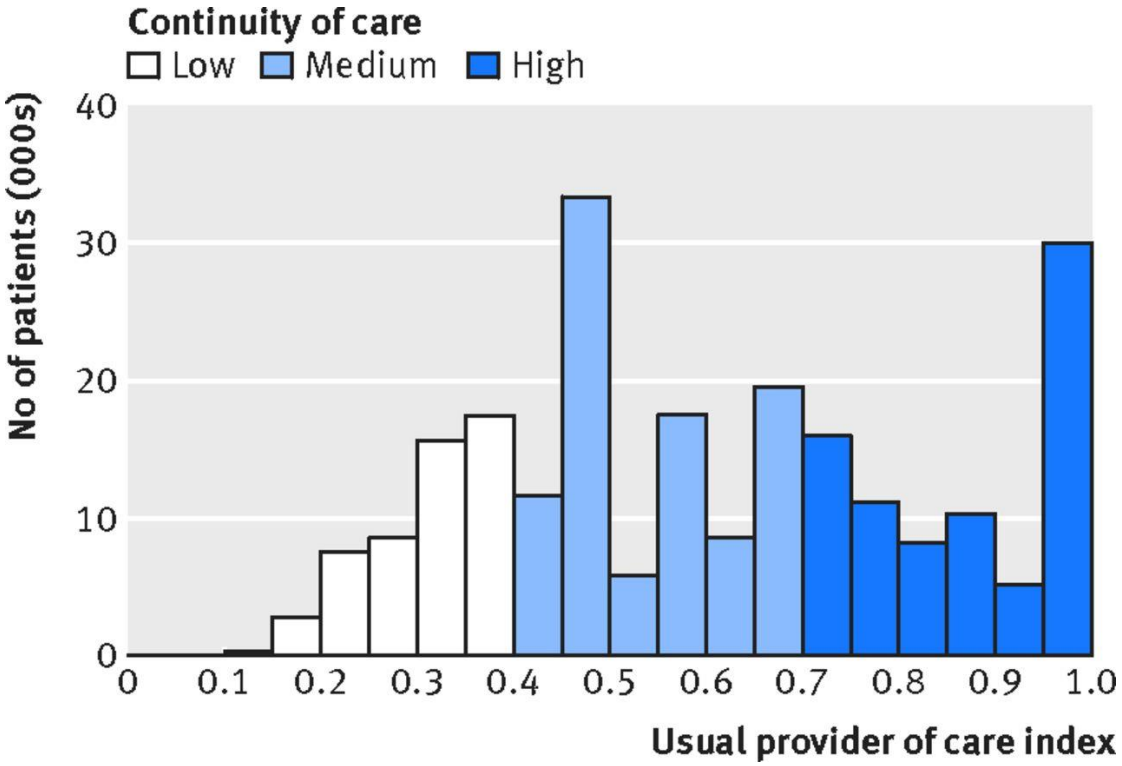
For example, Hjortdahl et al (1991) found strong associations between accumulated knowledge of patients by the practitioner and use of healthcare resources. This included time saved in the GP consultation, laboratory tests (ten-fold difference), prescribing, sickness certification and referral.

Van Walraven et al (2010) conducted a systematic review of the relationship between continuity of care and outcomes in healthcare; they found that increased provider continuity is associated with improved patient outcomes.

Bankart et al (2011) studied the characteristics of General Practices associated with the emergency admission rates to hospital in a cross-sectional study. The conclusion of that study shows that there is a direct association between continuity and lower emergency admission rates.

Huntley et al (2014) conducted a systematic review on features of primary care affecting unscheduled care use. They found international evidence that continuity of care is associated with reduced emergency department attendance and emergency admissions.

Barker et al (2017) found that higher continuity of care was associated with fewer admissions for ambulatory care sensitive conditions. Specifically, a Usual Provider of Care index (UPC) was used to measure the proportion of patient contacts with the most regularly seen GP. The range was 0.10 to 1.00 Overall average UPC was 0.61, for patients at small practices 0.70, for large practices 0.59. The researchers found that 0.2 increase in UPC would reduce admissions by 6.2%. A figure showing the distribution of usual provider of care index from their paper (all patients with a minimum of two contacts with general practitioners (n= 230,472)



Although the researchers do not model the impact of any further increase in UPC, given that the current range is 0.90 point, it would not be unreasonable to suggest that with the appropriate intervention an improvement of 0.40 would be feasible. This could be expected to reduce admissions by 12.4%.

Deeny et al (2017), giving an overview of the research and possible steps for frontline teams, found that patients who experienced higher continuity of care in general practice tended to experience fewer hospital admissions for ambulatory care sensitive conditions

Imison et al (2017) in their comprehensive review of evidence to support shifting care out of hospitals highlight positive evidence of continuity of GP care in reducing whole system costs, and evidence of potential to increase system costs from urgent care centres not co-located with EDs.

Tammes et al (2017) found a relationship between discontinuity of care and unplanned admissions for older patients.

Rosen (2018) points out that medical generalism involves using deep contextual knowledge of patients and their family and social situation to understand and interpret symptoms and problems. It enables GPs to hold clinical risk in the community in partnership with patients without onward referral to other services. For around a quarter of patients, it can help to 'de-medicalise' problems for which medicine may be unable to find an answer. Health systems like the NHS, which feature strong primary care with GP-registered lists and a gatekeeper function, generally have better health outcomes at lower cost. Evidence suggests that GPs contribute to this by requesting fewer tests and procedures and, where there is continuity with a lead GP, they refer to hospitals less. These approaches are characteristic of the medical generalist role. At a time when staff and money are in short supply, it is essential to clarify what we want from general practice and the role we want it to play in the wider NHS. There are opportunity costs associated with the current emphasis on timely and convenient access because fewer resources are left to deliver medical generalist and multi-disciplinary care.

Pereira Gray et al (2018) performed a systematic review of continuity in all medical settings. Of the 726 articles identified in searches, 22 fulfilled the eligibility criteria. The studies were all cohort or cross-sectional and most adjusted for multiple potential confounding factors. These studies came from nine countries with very different cultures and health systems. The authors found such heterogeneity of continuity and mortality measurement methods and time frames that it was not possible to combine the results of studies. However, 18 (81.8%) high-quality studies reported statistically significant reductions in mortality, with increased continuity of care. 16 of these were with all-cause mortality. Three others showed no association and one demonstrated mixed results. These significant protective effects occurred with both generalist and specialist doctors. The researchers concluded that increased continuity of care by doctors is associated with lower mortality rates. Although all the evidence is observational, patients across cultural boundaries appear to benefit from continuity of care with both generalist and specialist doctors. Many of these articles called for continuity to be given a higher priority in healthcare planning. Despite substantial, successive, technical advances in medicine, interpersonal factors remain vital in healthcare.

Quality of care, variation and employment of evidence

Broadly speaking, the research evidence suggests three things. Firstly, in terms of the current quality of care, the majority of care provided by general practice is good. Secondly, important dimensions of care are being eroded and quality is therefore declining. Thirdly, there are wide variations in performance and gaps in the quality of care that suggest there is significant opportunity for improvement. Practices need a lot of support to encourage them to seek out and address variable performance, including: appropriate data and information; skills development; protected time; and appropriate rewards for excellence (as well as consequences for poor performance). Policy-makers, regulators, commissioners and professional bodies could all do more

to create a better environment that supports general practice in its quest for quality. (Dawda et al, 2013)

The employment of evidence for quality improvement in general practice has been hampered by the lack of skills and capacity to do this, both in providers but also in commissioning organisations.

Given the complexity of primary care, and the lack of consensus on what constitutes quality (Heath et al 2009, Lakhani et al 2005) it is vital that both the selection and construction of quality measures is an open and collaborative process which fully involves clinicians. It should also involve clinicians and analysts with particular interest and experience in the creative use of health data to ensure that measures are both robust and clinically valid. Importantly, provider-led quality improvement initiatives seem to be much more effective than commissioner-led initiatives. The research evidence has not examined this issue in any depth but the best practice evidence is clear (cf Kings Fund 2017)

Dawda et al (2010) set out some of the challenges to measuring quality in general practice. In particular, they note that the use of benchmarking data which is not controlled for potentially confounding variables such as age, ethnicity and deprivation is of very limited use for inter-practice statistical comparisons. In addition, there are challenges to the introduction to general practice of measures often used in industrial service improvement processes.

The publication of practice-level comparative data is becoming more commonplace (Dawda, 2010), but for most primary care clinicians, opportunities to look at quality data across local practices are still exceptions rather than the norm.

Implementation of NICE guidance has been a problematic issue in Somerset since 2013, when Somerset diverged from the national quality incentive scheme, QOF. The main, although not the only, pathway for implementing NICE guidance is QOF. This is, however, a very imperfect way of implementing NICE guidance, as not all guidance is specifically reflected in QOF indicators, and without business rulesets it is difficult for practices to systematically implement NICE guidance. The profusion of guidelines is difficult for individual clinicians to manage. Innovative approaches have been developed, including in Kent and Medway PCT (2012, https://www.nice.org.uk/sharedlearning/making-nice-happen-in-primary-care-make-it-easy) which support clinicians by developing rulesets, prompts and audits to support implementation.

The evaluation of the Somerset local quality incentive scheme (SWAHSN, 2016) concluded that while there were small but measurable improvements in person-centred care, one effect of the scheme had been to render QOF invalid in measuring quality of care. This has been a significant disbenefit of the scheme, given the number of secondary uses which rely on QOF data.

The King's Fund, in its encyclopaedic investigation into the quality of general practice (2011) found considerable variation in the quality of diagnosis within and between general practices (Foot et al 2010). The evidence for such variation is not routinely available, but comes primarily from published research using SEAs. Variation in the quality of diagnosis, and in delays and errors in diagnosis, can occur for a number of reasons, including:

- atypical presentations or unusual symptoms
- non-specific presentations
- the very low prevalence of the condition
- the presence of co-morbidity and pre-existing disease
- perceptual features, meaning the missing of visual or auditory signs of a condition
- a GP's lack of exposure to the condition
- limited knowledge of signs and symptoms
- low adherence to guidelines recommending what to look for in certain conditions
- poor examination
- an over-reliance on patient symptoms and information, as opposed to signs and screening
- not doing a test or investigation
- general uncertainty in diagnostic methods

The King's Fund noted that it is difficult to establish the scale of the problem. However analysis of medical defence claims identifies three key themes:

1. lack of knowledge and skills
2. diagnostic difficulties in newborns and children
3. an insufficient level of suspicion regarding signs and symptoms of rare but life threatening diseases.

In depth investigations of diagnosis of particular conditions including cancer have found that diagnosis was appropriate in the majority of cases and there were many cases of exemplary practice, but in a small proportion (9 per cent) of the cases reviewed there was also evidence of missed opportunities for earlier diagnosis (Mitchell et al 2009).

It is fair to say that the major focus of improvement strategies in primary care in recent years has been financial incentivisation, both in this country and in others (Dixon and Alakeson, 2010), often to the detriment of other approaches which may have promise.

While payment has been the focus of much attention, there are many other influences on the quality of general practice. These include the culture of a particular

medical practice, the motivation and values of clinicians and the ethos of the contractual relationship between commissioner and provider.

The culture of a group of doctors working together can have a major impact on clinician's behaviour. Shackleton et al (2009), in a bold experimental study, showed that several variables related to practice culture influence the clinical treatment provided to patients with diabetes. Given what we know from the organisational development and leadership literatures, it is surprising that more attention has not been given to this are in health studies. Shackleton and her colleagues conclude that "In order to address worrisome variations in diabetes care at the level of the primary care provider, future interventions should focus on modifications to the practice and/ or organizational culture".

While cultural factors within organisations are clearly important in determining the quality of care for patients, the issue of personal motivation is also critical, and again, an area which has not attracted as much attention as might be expected. Dixon and Alakeson (2010), in their powerful analysis of the international context for healthcare reform, note that "Despite its importance, how to enhance this intrinsic motivation of professionals...has not been widely examined. These issues are mainly looked at through an economic lens at present which, while useful, provides only limited insight".

Workforce

The research literature is still catching up with the rapid changes in GP workforce that have taken place over the last five years in particular, as practices have sought to innovate new models which are less reliant on an increasingly scarce GP workforce.

The main body of the literature is focused on the General Practitioner, his or her experience, and how the personal and professional skills of the practitioner can be enhanced. A valuable theme of this literature is person-centeredness or holism, which is explored in the next section.

It is important to note that evidence on the workload and morale of GPs has shown a worsening trend over recent years highly consistent with other available evidence. For example the Ninth National GP Worklife Survey- 2017 (2018, Gibson et al) found low levels of satisfaction and high levels of pressure.

The impact of increased demand and reducing workforce on a service model which effectively offers a GP-only service is illustrated by Hobbs et al (2016) in a retrospective study of a million consultations. This clearly shows GPs soaking up the increased demand while consultations with nurses remained steady.

Following on from this is an emerging body of evidence about the application of skill mix models. Much of this is methodologically compromised by the newness of the

models being studied, however some early messages are emerging. Nelson et al (2018) carried out a systematic review which found:

"Evidence for skill-mix change in general practice from the review is patchy but suggests broadly that it can support care that is appropriate, safe, and satisfactory for patients. Importantly, however, such changes do not necessarily reduce GP workload or costs, at least in the short term, and may potentially increase both. Cost-effectiveness is poorly evaluated in such studies. Instead, studies largely address the implementation of single roles in isolation from organisational arrangements and assume that shifts will offer better value for money through targeting resources more effectively, improving access to services, and raising the quality of care. Nonetheless, some of this research usefully highlights the challenges and wider consequences (including unintended consequences) of implementing skill-mix change."

Some of the detailed studies have findings which are topical. These include:

- Potential for Physician Associates to safely take on minor acute conditions consultations despite the lack of prescribing rights (Drennan et al 2014)
- And from the same study, a high level of patient satisfaction where no continuity was desired by the patient and where there was a recognition that their compliant was not serious (Halter et al, 2017)
- A reduction in patient satisfaction where patients wished or expected to see a GP but instead saw a nurse practitioner (Paddison, 2018). However this highlights the importance of introducing skill-mix well as it appears to be highly acceptable to patients once they understand the service on offer (Haider, 2008).

Person-centred care

It could be argued that holism, or person-centeredness is the philosophical wellspring of general practice (Howie et al, 2004). As Dambha et al state in their 2014 overview:

"Patient-centred care is a core value in general practice and is increasingly recognised as a hallmark of good quality healthcare. It describes healthcare that considers the needs, expectations and preferences of the individual patient, and places the patient at the centre of the GP consultation. It encourages GPs to take into account a patient's subjective experiences of their illness, rather than focussing solely on the management of the disease. This approach to caring for patients has been associated with an improvement in both health and patient-reported outcomes." (Dambha et al 2014)

Little et al (2002) found that patients strongly favour a person-centred approach, and such an approach is also shown to lead to higher levels of enablement, i.e. an

increase in the knowledge and confidence of the patient to manage their own problem (Tolvenan et al, 2017).

The King's Fund has written extensively on the need for person-centred care as an enable for high quality, cost effective healthcare systems (cf Coulter, 2013), and it is clear that despite methodological challenges, person-centred care is of critical importance in meeting the changing needs of patients (Lloyd et al, 2017).

The organisation of general practice

The organisation of general practice is an area which has more focus in the policy sphere than in the academic literature.

Engstrom et al (2001) note in a systematic review of the effectiveness of general practice that although there is strong evidence of the overall effectiveness of general practice it is clear that studies with evaluation of how to most effectively organise primary care are far too few. There is an extensive need for future research in this area.

The King's Fund, in its review of quality in general practice (2011) did highlight a number of features of general practice that were conducive to good patient outcomes. These included the effective use of data for improvement, sufficient time to learn and reflect and the development of rigorous quality improvement skills and activities.

More recently, the focus has turned to scale with the concept of 'primary care at scale'. In general terms there is no clear logic model or theoretical underpinning to the term. It is used variably to describe some form of general practice provided on a larger scale than the traditional partnership model.

As the lack of definition of the term has increasingly become an obstacle to measuring change in a scientific way, researchers and primary care leaders have developed more appropriate conceptual models.

Chief among these is the concept of 'organised primary care' (Barry, 2017) which suggests that the benefits of general practice are easily defined, and that the job of commissioners and providers is to organise primary care at the right scale to realise these benefits. Primary Care Home (NAPC, 2016) is probably the best known model of organised primary care.

The idea that scale alone delivers benefits has been shown to be incorrect, for example Rosen et al (2016) in a study for the Nuffield Trust found that scale offered opportunities to deliver benefits rather than actually delivering them.

Looking at Primary Care Home test sites Rosen (2017) has found that organised primary care initiatives such as Primary Care Home are having an effect and delivering benefits although it is too early to draw definitive conclusions.

In Somerset, we have a number of innovations and leading examples of new primary care models, such as the Frome complex care and social prescribing initiative, the enhanced primary care model developed by the South Somerset vanguard programme (see Appendix G for further details of the service model) and other initiatives such as the Village Agents scheme in North Sedgemoor. We now need to build on our mosaic of innovation to ensure that all patients have access to an optimal model of primary care.

Commissioning and contracting general practice

There is little appropriate evidence which can assist commissioners in answering detailed questions about funding, commissioning and contracting.

Nigel Edwards (2014, unpublished, attached as Appendix C) led a piece of work with the King's Fund looking at what a future GP contract would need to cover. He concluded that the overall aim of the commissioning approach should be to develop primary care which has:

- Improved clinical management with more focus on anticipatory care and systematic case management
- Standardisation and consistency between providers
- Greater integration with community health services, social care and mental health
- Much closer working with secondary care specialists
- More focus on managing population health
- Better access, including online

In addition to the areas noted above, there are a number of difficult issues specifically related to the commissioning process for general practice, which Jones and Wood (2010) describe. These include:

- The ineffective nature of NHS commissioning in general
- The mismatch between a challenging national policy agenda and a small and underskilled primary care commissioning workforce
- The lack of investment and support within commissioning organisations to move from general practice contracting to general practice commissioning
- The lack of credible and detailed local strategies showing a detailed understanding of how sustained improvement is to be achieved
- The lack of contractual levers available to commissioners (2010, pp5-10)

Conclusion

Despite gaps in the evidence base, there is sufficient evidence to support the clinical and design principles highlighted in the first section of this evidence review.

The most striking finding from the literature is the central importance and benefit that continuity of care delivers. It will not be easy to act on this finding but there are feasible interventions.

Beyond that, a clear finding is that significant variation in quality and service for patients is not only unsatisfactory for individual patients but also presents a risk to the whole health and care system.

Overall, it is difficult to escape a conclusion that general practice could and should be a much more fundamental part of a placed based person-centred integrated health and care system, but that this will require systematic and co-ordinated action by both providers and commissioners.

References for all sources are provided at the end of this report.

6. OUR CURRENT CONTEXT – BASELINE ASSESSMENT

General practice in Somerset faces the same challenges that are being felt nationally but the services delivered by general practice in Somerset are considered to be good overall. This can be evidenced when looking at quality indicators such as CQC, patient questionnaire, pockets of innovation, new ways of working and integrated working.

There are however important areas where we are observing a decline in quality and performance. This is largely being observed in the form of variation, leading to an aggregate reduction in Somerset. Again, the GP patient survey demonstrates the decline in a number of areas along with some key clinical areas reporting significant variation.

The levels of significant variation need to be addressed to support the growth of a healthy and fit population across the county and secure the best possible health outcomes for patients.

From a commissioning perspective, there has been limited impact to date following the introduction of the GPFV. We continue to see a decline in GP numbers and an increase in the number of practices turning to other agencies in a bid to secure their future sustainability and resilience. As it stands, general practice in Somerset is not in a state to form the foundation of an integrated, modern care system.

Across the country we are seeing general practice expand its offer of services, delivering care closer to home through organised and effective system working. Somerset as a system has been rather slow to embrace the opportunities because of traditional boundaries, cultural differences or a lack of a shared system vision.

These traditional working relationships and contractual boundaries need to be broken down with a view to having integrated and joined up services, in particular community, mental health and hospital specialist services.

There are however pockets of innovation happening through local leadership by both individual and small groups of practices which needs to be recognised and supported. The challenge now is the adoption and spread of innovative approaches; failure to do so will encourage and widen the gap of unwarranted variation.

Somerset needs to embrace change and integration to recognise how patient outcomes can be improved and financial efficiencies can be gained by transforming the way services interact and how they are delivered.

This can only happen if the solid foundations of a well-functioning primary care system are in place. A key component to this will be the security and resilience of the general practice workforce.

However we are seeing a decline in workforce numbers which requires an intense focus by all stakeholders. The reduction of the GP workforce is evidenced at both a

national and local level. We are seeing the number of GPs reaching retirement age increase and the number of new GPs joining the profession not keeping pace with the numbers leaving. This poses real risk to the future of general practice; a complex and multi-faceted challenge which needs to be understood and addressed collaboratively across the system.

Another key component to a solid foundation is stable funding and investment in general practice. Somerset does benchmark low for the funding of GP services (full benchmark report available at Appendix D, although it should be noted that this conflicts with other data sources and is currently being investigated further) and whilst there is already a relationship between patient need and the pound per patient funding, Somerset could do more to target investment towards health need.

General practice continues to see a growth in patient demand and expectations, with an ever expanding complex workload comprising both health and social difficulties facing patients. The big challenge for general practice is the management of the increasingly complex needs and expectations of the growing patient list sizes within a shrinking workforce and constrained funding envelope.

In this context it is very difficult indeed for general practice to make the changes to secure a sustainable future as described in the GP Forward View.

There is a huge effort across the health and care system to reduce demand on costly interventions and deliver a safe service for patients. Continuity of care is one of the biggest benefits general practice has to offer when looking for improved outcomes and reduced costs (allocative efficiency) across the wider health system.

We continue to see a decline in continuity across Somerset which is likely to be a significant contributor towards the growing system costs. Urgent action is needed in order to maintain and enhance the benefits that continuity offers for both patients and the health care system.

Taking all this into account we have explored in more detail the current context and a baseline assessment of the Somerset general practice position for each one of the following areas, with the findings and proposals described for each area.

- Population Need
- Patient Experience and Access
- Workforce
- Quality and Variation
- Provider Organisation
- Funding and Contracting

6.1 POPULATION NEED

In 2016, as part of the development of the existing primary care strategy, Better Lives: A Primary Care Plan for Somerset, Somerset County Council Public Health Team undertook a health needs assessment of GP services. The summary of this work is reproduced below.

There is a national drive for primary care reform most clearly set out in the NHS Five Year Forward View. It sets out the shared vision for the future of the NHS based around new models of care with the aim of reducing the widening gap in health inequalities, improving the quality of care and addressing funding issues. Since 2013, commissioning of primary care services has been the responsibility of NHS England. However, more recently CCGs have increasingly been encouraged to take a greater role in planning these services and in Somerset they are now jointly commissioned by NHS England and Somerset CCG through the Primary Care Joint Committee. The aim of this needs assessment is to identify priorities for the Somerset population as a whole and review the available evidence to inform the Somerset primary care commissioning strategy.

Compared to other parts of England, Somerset is often described as an area of relative wealth and good health. However a more detailed look at the data reveals important inequalities with significant pockets of deprivation in both urban and rural parts of the county. There are 25 neighbourhoods in Somerset categorised as 'highly deprived' which represents a total of 38,000 Somerset residents living in one of the 20% most deprived neighbourhoods in England. Although overall health of the Somerset population is good, in the most deprived parts of the county life expectancy is lower with significantly more years lived with a disability compared to the least deprived areas. A&E attendance and hospital admission for injuries and substance misuse among children and young people is significantly higher in Somerset than the England average and these problems are also concentrated in the more deprived areas. The prevalence of chronic conditions such as dementia, stroke, coronary heart disease and diabetes are rising, due partly to an increasing elderly population. Somerset has an ageing population with projections suggesting that over the next 25 years there will be over 50% growth in the over 65s group. By 2033, most wards are predicted to have at least 25% of the population over 65 and some as high as 50%. Somerset is also one of the most rural counties in England with 48% of its population living in rural areas. The recent JSNA highlighted a number of challenges associated with rural living including social isolation, difficulties in accessing services, transport issues and those over 75 being more likely to be admitted to hospital as emergency cases.

The health and wider needs of the Somerset population that should therefore be addressed in any primary care reform programme can broadly be categorised into; *access to services, social isolation in older people, important diseases of now and the future, those living with multiple long-term conditions* and *emergency hospital admissions*.

Good access to general practice is a crucial element of the whole NHS system. It is influenced by individual practice arrangements around out of hours services and appointment booking processes, the distribution of surgeries and staff in relation to

need and deprivation, physical access particularly in rural areas and workforce capacity. In Somerset, a large number of practices do provide extended opening hours although to varying extent. However, a crude analysis indicates lower accessibility to out of hours services in rural, deprived and larger practices across the county where there is arguably greater need. Mapping of surgeries in relation to the Income Deprivation Affecting Children Index (IDACI) highlighted that no practices in Somerset are situated in the most deprived areas. Transport issues have also been identified as a barrier to access particularly in rural parts of West Somerset where a relatively high proportion of households do not have access to a vehicle. This is particularly relevant for older people as only 1 in 5 residents over 65 have access to a vehicle. Somerset also has a diminishing GP workforce with serious concerns over retention and recruitment which has a clear impact on the availability and access to services.

Social isolation is an important issue in Somerset where an estimated 12,000 residents are thought to be affected. Evidence shows that loneliness and isolation can have a significant detrimental impact on health and wellbeing and has been compared to smoking and alcohol in terms of mortality risk. It also has wider cost implications due to increasing demand on health and social care services. With an ageing population comes an increasing prevalence in chronic conditions. In Somerset the prevalence of dementia is predicted to rise by over 90% and CHD and strokes by between 50-60% over the next two decades. All these diseases are associated with lifestyle factors such as smoking, alcohol, diet and physical activity and therefore prevention and early diagnosis need to be central aspects of any primary care development. A substantial proportion of people living with long-term conditions experience multi-morbidity i.e. they are living with multiple long term conditions. Patients with multiple long-term conditions are likely to have high utilisation of services, poorer clinical outcomes, longer hospital stays and are more costly to health services in general. The Symphony project in South Somerset has revealed that increasing costs are explained more by the number of chronic co-morbidities than by age. Providing integrated and coordinated care for this cohort of patients is crucial and primary care lies at the heart of this approach.
Avoiding emergency hospital admissions is also a major concern for the NHS due to the high and rising costs of this form of care. The Commissioning for Value tools indicate a proportionally higher spend on emergency admissions in Somerset are evident in the diabetes, COPD, musculoskeletal and trauma and injuries pathways. The tools illustrate that reducing avoidable emergency admissions requires addressing issues throughout the wider health system including a shift in focus towards prevention.

Strong and effective primary care is critical to a well performing health system and research shows that good primary care is associated with reducing avoidable hospital admissions and lower premature mortality. However demand is rising and the system is under considerable strain from the pressures of an ageing population, increasing prevalence of chronic disease, rising patient expectations, workforce shortages and funding pressures. Primary care therefore needs to be comprehensive, patient-centred, coordinated, accessible, safe and of high quality. While the evidence around how to gain better value for money is limited there is work to suggest that gaining better ‘health value’ for every pound spent is both necessary and realistic. Reconsidering how to design and deliver primary care services needs

to be part of a system wide approach to achieving efficiency savings and better patient outcomes.

The literature indicates key areas for primary care development that are likely to help address the needs of the Somerset population. Firstly, healthy active ageing which includes a range of health promotion and disease prevention programmes and addressing social factors such as isolation and loneliness. There is good evidence for exercise programmes, falls prevention, earlier diagnosis and social prescribing as interventions to promote healthy active ageing and for which primary care is ideally located to be at the heart of delivering.

Secondly, providing support for frail older people, many of whom have multiple long-term conditions and who are at higher risk of emergency hospital admission. Supporting these people in the community is critical and requires early identification of those at risk and providing early support. There are a number of tools and services that are being run locally across the UK with some evidence of success.

Thirdly, improving access, which requires a broad range of issues to be addressed from individual practice working arrangements to physical location of surgeries to workforce issues. This is particularly relevant in the context of current changes to practices in Somerset with the closures of some surgeries and the formation of federations. The benefits need to be balanced with the risks and measures taken to ensure that the worst off in society have good access.

There is limited evidence for what may address these issues but there would likely be value in taking a more detailed look locally at provision of out of hours primary care services in combination with reviews of A&E attendances, appointment booking systems and other practice arrangements that may be associated with better access and patient satisfaction. The skill mix of healthcare professionals working in general practice should also be considered.

Finally, there needs to be a shift towards more integrated and coordinated care for which there is good evidence of the benefits particularly for older people and those with long-term conditions. The NHS is supporting new models of integrated care which are being developed locally. The Symphony programme in South Somerset integrating primary and acute care systems will provide enormous insight into the benefits and challenges of such a programme. A central part of moving towards integrated care is consideration of how to commission services with an increasing focus on holding providers to account for outcomes. While there are numerous proposed benefits of commissioning differently, the challenges and risks associated with new models of commissioning should not be underestimated.

Although considered a relatively wealthy and healthy part of the country, the Somerset population has important health and wider needs that primary care is ideally placed to help address. The primary care commissioning strategy provides an opportunity to do this and this analysis recommends broad areas on which to focus. Despite the sometimes limited evidence there is a wealth of projects taking place across the country which should be looked to as examples of good practice and opportunities to learn from. It is also crucial that primary care development be part of

a system wide approach to improving patient outcomes and gaining efficiencies if sustainable progress is to be made.

The full population needs assessment is available at Appendix E.

6.1.1 The needs of patients

As well as the needs assessment described above, we have engaged with patients in a number of different ways in order to understand their needs.

Patients have given us a consistent message; they value a local, personal GP service with continuity of care and good access. It is incumbent upon us a system to respond to these perfectly reasonable wishes.

The demographics of Somerset, with an ageing population of which half lives in rural areas, mean that a network of local services is vital. There is, of course, a tension between local delivery and efficiency. We can see this playing out nationally as a trend towards larger practices with closures of branch surgeries and a number of practices. The evidence that we have examined shows no clear relationship between practice size and quality. Put simply, bigger is not necessarily better.

There is, however, a need to organise GP services in the most effective way. We do not believe the term ‘primary care at scale’ is particularly helpful in describing this. We prefer the term ‘organised primary care’. By this we mean that GP services are organised in a way that delivers the following benefits for patients:

- Population health management is delivered optimally, missing no opportunity for primary or secondary prevention of disease. In practice, this means working with a larger population than the traditional individual practice list to deploy resources.
- Making sure we play our part in delivering on the wider determinants of health as set out in the Health and Wellbeing Strategy for Somerset
- Making good quality online information and advice available on every practice website to support a ‘digital first’ service offer
- A Somerset wide campaign, highlighting self-care resources and giving practical advice on common conditions and how to manage them
- Promoting tools like the TST child-health app which helps concerned parents make wise choices
- Emphasising and developing the role of community pharmacy as the first port of call for a wide range of ailments
- Clinical care is delivered in a consistent way for all patients. Unwarranted variation is identified and reduced through a peer-led, collegiate quality improvement approach.
- There is a high level of continuity of care for the whole population. This does not mean seeing the same GP for your whole life, but it does mean that there will be a high level of continuity of oversight by a senior clinician including

relationship where needed, informational continuity to stop patients having to re-tell their story, and critically management continuity including shared care planning that give patients trust and confidence.

- Workforce is managed to make the most of scarce and precious resources. This means embracing skill-mix models and deploying specialist staff across larger populations.
- Access is managed so that all patients receive a responsive service. All patients should be able to have their problem addressed by an appropriate member of staff within a reasonable time frame. Commissioners and providers should agree an ambition for this and then seek to achieve it. This is most likely to be achieved through peer-led service development support than contracting specification given the complexity of general practice and the risk of perverse outcomes of targets. Nonetheless the commissioners must be clear about their expectations on behalf of the population.
- There is a well co-ordinated service for people with multiple long-term conditions which identifies and supports individuals in the context of person-centred care.
- This includes support for family members and carers, including a Carers Champion in each practice (see Appendix F for full proposal). The vital importance of social networks in promoting health and wellbeing and aiding recovery from illness must be fully recognised.
- A wide range of services are delivered at a local practice level and at a ‘neighbourhood’ level covering perhaps 30,000- 50,000 people. Patients will not have to travel to hospital for services which can be safely, effectively and efficiently organised locally.

The points above set out the minimum required to meet the reasonable and modest aspirations of patients in Somerset. Furthermore they describe a GP service which is delivering maximum population benefit and is therefore able to provide the foundation for modern, integrated health and care system in Somerset.

6.2 Patient Experience and Access

Context

Having poor experience of a service or poor access to that service will influence how you use that particular service in the future. Patients reasonably expect timely and convenient access to their registered GP practice.

Poor patient experience can lead to disengaged patients who do not seek the most appropriate support and interventions from their registered GP practice in the most appropriate way. Without this support and intervention at the right time, from the right person and in the right place there is a risk patient health outcomes will be negatively affected, potentially leading to more costly interventions in the longer term.

The same applies for a poor experience of patient access, whether this is because the patient struggles to physically get to their registered practice or when they do, they find it difficult to get a timely and convenient appointment.

There is national recognition that good access to a GP practice is one of the important challenges facing modern day general practice, which is why it is one of the national priorities for investment in the GPFV with the aim to extend the times when patients can access appointments. However the investment and introduction of a service to extend appointment times in this way touches only on a small part of what is a much bigger challenge.

Measurement and Variation

At a national level there is no measure or expectation with respect to how long a patient should wait for an appointment at their GP practice. In 2010 a government target on GP practices to see patients within 48 hours was removed and has not subsequently been replaced. There are no current measures or robust indicators to determine the quality of patient access.

Patient experience and access are two of the areas where we see a large degree of variation in terms of what is reported by patients across practices in Somerset. This is evidenced in the national GP patient survey results in 2017 with 99% of patients at one practice describing their overall experience as good, and another practice with 59% of patients describing their overall experience of the GP practice as good.

Again, there is huge variation in the performance of practices with respect to patients describing their experience of making an appointment as ‘good’. At the highest performing practice 99% of patients agreed that their experience was good, whereas the lowest performing practice saw 53% of their patients agree that their experience was good.

Furthermore, Somerset has seen a 2% decline in the measure for overall experience being described as good or better in the last 4 years but remains above the national average of 85% by 3%. There was also a 4% decline in overall experience of making an appointment as being good or better but again, the measure remains above the

national average of 73% by 5%. Although this appears to be a slow decline, Somerset has not seen an improvement in either measure and if the current trend continues it will only be a matter of time before the CCG falls below the national average.

Whilst the GP patient survey is not a perfect tool for comparison between practices with confounding factors such as small sample sizes in some practices, it is the best indicator available to the CCG and still demonstrates an unwarranted degree of variation across practices.

Patient access journey

Access to a GP practice is more than just being able to make an appointment and applies to groups other than just patients (e.g. pharmacists, paramedics, hospitals, social services and many more). The first step in a patient's journey is their identification that they have a health care need and their decision to seek help.

This is followed by the patient's ability to access a GP practice which comprises factors such as a requirement for registration, ease of access via different modalities including by phone and internet, and also physical factors such as distance and the availability of transport.

Once these barriers have been negotiated, the patient may seek to book a convenient and timely appointment with the right person who can meet their needs. The offer that is available will depend on the available workforce and how this is configured is a separate challenge which has clear interdependencies with access.

Finally, the care that a patient receives after their initial appointment will also require good access but with a slightly different set of requirements e.g. continuity of care, access to investigations, access to other health and care services.

Each patient will be at a different stage in this journey and may have a different experience depending on which GP practice they wish to access.

One way to conceptualise access is to consider it from a patient's perspective and then the subsequent impact on a practice. The diagram below suggests that access needs to consider those patients who do access a GP practice, those who don't and those who struggle to.

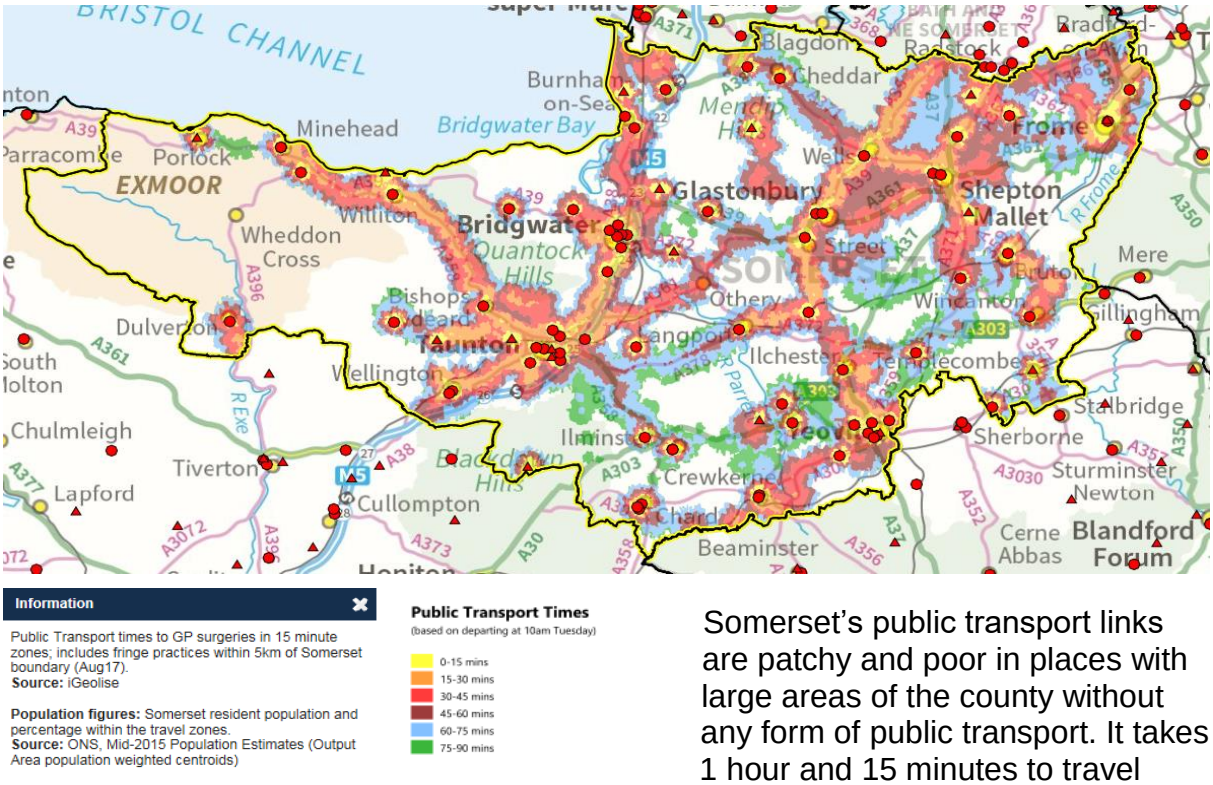
Patients who struggle to access a GP Practice

There may be a variety of reasons why a patient may struggle to access a GP practice:

- Registration – the patient may not be registered at the practice they are trying to access
- Educational Background – Literacy, communication skills, level of understanding of their health, their needs and how to access appropriate services will all impact on an individual's ability to access GP services
- Access to Technology –access (or lack of) to the internet and phones/applications
- Geographical Location & Access to Transport – Availability of public transport to the required destination, and proximity of friends/family or support network to assist.

There may also be contributing factors within the practices which don't support the ability for patients to access a GP Practice:

- Practice Website – lack of accessible high quality information
- Phone Lines – if call volume outweighs the available resource to deal with the calls
- Appointment Systems – every practice will have its own way of structuring appointments; some will offer better access than others
- Staffing – If capacity of available staff is not sufficient to meet the demand



Somerset's public transport links are patchy and poor in places with large areas of the county without any form of public transport. It takes 1 hour and 15 minutes to travel between the two major towns in the county using public transport, with a bus available every 3 hours. The image below shows the county's travel times and routes which clearly demonstrates (where there is no colour) significant areas with no available public transport.

Patients who don't access a GP practice

Reasons for patients not accessing their GP practice include:

- There is no actual need
- Believing (sometimes inaccurately) that they have no need to
- Previous poor experience
- Personal values and beliefs
- Social barriers – as above including education~~s~~, geographical and social support.

It goes without saying that significant inequalities do exist in Somerset. This has been demonstrated recently in a detailed local assessment which makes a number of recommendations and 'quick-wins' that can be achieved through the focus of dedicated resource and integrated working. Some examples are better education and communication on patient registration rights in the homeless community and greater integration, awareness and support of voluntary agencies that champion a range of inequalities. The following animation demonstrates the various access inequalities that could exist within communities and create an access barrier for patients; https://www.youtube.com/watch?v=JCc20BifI5k&feature=youtu.be

Patients who do access a GP Practice

As has been outlined previously, the national position is that demand for GP services is steadily increasing and already exceeds the capacity of the GP workforce if traditional staffing and service models are used.

One way to support better access is to educate and empower patients to take greater responsibility for the management of their health. This should also include education on self-help, and when, where and how to access signposting or support the meet their needs when they are unable to do so themselves.

Patient education and empowerment can help to streamline and increase the efficiency and effectiveness of the delivery of health and care to a practice population which in turn frees up capacity and improve availability of medical appointments to those who need them.

Continuity

There is a compelling evidence base that costly health interventions can be reduced through the achievement of good quality continuity of care in general practice. Again, based on the national GP patient survey this has decreased in Somerset from 48% in 2015/16 to 43% in 2017/18. Once again, we see wide variation in the responses to this question for different practices for this in the patient survey.

'Access' and 'Continuity' are often viewed as being in tension with each other competing for a constrained resource of appointments with the appropriate professional.

The reality is likely to be more complex: a system with good access and high continuity of care is likely to be highly effective and efficient – characteristics that become even more vital when resources (workforce, appointments) are constrained.

The actual experience of patients and practices is often a fragile juggling act between offering appointments promptly to meet perceived 'same day' demand and offering 'routine' appointments within a reasonable timeframe that offer continuity for a particular patient or problem with a particular GP.

Finding a way to maintain timely access alongside continuity for presentations that require one or the other or both will be one of the key challenges primary care service of the future will need to overcome and will have significant interdependence with the urgent care and proactive care for people with complex needs workstreams.

Findings & Evidence

The following questions were asked to better understand the evidence on quality of patient access and to inform our recommendations:

Based on the patient survey results, what is the relationship between patient experience and access?

Using the 2017 patient survey results (latest available at time of writing) there is a clear relationship between a patient's overall experience in accessing an appointment and their overall experience of the practice.

When the results for both questions are taken together eight practices fall into the bottom ten for both questions. This reinforces the point that poor patient access to an appointment is a strong determinant of a patients overall experience.

Is there a relationship between patient access/experience and A&E utilisation?

South West and Central Commissioning Support Unit has carried out a piece of analysis looking at the activity at one of the A&E departments during "in-hours" primary care. This identified some practices as "high performing" in respect of the number of their patients attending the A&E, with other practices identified as having high attendances.

To understand if there was a relationship between patient experience and use of A&E by patients the patient experience results were compared along with proximity to the A&E site.

Five practices have been identified as having a higher than expected number of their patients attending A&E, all of which show a decrease in patient satisfaction across three of the access measures when you compare the 2016 results to the 2017 results. ~~It~~ One explanation may be that poorer patient access to their GP practice has led to more patients choosing to attend A&E.

One of the "high performing" performing practices has however seen a 9% reduction in their patient satisfaction scores for access, suggesting that although patient satisfaction has decreased, patients do not appear to have opted to attend Musgrove Park Emergency Department instead.

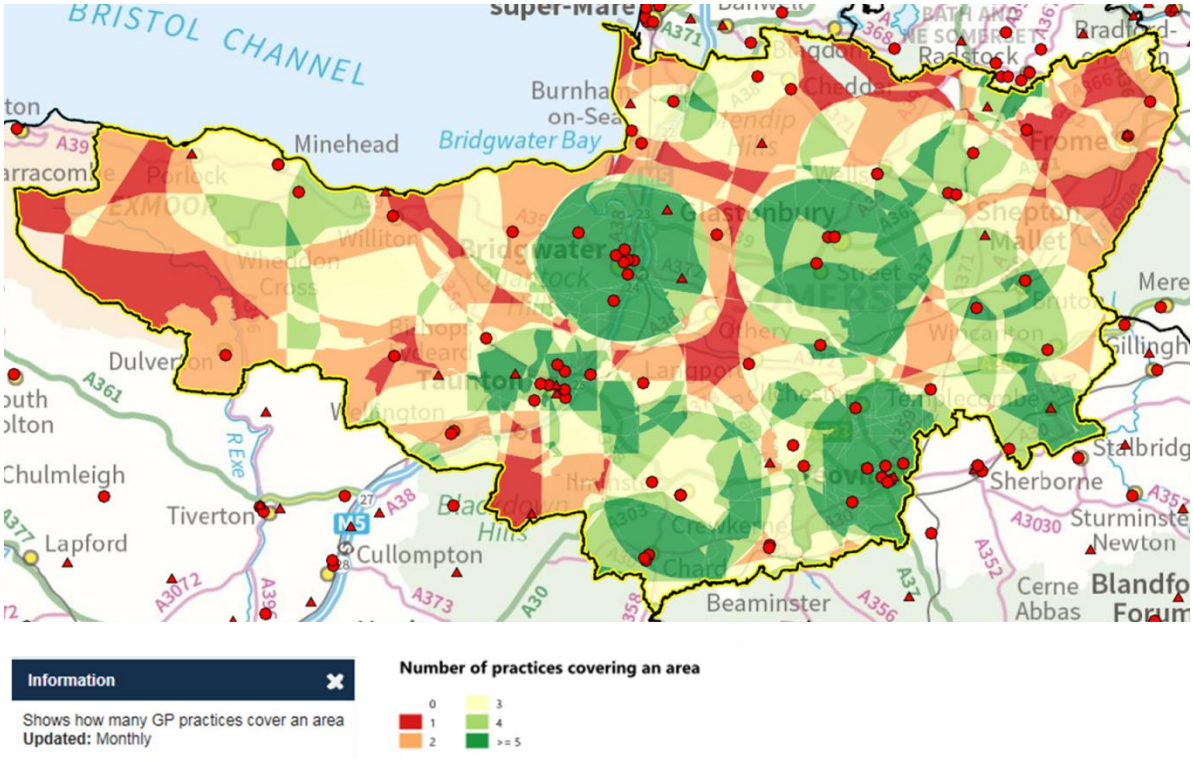
Proximity of the practice to Musgrove Park Emergency Department does not appear to be a major factor influencing patient behaviour in this instance. This is reinforced with one of the "high performing" practices having the closest proximity to the hospital with high levels of patient access satisfaction rates. The practice furthest away from the A&E in this group has the second biggest drop (40%) in patient satisfaction scores across all three access indicators and demonstrates high A&E attendances.

In conclusion, the data appears to suggest that patient access to their registered GP practice does influence the number of patients who attend the A&E department. The proximity of the practice to Musgrove Park Emergency Department does not appear to be a significant explanatory variable. Much more detailed analytical work is required before we can be confident about any local relationship between patient access and experience and ED utilisation.

Do the most deprived populations have reduced access/choice?

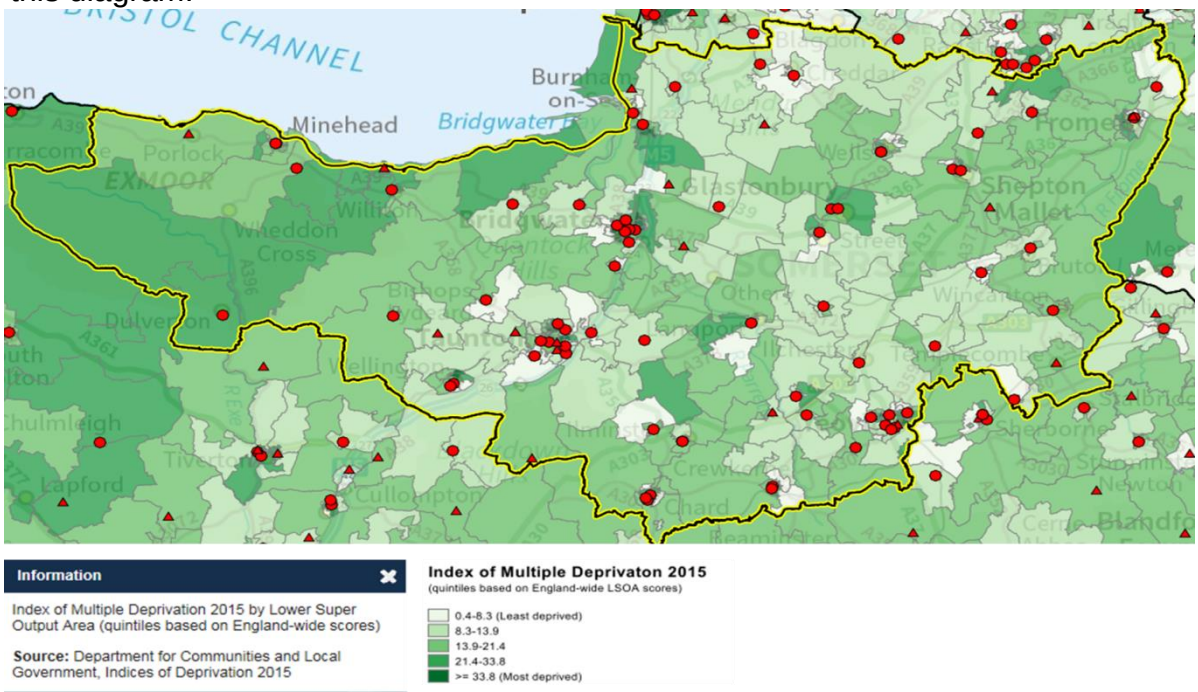
To answer this question we have compared Index of Multiple Deprivation 2015 results with mapping of GP practices.

The ten practices with the highest IMD score in Somerset were compared with the GP practice coverage map (below) to understand if patients at these practices had reduced choice or poor travel access.



Seven out of the ten practices are actually located within the urban areas of Somerset (6 in Bridgwater, 1 in Taunton), with patients from these practices having access to 5 or more practices. This would indicate that the majority of the deprived populations in Somerset do have a good level of patient choice with respect to GP practices.

The remaining three practices are in more rural locations and have somewhat variable patient choice. This is particularly evident when you compare the IMD map and the practice coverage map. The connection between the high levels of deprivation and lack of patient choice in the South of West Somerset can be seen on this diagram:



6.3 WORKFORCE

The recruitment and retention of the GP workforce is a challenge faced across the country and one of the government's priorities. There are many targets and goals set at a national level which advocate for ambitious numbers in respect of recruitment across the primary care workforce.

The complexity of workforce planning and intervention

Whilst the targets set are admirable, delivering the national targets and local ambitions is complex and multi-faceted. Workforce planning and intervention involves a wide range of agencies and change agents and is affected by a number of factors, all of which means that there is no one solution to secure workforce sustainability. Some examples of factors affecting our workforce:

- The messages and images portrayed in the media about working in the NHS
- Health and care workers being aware of and having a positive view of work opportunities within Primary Care when considering career choices.
- Access to training and being able to manage the costs of training
- Ensuring students have enough exposure to local primary care and have positive experiences of this during their local placements
- Pay, working conditions and development opportunities after completion of training
- The types of roles available in primary care
- Contractual terms and conditions and the quality of premises
- The reputation of local primary care organisations; for example the degree to which they are innovating and creating varied supportive roles which are keeping abreast of social and clinical expectations of the workforce
- The degree to which primary care organisations manage workforce pressures collaboratively and avoid 'robbing Peter to pay Paul' from the finite workforce supply
- Somerset being seen as an attractive place to live and work

General Practitioner baselines and trends

There are around 386 GPs (partners and salaried) working in Somerset which equate to an *estimated* 327 whole time equivalents. This represents 18 fewer GPs (by headcount) and 17 fewer whole time equivalents than in September 2015 which has mainly been caused by a reduction in GP partners (-26).

In April 2014, the Primary Care Information System suggested there were 434 GP (headcount) not including GP registrars, GP locums, GP retainers which indicates a downward trend in the number of GPs.

This downward trend is reflected nationally. For example for March 2017, NHS England have reported an overall reduction of 0.1% in GP numbers across England (not including locums) between December 2016 and March 2017 alone.

At present the proportion of GPs (partners and salaried) who are 55 years and older in Somerset is 26% and this is slightly higher than the national average of 21.5%. This is however set to rise significantly given that around 70 of the 386 GPs are in the 50 to 54 years age bracket. Within 5 years it is estimated that around 46% of GPs will be 55 or older.

Somerset CCG has a similar GP workforce profile to its CCG peer group and this includes areas like: NHS Kernow, NHS Gloucestershire, NHS Wiltshire and NHS Cumbria CCGs.

Population growth and GP to patient ratios

The population of Somerset is growing. For example between September 2015 and September 2017 the registered population grew by just over 11,000 people. Because GP numbers are reducing and our population is growing it is inevitable that GP to patient ratios are increasing.

At present the national average is around 1 full time equivalent GP (salaried or partner) to 2,000 patients and in Somerset the average is around 1 GP to 1,700 patients. This has risen both nationally and in Somerset over the last 18 months and for Somerset it will be at least will 1 GP to 1,800 patients within 5 years if there is no further reduction in GP numbers and 1:2,100 if GP numbers continue to decline in line with the rolling five year trend.

GP to patient ratios vary significantly across the county and the data suggests that 23 practices have higher than 2,000 patients per whole time equivalent GP and 4 practices have more than 3,000 patients per GP. The degree to which this is true, and not a consequence of data errors, differing interpretations of whole time equivalent, changes in skill mix or other factors needs to be clarified with the respective practices is not entirely clear.

Although some of the pressures arising from reductions in GPs, and perceived high patient to GP ratios are being offset by practices broadening their skill mix, GPs have a unique and central role and are ultimately clinically responsible for many aspects of care within a practice. They are also the holders of GMS and PMS contracts.

Somerset CCG and Somerset Local Medical Committee co-designed a vacancy survey which was run in October 2017 and completed by 58 out of the 70 practices. This revealed a mixed picture across the county with some practices having no vacancies, no imminent retirements and no significant workforce pressures and others who are wholly reliant on locum cover and have experienced long term vacancies and unsuccessful recruitment campaigns.

Different forms of GP Working

The National Performers List shows that a shift over the last 5 years in the type of role that GPs are registering with fewer GPs registering as GP partners and a

greater proportion than in the past registering as salaried and locum doctors. That is not to say that no GPs wish to become partners.

GP partnerships hold responsibility for their GMS contracts and GP partners carry personal unlimited liability for these and also staff and premises. In many cases, GP partners have felt stretched beyond the point of sustainability by increasing demand and activity alongside an environment in which recruitment is challenging due to a reducing workforce and investment that has not kept pace with demand.

Current contracting rules mean that there is a reliance on GP partners as contract holders which will present a problem if the current trend of year on year reduction in the number of partners continues.

At the time of writing Dr Nigel Watson is leading an independent review of the partnership model for NHS England.

GPs in Training

Somerset has no local medical school - the nearest are in Bristol and Exeter. Given that training to become a GP takes a minimum of 10 years (5 years at medical school and 5 years of post-graduate training), this means that people tend to become established with their lives around the location of the medical school and less likely to want to move elsewhere thereafter.

Somerset is however fortunate to have 41 practices designated as training practices. These provide good coverage across the county and have been able to cater for around 30 GPs who are in training in each of the training years, ST1, ST2 and ST3 – a total of around 90 GP trainees at any one time

By no means all GPs who train in Somerset choose to remain in Somerset to work – many complete their training then return to their ‘base’ nearer to our regional medical schools, for example in Bristol.

During 2017/18, 17 of the training places were filled by GPs who were part of the Targeted Enhanced Recruitment Scheme in England and offered a one-off bursary of £20,000 to train in Somerset. The previous year, we were unable to fill our target quota or GPs in training and it is unknown at this stage whether the TER will be available next year.

The TER does not require GPs to remain in the county after their training has been completed and at best, it is estimated that around 8 to 10 of these GPs will remain for a period of time in Somerset after qualifying. This is less than the number of GPs retiring or leaving each year.

The National Performers List shows that we have a greater proportion of GPs who are in the older age range than our comparators and only 13% of GPs in Somerset are aged 35 years and under.

Practice nursing

The number of individual nurses working within practices in Somerset has increased by 25 people or 8% since 30th September 2015 with the biggest growth area has been in using Advanced Nurse Practitioners.

Although there are significant variations between local practices, the ratio of nurse to patients across Somerset is better than the national average, and with a few exceptions the movement of nurses out of practices during this time period has been minimal.

The proportion of practice nurses in the county who are aged 55 years and over is lower than the national average and in only a minority of practices are all the nurses aged over 55 years.

A small number of practices are actively advertising for nurses. Given these factors, when compared to the net loss of GPs over the same time period, numbers of practice nurses seem relatively stable. It must be noted however that this data does not provide any insights into the wellbeing, support and development of nurses working in General Practice in Somerset.

Nurse training and the supply of nurses

Relative to practice nursing there are significant vacancies for nursing within acute and community sectors and an estimated shortfall in the region of 200 nursing posts which are being managed through the use of bank and agency staff which is in turn putting pressure on the local system. This has been highlighted as a critical concern within the Somerset Sustainability and Transformation Plan. Discussions are progressing with key partners and local colleges about the potential to develop a local nursing training course in addition to extending the use of nurse apprenticeships, introducing nurse associates and developing new varied, rotational or portfolio roles.

Although practice nursing is relatively stable at present, very few newly qualified nurses come into general practice and only 10 of the 66 Somerset practices offer training places for nurses training with the University of the West of England (UWE) or the Universities of Plymouth and Bournemouth. Each practice takes 1 nurse at a time for either 7 weeks (for year 2 students) or 10-12 weeks (for year 3 students).

All three universities have expressed a strong desire to place more nurse trainees in Somerset if a greater number of training practices could be brought on line.

A local workshop which looked at the flow of nurse and GP trainees to Somerset identified that the limited exposure to Somerset practices during nurse training and the lack of a local training provider were seen as barriers to encouraging newly qualified nurses to Somerset and in particular to general practice. This lack of exposure does not help to challenge views held by some student nurses that practice nursing roles are limited, lack development opportunities and are the kind of roles sought towards the end of one’s career.

Other roles

Practices in Somerset have begun to broaden their skill mix and many now employ or have shared arrangements for using:

- Paramedics
- Musculoskeletal practitioners
- Mental Health practitioners
- Health coaches or similar roles
- Clinical Pharmacists
- Clinical Administrators

In some circumstances practices and other partners have in place new arrangements where staff continue to be hosted by an external partner but work closely with GPs and the practice staff. Examples of this are joint working with Village Agents and Health Connectors who provide additional support to patients around their psycho-social needs.

Summary

There is a national target for GP numbers which we are unable to meet due to rapid reduction in GP numbers since 2013.

What do we want to continue doing?

- Sharing good practice
- GP Careers plus
- Recruitment campaigns
- Portfolio working
- Joint working with pharmacy
- Leadership development programmes
- Supporting the development of well-functioning skill mixed teams

What do we need to do that we aren't doing already?
We need to get serious about skill-mix- agreeing workforce numbers for skill-mix roles with the GP Board and then delivering them on time. The special role of primary care nursing in particular needs to be valued and developed.

Many GPs will require support, training and development to adjust to working in new care models (for example supervising a skill-mixed team) and many practice managers will need to be supported to develop more strategic business skills. A full programme is needed.

What are we going to do?
Recruitment and retention of GPs is the highest priority; this needs to link with wider workforce plans of the LWAB.

6.4 QUALITY AND VARIATION

The overall quality of general practice remains high despite the challenges it faces, as evidenced by the fact that all Somerset practices are rated Good or Outstanding by CQC. However, we found evidence of widespread variation in practices in a broad range of clinical and organisational areas. To some extent this is unsurprising, given that we have 58 different providers of GP services. And of course a standard distribution means that some practices will inevitably be below average on any given measure – not all can be above! Indeed variation is sometimes a good thing when it represents innovation. The essence of general practice is to respond to the unique needs of every single patient, which often does not fit neatly with guidelines or protocols.

Nonetheless, there is clear evidence of widespread variation in diagnosis, referral, prescribing, management of acute illness, management of long-term conditions, access, consultation length and other important aspects of care.

There are also fundamental challenges related to the integration of care between providers and sectors of care. In particular we believe that it is in the interests of patients for the historical division between primary and secondary care to be challenged and where it hinders rather than enables the delivery of care brought to an end. The organisation of general practice at scale is important in bridging this divide by creating structures to allow specialists, some of whose work should become increasingly community-orientated, to work alongside primary care teams.

It is widely agreed that clinical integration of services is a key factor to enable to NHS to make care closer to home a reality as well as reducing unnecessary use of hospitals. Too often, patients are admitted to hospitals because of a lack of alternative forms of support and care, or because general practitioners face difficulty in accessing specialists and experienced nurses quickly in times of crisis. Our vision of the future is one in which general practitioners and their teams work with geriatricians, paediatricians and other specialists in care networks to help patients remain independent in their own homes for as long as possible. A progressive shift of resources from hospitals to the community is needed to make this happen.

There is some evidence that provider-led quality initiatives which incorporate peer review are more successful in improving quality than initiatives which enforce change through contractual means or pathway changes. Organising the primary care provider sector to allow clinically-led peer review and improvement needs to be an important focus for us as we seek to identify and address unwarranted variation.

In the Somerset context of a system that is in turnaround, every single aspect of quality and service provision needs to be scrutinised to ensure that it is functioning as well as possible.

We also need to be clear how NICE guidance is implemented in general practice in Somerset. This is particularly pressing because one of the principal avenues for NICE implementation is QOF, and Somerset has pursued an alternative quality scheme since 2013.

6.5 DIGITAL INNOVATION

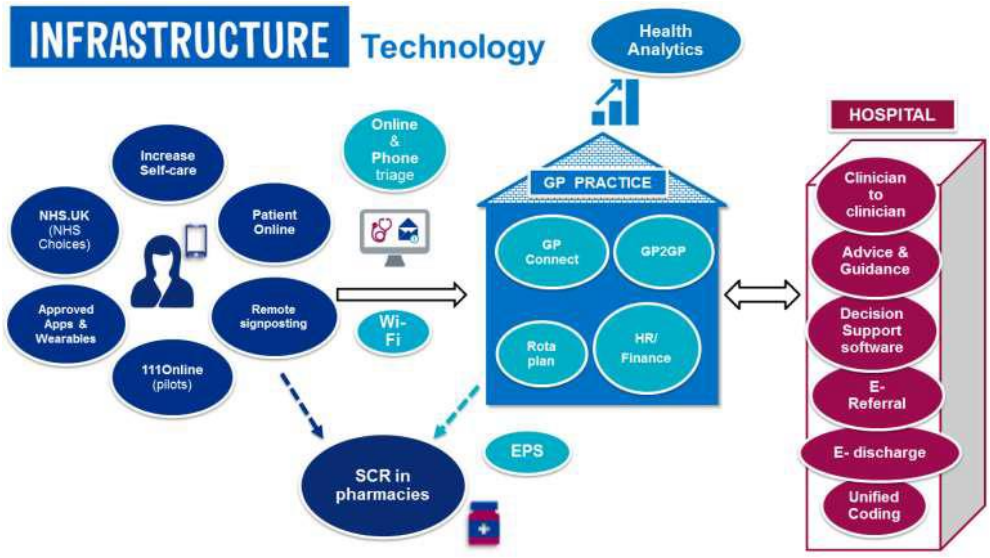
"Harness the power of technology in ways that empowers the patient whilst reducing the burden on our health services"

IT and Technology plays a critical role in creating the infrastructure necessary to support change, and interoperability throughout the health system is a key enabler in supporting practices to work together and operate at scale making sure patients see the right health professional in a timely manner.

The NHS England digital transformation strategy for primary care is part of the General Practice Forward View (GPFV) plan to invest in better technology. The GPFV contains actions to develop and sustain the workforce, boost workload efficiencies and manage demand, and modernise infrastructure and technology. Its digital interventions include:

- National fund to implement online consultation systems
- Interoperability across IT systems
- Implementation of free Wi-Fi for staff and patients in GP practices
- Roll out of access to the summary care record to community pharmacy

The national picture will look like this:



Locally the 'Somerset Digital Roadmap' October 2016, sets out the priorities for the whole health system and Somerset's framework for digital transformation. It includes the SIDeR programme (Somerset Integrated Digital e-record) for implementing seamless information sharing initiatives and initiatives such as EMIS viewer that provides frontline clinicians with read only access to a patient GP record in urgent and emergency care settings.

At a General Practice level online services now include the ability to make appointments on line, order repeat prescriptions and increasingly giving patients access to their patient record all of which add value to health staff and patients. The most recent initiative is the successful CCG bid to NHSE for funding to support the implementation of an online consultation system for Somerset practices. Online consultation will provide an additional option for patients to communicate with clinicians in their practice. In some cases a patient's issue can be completely resolved online, thereby saving on face to face appointments. Online consultations open up another means to access to self- care support, information and guidance with direct input from a clinician when necessary. This three year project is being led by the primary care commissioning team in collaboration with digital colleagues.

Information Technology in Primary Care

Digital innovation will play an increasingly significant role in general practice service delivery and in delivering accessible and co-ordinated care that supports staff delivering it by:

- Allowing timely information exchange across a multi-disciplinary team
- Enabling shared management of patient information, thereby increasing informational continuity of care
- Supporting the delivery of a paperless NHS
- Allowing more efficient productive workflows
- Enabling more effective management of demand and capacity

These initiatives are aimed at reducing the time taken to complete the patient journey and help with each stage of a patient's interaction with primary care. Most importantly Information technology can free up clinicians time, reducing the pressure on workloads, enabling them to work at the top of their licence and thereby helping to sustain and retain the workforce.

At the day to day operational level this will present health staff and patients with new ways of accessing and delivering services which will require a shift in culture and support with change management. The support that this will require should not be underestimated and will need dedicated time and resources to enable staff and patients to understand the benefits of digital services and how to use them to best advantage.

Digital platforms can enable investment in the patient to:

- Empower patients with information about their care that supports them in care planning and setting health goals
- Enables patients to better manage their own health conditions, increasing the level of independent self- management
- Provide patients with more choice about how and when they access healthcare

- Create a more streamlined patient journey throughout the healthcare system
- Provide a lifestyle gateway for the wider population to stay healthy focusing on identifying health risks and preventative self- care e.g. weight, alcohol, smoking, physical activity

Next Steps

One of our aims is to make a practice-based primary care online service available as the first port of call for patients wishing to access help via their GP practice in a bid to help address the increasing demand on General Practice and to maintain access and continuity for patients. Increasing patient uptake of online services will increase the level of benefit and improvement in terms of the patient experience, reduced workloads and managing demand. Investment in gaining the commitment of primary care staff to champion online services and supporting patient engagement to use online services will be the key to success.

Whilst using online services will not be suitable for everyone even a moderate shift to using online will have an immediate impact on reducing the number of telephone calls to the surgery and will help to better manage peaks in demand during the week.

We know that:

- Over 55s are the fastest growing market in terms of going online
- 82% of people have a smart phone (an issue is not all smart phones have enough space to support apps)
- Over 45s are more likely to use tablets and laptops
- Under 45s more likely to use mobile app

The potential across all age groups is growing as people get used to accessing other services online (such as banking). In order to take advantage we need to:

- Resource the implementation and delivery of digital initiatives in primary care
- Adopt a change management approach to embedding digital ways of working into business as usual
- Support patients to understand how and when to use digital services
- Develop digital inclusion support for vulnerable patients
- Put a focus on the empowerment of patients through web based self- care, information guidance and support

We will enable transformation in general practice, using technology and data to drive improvement in quality, safety and efficiency benefitting both patients and professionals and supporting the general practice of today and tomorrow.

6.6 PROVIDER ORGANISATION

The current organisation of general practice reflects historical accident more than deliberate design. However the independent contractor model of general practice within the NHS has provided great benefit over the last seven decades. The partnership model has provided a degree of autonomy for practitioners that has allowed them to retain an advocacy role in respect of patients' needs while providing a cost effective service to the NHS in which most of the liabilities are carried by the providers.

Nonetheless, the traditional partnership model has come under increasing pressure in recent years for a variety of reasons including medical workforce preferences and lifestyle choices, a failure to train and retain adequate numbers of GPs, excessive workload, falling earnings, a difficult relationship with government, consequent poor morale and in this context increased concern about the unlimited liabilities of GP partners.

We all have a stake in effective general practice, whether as patients, providers or commissioners. It is important that we have stable, well organised GP provision in Somerset.

We have seen much innovation and development in practices including the rapid widening of skill-mix roles such as clinical pharmacists, health coaches and paramedics, the redesign of access systems and an increasing number of practice mergers.

There is much written about new models of general practice and 'primary care at scale'. Some of this has clear theoretical underpinnings and associated logic models, but some rests on untested assumptions. In particular the idea that bigger is better should not be accepted uncritically. Scale does provide opportunities to do things differently and increase workforce resilience, but we also need to be very clear that some of our most successful practices in Somerset are also the smallest.

So our challenge is to realise the benefits of scale while retaining the benefits of local familiar general practice.

Here there is much we can learn from international examples. For example, the Pegasus Primary Care Network in New Zealand is a GP network organisation that supports a large number of small independent contractor practices to deliver high quality primary care through:

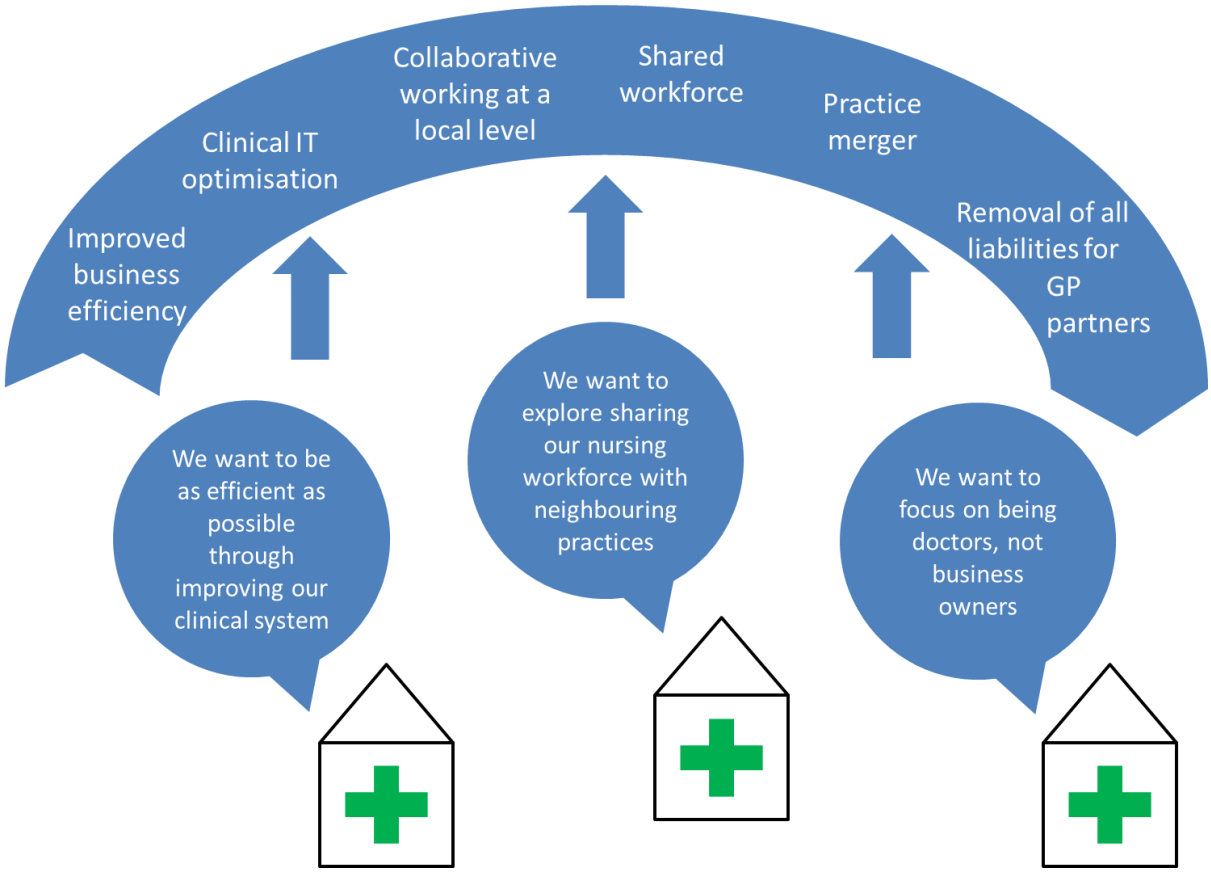
- Providing specialist workforce to practices when needed
- Managing claiming processes for practices
- Running a 24 hour urgent care facility
- Delivering a wide range of business support to practices
- Being a strong GP provider voice in discussions with system partners

There are many other examples which combine the benefits of local and familiar general practice with the benefits of scale.

We believe that this type of model could offer us some clues about how best to provide GP services to a dispersed rural population in an effective way. In essence:

- Every practice delivering a responsive, accessible service with a high level of continuity of care
- Collaborative local working including as part of 'neighbourhood care teams' covering 30-50,000 patients
- Effective collaborative groupings of practices such as federations
- A county-wide provider organisation that can hold large contracts and deliver large scale change programmes that need to involve every practice.

From our investigations it is clear that there needs to be a much more coherent spectrum of support for providers so that the current multiplicity of initiatives and organisations currently involved are brought together into one comprehensive whole. This is expressed in the figure below:



We have invited the Royal College of General Practitioners to join us in this work and ensure that our proposals for organised primary care in Somerset are evidence based and accord with best practice.

6.7 COMMISSIONING

As part of the development of a more integrated and better functioning health and care system in Somerset it is vital that there is a strong foundation of general practice.

The CCG needs to take on fully delegated responsibility for commissioning GP services in order to provide a clear expectation for providers, relationship management including practice visits, and effective contract management.

Although the core GP contract is nationally negotiated and local commissioning decisions are governed by the national policy guidebook, there is substantial flexibility and freedom for local commissioners to shape general practice.

There is an extensive literature on effective commissioning of GP services. Key priorities for Somerset are:

- Continued investment in general practice to support integrated out of hospital care and to ensure that every practice is able to offer high levels of access and continuity which then deliver system benefits.
- Somerset benchmarks below mean average for investment in GP services, according to the NHS benchmarking data (full report at Appendix D). We are now examining other data sources to triangulate this.
- Although almost every funding stream for GP services in Somerset is already weighted for age and deprivation there could be further targeting of investment to address health inequalities.
- To ensure a consistent service offer to patients through the use of a bundled contract such as the Primary Care Improvement Scheme. This ensures that providers deliver all the services in the contract, rather than having freedom to choose which services to provide.
- To manage the provider landscape, in particular to define our approach to issues such as patient choice and at-scale provider market share. We need to ensure that emerging large provider organisations are stable, successful and deliver a good service to patients.

7. ACKNOWLEDGING THE INTERDEPENDENCIES

It is important to note the context for GP services; they are not an island but a fundamental part of any modern integrated health-care system. For this reason we need to be clear about the inter-relationships between GP services and the wider system, particularly when identifying opportunities for GP services to do more. As Imison et al (2017) state in their overview of evidence for STPs seeking to shift care out of hospital;

“Many initiatives we examine place additional responsibilities upon primary and community care, at a time when they are struggling with rising vacancies in both medical and nursing staff, and an increasing number of GP practices are closing. Addressing these issues is a necessary precursor to success.”

This concise report focuses on GP services, but some of the biggest questions about the future of general practice in Somerset relate to the design of the wider system. These questions form part of the work of the pathway workstreams within the Fit For My Future strategy, but are summarised here:

Workstream	Implications
Urgent Care	What will be the impact of Urgent Treatment Centres and the new Integrated Urgent Care services on ‘in-hours’ general practice, particularly in relation to same day demand and Improved Access?
Proactive Care	What is the best model of proactive care for people with multiple long term conditions and how will it be implemented across all practices?
Maternity and Children’s Services	How do we remove the false barrier between primary and secondary care clinicians in respect of paediatrics?
Planned Care	Will we seek to recommission large amounts of what is currently secondary care activity in primary care? If so, how will we do this?
Mental Health and Learning Disabilities	How will we provide a much better mental health service to patients which provides the right resources in primary care? How do we ensure that GP services are doing all they can to close the inequalities gap for people with learning disabilities?

CONCLUSION

The case for change in GP services is clear. Briefly there are a number of issues that need to be addressed including:

- Growing demand and expectations
- Constrained workforce supply including a reduction in GP numbers in Somerset
- Increased complexity of patients' conditions
- Growing opportunities for primary care to offer a wider range of services, but in tension with increased demand and reduced capacity
- Significant variation in standards of care and the level of service offered
- A lack of integration with other health and social care services, in particular an increasing disconnection from community services, mental health and hospital specialists

Having examined the local and national evidence thoroughly, the workstream can make the following headline conclusions about the priorities for delivery of GP services in Somerset :

- The population of Somerset has a clear need for responsive, local GP services
- Continuity of care delivers the greatest system benefit and must be developed through team-based continuity
- Widespread variation needs to be addressed in a much more sophisticated way
- We need to move to 'organised primary care' and should deploy transformation funding to do this. This will provide: continuity of care, workforce resilience and integrated care that will reduce system cost

The challenge now will be to consider these recommendations carefully, and if adopted, to rapidly but sensitively make progress in order to benefit patients.

For ease of reading the specific and detailed recommendations and next step priorities for delivery contained in the report are reiterated below:

Delivery: Workforce

- Retaining GPs- our most difficult resource to secure
- Getting serious about skill-mix- agreeing workforce numbers for skill-mix roles with the GP Board and then delivering them
- The special role of primary care nursing in particular to be valued and developed

- Addressing the development needs of practice managers – a proper programme of development is required

Delivery: Access

- Introduce a shared ambition between commissioners and providers for patient access
- Define a package of support for practices to review and adapt their access models
- Enhance our understanding between continuity and access
- Support practices to understand demand, capacity and organisation of patient access. This includes patient demographics and sharing of good practice.
- Automate the collection of activity data from GP practices for service improvement and system planning
- Invest time and human resource to undertake the actions set out in the access inequalities assessment.

Delivery: Helping people care for themselves

- Making sure we play our part in delivering on the wider determinants of health as set out in the Health and Wellbeing Strategy for Somerset
- Making good quality online information and advice available on every practice website, to support a 'digital first' service offer
- A Somerset wide campaign, highlighting self-care resources and giving practical advice on common conditions and how to manage them
- Promoting tools like the TST child-health app which helps concerned parents make wise choices
- Emphasising and developing the role of community pharmacy as the first port of call for a wide range of ailments

Delivery: Practice Organisation

- Promote person-centred care
- Enhance continuity of care
- Ensure all clinicians have a safe working day
- Constantly improve clinical quality including implementation of NICE guidance
- Investigate variation and where unwarranted, seek collaborative peer-led improvement
- Ensure that the mix of provider organisations meets our current needs

Delivery: Commissioning and contracting

- Continued Investment including targeting health need
- A bundled contract at practice level is vital to deliver consistent service offer

- The CCG should take fully delegated responsibility for commissioning GP services as soon as possible.

Delivery: Planned Care (note that we have not examined this issues in detail as they are being taken forward by the planned care workstream)

- Delivering as much as possible locally, either at your own practice or in a 'neighbourhood' area
- Making best use of GPs with Extended Roles
- Organising delivery in primary care through GP provider organisations

Delivery: Urgent Care (note that we have not examined these issues in detail as they are being taken forward by the urgent care workstream)

- General practice is not an emergency service, but has to deal with emergencies
- However general practice is local and should provide a comprehensive service
- Good access to GP services is critical
- We do not support GP 'overflow hubs' because we would rather invest in good quality GP services that can meet demand in the first instance. That is not to say that co-location of GP services as part of a well-considered approach to integrated urgent care would not work well.

Delivery: Maternity and paediatrics (note that we have not examined these issues in detail as they are being taken forward by the maternity and paediatrics workstream)

- Better training for GPs in paediatrics; this is a significant weakness of the English GP training system

Delivery: A Transformation in our approach to long-term conditions (note that we have not examined these issues in detail as they are being taken forward by the LTC workstream)

- The simple truth is that our current model of general practice is simply not designed to cope with multi-morbidity. It reflects a 1948 model of chronic disease management which is fundamentally unable to deliver what is required now
- Access to Social Prescribing to be in place for every practice by March 2019 (Operational Planning requirement)
- Person-centred consultations
- Empowerment of patients to manage their own care
- Proactive primary and secondary prevention in order to improve population health

- Organised and systematic care planning across whole system
- Better support for people with cancer

Delivery: Organised and optimised infrastructure

- Digital transformation including whole system shared care records
- Availability of sophisticated analytical support to commissioners and providers of GP services
- The right estate infrastructure

Delivery: Better care for people with long-term conditions and locally integrated care

- Practice collaboration at 30-50,000 population level can deliver significant benefits
- But the bigger prize is the integration of community services (in their widest sense) with general practice to deliver locally integrated care; community nursing, community pharmacy, social care etc.

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