Somerset Primary Care Needs Assessment

Georgina Angel

Public Health Specialty Registrar

Somerset County Council

May 2016

CONTENTS

Executive Summary

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 has 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.

Introduction

Primary care is the part of the NHS that almost everyone comes into contact with. Approximately 90% of NHS activity takes place in primary care (1) which also plays a vital role in prevention and population health. In Somerset there are 75 practices spread across the county delivering primary care which are independent contractors controlled by partnerships of GPs practicing together or alone. Since 2013, NHS England has been responsible for commissioning primary care services but more recently CCGs have been encouraged to take on a greater role in planning these services. In recognition of the importance of GP services in the community NHS England and Somerset CCG are now jointly commissioning these services through the Primary Care Joint Committee.

There is a national drive for primary care development in England, perhaps most clearly set out in the NHS Five Year Forward View, which states that, the "*foundation of NHS care will remain list-based primary care*" (2). It proposes new models of delivery encouraging more integrated care. The Royal College of GPs has also set out its priorities for development including promoting the value of generalist care, developing more integrated services including community teams, expanding the workforce and enhancing their skills and flexibility (3). The GP Taskforce reported in 2014 in response to serious concerns over a dwindling workforce (4). The BMA also recently reported on a large scale consultation exercise of patients, GPs and other stakeholders and what their priorities were. It proposed five key steps to meeting these priorities; new models of care, addressing the workforce crisis, increasing funding, modernising premises and infrastructure including IM&T (5).

In light of this drive for reform the Joint Committee for Primary Care are writing a commissioning strategy which sets out its vision for quality primary care services in Somerset. In order to do this it must consider the specific needs of the Somerset population and how best to address these.

Aim of the Needs Assessment

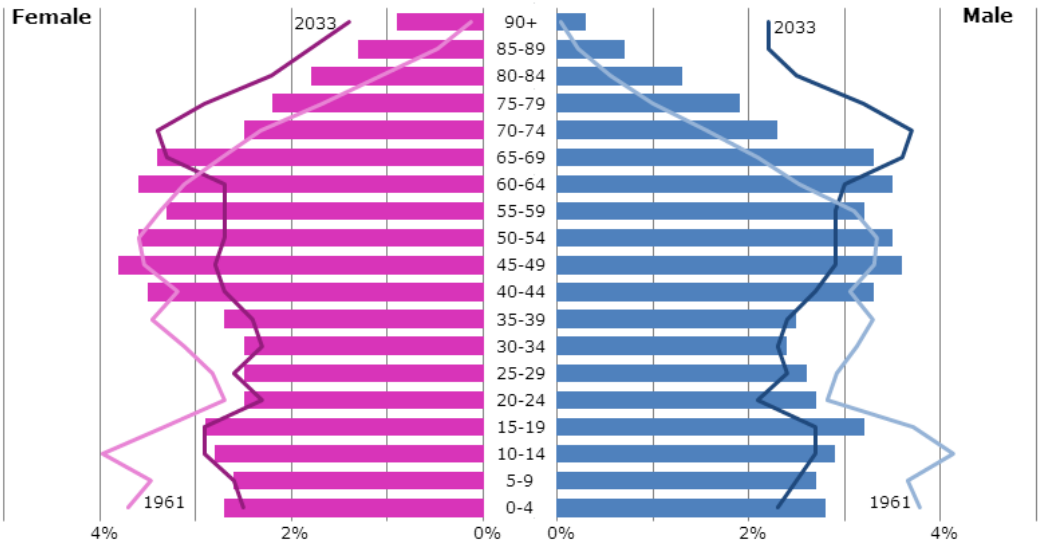
The aim of this needs assessment is to identify priorities for the Somerset population as a whole and review the available evidence to inform the Somerset primary care commissioning strategy. It will provide a brief overview of the Somerset population with a deeper dive into the most pressing health needs and wider determinants relevant to the delivery of primary care. It will consider the evidence for what is driving change in primary care and the principles underlining high quality, value for money primary care in the future. Finally it will be provide evidence based recommendations for where investment may be best focused to address the needs of the population and improve value for money.

Somerset population and their primary care needs

An Overview of the Somerset Population

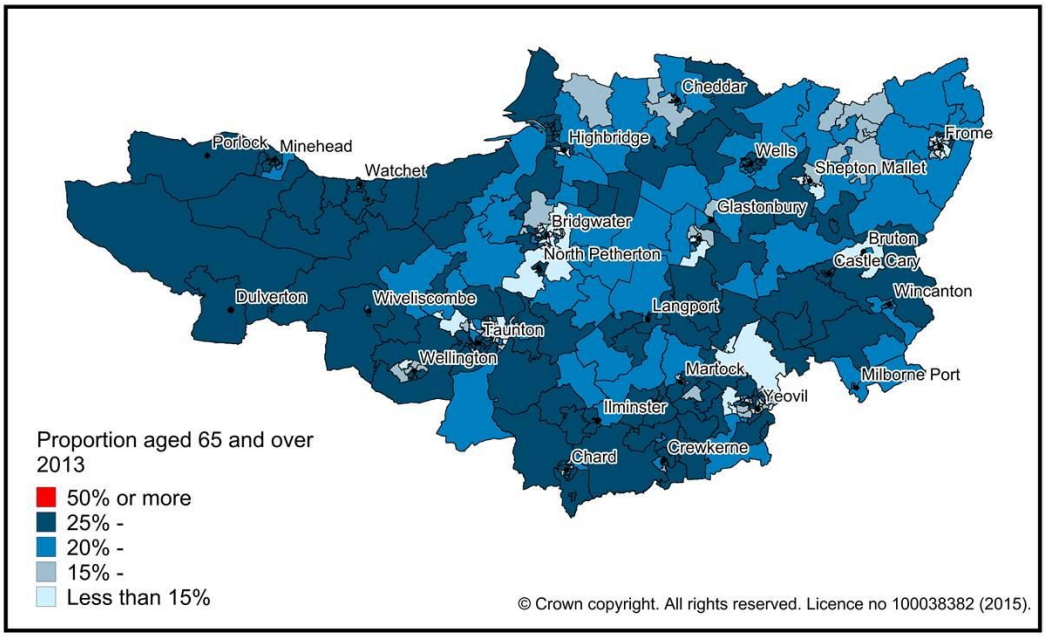
According to ONS mid-year 2014 population estimates there are 540,000 people resident in Somerset of which 125,000 of them are people aged 65 or older. Population projections suggest the most significant growth in the Somerset population over the next 25 years will be among people aged over 65 which in most districts will be by over 50%. The population pyramid (see Figure 1) highlights the ageing profile of Somerset indicating that by 2033 there will be a bulge in the 70-79 age group and almost as many residents in their 80s as in their 20s. Local projections show in comparison to the population in 2013 most areas are likely to have at least 25% of the population over 65 and some as high as 50% (see Figure 2) (6).

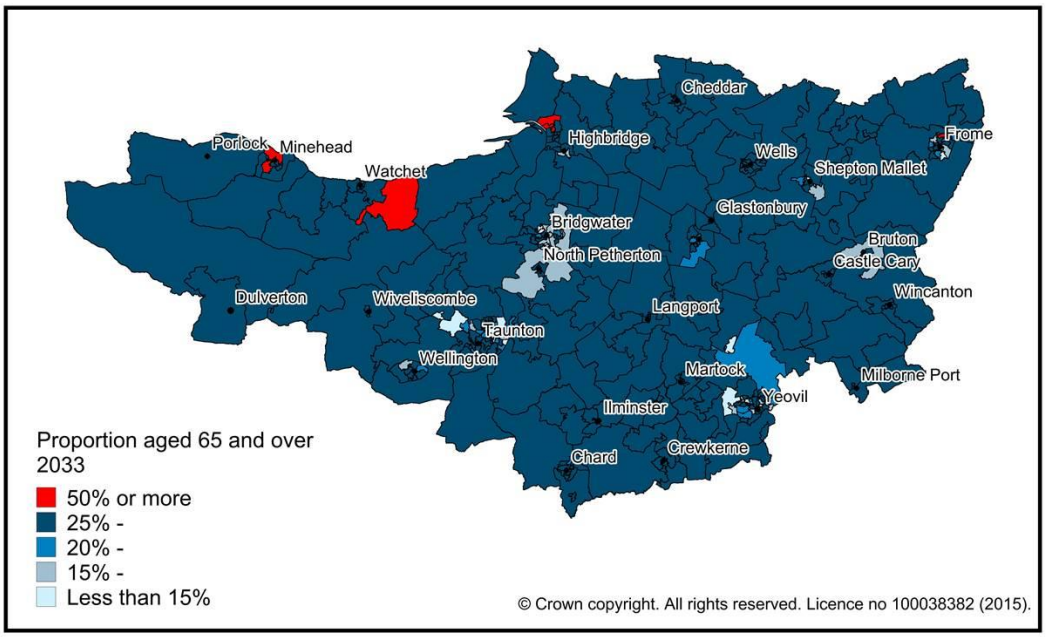
Figure 1: Somerset population pyramid highlighting the projected ageing profile (6)



While life expectancy is at an all-time high and those aged over 65 can expect to live for another twenty years it is essential to note that barely half of this will be disability free (7). The prevalence of conditions of older age such as dementia, stroke, falls and wider social issues of isolation and loneliness are increasing. An ageing population presents significant challenges for Somerset's health, social care and housing providers.

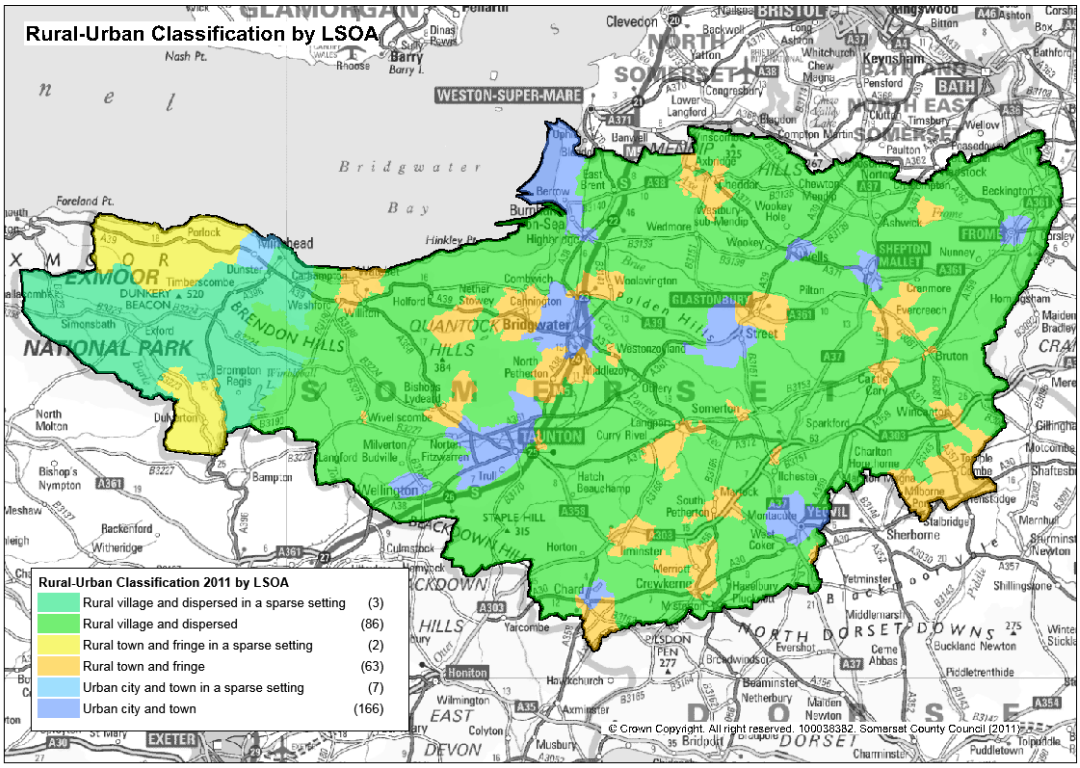
Figure 2: Proportion of population aged 65 and over in 2013 and projected 2033 (6)





Somerset is also one of the most rural counties in the country (see Figure 3) with 48% of its population living in rural areas. The 2015 Somerset Joint Strategic Needs Assessment (JSNA) focussed on the needs of those living or working in rural areas and highlighted a number of positives including healthier living, a higher life expectancy and strong community. Rural residents self-reported better health than their urban counterparts. However there are also a number of challenges associated with living in rural areas. These include social isolation, difficulties in accessing services, infrastructure and transport issues and those over 75 being more likely to be admitted to hospital as emergency cases (8).

Figure 3: Map or rural-urban classification by LSOA (8)



While Somerset is generally better than the national average in terms of overall levels of deprivation, there are 25 neighbourhoods in Somerset categorised as 'highly deprived'. This is an increase from 14 neighbourhoods in 2010 and represents a total of 38,000 Somerset residents who are living in one of the 20% most deprived neighbourhoods in England (9). The pattern of deprivation in Somerset is a mix of urban and rural deprivation and is therefore complex. Areas of significant deprivation include some of the county's larger urban areas such as the Lambrook / Halcon area of Taunton, Bridgwater and Highbridge but significant pockets are also seen in the rural areas, particularly West Somerset (see Figure 4). Bridgwater and West Somerset commissioning localities are starkly different in terms of rurality but have the same IMD score of 22.7 representing the most deprived areas in Somerset. However, if we look at the individual domains making up IMD score and compare these for Bridgwater (an urban area) and West Somerset (a rural area) we see clear differences in the factors contributing to deprivation. For example, where income, employment and education are the most significant factors in Bridgwater, health deprivation and disability, the living environment and barriers to housing and services are more relevant in West Somerset (10)(11).

The supplementary Income Deprivation Affecting Children Index (IDACI) score indicates that Somerset has 19 neighbourhoods within the most deprived 20% in England (9). What is most striking is the geographical concentration of these children and young people (see Figure 5). Half live in an area composing only 5% of the county namely in Taunton, Bridgwater and Yeovil which means that the other 50% are dispersed over 95% of the county. This poses an opportunity to focus services on a few small areas and also a challenge to provide services equally in the more dispersed rural areas. Health and social care planning will need to take account of these urban / rural differences if they are to bring about equitable positive change.

Figure 4: Index of Multiple Deprivation (IMD) 2015 in Somerset (9)

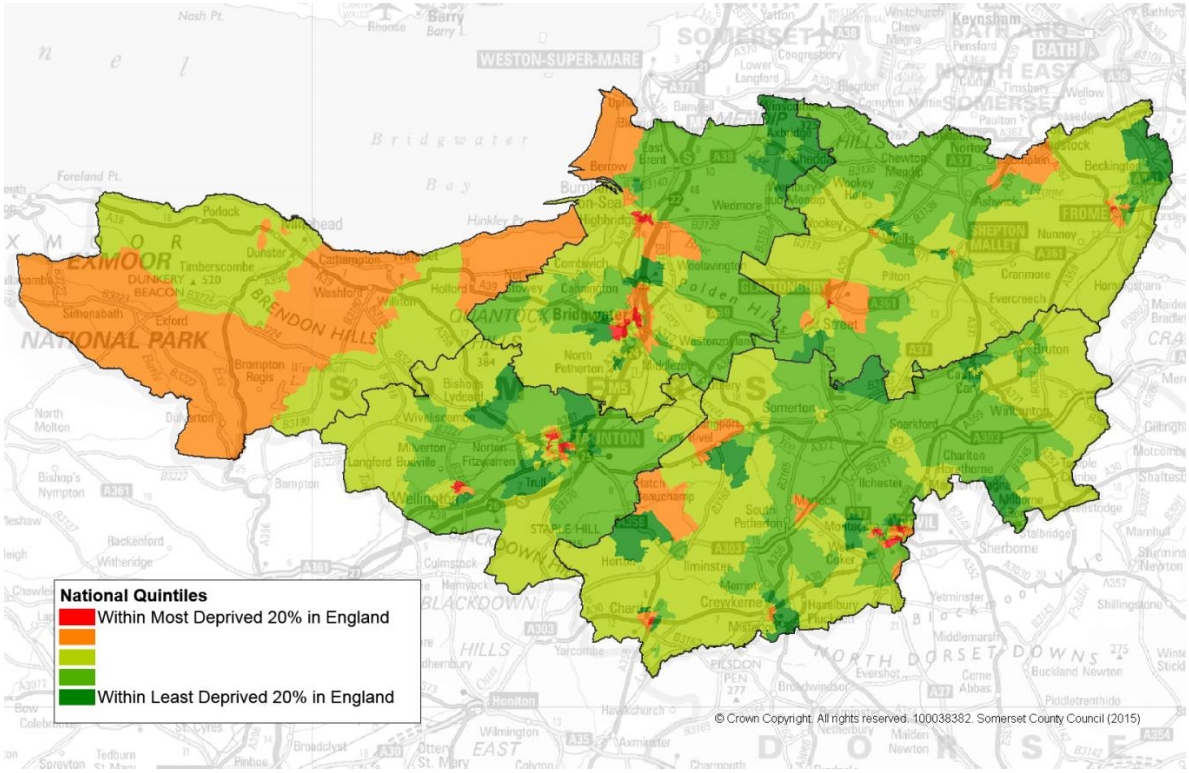
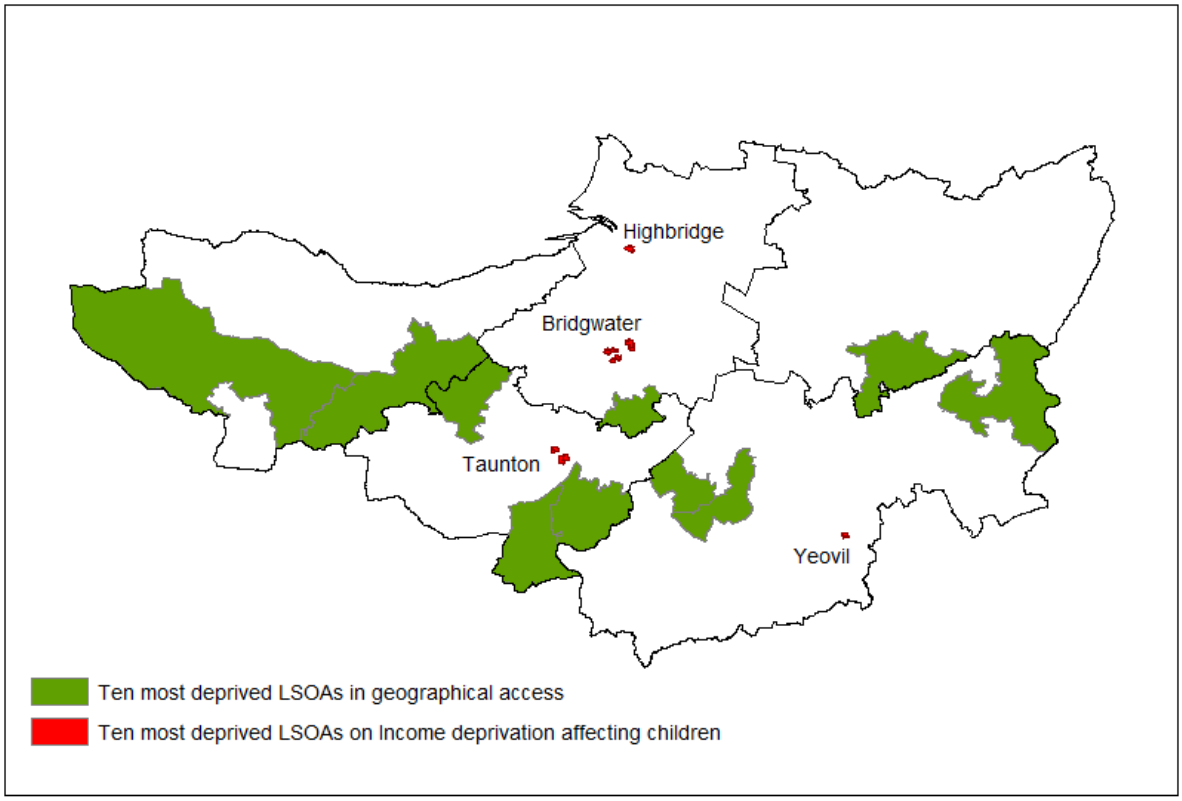


Figure 5: Map showing the 10 most deprived LSOAs on IDACI score and 10 most deprived on the 'access to services' domain



Overall health of the Somerset population is good. Life expectancy at birth continues to rise for both males and females, currently set at 80 and 84 years respectively which is higher than the national average. However inequalities persist and life expectancy is 6.9 years lower for men and 3.7 years lower for women in the most deprived areas of Somerset compared to the least deprived areas. People in the least deprived areas are also estimated to live disability-free fourteen years longer than those in the most deprived areas. Crude prevalence rates for most chronic conditions have risen over the past year which can partly be explained by the increasing elderly population (12). The rate of emergency admissions due to falls and hip fractures in people aged 65 and over is also higher in Somerset than for rest of the region and the England average (13). A&E attendance among 0-4 year olds is significantly higher than the England average as is hospital admission for injuries and substance misuse in children and young people(14). These problems are also concentrated in the more deprived areas. The needs of children and young people living in poverty is complex and general practice needs to be well placed to address these needs holistically working with multiple agencies such as drug and alcohol teams, child and adult social care, schools and housing.

Health needs and wider issues relevant to primary care

Access to services

Good access to general practice is a crucial element of the NHS and "*matters for patients themselves and for the health system*" (15). It is important for achieving the best health outcomes for patients and to reduce pressure on other parts of the NHS therefore making the best of its resources. It is estimated that 5.8 million people attended A&E or walk-in centres in 2012-13 because they were unable to get a convenient appointment in general practice. Typically hospitals are paid £124 for a visit compared to £21 for a GP consultation.

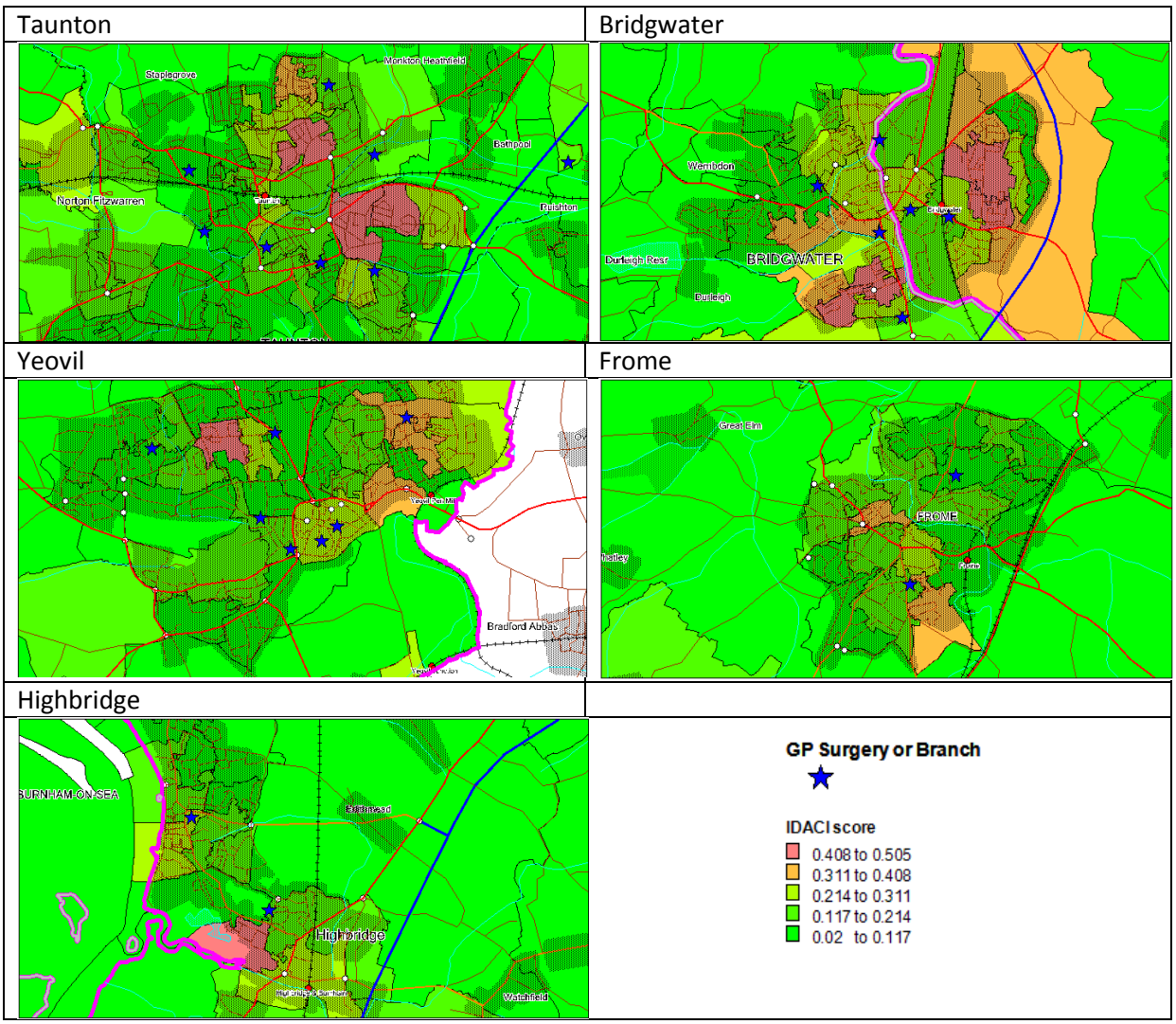
The NAO audit of access to general practice undertaken in 2015 found that although 89% of patients reported they could get an appointment overall satisfaction is slowly declining particularly in terms of the process of making an appointment, convenient opening times and continuity of care. It found that different patient groups had different expectations of access with older people more likely to value continuity of care than same-day appointments. The distribution of general practice staff does not necessarily reflect need and deprived areas tend to have a lower ratio of GPs and nurses to patients equating to more difficulties with getting an appointment. 37% of people in rural areas do not have a GP surgery within 2km compared to only 1% of people in urban areas. The audit also suggests that practice working arrangements are an important factor in the variation in appointment availability and there are lessons to learn from each other. Additionally, recruitment and retention of GPs is a growing problem with 12% of training places unfilled in 2014-15 and higher proportions of GPs leaving the profession. Nationally the proportion of GPs aged 55 to 64 leaving the profession doubled between 2005 and 2014. GPs only make up 29% of the general practice workforce, however, data for other general practice staff and the effects of using a greater skill mix are limited (15).

In Somerset 67 out of 75 general practices now provide extended opening hours to a varying extent. A crude analysis shows that this is 82% of rural practices compared to 97% of urban practices. Over 90% of practices in deprivation quintiles 2, 3 and 4 provide extended opening hours but only 87% in the most deprived quintile and 73% in the least deprived. 92% of practices with a population under 3500 per whole time equivalent (WTE) GP provide extended opening hours in contrast to 80% of

practices with a larger population per WTE GP where arguably extended hours are in greater need (16).

Mapping of GP surgeries across Somerset in relation to the IDACI score highlights that there are no practices situated in the most deprived areas, and only the Oakfield practice in Yeovil is in the second most deprived area (see Figure 6). Inequalities in health, the association of poor health outcomes with deprivation and the importance of early intervention are all well known. The location of practices outside these areas of deprivation is a challenge for primary care in addressing the health of the worst off in society.

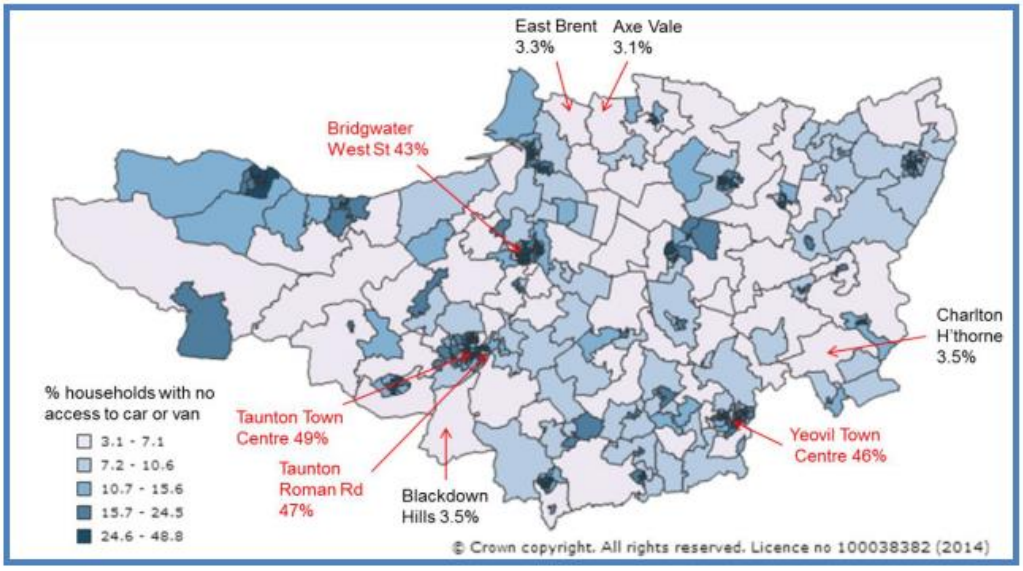
Figure 6: Maps of largest towns in Somerset with location of GP surgeries according to deprivation (IDACI score) (provided by Somerset Public Health team by request)



Infrastructure and transport issues have been identified as important issues limiting access in rural parts of Somerset. Although figures indicate that 100% of households in Somerset are able to reach a GP within 15 minutes by car, for households reliant on public transport or walking this falls to 84%

which is lower than the national average (17). In parts of Exmoor, households can be 50 minutes from a GP surgery. On average 15.9% of households in Somerset do not have access to a vehicle and this is significantly higher in parts of rural West Somerset and a number of town centres where we know surgeries are not always located in close proximity to where there is need (see Figure 7). Access to a vehicle is a particular issue for older people as only 1 in 5 Somerset residents over 65 has such access and the proportion is higher in rural towns and villages and amongst women (18).

Figure 7: % households with no access to a car or van (18)

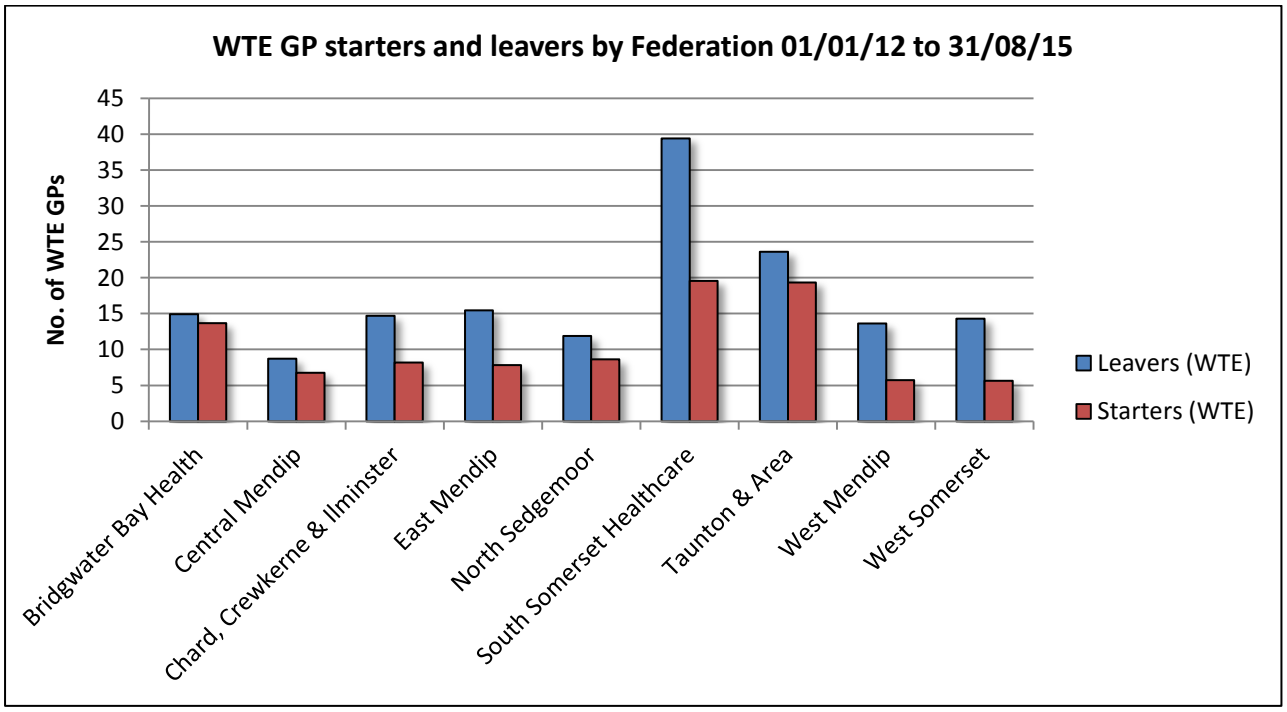


In line with national concerns regarding retention and recruitment, Somerset has a high proportion of GPs who will be reaching retirement age within the next 5 – 10 years (see Figure 8). Analysis of starters and leavers over the last 3 years indicates a deficit in GPs across the whole of Somerset, particularly in South Somerset, West and East Mendip, West Somerset, Chard, Crewkerne and Ilminster (see Figure 9) (19). Unfortunately there is little or no data regarding other healthcare professionals working in general practice.

Figure 8: Number of WTE GPs predicted to retire in next 5 years if all GPs retire at 59 (national median retirement age). Extracted 14/09/15 (19)

Federation	WTE GPs by working 2020 if all retire at 59	WTE GPs retired in 2020 if all retire at 59	Grand Total	% WTE predicted to retire by 2020 (if retirement age is 59)
Bridgwater Bay Health	23.59	22.6	46.19	49%
Central Mendip	6.53	6.42	12.95	50%
Chard, Crewkerne & Ilminster	17.46	8.66	26.12	33%
East Mendip	16.85	5.17	22.02	23%
North Sedgemoor	16.38	9.15	25.53	36%
South Somerset Healthcare	47.71	20.05	67.76	30%
Taunton & Area	58.75	13.25	72	18%
West Mendip	18.67	6.44	25.11	26%
West Somerset	12.17	8.32	20.49	41%
Grand Total	**218.11**	**100.06**	**318.17**	**31%**

Figure 9: WTE GP starters and leavers by Federation. Extracted 14/09/15 (19)



Social isolation in older people

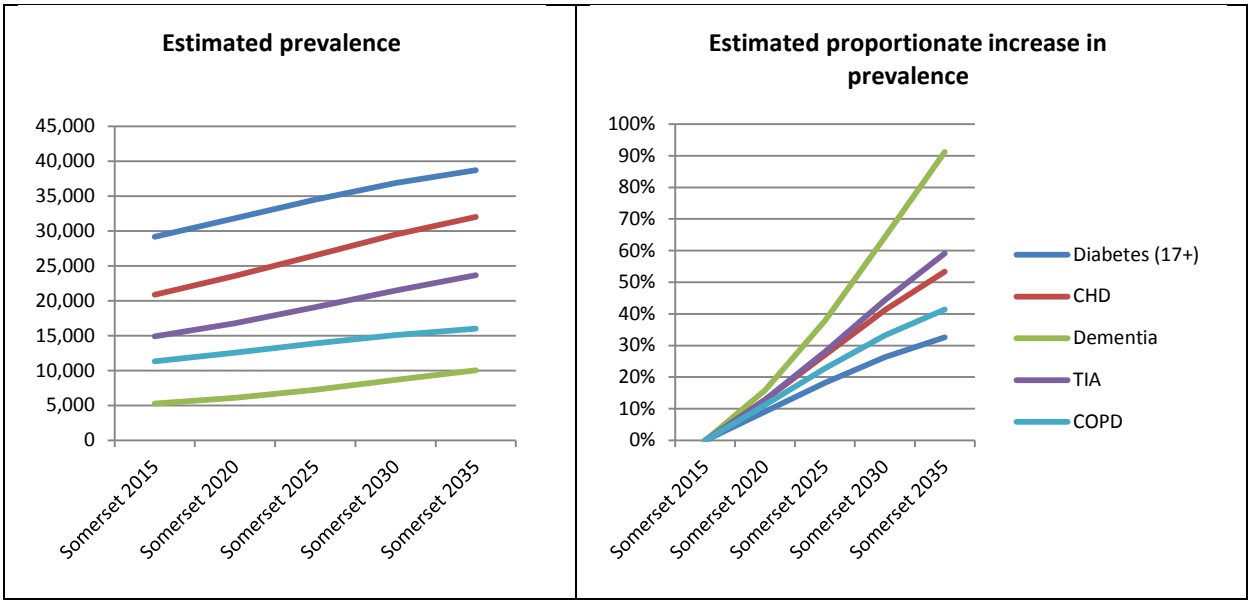
Older people are particularly vulnerable to social isolation and loneliness due to loss of friends and family, reduced mobility or limited income. It is estimated that between 5% and 16% of those aged over 65 report loneliness and 12% feel isolated with these figures expected to increase (20). In Somerset an estimated 12,000 residents are thought to be affected by social isolation with 1 in 7 households containing someone aged 65 or older living alone. Social isolation is felt to be particularly relevant for older women in Somerset due to public transport difficulties and this group of people being less likely to drive. Around 1 in 6 social care users aged 75 or older in Somerset said they had insufficient social contact and / or felt socially isolated (21).

Studies show that loneliness and isolation can have a significant detrimental impact on health and wellbeing with research highlighting the influence of social relations on the risk of death as comparable to risks of smoking and alcohol consumption. Being lonely and isolated has been found to negatively correlated with blood pressure and be associated with depression and higher rates of mortality. Social isolation and loneliness also has wider cost implications for health and social care services due to increasing demand and dependence on costly services (20). For example, socially isolated people are more likely to undergo early admission into a residential or nursing home.

Important diseases now and in the future

The ageing profile of the Somerset population means we can expect an increasing prevalence in a number of chronic conditions. There is a dramatic increase with age in the recorded prevalence of diabetes, coronary heart disease (CHD), dementia, stroke and COPD reaching 21%, 28%, 14%, 25% and 11% respectively in those aged over 80 in Somerset. Modelled projections estimate an overall increasing prevalence over the next two decades in all 5 of these conditions across Somerset with dementia prevalence predicted to rise by over 90%, CHD and strokes by between 50-60%, COPD by over 40% and diabetes by over 30% (see Figure 10).

Figure 10: Estimated increases in prevalence in chronic conditions in Somerset, 2015- 2035 (provided by Somerset Public Health Intelligence)



It is important to note that all of these diseases are associated with lifestyle factors and wider determinants of health such as smoking, alcohol, diet and physical activity. Prevention and early diagnosis in primary care therefore need to be central aspects of any approach to reduce their risk and impact.

Somerset also has one of the highest rates of emergency admissions for hip fractures nationally at 633 per 100,000 people aged over 65 and 1704 per 100,000 people aged over 80. The rate of emergency admissions for injuries due to falls in older people is also higher than the national average (13). The increasing number of Somerset residents aged over 60 means these are important issues to be addressed today and in the future in terms of quality care, pressure on secondary health services and the relative high costs associated with management of falls and hip fractures in older people.

Living with multiple long term conditions

A substantial proportion of people living with long-term conditions experience multi-morbidity - that is the presence of two or more conditions simultaneously. Research indicates that 98% of those aged 65 and over may have two or more long-term conditions (22) and there is evidence that multi-morbidity is also more prevalent among lower socioeconomic groups (23). Mental health problems or neurological conditions such as dementia alongside physical health problems are a particularly common form of multi-morbidity (24). Patients with multi-morbidity are likely to have high utilisation of services, poorer clinical outcomes, longer hospital stays and are more costly to health services in general. There is some evidence that people with multiple long-term conditions receive poorer treatment from health services and are often perceived as 'problem patients'. Studies have found that patients feel consultation times are often insufficient to discuss multiple problems and there can be disagreement with health care professionals over which is most important (25).

In South Somerset, analysis of the data revealed that increasing costs are explained more by the number of chronic co-morbidities than by age. For example, the average costs for patients with

diabetes increased dramatically with the number of comorbidities (see Figure 11) and the same was also true for dementia (26).

This helped to shape the Symphony Project, which aims to provide integrated health care services, to focus initially on those residents with multiple long-term conditions. Around 20% of people aged 65-69 have 3 or more co-morbidities increasing to a proportion of 40% of over 80 year olds (26) (see Figure 12).

Figure 11: Average costs for patients with diabetes with increasing number of co-morbidities (26)

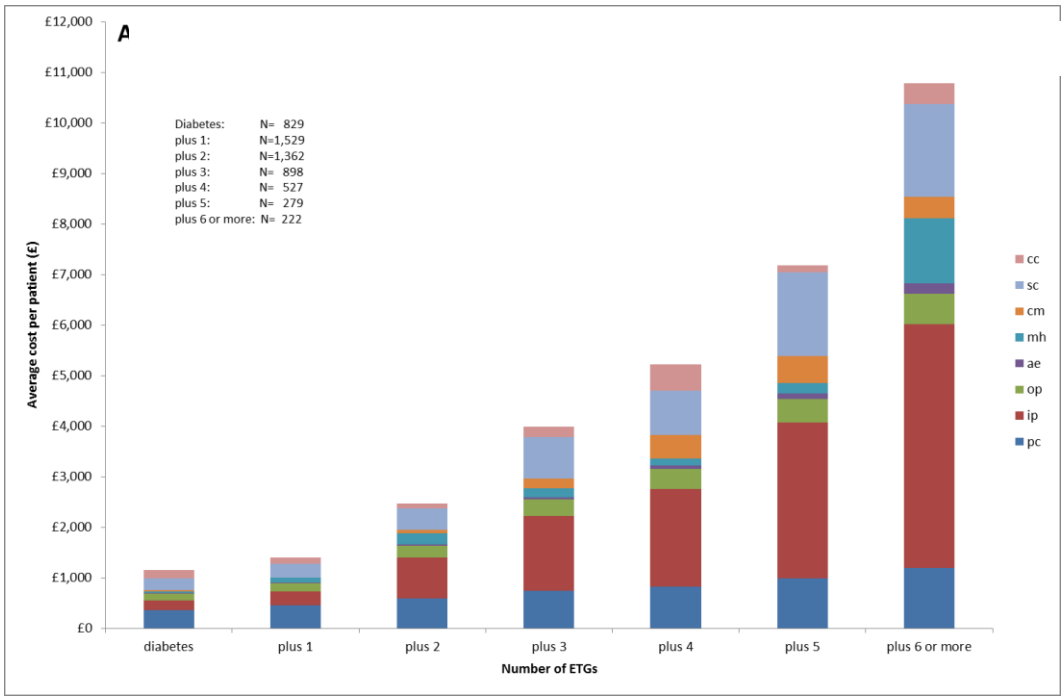
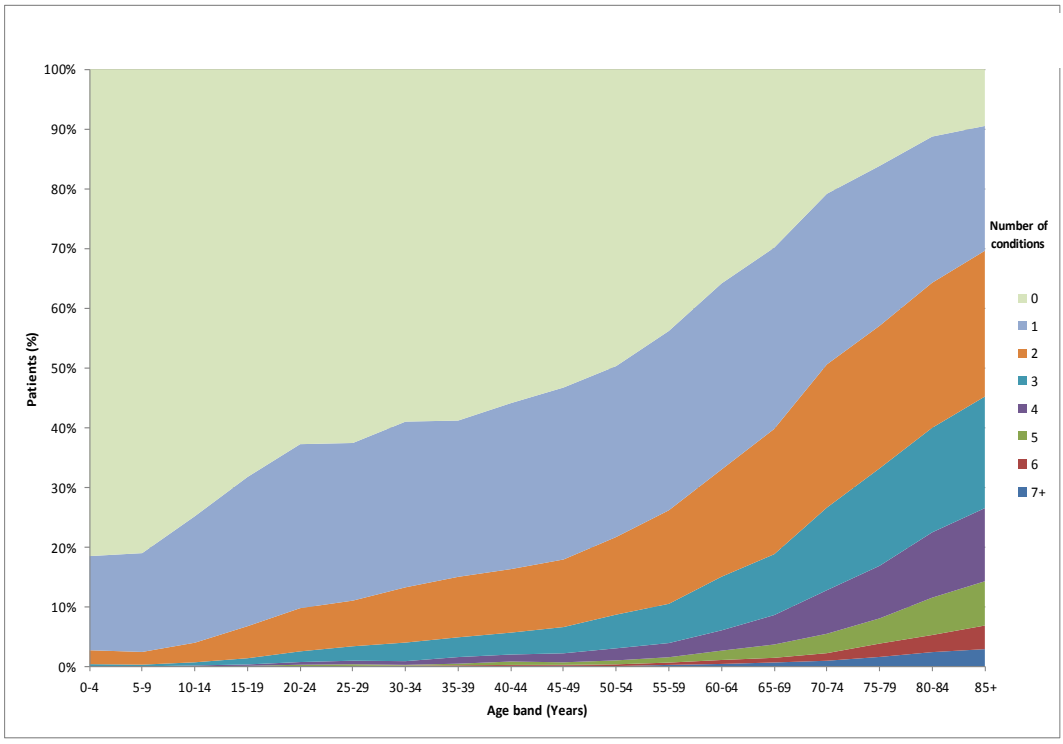


Figure 12: Degree of co-morbidities present with increasing age (26)



Emergency hospital admissions

Avoiding emergency hospital admissions is a major concern for the NHS due to the high and rising costs of emergency admission compared with other forms of care, disruption to elective health care and to individual patients admitted (27). The national rate of emergency admission for acute conditions that should not usually require hospital admission was 1,273 per 100,000 registered patients in 2014-15. The rate in Somerset was slightly lower at 1,093 per 100,000 but still represents a year on year increase as seen nationally (28). A closer look at spend on emergency admissions suggests a potential saving opportunity of £1.9million across the top 15 ambulatory care sensitive conditions. Influenza and pneumonia, COPD and diabetes were the top three conditions identified as offering the greatest saving potential (see Figure 13) when compared to the 25th best performing CCG nationally (29). The Commissioning for Value tools looked at spend on emergency admissions compared to similar 10 CCGs and may therefore provide a more realistic view. The disease pathways with proportionally higher spend in Somerset were again diabetes and COPD, but musculoskeletal and trauma and injuries were also highlighted as areas with the greatest value opportunity. These tools looked back at an entire care pathway in order to explore where particular problems may arise. The trauma and injury pathway highlighted poorer outcomes in Somerset compared to similar areas in terms of injuries due to falls in older people, admissions for fractures and specifically hip fractures in older people and the proportion of hip fracture patients returning home within 28 days (30) (see Figure 14). This illustrates that reducing avoidable emergency admissions will require addressing issues throughout the wider health system including a shift in focus towards prevention.

Figure 13: Saving opportunities across top 15 emergency admissions in Somerset (29)

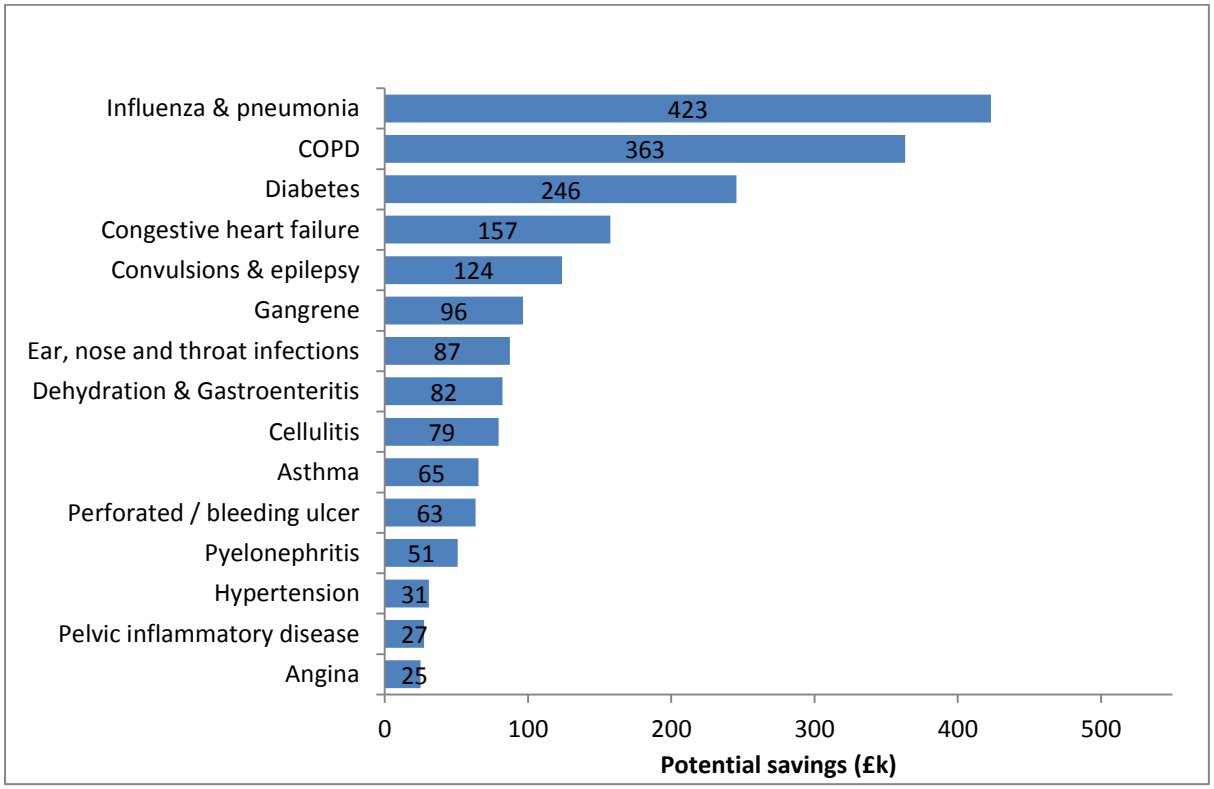
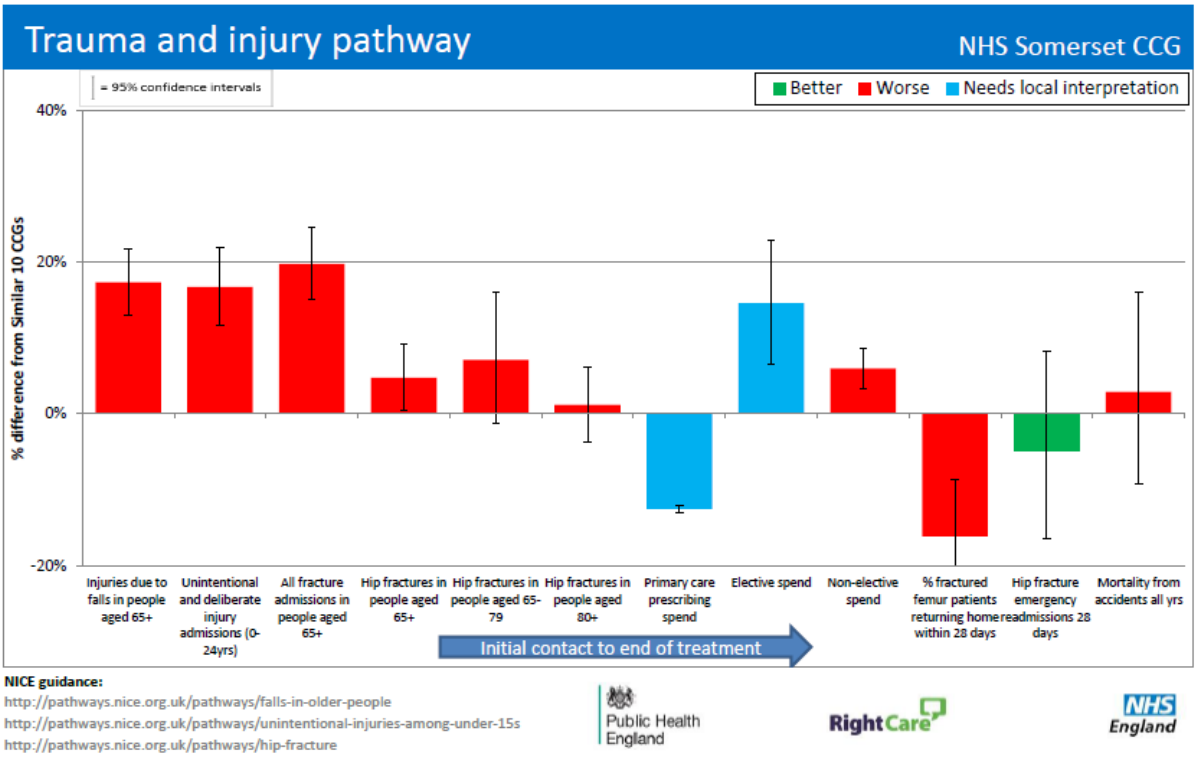


Figure 14: Trauma and injury pathway outcomes in Somerset compared to similar 10 CCGs (30)



NICE guidance:

http://pathways.nice.org.uk/pathways/falls-in-older-people

http://pathways.nice.org.uk/pathways/unintentional-injuries-among-under-15s

http://pathways.nice.org.uk/pathways/hip-fracture

Public Health England

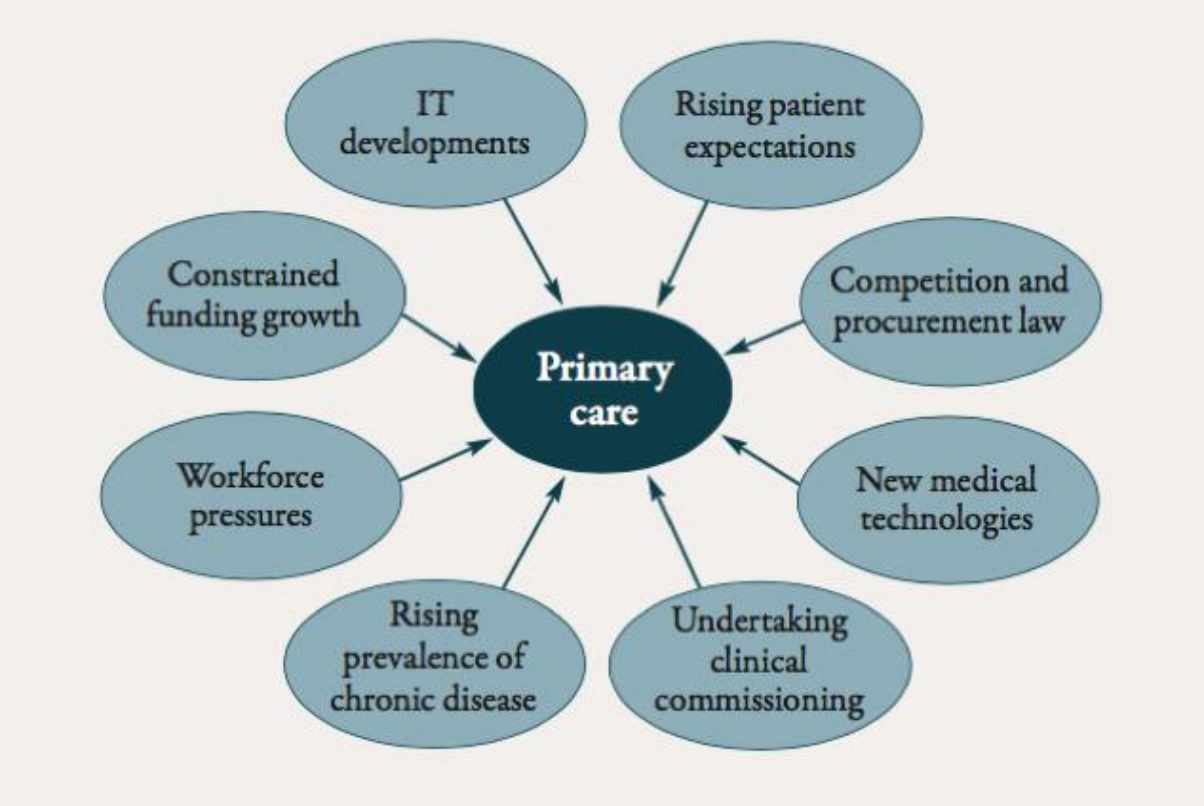
RightCare

NHS England

The need for high quality primary care

Strong and effective primary care is critical to a well performing health system through its contribution to improving patient outcomes and containing cost (31). Research has shown that primary care is associated with reducing avoidable hospital admissions and lower premature mortality when delivered effectively (32). However demand for primary care services in England has been rising significantly over time putting it under considerable pressure. According to a report by the Kings Fund these pressures, outlined below (see Figure 15), likely arise from an ageing population and increase in prevalence of chronic diseases, rising patient expectations, workforce shortages and funding pressures. They considered these pressures as drivers of demand and change (33).

Figure 15: Figure 15: Pressures on primary care in England (33)



The project considered a number of national and international frameworks for identifying high performance in primary care and adapted these for the England context to outline five core principles; that primary care should be comprehensive, patient-centred, coordinated, accessible, safe and high quality (see Figure 16).

Current trends in demand and funding have created a significant funding gap for the NHS which projections from the Nuffield Trust and NHS England suggest could grow to £30 billion by 2021. They suggest that gaining better 'health value' for every pound spent is both necessary and realistic but would require a systems wide approach (34). The opportunities for gaining better value for money can be broadly considered in four areas; improving productivity within existing services, delivering

the right care in the right setting, developing new ways of delivering care and allocating spending more rationally. In terms of primary care, a potential £1.2 – 2.5 billion of savings were identified through improved productivity in existing services and would also have the added benefit of reducing demand for secondary care. The evidence indicates that these productivity gains could be achieved through process and clinical redesign, for example revising appointment processes, shifting job roles and using telephone triage and appointment systems; and better utilisation of estates and procurement. A total of between £2.4 and £4 billion of potential savings were identified from focusing on 'delivering the right care in the right setting' predominantly by preventing hospital admissions through the provision of integrated care but also through shifting acute activity to more cost-effective settings and teaching patients with long-term conditions to better manage their own care.

Figure 16: The characteristics of high-quality primary care (33)

Comprehensive	The organisation is accountable for meeting the majority of patients' physical and mental health care needs, including in relation to wellness, prevention, and acute and long-term conditions care. Where the right skills or services are not available within the primary care organisation, staff play a central role in coordinating virtual care teams involving professionals from other community services and specialists in secondary care, and signposting people to relevant local welfare and other social support services.
Person-centred	This is relationship-based, premised on trust, and concerned about the whole person. Patients and their carers are recognised as core participants in decision-making about care and treatment. When registered with a primary care organisation, a patient benefits from continuity of care with a professional, when that is important to the patient and beneficial for their treatment. Person-centred care takes seriously the ways in which broader life experiences (such as wealth, housing and family circumstances) carry consequences for an individual's health and care.
Population-oriented	The organisation is responsible for providing services not only to those who attend their premises, but also for a specified population. Depending on the model in question, this might include all individuals registered with the organisation; all those who are resident in a specific geographic area; and/or individuals who belong to a specific population group (e.g. the frail elderly or homeless).
Coordinated	Care is coordinated across all elements of health care system, with particular attention paid to overseeing and being accountable for transitions between providers, and building and sustaining open and clear coordination between the patient and their various care teams.
Accessible	Patients experience appropriate waiting times for initial consultation and advice, diagnosis and care; they have 24/7 access to medical and nursing advice and care; and organisations are responsive to patient preferences around access.
Safe and high quality	Care is evidence-based wherever possible, and clinical decisions are informed by peer support and review. Clinical data are shared within the organisation to inform quality assurance and improvement. The organisation is financially sustainable, such that safety and quality standards will not be compromised by resource pressures.

Adapted by the authors from the Patient Centered Medical Home model, as described by the US AHRQ (AHRQ, 2013)

Evidence-based recommendations for primary care development to address the needs of the Somerset population

Healthy active ageing

Healthy ageing, which can be considered as maintaining good health into older age and remaining autonomous and independent over a longer period, is generally considered to improve welfare of the elderly and reduce costs of health and social care (35). The scope of healthy ageing policies is wide and includes improving lifestyles through health promotion and disease prevention programmes, early diagnosis and management of conditions such as atrial fibrillation and hypertension and addressing social factors such as isolation and loneliness. Primary care is at the heart of delivering interventions that promote healthy active ageing.

The WHO estimates that more than half the burden of disease among older people is potentially avoidable through changes to lifestyle (36) and there is increasing evidence that adopting lifestyle changes in old age can yield health benefits (37). Disease prevention programmes for elderly people should consider the overall disease burden rather than single disease models with immunisations, smoking cessation, alcohol consumption, falls prevention and physical activity being key components of any programme. A systematic review of the evidence confirmed that non-smoking, being physically active, maintaining weight within moderate ranges and consuming alcohol in moderation were all associated with healthy ageing (38). Physical exercise in particular is thought to be a strong predictor of healthy ageing being associated with reduced risk of falls, stroke, depression and dementia (35). Regular exercise programme have been found to reduce the incidence of falls by as much as 25% if the focus is on balance (39). It is recognised that there is more doubt about how to engage people to exercise more and changing patterns of elderly individuals is challenging, particularly those who exercised little in earlier life. The evidence suggests that exercise programmes are more likely to be effective if i) they incorporate self-monitoring and regular contact with an exercise specialist promoting moderate intensity activity ii) they are supported by the advice of a health professional accompanied by written material or advice from a primary-care professional and iii) they are home based; unsupervised and informal; used walking as the promoted exercise; involved exercise of moderate intensity and involved frequent professional contacts.

Improving earlier diagnosis can also reduce risk and promote healthy ageing as can addressing issues of poly-pharmacy among the elderly. General practice is well placed to address these issues. In West Hampshire, the CCG made atrial fibrillation (AF) a priority in its stroke prevention activities where GPs were incentivised to find, assess and treat where appropriate. The results already indicate a modest reduction in strokes with more significant reductions predicted and further benefits in reducing mortality and long term disability (40). For further information and examples of improving earlier diagnosis please refer to Delivering a healthier future: How CCGs are leading the way on prevention and early diagnosis.

Provision of supportive environments and reducing social isolation and loneliness is another essential element of healthy ageing. Effective interventions often involve collaborative working with the third sector and older people themselves undertaking voluntary work has been associated with improved wellbeing and quality of life (41). Examples of practice around the country indicate that schemes bringing together health, social care, the voluntary sector and communities have had a

huge impact locally. Models of social prescribing and health connections enable health professionals to "*view patients through a social lens*" (40) and provide a more holistic approach. The positive impact of these programmes on health and wellbeing is increasingly recognised and should be supported and made available through primary care.

Support for frail older people

As an area facing a rapidly growing older population, many of whom have multiple co-morbidities, providing good support for this group is paramount both for patients as individuals and the NHS system as a whole. It is well known that older people are at higher risk of emergency hospital admission with local experience indicating that those over 75 living in rural areas are more likely to be admitted to hospital as emergency cases. Supporting older people in the community before crisis point can help to reduce emergency admissions and admission into long term institutional care. The evidence suggests that there are several tools available for use to help identify people at risk of future emergency admission (36). These tools should be used in primary care to engage in proactive case finding. This could help to identify the cohort of patients with complex needs requiring extra support and who, for example, might be suitable for the Frail Older Person's Assessment Service at Yeovil Hospital (FOPAS). FOPAS is a dedicated assessment unit consisting of a multidisciplinary team who provide a comprehensive assessment for frail older people in medical crisis with the aim of avoiding unnecessary hospital admissions (42). Continuity of care in primary care has been associated with lower emergency admissions and the recommendation is for all people aged over 75 with complex, long-term conditions to be cared for by a named GP (43). Proactive case finding should again be employed to identify these individuals. Support can then also be provided to family and volunteer carers for these patients as this is crucial in the face of the significant proportion of care provided by informal carers.

Particular focus should be placed on conditions known as ambulatory care sensitive conditions (ACSCs) which are those conditions for which hospital admission could be prevented by interventions in primary care. However, attention should also be paid to conditions such as dementia, which may not always be so amenable to preventing emergency admission, but for whom support from primary care and the community is essential. Key issues to address are early diagnosis, information and support for patients and their carers, ensuring there is adequate capacity in support services to meet need especially in the context of a drive to increase diagnosis rates, reduced antipsychotic prescribing and better training and education for health care professionals and carers on how to support people with dementia and how to navigate the wider care system (36).

As well as unplanned admissions, the issue of readmission also needs to be addressed and requires a system wide approach involving integrated information systems, multi-professional communication, early senior assessment, a clear focus on patient flow and involving patients and carers in discharge planning (36). The development of personalised health care programmes for those at high risk and structured discharge planning have been found to be associated with lower rates of readmission (27).

Improving access

Access to general practice is an important issue nationally and locally and is influenced by a number of different elements; practice working arrangements such as opening hours and processes for allocating and booking appointments; distribution of staff particularly in relation to deprivation;

recruitment and retention of GPs and the skill mix e.g. nurses employed within practices; and physical access issues particularly in relation to a rural setting. Improving access to services in Somerset must take account of all these issues, particularly in the context of recent practice closures and the formation of federations to deliver services to a larger geographical area. While this may bring efficiency savings and wider benefits, it also poses challenges with certain areas facing long travelling times and extensive distances to the nearest practice. There is also clear evidence locally that practices are not necessarily located in the most deprived areas where there is greatest need (see Figure 6). Future planning of primary care commissioning and delivery must address these local factors.

Nationally, the evidence shows that timely access to primary care in and outside of usual surgery hours is important and in general, patients and their carers have expressed dissatisfaction over access to out-of-hours provision (15). The recommendation is for local service leaders to review the effectiveness and consistency of local provision of urgent primary care and carry out regular reviews of A&E attendances to inform service redesign. Additionally, it is believed that appointment booking systems and other practice arrangements play an important role in the ability of patients being able to get an appointment. Unfortunately NHS England does not hold information on practice booking systems so it is difficult to assess what systems contribute to improved access. It may, however, be worth exploring this locally to establish any areas of good practice.

There are serious national concerns over the dwindling GP workforce with a shortfall in recruitment and significant numbers leaving the profession. Somerset is an area of the country that is particularly affected by this issue. The GP Taskforce has set out a number of recommendations to tackle GP workforce expansion (4), the majority of which need to be addressed at the national level. There appears to be limited evidence of what can be done locally to improve GP recruitment and retention, however addressing the skill mix employed in general practice may be part of the solution. As part of the BMA's Building the Workforce 10 point plan there is a drive to pilot part-funded employment of clinical pharmacists in general practice with the aim of helping GPs manage the demands on their time (44,45). Somerset is among the pilot sites and it will be vital to evaluate the impact of this pilot intervention. It may also be valuable to collect local data on the number of healthcare professionals other than GPs i.e. practice nurses, healthcare assistants and wider specialists working in general practices across Somerset and explore the potential benefits and challenges of employing a skill mix.

Integrated and coordinated care

Better management of people with long-term conditions has long been a priority for the NHS in England with increasing acknowledgment of the role general practice should play in partnership with other hospital and community care providers. Health and social care policy is gradually moving towards new integrated care organisations with the potential to provide a comprehensive set of health and social care services to patients, as well as an advocacy role in brokering the provision of care(24). Integrated care can take a number of different forms which may focus on the integration of primary and secondary care or the integration of health and social care services. There is good evidence of the benefits of integrated care particularly for older people and those with long-term or complex conditions and that coordinated care provides benefits for service users and their carers particular when a whole picture approach is taken rather than focusing on single conditions (46).

In recognition of the traditional divide between primary care, hospitals and community services and the barriers this creates for providing cost-efficient care that is responsive to patients' needs, the NHS is supporting new models of care to be piloted locally across England. The work is being undertaken via the Vanguard sites, each of which has developed a programme to transform delivery locally within the remit of one of three models of care; integrated primary and acute care systems (PACS) joining up GPs, community, mental health and hospital services; multispeciality community providers (MCPs) which aim to move services out of the hospital and into the community; and models of enhanced care in care homes (47). In south Somerset the Symphony programme vanguard site is working to deliver an integrated primary and acute care system through partnership between the hospital, CCG, GP federation and county council and a single pooled budget. The programme focuses on residents with multiple long-term conditions and aims to see improvements in the way people work together to meet patients' needs by providing integrated and coordinated care from hubs. Treatment is guided by a care plan that patients design in collaboration with their care coordinator and is delivered by a multidisciplinary team. The aim is less duplication, fewer delays, a more proactive service which helps prevent avoidable admissions to hospitals and responds to individuals' wider health and social needs (48). Early results suggest a dramatic fall in emergency admissions, A&E visits and outpatient appointments and also high patient satisfaction. However, in terms of saving money it is possible that it may take 10 years before it is cost-effective and even cost more in the first few years of implementation (49).

A central part of moving towards integrated care is consideration of how to commission services. Many CCGs have started to develop novel models of contracting and commissioning in order to drive transformation and sustainable integration of services (50). The main aims of these models seem to be concerned with holding providers to account for outcomes, for streamlining the delivery of patient care across gaps between providers and to shift the flow of money between providers. The challenges and risks associated with developing new models of commissioning should not be underestimated. The literature suggests the following recommendations in approaching new commissioning arrangements:

- It is essential to continually engage and communicate with providers, patients and the wider community to define the problem and identify appropriate solutions
- It will be important to develop transactional and relational approaches
- Payment mechanisms and incentives will need to be aligned across providers
- Providers will need to develop appropriate governance and organisational models

Conclusion

Although considered a relatively wealthy and healthy part of the country, the population of Somerset has a number of needs associated with its ageing and rural demographic and areas of deprivation and health inequalities. Access to services, social isolation, the rising prevalence of chronic diseases, those living with multiple conditions and emergency admissions are key areas of need that primary care is at the heart of and that will need to be addressed in Somerset's primary care commissioning strategy. Broadly speaking the areas that would be recommended to focus on are healthy active ageing policies, providing support for frail older people, improving access to services particularly for the worst off in society and shifting towards integrated and coordinated models of care. The evidence to support programmes is variable and limited in some areas, however, it is crucial not to rely only on published research but to look at the numerous examples of good practice across the country and learn from these. Additionally, any strategy aimed at improving patient outcomes and gaining better efficiencies needs to be part of a system wide approach if real sustainable progress is to be made.

References

1. Health & Social Care Information Centre. Support & Guidance, Primary Care [Internet]. Available from: http://www.hscic.gov.uk/primary-care

2. NHS England, Public Health England, Health Education England, Monitor, Care Quality Commission. Five Year Forward View [Internet]. 2014. Available from: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

3. Royal College of General Practitioners (RCGP). The 2022 GP: A Vision for General Practice in the future NHS [Internet]. 2013. Available from: http://www.rcgp.org.uk/~/media/Files/Policy/A-Z-policy/The-2022-GP-A-Vision-for-General-Practice-in-the-Future-NHS.ashx

4. NHS GP Taskforce. Securing the Future GP Workforce: Delivering the Mandate on GP Expansion [Internet]. 2014. Available from: https://www.hee.nhs.uk/sites/default/files/documents/GP-Taskforce-report.pdf

5. BMA. GP Vision Executive Summary [Internet]. General Practitioners Committee. 2015. Available from: http://www.bma.org.uk/working-for-change/negotiating-for-the-profession/bma-general-practitioners-committee/gpc-vision-2015/executive-summary

6. Somerset Intelligence. Population Estimates and Projections [Internet]. People & Neighbourhoods. 2015. Available from: http://www.somersetintelligence.org.uk/population-estimates-and-projections.html

7. Somerset Intelligence. Older People [Internet]. 2015. Available from: http://www.somersetintelligence.org.uk/older-people/

8. Somerset Public Health. Somerset: Our County, Joint Strategic Needs Assessment for Somerset Summary 2014/15 [Internet]. 2015. Available from: http://www.somersetintelligence.org.uk/files/JSNA_Summary_2014_15.pdf

9. Somerset Intelligence. Indices of Deprivation 2015 [Internet]. People & Neighbourhoods. 2015. Available from: http://www.somersetintelligence.org.uk/imd/

10. Somerset Intelligence. Commissioning Locality Profile: Bridgwater [Internet]. 2015. Available from: http://www.somersetintelligence.org.uk/files/Bridgwater - Revised.pdf

11. Somerset Intelligence. Commissioning Locality Profile: West Somerset [Internet]. 2015. Available from: http://www.somersetintelligence.org.uk/files/West Somerset - Revised.pdf

12. Somerset Intelligence. Health & Wellbeing [Internet]. 2015. Available from: http://www.somersetintelligence.org.uk/health-and-wellbeing/

13. Public Health England. Public Health Outcomes Framework: Healthcare & Premature Mortality [Internet]. 2015. Available from: http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000044/pat/6/par/E12000009/ati/102/are/E10000027

14. Public Health England. Child Health Profile: Somerset [Internet]. 2016. Available from: http://www.somersetintelligence.org.uk/files/ChildHealthProfile2016-Somerset.pdf

15. National Audit Office (NAO). Stocktake of access to general practice in England [Internet].

2015. Available from: https://www.nao.org.uk/wp-content/uploads/2015/11/Stocktake-of-access-to-general-practice-in-England.pdf

16. Somerset CCG. Exetended Hours Provision. 2015.

17. Somerset Intelligence. Core Accessibility Indicators [Internet]. Travel & Access. 2013. Available from: http://www.somersetintelligence.org.uk/accessibility/

18. Somerset Intelligence. Rural Transport [Internet]. People & Neighbourhoods. 2015. Available from: http://www.somersetintelligence.org.uk/rural-transport.html

19. South Central and West Commissioning Support Unit. Somerset GP Workforce Review September 2015 Update. 2015.

20. Social Care Institute for Excellence. At a glance 60: Preventing loneliness and social isolation among older people [Internet]. 2012. Available from: http://www.scie.org.uk/publications/ataglance/ataglance60.asp

21. Somerset Intelligence. Social Isolation & Loneliness [Internet]. Health & Wellbeing. 2015. Available from: http://www.somersetintelligence.org.uk/social-isolation.html

22. Fortin M, Bravo G, Hudon C, Vanasse A, Lapointe L. Prevalence of multimorbidity among adults seen in family practice. Ann Fam Med. 2005;3(3):223–8.

23. Ogle K, Swanson G, Woods N, Azzouz F. Cancer and comorbidity: redefining chronic disease. Cancer. 2000;88(3):653–63.

24. Goodwin N, Curry N, Naylo C, Ross S, Duldig W. Managing people with long-term conditions. 2010.

25. Noel P, Frueh B, Larme A, Pugh J. Collaborative care needs and preferences of primary care patients with multimorbidity. Heal Expect. 2005;8(1):54–63.

26. Hudson K, (SWC CSU). Supporting New Models of Care: How data informed the Symphony Vanguard Project in Somerset. 2015.

27. Purdy S. Avoiding hospital admissions: What does the research evidence say? 2010.

28. Health & Social Care Information Centre. Dataset: 3.1 Emergency admissions for acute conditions that should not usually require hospital admission [Internet]. Indicator Portal. Available from: https://indicators.hscic.gov.uk/webview/

29. NHS Improving Quality. NHS Somerset CCG: Emergency Admissions [Internet]. NHS Better Care, Better Value Indicators. 2015. Available from: http://www.productivity.nhs.uk/PCT_Dashboard/DetailedView?practiceCode=11X&pctCode=Q65&percentileId=2&yearQtrId=26&indicatorId=608&indicatorTypeId=2

30. NHS England. Commissioning for Value: Comprehensive data packs to support CCGs and NHS England in the regions [Internet]. Available from: https://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/

31. Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Q. 2005;83(3):457–502.

32. Baker R, Honeyford K, Levene L, Jones D, Bankart M, Stokes T. Population characteristics, mechanism of primary care and premature mortality in England: a cross sectional study. BMJ

Open. 2016;6(2):e009981.

33. Smith J, Holder H, Edwards N, Maybin J, Parker H, Rose R, et al. Securing the future of general practice: New models of primary care [Internet]. 2013. Available from: primary care is associated with reducing avoidable hospital admissions and lower premature mortality when delivered effectively

34. Monitor. Closing the NHS funding gap: how to get better value health care for patients. 2013.

35. OECD. Policies for Healthy Ageing: An Overview. 2009.

36. Oliver D, Foot C, Humphries R. Making our health and care systems fit for an ageing population. 2014.

37. Kenfield S, Stampfer M. Healthy behaviours yield major benefits in ageing. BMJ. 2013;347:f5156.

38. Peel N, McClure R, Bartlett H. Behavioural determinants of healthy ageing. Am J Prev Med. 2005;28(3):298–304.

39. Province M, Hadley E, Hombrook M, Lipsitz L, Miller J, Mulrow C, et al. The effects of exercise on falls in elderly patients. A pre-planned meta-analysis of the FICSIT Trials. JAMA. 1995;273(17):1341–7.

40. NHS Clinical Commissioners. Delivering a healthier future: How CCGS are leading the way on prevention and early diagnosis. 2016.

41. Nazroo J, Matthew K. The impact of volunteering on wellbeing in later life. A report to WRVS. 2012.

42. NHS Yeovil Hospital. FOPAS: Make your future with Yeovil Hospital [Internet]. 2015. Available from: http://www.yeovilhospital.co.uk/wp-content/uploads/2015/08/Medical-recruitment-brochure-FOPAS.pdf

43. Department of Health, NHS England. Transforming primary care: Safe, proactive, personalised care for those who need it most. 2014.

44. RCGP, BMA, NHS HEE. Building the Workforce - the New Deal for General Practice. 2015.

45. NHS England. Clinical Pharmacists in General Practice Pilot [Internet]. NHS Commissioning. 2015. Available from: https://www.england.nhs.uk/commissioning/primary-care-comm/gp-action-plan/cp-gp-pilot/

46. Ham C, Curry N. Integrated Care: What is it? Does it work? What does it mean for the NHS? 2011.

47. NHS England. New care models - Vanguard sites. FIve Year Forward View. 2015.

48. NHS England. Integrated primary and acute care systems vanguards. New Care Models - vanguard sites. 2015.

49. Neville S. South Somerset deploys “health coaches” to take pressure off NHS. Financial Times. 2016;

50. Addicott R. Commissioning and contracting for integrated care. 2014.